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APinB

inside this issue

Causes of stress in mental health nursing

Occupational Therapy in mental health

Protected therapeutic and engagement time

Audit of seclusion record keeping

and more...

Advancing Practice in Bedfordshire

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developing excellence

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All articles for submission should be forwarded as e-mail attachments in MS Word (doc) format, to: John.Butler@blpt.nhs.uk

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 2 (3) will receive a free book:

Liz Harris, Development Manager, Services for People who have a Learning Disability (SPLD)
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Editorial:

Jay Nair
Team Manager
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Welcome to our latest edition of the Journal of Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. I would like to take this opportunity on behalf of the editorial group to thank all the people who have written articles to make this journal a success. Following the evolution of the Partnership Trust, we are still optimistic that our social care colleagues will also enrich this journal with their contributions.

Stress at work in the NHS has again been a topic that has resurfaced. The recent publication by the Royal College of Nursing, 'At Breaking Point', suggests that nurses experience more stress than the general working population, as measured using the Health & Safety Executive stress standards. The first two articles in this journal are related to stress: Kevin Watson provides an excellent and detailed literature review of the experiences of mental health nurses both in the community and the in-patient area, highlighting the problems endured by the nursing staff in both of these areas, with which I am sure our nursing readers will be familiar; Helen Hirst's experimental study of the impact of potted plants on anxiety management is an interesting one and, even though not providing any conclusive results, definitely highlights the potential therapeutic value of adding potted plants to the group intervention setting, emphasising the generally accepted view that the aesthetic qualities of nature have a positive impact on the human mind.

The article by Rachel and Sarah provides a snapshot of occupational therapy in mental health. Highlighting the importance of occupational therapy as part of the multi-disciplinary approach to care, the use of meaningful activities in a group or individual setting is a powerful therapeutic tool in stimulating, developing and maintaining a person's skills.

It is very refreshing and encouraging to have a service-user contributing to the journal, which we would like to encourage. Chidozie Izuogu tells us of his experience with Nyabingi (a mental health charity for Afro-Caribbean people). His experience reflects a positive image and not the stigma of being mentally ill that continues to plague our society still. We wish him well in his journey through life, maintaining that positivism.

It has been a perennial problem in in-patient settings in the NHS where staff have not able to provide quality time for staff - patient interaction that has high therapeutic value due to other pressures and demands of work. The evaluation of the pilot project of Protected Therapeutic and Engagement Time (PTET), by John Butler, highlights an initiative that can improve staff-patient relationships and has a definite motivational quality for staff. Well done to all of the staff and patients who participated in the pilot, as such initiatives are important for staff and patient morale.

Finally, we have included a record keeping audit of seclusion by Ruben Campbell and Seema Jassi. This audit shows a very positive compliance with record keeping standards and thus reflects a positive staff attitude to a practice that has important implications for care.

We hope that you will find this edition enjoyable and stimulating, such that you will consider contributing to the journal.

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Mental Health Nursing: sources of stress and strategies for coping

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LITERATURE REVIEW

Introduction

Health care workers at every level, qualified and unqualified, appear to have a higher than average sickness and absence rate than workers in other sectors, and it has been identified that stress may play a leading role in nurses leaving the profession. There are further strong indicators that sickness and absence is higher amongst mental health workers. Numerous small scale studies (Mazure 1995, Moore & Burrows 1996) were undertaken in the 1990s, mainly in England, to try and identify factors that lead to stress and burnout amongst staff in the community, and comparison studies have also been conducted, comparing community based staff with ward based staff. In this paper, the literature from 1994 onwards is reviewed, with a particular focus upon Community Mental Health Nurses (CMHNs) and, where comparisons are made, ward based staff.

Sources of Stress

An examination of the literature on stress within mental health nursing supports the argument that stress does exist within the profession (Dawkins et al 1985, Trygstad 1986, Dolan 1987, Firth et al 1987, Jones et al 1987, Newnes 1990, Sullivan 1993), though many of theses studies have been criticised on the grounds that: the samples have been too small or unrepresentative; a lack of measures to assess stress; and, have too little information to prove reliability or validation.

Carson et al (1991) conducted one of the first studies to be carried out with CMHNs for stress and burnout. Conducting a survey with 61 nurses, he found that a number of factors led to stress – the top three factors were:

- a lack of facilities in the community for the CMHN to refer clients to;
- working with violent or potentially violent clients;
- interruptions while in the office.

In an 18-month follow up study involving 250 CMHN's and 323 ward-based mental health nurses in the North East Thames Region, Carson et al (1994) discovered that there was a change in this hierarchy. Community referral remained the top factor, but

interruptions within the office had overtaken violent clients. They discovered that interruptions was the sixth most commonly cited stress factor, with violent clients being the ninth of ten top stressors for community nurses. Completed concurrently, a further study involving 144 qualified staff from two mental hospitals was conducted by DeVilliers, resulting in the creation of a specific stress questionnaire for ward-based staff.

The measures adopted for each study were identical: Demographic questionnaire (DQ) (Brown & Leary 1994); General Health Questionnaire (GHQ) (Goldberg & Williams 1998); Maslach Burnout Inventory (MBI) (Maslach & Jackson 1986); Rosenberg Self-Attitude Questionnaire (RS-AQ) (Rosenberg 1995); Minnesota Job Satisfaction Scale (MJSS) (Koelbel et al 1991); Coping Skills Questionnaire (CSQ) (Cooper et al 1998); Claybury CPN Stress Questionnaire (revised) (CPNSQ-R) (Brown et al 1995); DCL Stress Scale (DCLSS) (DeVilliers et al 1995).

These two studies indicated that stress exists within the CMHN service and is work related, raising some key points. Whilst previous studies had been conducted on small or highly selected samples, this study was large, used validated questionnaires and measures throughout, and was conducted over an extended period of time rather than being a snapshot of the here and now. However, the published report failed to demonstrate how often the measures and questionnaire were used, nor did it explain how the 717 nurses continued to support the study through an 18-month period. Neither dropout rates nor staff throughput were indicated, which would have been expected during such a study.

Ryan & Quayle (1999) suggested that it is organisational, rather than work-related, stress that CMHNs experience. Of 179 (42%) Irish CMHN respondents, representing a response rate of 42%, a mean score of 4.7 was obtained on the GHQ60, which compares with a mean score of 4.8 on the GHQ28 in Leary & Brown's (1995) UK study of CMHNs, showing a reduction in the levels of stress experienced. Ryan & Quayle (1999) indicated that the source of the stress experienced was due to:

- factors intrinsic to the job;
- managerial roles within the service;
- work-related relationships;
- career development and achievement;
- the organisational structure and climate of change;
- the difficulties of the home/work interface

Whilst they acknowledge that their study contradicts the findings of previous studies, in that it is reported that organisational issues cause most stress, this may be the consequence of using only a limited range of questionnaires. They achieved only a 42% response rate, some of whom were student nurses, unlike in other studies. Their study does, however, indicate high levels of stress in psychiatric nursing.

McLeod (1997) conducted a study of 60 CMHNs, randomly selected from Central England to test his hypothesis that CMHNs with caseloads of long-term mentally ill clients (schizophrenia or bipolar disorder) would suffer more stress than a CMHN with a mixed group consisting of enduring mental disorders or neurotic / psychological problems (affective and anxiety disorders), or a CMHN with primary / generic clients (anxiety, affective, transitional or adjustment disorders). Each group of 20 CMHNs completed the GHQ28: on the GHQ28 questionnaire, those working with the long-term mentally ill scored above the threshold of 5, at 8/20 (40% were above the threshold); those with a mixed caseload scored 4/20 (20% were above the threshold); and, those with the neurotic

caseload scored 3/20 (15% were above the threshold. The group working with the more severely mentally ill reported greater stress levels.

McLeod (1997) acknowledged that the small sample was not indicative of the CMHN population as a whole, but it did seem to go some way to prove that the more severe the illness of the client group, the more stress the mental health worker can be under. He also found that the CMHNs who were working with the more severely ill were younger and less experienced than those working with primary care patients, and that lower graded staff were responsible for the more severe mentally ill. Qualifications such as the CMHN ENB811 and ENB812-diploma post-basic courses were held mainly by the higher graded staff resulting in an imbalance of skill-mix throughout the service area.

Majomip, Brown & Crawford (2003) conducted a semi-structured interview about stress and its impact on home life with twenty nurses. In a grounded theory analysis, they found conflicts between the work and home roles of the participants. The aim of the study was to explore those conflicts. Difficulties were being experienced due to the demands of home life and organisational changes at work. This led to more stress, periods of illness and to a re-assessment of their work role. As this was a hitherto neglected area of research, the inter-relationship was explored using a qualitative and grounded theory approach, which involved conducting open structured interviews.

They concluded that all the roles undertaken by CMHNs should be considered when looking at stress. The balance between home and work kept crossing boundaries, especially when child-care became an issue, leading to role conflict. Stress and sickness became the norm rather than the exception, leading to burnout (Ray & Miller 1994). The stress experienced by participants was highlighted thus, ‘looking around me here, I know of four nurses who are off because of stress-related problems’, and there is growing evidence to support this finding (Rabin et al 1999).

Majomip et al (2003) also felt that there was a lack of formal and informal support for CMHNs, as they worked outside of the institutions that historically provided it. They also felt that as the nursing role has become extended, out of hours working to enable contact with other agencies has become common practice, making it more difficult to separate work from family time. Specific difficulties relating to the care of people with long term and enduring mental health problems were highlighted.

Comparing CMHN & In-patient Mental Health Nurse Experiences

The Claybury CPN Stress Study (Fagin et al 1994) involved the collection of data from 250 CMHNs and 323 ward based psychiatric nurses (WBPNs). Conducted at the time of the closure of a large psychiatric hospital, with many patients being transferred back into the community, the results clearly showed that CMHNs were under a great deal of work-related stress: 41% of CMHNs scored highly on the GHQ28; 48% scored highly on the MBI. This is well beyond the accepted norm, being almost double the rates report by Carson et al (1991) in their earlier research. However, CMHNs reported higher levels of job satisfaction and lower rates of burnout compared to their ward-based colleagues. Some 71% of WBPNs felt that their job security was threatened, mainly because of the closures taking place. WBPNs had greater feelings of depersonalisation / detachment than the CMHNs and were less likely to report a sense of personal achievement within their working

environment. A certain amount of dissatisfaction was experienced by both groups, especially around salary, status and the low levels of respect from the general public.

