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Is there a crisis in inpatient mental health care?

By

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Key points

- Mental health nursing is in a state of crisis. In particular, inpatient care is need of revamping.
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- The crisis in mental health nursing is best manifested in nursing staff attitudes.
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- The decline in standards can be attributed to many factors some of which relate to the way nurses are being trained and supervised in clinical practice. Contentious it may be, the move towards marketisation of health may not be compatible with values.
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- The mental health nursing profession need to place greater emphasis on skill based training, better use of continuous professional development and clinical supervision.

Abstract

The standards of care in the NHS are currently the subject of debate. Frequently, members of the public have complained about poor staff attitudes towards patients and visitors alike and this has generators debate as to the best way forward for the nursing profession. In mental health, poor standards have been reported on numerous occasions and the first author had firsthand experience of casual nursing attitudes when she visited a friend in an acute inpatient mental health ward. This gives an anecdotal account of the first author as a way of highlighting the prevalence of poor standards in mental health. The paper then examines possible antecedents to this vexed issue before suggesting a way forward.

Introduction

Concerns over poor standards of care by nurses have dominated the media debate for some time. In mental health, debate regarding poor standards of care mainly centres around poor staff attitudes in acute mental health units in the United Kingdom (Scott 2005; NIHCE 2007; Hamilton 2010; MIND 2011; The Sainsbury Centre 2002). As early as 2002, the Sainsbury Centre for mental health warned that unless we take remedial action, we would see an increasing cycle of decline in acute mental health care that will result in an increase in service user dissatisfaction, incidents, inquiries and the loss of high quality staff. The report further asserts, "*the situation is little short of a crisis and has to be addressed now. In some instances the*

quality of care is so poor as to amount to a basic denial of human rights" (The Sainsbury Centre 2002). The government published best practice guide for admission to mental health acute wards some ten years ago but it appears many of its recommendations have not been put into practice(DoH 2002) and therefore calling the effectiveness of inpatient care into question. For example, service users, researchers, popular press, are now reporting many incidences of poor care and they have called for improvements (Hamilton 2010). .The first author had firsthand experience of problems beset by acute mental health problems when visiting a friend admitted to a ward after a crisis. This article seeks to share the first author's experience in order to provide the necessary background for discussing the crisis of confidence the nursing profession is experiencing. We suggest possible aetiological factors and proffer a way forward.

Experience

Sometime back, the first author visited a mental health ward where a friend was receiving care following a mental health crisis. My visit to see a friend was fraught with difficulties in spite of my experience of working in the mental health nursing field for many years. On arrival to the ward, I noticed that the front door was locked and I immediately thought of a past review paper that found an association between locked wards with increased patient aggression, poorer satisfaction with treatment and more severe symptoms.(Van Der Merwe *et al.* 2009). After a prolonged period of ringing the entry door bell, I finally gained entry to the ward and to my surprise, I observed that most of the ward staff had locked themselves inside the office and patients were not permitted to enter. The majority of staff remained in the office there throughout the duration of my visit with no observable interaction with service users', or anyone else outside the staff fraternity.

Despite having knocked on the locked office door several times and being in full view of the nursing staff in the office, I stood outside the office attracting little attention. Finally, a member of staff opened the door in response to my continued and as I tried to enter, I was told by the staff nurse that I was not allowed in the office. I felt like an intruder and a sense of undeclared hostility towards me. The locked doors compounded my feelings of unease as it gave the impression of a penal environment. As a lecturer in mental health nursing, I wondered whether the

disconnection between mental health recovery principles and the clinical reality is perhaps too huge to reconcile. This was indeed a wakeup call for me.

Finally, after a long period of waiting outside the office, I was attended to by one of the staff nurses who appeared disgruntled and annoyed at my enquiry about the whereabouts of my friend. In an abrupt and loud voice, the staff nurse shouted " Bank nurse!, take this person to room 10. "***This person?,"*** I thought." Unfortunately for the poor bank nurse, she was not familiar with the ward layout and room 10 turned out to be the wrong room. The redeeming feature came in the way of my friend who managed to spot me and we went to a quiet room where we spent an hour catching up on events. What was disconcerting during my conversation with my friend was he stating that, "*you have to 'say the right things to get out of here' and play the system, and cope by bringing in and hiding substances ...."* This statement, the locked doors and my experience with staff attitudes earlier on reminded me of how relevant the Sainsbury report (2002) is today even though it has been around for 10 years. I was concerned for my profession but more importantly, I was concerned for the services users and their families who put trust in our profession to give the best possible care.

Before taking leave, I went to the staff office to make enquiries about my friend's progress. I can only describe the reception I got as cold and hostile and I wondered if I was being tiresome and difficult. At this point, I felt anger swelling up inside me I decided to tackle the poor attitude head on. This proved to be an exasperating experience as the conversation became circular and resulted in an escalation of hostility. Frustrated, I asked to see a more senior manager.

A time for reflection

The nursing profession need to reflect on the ever growing empirical and anecdotal evidence of declining standards in care and professionalism. The first author's experience is by no means unique as several high profile TV documentaries can attest. On the 31st January 2005, Channels 4's Dispatches programme showed a disturbing documentary, 'Undercover Angels'. This piece of investigative journalism sent two undercover journalists to work