It is worth noting that staff cover has always been an issue, with most wards being perceived as understaffed. Changes in the service and hospital closure, especially if redundancies are involved, would be stressful in any industry and thus this study cannot truly reflect the normal stresses experienced. As indicated, there is a great difference between this study and the smaller scale study of Carson et al (1991) – perhaps a consequence of the projected hospital closure becoming a reality. A follow-up study of the respondents may have given a different picture. It is also worth noting that the nursing shortage of the last few years has greatly reduced the need for redundancies within the NHS and, while no job is secure, the stress of feared redundancy has reduced.

Comparing CMHN, Health Visitor & District Nurse Experiences

In her comparative study of health visitors, district nurses and CMHNs, Snelgrove (1998) examined self-reported stress and job satisfaction in one health authority in the UK. She used the GHQ12 and an undisclosed 47-item likert scale questionnaire, compiled by herself – the latter was validated by asking nurses and health visitors to examine the terms and items for clarity and relevance. The numbers were small: 68/122 health visitors (HV), 56/122 district nurses (DN) and 19/33 CMHNs responded. The sources and levels of stress were examined in relation to each speciality. All of the respondents worked at Grade ‘F’ or ‘G’ level and as part of a team with two or more colleagues of the same discipline.

Health Visitors showed higher levels of stress on the GHQ12 (14.3) than the two other groups (DNs = 12.6 & CMHNs = 9.7). The most significant sources of stress for the Health Visitors were: worries over decision-making; quantifying work; the home / work interface; not liking a colleague; and, feelings of emotional pressure. For the District Nurses, they were: lack of time on visits; and, physical exhaustion. For the CMHNs, they were: the stress of failed visits; and, feeling pressured. Using Snelgrove’s own questionnaire, 25% or more showed ‘considerable to extreme stress’ due to organisational issues, a lack of resources and administrative duties. For the HVs and DNs, 60% found that the ‘lack of resources’ caused considerable to extreme stress. HVs reported less job satisfaction than the other groups.

Snelgrove showed similarities between her study and that of Hipwell et al (1989), indicating few differences in the levels of stress between specialities. Her study also supports previous research that suggests that stress in nursing may vary as a function of the speciality (Marshall 1980, Slater 1993). Whilst there were similarities between all three groups, the severity of the source of stress seems to be a function of the demands peculiar to each occupational group.

Although an interesting study, it demonstrates the difficulty researchers face when trying to compare groups who work in different fields of nursing and will have had different training routes. The study did not account for the impact of the development and changing nature of the nurse – patient relationship, the impact of the core nature of the role, likely emotional pressures, patient recovery rates and contact time on job satisfaction between the three occupational groups. Due to the nature of mental illness, CMHNs take a long-term view of the person’s health and recovery, offering

support and working with them on regular and long–term basis, which may increase their understanding of the individual, their situation, and consequently reducing stress for the CMHN and giving job satisfaction as the individual develops emotionally during their recovery from illness. These factors may account for HVs reporting lower job satisfaction and higher levels of stress

Developing Intervention for Stress

Cottrell (2000) conducted a small-scale action-research study examining stress and job satisfaction in CMHNs working in a semi-rural area of Wales. He hypothesised that 'many of the problems typically categorised as "work stress" may well be symptoms of underlying and possibly unrelated organisational issues'. Fitter (1987) identified eight factors as potential sources of stress in nursing: responsibility; workload; physically arduous work; shift work; overtime and covering for absent colleagues; interpersonal conflict; responsibility for training; uncertainty and unpredictability; and, keeping up with change. Jones et al (1987) and McGrath et al (1989) identified similar factors in other studies. Sullivan (1993) and Ryan & Quayle (1999) also noted 'that organisational constraints and administrative requirements may become more significant stressors than direct client care itself'. Using the 120-item self-report Pressure Management Indicator (PMI) (Williams & Cooper 1998), which encompasses workplace stressors, Cottrell (2000) received 32/58 postal returns. Major stressors for the study sample were: workload; managerial roles; relationships; and, the balance between home and work.

Cottrell (2000) used this information to develop protective and risk factors, and suggested a number of interventions for stress management. A matrix of organisational stress management interventions was developed, to be offered on an individual, group and organisational basis (Table 1).

Cottrell (2000) emphasised caution when using stress management interventions, in highlighting that enduring work stressors are not overlooked, as such would limit the impact of stress management. A model of supervision, based on Procter's (1986) tripartite model of support, education and oversight, was introduced. The planned interventions were designed to facilitate emotional contact through planning time for clinical supervision and managerial review on a regular basis. Clinical supervision was introduced through a planned and systematic process of awareness raising and skills training. Study participants reported that their levels of stress were reduced, providing an atmosphere that provided greater control and autonomy, assisted with problem solving, facilitated interpersonal awareness and allowed for feedback and advice.

Table 1:

Stress Management Matrix

Primary = stress reduction	to reduce exposure to psychologically harmful working conditions
Secondary = stress management	to enable people to utilise the skills necessary to deal with potentially harmful working conditions
Tertiary = stress treatment	to treat people who have been harmed in some way by work-related stress

summarised by Murphy (1986) and adapted by Schaufeli & Enzmann (1998)

Cottrell (2000) concluded that: workload and working relationships were the major stressors for CMHNs; clinical supervision was effective in helping to reduce occupational stress; and, 'the provision of time to reflect upon practice demonstrates a Trust's commitment to an organisationally endorsed process whereby staff may address practice and personal issues as an integral part of their working day."

Cottrell's study (2000) thus attempts to address the stress that CMHNs are experiencing, and principally through: a model of supervision that allows for a two-way dialogue to take place between the different levels of the organisation; and, keeping the CMHN informed of what is going on regarding organisational change, allowing ventilation of staff through this process. He demonstrates that stress can be managed and reduced in the workplace through supervision and stress management.

Burnard et al (2000) surveyed 614 CMHNs in Wales, of whom 301 (49%) responded. Respondents completed a number of validated instruments measuring stress, burnout and coping, together with a demographic questionnaire. Three open ended questions were included to determine their views of the sources of stress in the workplace and to investigate which coping methods were used. They established a working hypothesis, that 'there is evidence that community mental health nurses experience stress and burnout related to their work', as supported by the literature (Parahoo 1991, Fagin et al 1995, Mcleod 1997, Snelgrove 1998). They asked three key questions:

- What are the three things that cause you most stress?
- What would you say was the most stressful thing that has happened to you at work in the last month?
- What factors do you feel help you to cope with your job as a CMHN?

The data was analysed using Clamp & Gough's (1999) content analysis. The most frequently reported stressors are indicated in Table 2.

Table 2:

Workload / time-related issues	101 (14.6%)	Client-centred issues/general	43 (16.7%)	Support from colleague / manager etc...	285 (42.9%)
Paperwork / administration	96 (13.9%)	Client centred issues - behavioural	26 (10.1%)	Personal approaches	74 (11.2%)
Client-related issues	79 (11.4%)	Paperwork/ admin	22 (8.6%)	Supervision	66 (9.9%)
Case overload	56 (8.1%)	Other agencies / disciplines	21 (8.2%)	Interests / hobbies	48 (7.2%)
Poor resources	52 (7.5%)	Team/Trust changes	21 (8.2%)	Role as a CMHN	40 (6.0%)
Lack of supervision / support	30 (4.3%)	Inter-personal problems	20 (7.8%)	Happy home life	32 (4.8%)

They divided the sources of stress into two broad categories: those which are related to the demands of working with patients, and those related to other aspects of the work. A picture of CMHNs perceiving themselves to be overworked, struggling with paperwork / administration issues, too many clients and concerns about their client group, emerged. This study thus reinforced the findings of the Claybury study (Carson et al 1995). Difficulty arising from relationships with clients was identified as the main stressor for the CMHN, concurring with Coffey's (1999) study of forensic CMHNs.

CMHNs reported using a variety of coping strategies, which included peer support, personal approaches, good communication skills and clinical supervision. Whilst being complementary about the support received from colleagues and managers, having a 'satisfactory and supportive life outside of the job' was regularly cited as a strategy for coping with stress. CMHNs appeared to favour informal approaches to coping with stress, with only a small number favouring clinical supervision – a finding that is supported by other studies (Trygstad 1986, Carson et al 1995, Coffey 1999). The most favoured coping strategy found in all of these studies was support from colleagues, managers and other professionals.

They concluded that the effects on individuals of stress and inadequate methods of coping may be problems of mental or physical health and a reduction in job satisfaction. For the organisation, the effects of stress may be many, including high absenteeism, poor job performance and reduced efficiency and effectiveness, low staff morale and high staff turnover (Rees & Cooper 1990). They also concluded 'that a range of factors such as organisational pressures and factors related to working with patients are important in determining stress levels, and that informal rather than formal support networks are the preferred methods of coping'.

Review of the Major Studies: summarising the findings

Edwards et al (2000) reviewed the literature relating to stress and burnout experienced by CMHNs: 17 papers were identified, of which 7 focused on community mental health teams (CMHTs) and 10 focused on CMHNs. They cited that 'there is a growing body of evidence that suggests that many CMHNs are experiencing considerable stress' (Parahoo 1991, Carson et al 1995, Fagin et al 1995, McLeod 1997, Snelgrove 1998) and that the causes of stress in the workplace are complex and multi-factored. The evidence suggests that stress and burnout not only affect the level of performance and the success of interventions by mental health workers but also job satisfaction and ultimately their own health (Carson & Fagin 1996). Mental health care workers face additional strain by the very nature of their professions and as a result may be more at risk than their colleagues who work in a more physical environment (Moore & Cooper 1996, Nolan et al 1995). Increased workloads, understaffing, job insecurity and continuing, rapid organisational change have all been identified as major sources of stress amongst mental health workers. So too has the increasing intensity of work with more highly disturbed and potentially violent and dangerous patients (Thomas 1997).

Leitier & Harvie (1996) reviewed research articles in relation to stress and burnout. Their review suggested that 'burnout occurs as a result of problems arising through excessive demands associated with caseloads or personal conflict that interfere with opportunities to attend thoroughly to the needs of the service recipients'. They concluded that these problems are 'often exacerbated by insufficient support from colleagues, family or the nature of the work

itself'. Mental health nurses and CMHNs have been identified as 'the professional groups with the highest sources of stress along with speech therapists' (Rees & Smith 1991). Jones (1987) concluded that two major factors emerged as potential sources of stress for mental health nurses: patient contact and administrative / organisational factors. Other specific sources of stress include: staff shortages; conflicts with patients, relatives and staff; a lack of resources; interpersonal involvement; difficulties in nurse relationships; poor supervision; and, home / work conflict (Trygstad 1986, Travers & Firth-Cozens 1989, Dawkins et al 1985).

Parry-Jones et al (1998) looked at the impact of care management practice on social workers, community nurses and CMHNs in Wales. Their research indicated increases in stress and decreases in job satisfaction, which was associated with increased workload and administrative duties combined with reduced time for service-user and family contact. Due to a small response rate, it is not possible to generalise this study.

In 1993, the Sainsbury Centre for Mental Health collected data on the current organisation and operation of the CMHTs. They identified 517 teams in 144 district health authorities. 60 individuals from 302 teams responded by supplying data on job satisfaction, team role clarity, personal role clarity, team and professional identification, sources of pressure and reward, and features of practice (size and composition of caseloads). Overall, team members reported team and personal role clarity and positive identification with both the team and their discipline (Onyett et al 1997). Major concerns were threats to their efficacy arising from a lack of resources, work overload and bureaucracy. Team members cited contact with team colleagues and multidisciplinary working as being the most rewarding part of their job along with working directly with service-users and being clinically effective (Onyett et al 1995). 44% of respondents were in the 'high' burnout category for emotional exhaustion, as based upon the norms for mental health workers. This included 45% of community nurses, 54% of social workers and 63% of consultants. CMHNs had significantly higher caseloads, though caseload size, composition and the frequency with which service-users were seen were neither associated with job satisfaction nor burnout (Onyett et al 1997).

Wykes et al (1997) examined the levels of stress and burnout that affect community mental health staff. There were indications that staff experienced high levels of burnout due to work stressors. Further evidence supports the view that burnout is the consequence of increased workload, increased administration and a lack of resources.

Parahoo (1991) conducted a study in Northern Ireland and identified 30 factors that contributed to CMHN job satisfaction and 36 that did not. It was cited that the most frequently identified factors contributing to job satisfaction were 'working independently', 'being ones own manager' and 'being an independent practitioner'. 70% of respondents rated their job satisfaction as 'high' or 'very high'.

Edwards et al (2000) concluded that stressors intrinsic to the job were: increased workload; administration; time management; inappropriate referrals and safety issues, especially where seeing potentially dangerous or suicidal patients. Role stressors were identified as: role conflict; uncertainty and changes in role or levels of responsibility. Other stressors were concerning relationships, including the lack of supervision. Organisational stressors included the structure of the organisation

and the climate of NHS reforms, general working conditions, a lack of support and lack of funding.

Edwards et al (2000) conducted a study on stressors, moderators and stress outcomes, with the following objectives: to examine the variety, frequency and severity of stressors amongst CMHNs; to describe the coping methods used to reduce work based stress; and, to determine stress outcomes. A number of validated questionnaires were used including a tool designed by the authors and used by Burnard et al (2000). The ten most and ten least stress inducing factors were identified from the findings using the CPN Stress Questionnaire (Revised). The top four for each category were:

Most Stressful:
- Not having the facilities in the community that I can refer my clients to
- Trying to keep up good quality care in my work
- Having too many interruptions in the office
- Long waiting lists for client access to services

Least Stressful:
- Not been able to rely upon support of colleagues
- Having to carry drugs around
- Communication problems with colleagues
- Receiving supervision that I don't find helpful

Considering coping strategies: 93% of the CMHNs felt they could discuss their work-related problems with their work colleagues and found this a way of alleviating their work-related stress; 86% found their managers to be supportive. The most and least commonly used coping methods were:

Most Common:
- Having a stable home life, separate from my work
- Life outside of work, that is enjoyable, healthy and worthwhile
- Talking to people I get on with
- Looking forward to going home at the end of the day

Least Common:
- Having team supervision
- 'One to one' supervision
- Reminding myself that others have placed their trust in me
- Having a satisfying sex life

On the GHQ12, 35% of CMHNs crossed the threshold of 'psychiatric caseness' (having or developing a mental illness) and there was significant positive correlation between GHQ12 scores and the MBI emotional exhaustion scale, the MBI depersonalisation subscale and the total Rosenberg Self-Esteem score. The MBI scales indicated high burnout rates for the CMHN sample group.

Having used a number of validated stress and burnout questionnaires, this is a very good, comprehensive and in-depth study of the levels of stress experienced by CMHNs in Wales, complementing the companion study of Burnard et al (2000).

In Conclusion

In the United Kingdom (UK), there have been a large number of reports that between 25-50% of National Health Service (NHS) staff have experienced significant personal distress (Weinberg & Creed 2000). There exists a substantial body of evidence to suggest that high stress levels are endemic throughout the NHS (Anderson et al 1996) and that many of the stressors may be unique to health care (Payne & Firth-Cozens 1987).

In the last 10 years there have been a number of studies of the impact of stress and stressors in the psychiatric nurse's work-place (Carson et al 1994, Fagin et al 1994, McLeod 1997, Snelgrove 1998, Ryan & Quayle 1999, Cottrell 2000, Edwards et al 2000, Burnard et al 2000, Majomip et al 2003). The conclusion of each study indicates that mental health nursing in both ward and community settings is stressful to the workforce. High levels of stress and burnout have been identified, especially in community mental health nursing. Carson et al (1994) conducted one of the largest studies of mental health nurses, finding a number of factors that could lead to stress for community-based workers. This was quite unique, as previously nurses had worked in large institutions where there were a number of staff to call for support and the hospital provided facilities for the day care of the patients. The fact that at the time of their study the large hospitals were in a state of closure may have been a contributing factor adding to the stress levels of the CMHN.

Organisational issues, such as managerial roles within the service and work-related relationships, has also been seen to be a major stressor for the CMHN. Lack of support and training opportunities within a climate of change increases the stress experienced.

Parry-Jones et al (1998) found, since the implementation of the NHS and Community Care Act, that stress levels had increased and levels of job satisfaction had decreased as more demands were made of the CMHN's time. It was clear that these stressors were not indicative to that study sample, as evidence exists to support that they were not alone with those problems (Brown & Leary 1995).

Snelgrove (1998), in her comparative study of community nursing staff, demonstrated the difficulties of research when comparing workers from different nursing fields. While they may all work in the community, their roles and client groups vary greatly. Her study supported the work of Guppy & Gutteridge (1991) as a representation of 'accentuated stress due to working in an organisation such as the NHS with stress-related nursing duties'.

Edwards et al (2000) reviewed the literature on stress, burnout and stressors and drew together all of the studies to date. Edwards et al (2000) went on to replicate the Carson et al (1994) study, drawing similar conclusions in that CMHNs are suffering from high levels of work-related stress and high levels of burnout. A number of stressors have been identified by all of the studies undertaken in this field and further research needs to be carried out on larger groups of CMHNs in gaining a clearer picture.

In conclusion, I feel that the studies that have been reviewed have demonstrated that CMHNs do experience a high level of stress in the working environment and this can lead to burnout. These studies confirm that CMHNs continually juggle a multitude of responsibilities demanded by their various roles. These studies have also highlighted the adverse impact of occupational stress on health and life expectancy.

Dissatisfaction with their work and a lack of personal achievement have led to feelings of depersonalisation, not relating well to their client group and severe long-term feelings of a lack of personal achievement.

As CMHNs are central to the Government's community care policies, more care will have to be given to the emotional needs of the people who will deliver care if these care policies are to succeed. There is a need to address the stress that is experienced by CMHNs – whether through initiatives such as anxiety management and relaxation

courses for the staff (and thus not only for service-users), and through effective clinical supervision and support systems. While it may be difficult to reduce the stressors that exist within the service, we can effectively treat the stress it produces, reducing both the amount of stress and burnout that is experienced.

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Determining the Impact on Clients when Potted Plants are present within their Anxiety Management Sessions

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RESEARCH STUDY

Introduction

Research conducted mainly in the United States suggests nature matters to our health because it has a calming effect and it can help adults shrug off stress. Green spaces may help individuals mentally by providing a sense of control in their lives, and adults may be less overwhelmed by their problems when there is near-by nature (plants, grass, trees). There is less British evidence. There are particular qualities of the plant-person relationship that promote people's interaction with their environment and hence their mental well-being. The needs of people with mental health problems are frequently not met by services. An experimental study was used to collect data from adults attending the Bedfordshire & Luton Partnership NHS Trust anxiety management courses.

Defining Anxiety

Anxiety disorder is the most common mental health problem, and there is a demand and long waiting lists for anxiety management courses. Anxiety disorder is defined as a combination of physical and psychological manifestations that are not attributable to real danger (Powell and Enright 1991). Anxiety symptoms, including poor concentration and being easily fatigued, may begin for a number of reasons, such as making important decisions, changing routines or jobs, coping with divorce or bereavement, and these can exceed coping skills, lead to high levels of stress and anxiety can result. Most people who seek treatment for anxiety consider themselves as nervous and excessive worriers, and pessimism and negative thoughts can be a deficit, as these personality traits are the seeds from which anxiety problems grow (World Health Organization 1999). Moderate levels of anxiety are normal, and high arousal in situations where real danger is present will enable survival: the fight or flight response. However severe anxiety is not helpful and can prevent the capacity to take in new information, plan appropriate responses and carry out daily activities (WHO 1999).

Rationale for this research study

Many National Health Service treatment environments are uninspiring and institutional – adding plants might be a cost-effective

intervention. Anxiety is a common problem and many of the referrals to a community mental health service are for anxiety management. The purpose of this study was to investigate if service users attending the anxiety management courses benefited from an environment with plants, and if the course was effective in reducing anxiety symptoms, by measuring if there was a reduction in anxiety post treatment.

Background

There is an increasingly accepted belief (Relf 1992) that interaction with plants, both passive and active, can change people's attitudes, behaviours, perceptions and even physiological responses (heart rate, blood pressure and muscle tension). In reality there is a lot of very subjective and anecdotal evidence of plants playing a role in helping people such as relieving mental fatigue. There is very little scientific research to document the impact of plants, which has mostly focused on the natural setting of plants, whereas the structured use of horticulture, which developed from rehabilitation and occupational therapy, has been used in many different forms as a therapeutic intervention / treatment of illness and disease (Sempik et al 2003). This is because therapeutic horticulture has been used successfully in promoting health gain, mental well-being, social cohesion, employment and development of skills.

Related literature

Literature on nature in the environment and the benefits on mental health are quite limited in the United Kingdom. However, where allotments have been used in the area of mental health, they have been reported as having had great occupational therapy potential. As qualities of the plant-person relationship promotes a person's interaction with their environment, their health, functional level and mental well-being improve, which includes a positive impact on anxiety (Fieldhouse 2003). The plant-person relationship is described as involuntary attention, as it is considered effortless attention, such as simply noticing the sights, sounds and smells of your environment (Kaplan 1995). What is not known is if plants used passively, as an aesthetic focus in treatment sessions, still have the same plant-person relationship effect.

Literature on nature and the benefits is more obvious in the USA. People do (reportedly) respond to plants in their environment, and when combined with the aesthetic qualities of plants, this belief is becoming increasingly accepted (Relf 1992). For instance, the restaurant industry has found that a customer feels happier when potted plants or fresh flowers are present and s/he is more likely to return to that restaurant. Furthermore, although people do not recognise it, we often think in terms of plants because our language, history, art and literature are filled with plants as metaphors, similes, icons and symbols (Relf 1992). The problem is that there is a paucity of published scientific evidence of the psychological or value-added role that plants play.

Studies centred around the psychological restoration / effects of the environment, found that natural settings were preferred over urban settings when the participant was rated as being fatigued. Fatigue may result in a lowered ability to concentrate, heightened irritability and impaired functioning – symptoms found in anxiety. It was proposed that the best way to get individuals to appreciate the restorative benefits of nature were through personal experience (Herzog et al 2002). Interestingly, a study focused on visual contacts with plants by adding potted plants to a room after a stressful event (video scenario) had taken place, measuring the

psychological (attention deficit) and physiological well-being (blood pressure) of participants before and after a view of the plants (Ulrich and Parsons 1992). Particular emphasis was given to the stress-reducing benefits of plants, and whilst they found that performance decline in general was a consequence of stress, a view of plants increased attention.

A clinical study of individuals recovering from cancer (Cimprich 1993) provides a scientific link between the restorative experience of nature and enhanced human effectiveness. The authors were interested in identifying why individuals who had received hospital treatment for cancer and had been discharged with a positive medical prognosis, had coping difficulties, which prevented them from attainting optimal treatment outcomes. The participants (all individuals recovering from cancer) were randomly assigned to either the experimental group, who consented to participate in three restorative activities such as walking in nature or gardening (of at least 20 minutes each per week), or the control group, who received no information about restorative activities. Although both groups showed severe attention deficits post surgery and pre intervention, the experimental group showed significant improvement in attention performance versus the control group at post intervention. The intervention appeared to have had an impact on life styles / quality, as participants in the experimental group were more likely to return to work as well as start new self-help projects. What is strikingly similar about these studies is the effect of very modest interventions in providing a benefit to individuals in reducing stress or recovering from cancer or learning to manage their anxiety.

Anxiety management

Anxiety management involves educating individuals about anxiety and generalised anxiety symptoms. Generalised Anxiety Disorder (GAD) is characterised by persistent, generalised and excessive feelings of anxiety, which result from excessive worrying (Lydiard 2000). Typically, worries include the possibility that the individual or a relative may become ill or have an accident, exaggerated concerns about finances and / or excessive worries about work or social performance. Occupational therapy intervention teaches individuals: positive thinking / challenging negative thoughts, the link between mind and body, structured step-by-step problem solving, deep muscular relaxation, breathing techniques, assertiveness and healthy lifestyle options. Occupational therapists working in adult mental health increasingly facilitate anxiety management courses to provide psychological based intervention in order to counteract the short-term effects of drug treatments such as benzodiazepines, which are commonly prescribed by general practitioners (Prior 1998). This Trust offers eight-week anxiety management courses, based upon cognitive behavioural therapy, which has been shown to be therapeutically effective and time-efficient in reducing anxiety. The course is run by two senior facilitators: one a psychiatric nurse and one an occupational therapist. The content of anxiety management courses, as well as methods for reducing anxiety, have been widely published, although there is limited (clinical and research) statistical data to demonstrate the effectiveness of these courses or determine that the course techniques used are beneficial to service users.

Research methodology

This research study set out to investigate if any reduction in the anxiety scale score at the end of the eight-week anxiety management course was related to green potted plants being added to their sessions.

In the design (pre-test / post-test, with a control), there were two groups of participants, who were both tested before and after the treatment period. One group received potted plants and the second group acted as the control group. Data was gathered from the completed questionnaires for a total of four anxiety management courses held within the Trust over a 6-month period – each weekly course session was 90 minutes in duration. For two of the courses, plants were present, whereas for the other two courses, no plants were present. The anxiety management programme content for all courses was the same. The independent variable was the experimental condition and the dependent variable was the post-treatment anxiety score.

There were 12 participants in the plant cohort and 14 participants in the no plant cohort. All 26 participants (18 female and 8 male), whose ages ranged from 19 to 52 years, met the inclusion criteria of scoring 8 and above on the anxiety scale and 9 and below on the depression scale of the Hospital Anxiety and Depression Scale (HADS). Two standardised measurement tools were used to provide a baseline and evaluate intervention (any difference in symptoms). These were the HAD Scale (Snaith and Zigmond 1994) and the Beck Anxiety Inventory (Beck 1993). The participants completed the two questionnaires on two occasions: pre-treatment and post-treatment. At the last group session, participants also completed a User Evaluation Questionnaire which was devised to obtain valid and reliable responses that could be statistically analysed. The ethics of conducting this study needed consideration: participants were provided with an information sheet; written consent was obtained from each participant; and, all of the data collected was treated as strictly confidential.

Findings

The research data was analysed using the Statistical Package for Social Sciences (SPSS) for Windows. This yielded both descriptive and inferential statistics. At post-treatment, both groups showed a statistically significant ($p<0.05$) reduction in anxiety symptoms. The post-treatment Beck Anxiety Inventory t-test showed that the group with plants present experienced a reduction in anxiety symptoms when compared with the group without plants, and this finding was statistically significant ($p<0.05$).

The post-treatment Hospital Anxiety and Depression Scale t-test was not statistically significant ($p>0.05$) and did not show a reduction in the anxiety score for participants with plants. The first hypothesis, that there will be a difference between the two groups, with the experimental group showing a reduction in anxiety scores post treatment versus the control group, was confirmed by the BAI scores but rejected by the HADS score.

Therefore, the findings are ambiguous and only partially support adding plants to the environment.

A possible explanation for this limited finding relates to the small number of participants ($n=26$). However, the second hypothesis was confirmed: there was a statistically significant (reduction) difference between the anxiety symptoms measured by both the HADS (significance=0.00025, one-tailed) and the BAI (significance=0.002, one-tailed) at the beginning and end of the 8-week course. This means that the course was effective in reducing anxiety symptoms. At post treatment, all of the participants scored significantly lower, illustrating that the majority had normal to mild anxiety. Analysis of the User Evaluation Questionnaire showed that most aspects of the course were beneficial to both cohorts. These results are considered clinically significant for Bedfordshire & Luton Partnership NHS

Trust. However, given the small number of participant, caution in generalising the results is advised.

Critique of research study

The key to evaluating this completed study was to consider whether or not the selected method was sufficiently rigorous and appropriate to answer the research question. The results are promising as they provide some justification for the recommendation that we experiment by adding plants to healthcare settings / therapeutic sessions. However, the results are not conclusive. The sensitivity of the measurement tools to measure for any impact of the plants reducing anxiety is an issue. The participant numbers are another concern. If a greater number of participants had been included in this study the findings may have been statistically significant at the 0.05 probability level. The sample population was representative of the population / referrals to anxiety management courses but it was a small sample. Therefore caution needs to be taken in applying the results to the entire group of individuals eligible to be included in this study. There are also confounding variables such as the number and type of plants used and the grey picture added to the control group. Furthermore, data on prescribed psychotropic medication was not collected. No direct link was made in this study between the environment and anxiety. Critically, Rudestam and Newton (2001) made a valid point when they stated that one single research study is not likely to establish and verify all the elements of a complex concept, it is rather more like a snap shot providing a useful context for future research studies.

Conclusion

It could be concluded from this study that the eight-week anxiety management course was effective in helping to reduce anxiety symptoms. The service users evaluated the course and rated it as being extremely beneficial in understanding anxiety. Although the potted plants were not found to directly reduce anxiety, it is anticipated that the findings will help improve understanding of the influence of the therapeutic environment. The information gained from this study is likely to help treat future individuals with anxiety problems. This study demonstrated evidence based occupational therapy practice and may help provide a better quality of service by advancing practice in the Trust.

Recommendation

There is potential to expand this research to include a larger sample, measured over a longer period of time. A more clinically sensitive measure of change in anxiety symptoms such as the Session Evaluation Questionnaire would be recommended, as the measurements used in this study may not have been sensitive enough to detect a reduction in anxiety related to plants. Measuring the impact of anxiety management sessions after each session could establish whether there is any initial (at session 1) or lasting value (for example, at sessions 4 or 8) of adding potted plants during course sessions. A recommendation for future research is therefore to use the SEQ to assess how specific interventions, such as adding plants to anxiety management sessions, affect clients after each session, in relation to evaluating long-term therapeutic benefits.

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What exactly is Occupational Therapy in Mental Health?

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DISCUSSION PAPER

Introduction

We have been given a mission: to define exactly the role of Occupational Therapy in Mental Health and to clarify the function of group work. In this short discussion paper, we hope to eradicate some of the misconceptions others have of the profession, so as to enhance understanding and application in a multi-disciplinary setting

What is meant by Occupation?

In its simplest terms, ‘occupation’ refers to any activity that meaningfully and actively occupies our time. Occupations cover all aspects of life, ranging from activities involved with meeting our basic needs – for example, to eat, sleep and have security – to fulfilling our greatest ambitions.

Why is Occupation important?

Occupation is a basic human need and hence an essential component of life’ (Townsend 1997, cited in Mee and Sumsion 2001). A ‘healthy occupational’ person has a variety of meaningful roles, a

balanced lifestyle of varying occupations, as well as self-perceived competencies to carry out the activities to fulfil their roles.

Our occupations are made up of a constellation of activities which give meaning to our life by determining roles, values, habits and routine. Those aspects give shape and purpose to our lives and as such provide the vital ingredients which contribute to a sense of well being' (Blair and Hume 1997, cited in Creek 1997).

Therefore, engagement in occupations contributes to an individual's sense of personal and social identity, as well as providing a sense of control and quality of life. When occupation is so key to our identity it is possible to see how any deficit in our ability to engage in activities can have serious effects on an individuals mental health. Williams (1997) states that 'Dysfunction is often demonstrated by a basic lack of structure to the day which has the effect of generating low self-esteem, a lack of motivation and general hopelessness, all of which exacerbate the original problem.'

What is Occupational Therapy in Mental Health?

We are concerned with how an individual's mental and physical health difficulties impact upon their daily functioning, independence and quality of life. We take a holistic, client-centred approach, which focuses upon the individual's self-maintenance (for example: eating, sleeping and personal hygiene), their productivity (for example: work, education and domestic responsibilities), as well as their leisure (for example: hobbies and interests). A balance of all of these occupational areas is vital for good mental and physical health.
Blair and Hume (cit. in Creek 1997) suggest that a 'central component of Occupational Therapy …is the promotion of a balanced and satisfactory lifestyle.' Occupational Therapists aim to empower individuals, so as to gain a quality of life that is satisfactory to them.

Empowering the Individual

Occupational Therapists use occupation to enable people to retain current skills, re-learn lost skills and learn new skills that are required to effectively fulfill their roles in life. Roles shape our identity and are a vital component in maintaining a healthy view of ourselves. An individual will have a variety of roles – for example, as a mother, employee, daughter, wife, student, musician, runner and friend.

The primary aim of Occupational Therapy is to help the person to transfer the skills that are acquired and developed through intervention, into their daily life so that an individual's roles and identity can be recreated. Consider, as an example, the complex skills required in completing a quiz – for example: problem- solving, concentration, multi-tasking, planning, memory and social skills. All of these skills are developed and transferred to the many activities a mother needs to engage in to fulfill her role.

Using group work as a form of intervention in mental health

Finlay (1997) states that 'Groups help us develop our sense of personal and social identity. Through interaction with others we acquire skills, attitudes and ways of behaving ….we gain strength as we share with others, both giving and gaining support.'

Therefore, participating in a group setting promotes learning from others, the development of self-awareness, interactive skills and provides the opportunity to enjoy

being in the presence of others, in a non-threatening environment, whilst engaging in purposeful activity. All of the skills that are developed through participating in a group can then be transferred into the individual's ability to fulfill their roles – for example, in working with colleagues in a team or being a member of a family unit or a friendship group.

Lloyd and Maas (1997) identified that 'Group therapy is effective as a treatment model in acute psychiatry because the inter-relationships and personal interactions create the potential for therapeutic change.'

Occupational Therapists carry out a variety of groups, which include social-based, activity-focused, creative and expressive, promotional and educational groups. It is essential when providing interventions to provide a variety of these types of groups, each with their own focus, if we are to ensure that lifestyle balance is being encouraged and that a wide range of skills are being developed. Each group will have identified aims and objectives, which are shared with the participants to aid understanding.

The Occupational Therapist's role is therefore to be a facilitator, rather than an instructor, and to become an active member of the group using themselves therapeutically to guide and motivate participants.

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Nyabingi: promoting social inclusion

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USER EXPERIENCE

Nyabingi is a mental health charity for Afro-Caribbean people and seeks to avoid social exclusion in communities, promote social links between black mentally ill people and provide a culturally appropriate service. The charity's specific aims our outlined in our constitution, which can be obtained from our manager, Fitzroy Wilson.

In May 2005, Nyabingi was entered into 'The Accolades', a national competition for voluntary groups dealing with community care for adults. The awards ceremony was held in central London at the Café Royal. We won the award for Best Model for Practice Learning, beating social service institutions from around the country in the process. Nyabingi also won a second award, for overall best group amongst those entered into the competition – thus the Winner of Winners. As vice chairman of the Nyabingi executive committee, I would like to congratulate our Trustees, Members, Executives and donors to the charity. We hope to be diligent in maintaining a quality service for the coming years.

My personal experience of Nyabingi has been positive: as a service user, I have forged fruitful relationships with others who have had mental health crises. There is also a great deal of self–worth amongst all Nyabingi members – a quality that is often ignored amongst people with mental health issues.

Participants in the charity are able to obtain leadership skills, which is important in social integration. We aim to have specific fundraising initiatives in action in the near future, enabling Nyabingi to expand and become a beacon for black people with mental-ill-health. Being a National award winner will facilitate this.

Nyabingi, a survivor-led service which is run by black survivors who have personal experience of mental health crises, aims to challenge stereotypes, reinforce cultural heritage of members, provide a culturally appropriate service, promote preventive work and safeguard the rights of black mental health clients. For more information email: nyabingiashanti@yahoo.co.uk

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Protected Therapeutic and Engagement Time: an evaluation of a service improvement initiative

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SERVICE IMPROVEMENT

IIntroduction

Adult acute mental health wards have been often criticised as very busy, often chaotic and unpredictable places, where there is a lack of meaningful activity and high levels of boredom (SCMH 1998, HCM 2003). Moreover, in-patient units that provide stimulation and structure as a part of individualised care-planning demonstrate a more therapeutic and safe environment (Garcia et al 2005).

In a recent national survey of adult acute mental health wards (Garcia et al 2005), whilst social and leisure activities (64%) and practical therapeutic activities (73%) were routinely available on almost least two-thirds of wards, there was comparatively little evidence of family work (<20%), psychosocial (35%) or cognitive-behavioural intervention (<20%) being routinely available on in-patient wards. Of course, there are many obstacles to providing the latter, even though there is evidence of effect, which include:

- the view by some of the questionable appropriateness of such interventions with those who are acutely unwell or are disturbed;
- the lack of availability and access to the training and supervision that is needed for providing such therapeutic intervention;
- the lack of time within the practice setting for offering such intervention, with lengthy periods of time being devoted to administrative tasks;
- the lack of confidence of acute mental health practitioners.

It is also worth noting the concerning findings of national service-user surveys, with many service-users reporting a lack of opportunities and times for talking with someone.

Therefore, it is not surprising that it is recommended that services recognise the important role of activity in the service-user’s pathway to recovery by ensuring that staff have planned and protected time for making therapeutic activities and interventions regularly and routinely available (Garcia et al 2005: 116).

Method

Inspired by a short descriptive article by Kent (2005), it was decided

to plan and implement a 'protected therapeutic and engagement time' (PTET) initiative.

Very simply, this initiative involves re-organising the available clinical time to ensure that there are protected sessions for actively engaging service-users in basic therapeutic interventions and activities, thus promoting and maximising meaningful contact between staff and service-users.

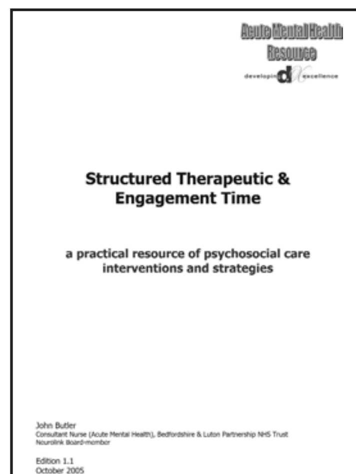
Similar to the initiative described by Kent (2005), this means agreeing a set time during the day, during which all other activities stop – visitors are asked not to attend during the PTET session, telephone calls are, preferably, diverted to a ward clerk or other nominated administration person, administrative tasks such as completing documentation are not undertaken, planned admissions, meetings and educational sessions are planned for alternative times of the day or week. This therefore frees staff time for direct engagement, activity and therapeutic intervention with service-users. In practice, any planned occupational therapy activity is best viewed as a complementary aspect of PTET and members of the wider multi-disciplinary team may contribute to a PTET session.

Through the Trust's Acute Care Forum, it was agreed to introduce and pilot the implementation of the PTET initiative in one adult acute mental health unit over a 4-week period. The team at Calnwood Court, a 16-bed acute mental health unit in Luton, agreed to pilot this initiative from October 2005. As preparation for the pilot, the initiative was discussed in detail with the acute in-patient staff team, and introduced to the team-members of several community teams that relate to the unit: two community mental health teams, the local Crisis Resolution and Home Treatment Team, the Early Intervention Team and the Assertive Outreach Team. The initiative was also discussed with service-users and their relatives / informal carers. The team decided to offer 90-minute PTET sessions on three days per week, from 11AM to 12.30PM, to be followed by a protected meal-time.

As preparation for the initiative, a resource of worksheet-based practical strategies and exercises (see Fig. 1) was provided to the staff team by the consultant nurse, as a series of potential exercises (or basic therapeutic interventions) that could be used within PTET sessions when working with individual service-users or within small group settings. These strategies and exercises were based upon basic concordance, cognitive-behavioural and relapse prevention interventions. A discussion was also facilitated with staff in generating their ideas for the content of planned PTET sessions, which helped in responding to the considerable anxiety expressed by some staff about what they would do during PTET sessions.

A simple monitoring tool was designed to facilitate the summary recording of interventions and activities that were provided as part of PTET, as an aid to the monitoring and evaluation process.

FIG. 1 PTET Resource



Acute Mental Health Resource

developing excellence

Structured Therapeutic & Engagement Time

a practical resource of psychosocial care interventions and strategies

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Neurolink Board-member

Edition 1.1
October 2005

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Two survey questionnaires were developed to assist the evaluation of the PTET pilot, for use after 4-weeks. Both questionnaires, a staff-member and a service-user version, incorporated a series of fixed response items, using a likert-style responding scale, a series of open comment items and one (for service-users) to three (for staff-members) visual analogue rating items.

The evaluation of the pilot was undertaken through two discussion groups, one with staff-members and the other with service-users, following which the evaluation questionnaires were distributed.

Seven weeks after commencing a pilot of the initiative at Calnwood Court (from October 4th), the pilot was introduced in another two adult acute mental health wards, at Weller Wing in Bedford: Bronte Ward (from November 28th) & Keats Ward (from November 29th). As preparation for the pilot in these two clinical areas, briefing meetings were held with the staff teams and with the medical team by the Consultant Nurse and a Charge Nurse or Unit Manager. The initiative was considered to be a good concept worthy of a pilot. For Bronte Ward, 3 x 90-minute PTET sessions were to be provided per week, from 10.30AM until 12 noon, to be followed by a protected meal-time. For Keats Ward, it was agreed to provide 3 x 90-minute PTET sessions per week, commencing from 1PM, although the timing was changed to 4PM after two weeks, in ensuring that the shift handover was completed before the planned PTET session and in an effort to minimise any overlap with scheduled Occupational Therapy activities for the unit.

Findings

What types of level of interventions and activities are provided during PTET sessions?

A total of 61 PTET activity monitoring forms were completed and returned for the period from October 2005 to end of January 2006: 30 from Calnwood Court; 14 from Bronte Ward; and 17 from Keats Ward. This represented 63.5% of the expected monitoring returns.

A summary of the types of interventions and activities provided to service-users during PTET sessions is shown in Chart 1 (see page 36). As shown, the most frequent type of activity was ‘interactive activities / games’, which included pool, social bingo (an interactive variation of the well-known game), various board games and discussions of films. It was highlighted by some staff-members that such activities provided opportunities to assess and develop social skills, to strengthen relationships and to provide distraction from individual problems. At Calnwood Court, an Occupational Therapy Technician and a Dramatherapist participated in providing individual and group based activities and interventions during PTET sessions.

Practical concordance and motivational strategies were used with some service-users, which included developing an

illness timeline, exploring beliefs and attitudes towards illness and treatment, exploring ambivalence and providing education about the stress-vulnerability model as a rationale for treatment and care. Some skills-based sessions were provided, which included relaxation techniques, coping strategy enhancement (e.g. for voices and for managing stress) and problem-solving. Some service-users received individual sessions as part of PTET sessions, which included a focus on assessment, measurement and monitoring, and care-planning / review. A few service-users also received sessions focused on relapse prevention planning.

What do service-users say about PTET?

A group discussion of PTET was facilitated with service-users as part of the weekly patients community meeting at Calnwood Court (N = 6) and at Bronte Ward (N = 9), six to seven weeks after the pilot commenced: a total of 15 service-users attended these two meetings. In addition, service-users on all three wards / units were given the option of completing a short evaluation questionnaire, to indicate their level of agreement with 10 statements about PTET – a total of 12 service-users returned a completed questionnaire: 7 at Calnwood Court; 2 at Bronte Ward; and, 3 at Keats Ward. Responses from the questionnaires are summarised in Chart 2 *(see page 37).*

As shown (Chart 2), the majority of service-users reported a positive view of PTET, as an initiative that:

- helps in ensuring that s/he has specific time with staff;
- ensures access to a variety of activities and practical interventions, which were viewed as helpful;
- offers a choice of activities to take part in;
- has helped him/her to become more involved in his/her own treatment and care;
- has helped him/her to form relationships with staff.

Service-users at Bronte and Keats Wards were more likely to report that PTET sessions had sometimes not been provided as a consequence of emergency or difficult situations on the ward. Only one service-user (from Keats Ward) gave a negative view of PTET, although did refer to their limited experience of PTET sessions.

Service-users reported being involved in a wide variety of activities (for example: an interactive ‘social bingo’ game, playing pool and physical activities) and interventions (for example: art, drama, relaxation, discussions about mental health, working through practical exercises and relapse prevention planning) during PTET sessions. They reported finding all of these activities and interventions as ‘most helpful’. One service-user commented that ‘some people prefer a group game rather than sitting in a group discussing things’. Only one service-user, from Keats Ward, reported not finding anything helpful. Only two service-users reported finding any activities unhelpful, which related to playing cards and painting.

Service-users made a variety of positive comments about the benefits of PTET sessions, as highlighted in Table 1. Only one neutral or negative comment was made, by a service-user from Keats Ward.

Table 1: What is helpful about PTET?

In what ways has PTET been helpful to you or other service-users on the ward?
'Helped us to get to know each other better and interact with staff freely.' ***Calnwood***
'It has helped me to communicate better with patients and staff.' ***Calnwood***
'Interacting with people.' ***Calnwood***
'Helped us all interact.' ***Calnwood***
'Became more aware of expressing my emotions and needs, also being stronger and confident.' ***Calnwood***
'It's very interesting, has opened up mind and helped me to express myself through activities – I have now set myself goals and targets.' ***Calnwood***
'It has helped me to ask for things.' ***Calnwood***
'It helps bring the ward together.' ***Bronte***
'Has given me a more comprehensive view of the services on offer.' ***Bronte***
'Through games.' ***Keats***
'Not really sure it has made much difference.' ***Keats***

One service-user also reported that 'Sometimes I find it difficult to express how I feel.'
Service-users made a number of comments on how PTET could be improved: by having more regular activities, by extending the time periods for PTET to include afternoons and weekends, by having more rooms / areas for activities, by trying to involve more service-users in group discussions, and by having regular feedback meetings.

Service-users were asked to rate their overall evaluation of PTET, by placing a mark on a visual analogue scale (from not helpful to very helpful). Ratings were converted to numerical scores, which indicated an overall evaluation of:

- 8.5 / 10 (for 6 service-users at Calnwood Court)
- 6 / 10 (for 5 service-users at Weller Wing – Bronte & Keats Wards)

Several overall comments were made by the service-users: 'I forgot where I was – it was enjoyable and helped me laugh again'; 'Enjoyable, helpful and very interesting'; 'This makes us part of the team and also gets people involved and responsible for themselves'; 'I enjoyed the stimulation and interaction, especially the social activities'.

What do staff-members say about PTET?

A group discussion of PTET was facilitated with the staff-members on each unit / ward as part of the scheduled staff business meetings and practice development group meetings, following which the staff-version of the questionnaire was distributed for completion. Of the 25 staff-members returning a completed questionnaire, this included: two ward / unit managers, two charge nurses, twelve staff nurses, an adaptation nurse, six clinical support workers, a student nurse and a clinical observer (a doctor). For Calnwood Court, 15 staff-members completed an evaluation questionnaire, with the remaining 10 questionnaires being completed by Weller Wing staff-members (4 for Keats Ward and 6 for Bronte Ward).

As shown (Charts 3 & 4 - see pages 38 & 39), the majority of staff respondents reported a positive view of PTET, as an initiative that:

- helps the staff team to offer dedicated contact time to the service-user;
- provides a structure for engaging service-users in therapeutic interventions and activities;
- helps the staff team to focus upon the needs of all service-users;
- helps service-users to become more involved in their own treatment and care;
- makes time available for offering the interventions and activities that staff-members are trained to provide;
- encourages team-work and positive working relationships;
- helps to provide a therapeutic atmosphere on the ward.

Whilst also positive responses, there was some difference of opinion about whether all staff-members were willing to participate in offering PTET, about the occurrence of difficult situations on the ward that have interfered with offering PTET, and concerning the ease with which it is possible to think of meaningful interventions and activities to offer during PTET sessions.

The majority of staff respondents did not feel that PTET had presented an additional burden to them and 24/25 respondents reported that they would recommend the initiative to other units / teams. Furthermore, the Calnwood Court staff team were unanimous in wishing to continue the PTET initiative beyond the planned pilot phase.

Only one staff respondent (from Bronte Ward) provided a negative view of their experience of PTET, which they attributed to low staffing levels and competing demands that they felt resulted in increased stress levels for staff-members.

Staff-members reported having offered a wide variety of activities (for example: social bingo, pool tournaments, card games, watching educational programmes followed by discussion, and accompanied walks) and interventions (for example: care-planning, medication management, relapse prevention planning, basic cognitive-behavioural strategies, enhancing coping mechanisms, use of assessment and measurement tools, problem-solving, stress management and relaxation) as part of PTET sessions.

The two unit / ward managers who responded confirmed their facilitation and support of the PTET initiative.

Extensive comments were made about the benefits and value of PTET sessions, as highlighted by the comments of staff-members, shown in Table 2.

Table 2: What are the benefits of PTET?

What do you think are the benefits of PTET – whether for service-users, the staff team or for the Acute Service?
'Provides quality time / interactions, gives structure to daily activities and fosters interpersonal relationships and communication.' **Calnwood**
'Getting service-users more involved in the service we provide. It has also been an opportunity for us to work as a team and improve communication.' **Calnwood**
'Improves communication skills, patient – nurse relationships, medication adherence and relapse prevention.' **Calnwood**
'It helps to know your service-users better, service-users are more informed about how to manage their illness, and it creates an atmosphere of partnership.' **Calnwood**
'Patients get the time to interact with staff, and patients and staff become more confident.' **Calnwood**

'It affords the staff the opportunity of devoting some times for the service-users, which is a boost for the acute service.' **Calnwood**
'Enables staff to engage in activities without other pressures and allows staff to engage in sessional activities at a relaxed pace, with more time to carry out these events with a meaningful outcome.' **Bronte**
'Allow patients to ventilate feelings and allow staff time to engage with patients.' **Bronte**
'It enables nursing staff to leave the office and concentrate without rushing, and spend quality time with patients.' **Bronte**
'Some service-users who tended not to engage previously are now doing so and positive working relationships are developing.' **Bronte**
'It brings some withdrawn patients out of their shell, giving them the opportunity to interact with other patients.' **Keats**
'It is a therapeutic session that helps those patients who are willing to participate.' **Keats**

Of course, as with the introduction of any new initiative, a number of obstacles and challenges have been encountered by the staff teams, which have included: unannounced visits by relatives and friends, and interruptions by doctors and others during PTET sessions; the refusal, reluctance or lack of interest of some service-users in participating, or deciding to leave in the middle of an activity; the shortage of staff, coupled with competing priorities, such as the varying demand for special observation. Another major challenge for Keats Ward was the considerable difficulty in agreeing a time of day for PTET sessions, being a ward which relates to three Community Mental Health Teams and thus having a considerable number of team review meetings over the week. The initial agreed timings for PTET sessions on Keats Ward did not allow for the completion of shift handover meetings before sessions and tended to clash with planned Occupational Therapy activities. The impact of some of these challenges has been to dampen the enthusiasm of some staff and, on occasions, for PTET sessions to be cancelled.

However, staff-members were also able to identify a number of strategies for managing or over-coming many of these challenges, which have included: asking other teams / agencies to plan their own time / tasks, so that PTET is not interrupted; giving service-users the opportunity to choose what they would prefer to use PTET sessions for; involving service-users in the planning process; openly inviting frequent feedback from service-users and staff; learning from experience; praising and encouraging service-users; acknowledging the positive work and effort of the staff team; frequently discussing difficulties and identifying sources of support; experimenting with the timing of PTET sessions at Keats Ward; delegating a staff-member to act as a 'coordinating person' with the responsibility for attending to any issues that arise on the ward during the protected time.

Staff respondents have suggested a number of key messages for other teams who may be considering the implementation of the PTET initiative: 'Go for it. It's very beneficial. Don't be afraid – it's extremely rewarding'; 'It helps to understand the service-users more

and it helps to build trust among service-users and staff'; 'It gives staff time with the patients, you get to know each other and it prevents non-adherence'; 'It's useful, fun and stimulating'; 'Give it a try, as you really have to participate in the PTET groups to feel the rewards.'

Most importantly, staff-members have highlighted the following five planning considerations:

1 inform and educate everyone who will be involved on what the initiative is all about – this needs to include informing and educating service-users and their families on the importance of the programme to their care;

2 prepare for forthcoming PTET sessions by planning ahead (advance preparation);

3 work as a team and encourage each other – if team-members are not motivated, then the service-users will notice;

4 plan to minimise interruptions as much as possible;

5 maintain adequate staffing levels.

Staff-members were asked to rate their commitment to PTET, their confidence in providing PTET, and their overall evaluation of PTET, by placing a mark on three visual analogue scales. Ratings were converted to numerical scores, as shown in Table 3.

As shown, the Calnwood Court staff team provided a very positive evaluation of the initiative, whereas the evaluation for the other two wards was, whilst still positive, more mixed.

Conclusion

The implementation of PTET as an initiative designed to ensure a certain standard of dedicated time for offering engagement, therapeutic interventions and activities has, with one or two exceptions, been evaluated very positively by staff-members and a number of service-users.

Furthermore, although not wholly attributable to PTET, it is interesting to note that the staff team at Calnwood Court reported a number of other observations during the pilot period: a reduced use of 'as required' medication, a reduced use of seclusion, a reduced length of in-patient stay, a reduction in incidents of verbal and physical aggression, an increased level of motivation and interaction for some service-users.

The success in effectively implementing PTET clearly depends upon a number of factors, which helps to explain the variation in the evaluation of PTET between the three

Table 3: Overall Evaluation of PTET (staff respondents)

	Calnwood Crt (N = 12)	Bronte Ward (N = 6)	Keats Ward (N = 4)
Commitment (from not committed to very committed)	8.9 / 10	8 / 10	8 / 10
Confidence (from no confidence to very confident)	8.8 / 10	7 / 10	7.5 / 10
Overall Evaluation (from no value to highly valuable)	9 / 10	6.5 / 10	7.5 / 10

units: achieving a committed team approach by enthusiastic and motivated staff who have the active support of community team-members; the degree of planning and advance preparation for scheduled PTET sessions (whether undertaken during the preceding weekend or earlier in the working day); opportunities for frequent discussion and problem-solving of the varied obstacles and challenges that are encountered in offering PTET; the level of praise and encouragement that is offered both to service-users and to the staff team; and, the maintenance of adequate staffing levels.

As would be the case with any such initiative, there is a need to expect and accept that not all service-users will feel able to participate fully within PTET, if at all. However, PTET sessions offer the space and time to actively promote engagement and offer meaningful interaction with minimal disruption. Furthermore, although this evaluation confirms that basic evidence-based therapeutic interventions are being offered as part of PTET, this is best considered as a foundation to build on.

The potential benefits of PTET to the service-user, staff team and service appear to be considerable and varied, and include: breaking down the barriers between the staff team and service-users; assisting the development of therapeutic relationships; promoting the engagement and interaction of service-users; increasing the motivation and confidence of service-users, and promoting their recovery; and, increasing the confidence and approachability of staff-members.

As PTET continues at Calnwood Court and the staff teams at Bronte and Keats Wards re-focus their implementation of PTET, the initiative has recently been introduced in another two wards (from March 2006) – both secure in-patient settings, and is now being considered by a fourth acute in-patient ward – Oakley Court. It is thus planned to continue to evaluate the benefit of this initiative, and incorporate the views of greater numbers of service-users and staff-members. If, as this initial evaluation suggests, PTET proves to be a beneficial initiative in the medium to longer term, then each team should focus upon reaching the stage where PTET sessions become an integral component of the in-patient therapeutic programme and structure.

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Peter Toyloco, Ward Manager, Bronte Ward, Weller Wing, Bedford.
Jane Plummer, Charge Nurse, Keats Ward, Weller Wing, Bedford.
The Staff Teams of Calnwood Court, Bronte Ward & Keats Ward.

Chart 1: What happens during PTET?

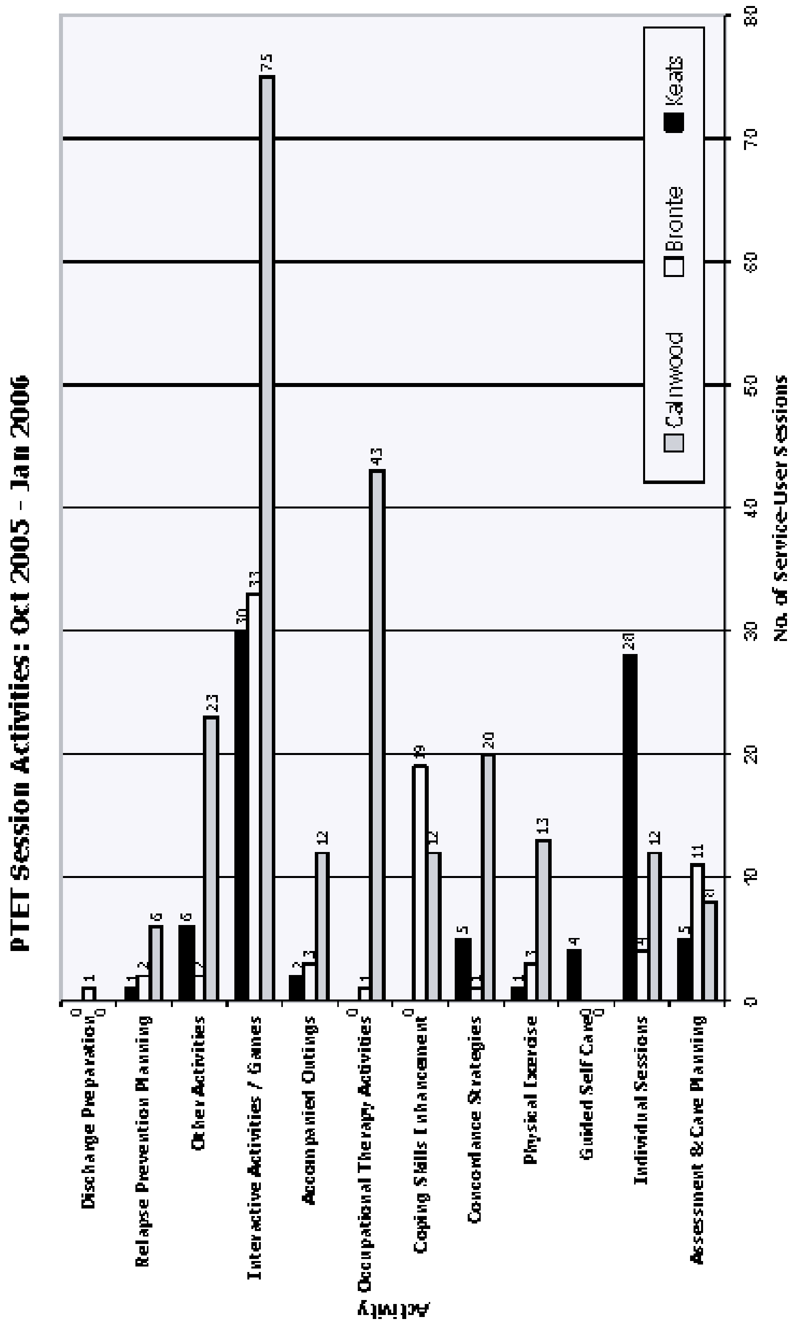

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Chart 2: What do you think of PTET (service-users)?

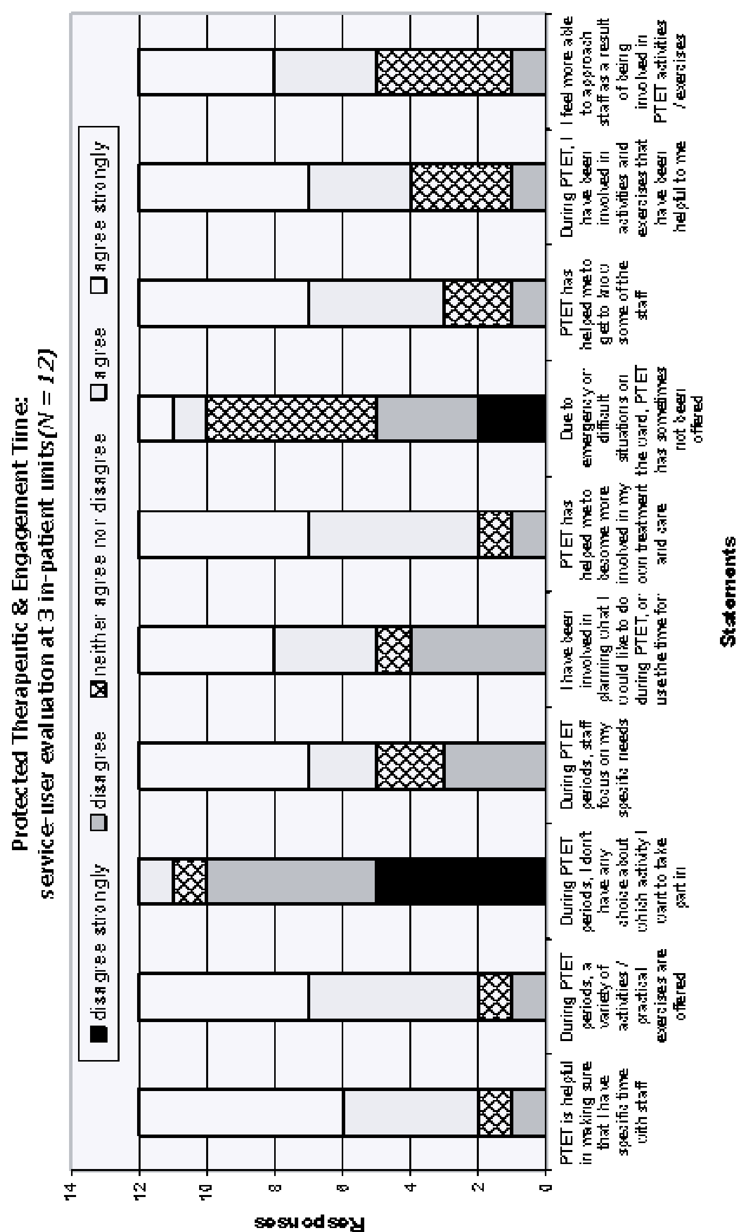


Chart 3: What do you think of PTET (staff-members)? – part 1

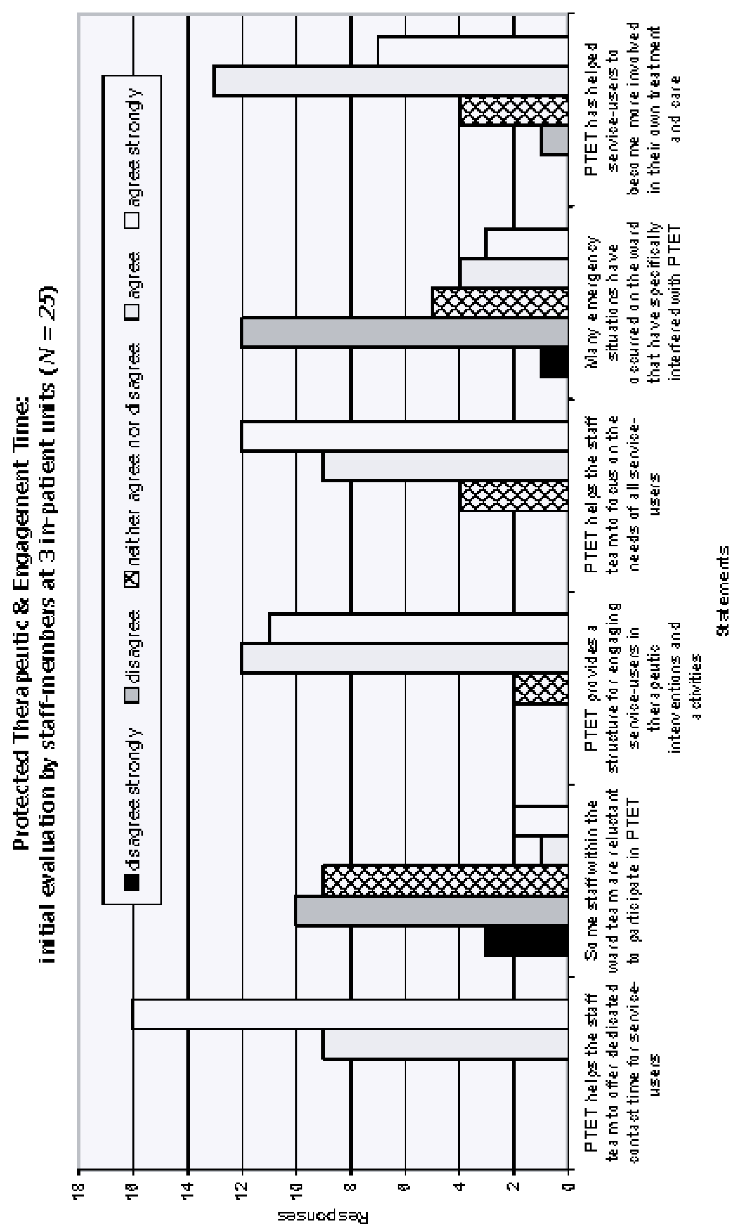
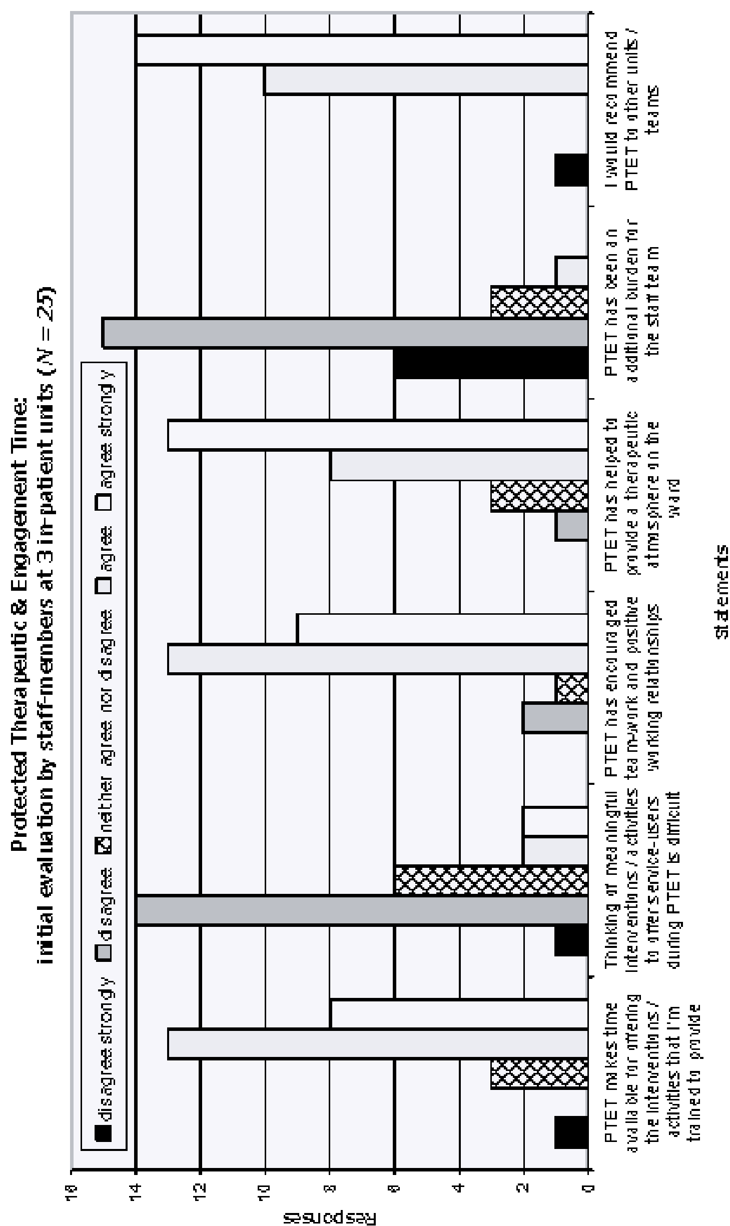


Chart 4: What do you think of PTET (staff-members)? – part 2



The Practice of Seclusion: an audit of record-keeping within a secure mental health setting

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CLINICAL AUDIT

Introduction

Seclusion is defined as the supervised confinement of a service-user in a room, which is locked. The seclusion of a service-user should only be used when other interventions have proved unsuccessful and the service-user is at risk of harming themselves or others.

Following the revision of the Policy and Procedure for Seclusion in September 2004, there was a need to measure staff compliance with the completion of seclusion documentation in accordance with the revised policy. In addition, the high profile David Bennett report drew attention to control and restraint measures when dealing with challenging behaviour, which may have some impact on the use of seclusion.

An audit of seclusion was identified as a priority in the Working Age Mental Health (WAMH) directorate's clinical audit forward plan 2004-5. This audit project was the focus of an Intermediate Clinical Audit Workshop, from which a multidisciplinary audit group was formed to progress the project.

Aim

The overall aim of the audit was to ensure that the documentation for service-users who are subject to seclusion is maintained in accordance with the Policy and Procedure for Seclusion.

Objectives

Two objectives were set for the audit:
1. To improve the completion of documentation on seclusion to ensure compliance with the policy;
2. To highlight staff training needs with regard to the completion of documentation on seclusion.

Methodology

The audit group developed a set of criteria for the completion of documentation on seclusion, to reflect the content of the policy and the seclusion forms that are used to document the seclusion process

when it occurs. A data collection tool was then designed, based on these criteria. The tool was then piloted to ensure that it was efficient and accurate in measuring the criteria set within the policy.

Some discussion took place regarding the recording of articles of clothing / personal belongings that were removed from the service-user upon entering seclusion. This section was left blank on some forms which resulted in a 'no' response on the data collection tool – although it seemed that the removal of items was not being recorded, staff-members reported that a blank entry in fact indicated that no items were removed from the service-user, thus requiring a 'not applicable' response. Staff were asked to indicate a 'not applicable' response where no items were removed.

On completion of the pilot, no further amendments to the audit tool were deemed necessary and an audit form was completed for each case of seclusion as recorded in the ward seclusion book. Data was collected during January 2005 and then forwarded to the Clinical Audit Department for analysis.

Summary of Findings

Of an audit of 29 seclusion forms, 100% compliance was achieved for many of the record-keeping audit criteria:

✓ the client's full name;
✓ the name of the Responsible Medical Officer;
✓ the name of the ward;
✓ the full name of the person authorising seclusion;
✓ the date and time when seclusion commenced;
✓ the service user being monitored every fifteen minutes;
✓ the reason for seclusion;
✓ the dating and timing of observations by nurses;
✓ the service-user's current condition being recorded every fifteen minutes;
✓ observation duties not being undertaken by staff for more than one hour;
✓ completion of the required two hour nursing review;
✓ the full name and signature of the nurse in charge being recorded at the two hour nursing review;
✓ the signature of the second qualified nurse (whilst compliance for recording their full name was 92%);
✓ the time of the two hour review; and,
✓ recording the reason for the continuation of seclusion after the two hour review in the service user's notes.

97% (28 / 29 cases) compliance was achieved for the following criteria:

✓ the service user's date of birth;
✓ the time at which the doctor was informed of seclusion;
✓ the full name of the person who informed the doctor;
✓ the time at which the doctor arrived;
✓ whether the doctor arrived within an hour of seclusion commencing;
✓ the doctor's assessment of the service user;
✓ the reason for seclusion;
✓ the doctor's signature indicating the authorisation of seclusion;
✓ the date and time upon which the doctor authorised seclusion;
✓ the observing nurse signing their observation;
✓ the reason for the termination of seclusion;
✓ the full name of the nurse and doctor authorising the removal of seclusion;
✓ the signature of the nurse in charge when terminating seclusion; and,
✓ the time and date when seclusion was removed.

Of the remaining audit criteria:

❑ the service user's legal status was recorded in 93% of cases (27 / 29);
❑ 83% compliance (5 / 6 cases) was

achieved for recording the four hour review, the full name and signature of the doctor, the full name and signature of the nurse in charge, the time of the four hour review, and the reason for continuation of seclusion after the four hour review being recorded in the service user's notes;

- the removal of the service-user's clothing or personal belongings was recorded in 33% of cases (9 / 29);
- ethnicity was recorded in 90% of cases (26 / 29), and there was no reply for the remaining four cases (14%);
- where ethnicity was recorded, 56% of clients were White British, 14% were Black Caribbean, 7% were Black African, 3% were Pakistani, 3% were of an Other Asian Background and 3% were White and Black Caribbean.

In terms of the records audited, the quality of the documentation of the seclusion process was considered excellent, with staff achieving 100% compliance on 18 of the audit criteria, 97% compliance on 16 of the audit criteria and 83% compliance on a further 7 audit criteria.

The service-user's details are being accurately documented, as are staff details, when they become involved in the seclusion process. Reviews and observations take place as appropriate and as outlined within the Trust Policy.

There appears to be some confusion regarding the recording of articles that are removed from service-users before entering seclusion. A blank entry is somewhat ambiguous as it seems to communicate two very different things – that either nothing has been removed or that something has been removed but this has not been recorded, which is an issue to be addressed.

Conclusions

This audit clearly highlights evidence of a high level of compliance with the Trust Policy on Seclusion – the policy is effectively implemented and the conditions under which seclusion take place match those outlined within the policy.

The documentation for service-users who are subject to seclusion is maintained and completed in accordance with Trust Policy.

Recommendations

It is hoped that the staff team will maintain these high levels of compliance and continue to implement the policy in ensuring that this good practice continues. The staff team are commended on their good work.

Managers now advise staff on how to complete the 'Any articles of clothing/ personal belongings' section of the seclusion documentation and ask that they document, where necessary, if something is not applicable e.g. no items removed/ nothing removed / not applicable, rather than leaving sections blank.

Action Plan

- The ward manager agreed to commend the staff team for their high standard of record keeping at their next team meeting.
- The Audit Team Manager agreed to forward the audit report to the Chair-persons of Trust Clinical Improvement Groups as a way of sharing good practice.
- It was agreed to summarise the audit findings and actions in the form of a poster presentation that could be displayed in the ward and unit, and uploaded to the clinical audit section of the Trust's intranet.

References

Simmon S, Robinson D & Kvilums B (2004) Restriction of Free Movement: Policy and Procedure. Luton: Bedfordshire & Luton Community NHS Trust.

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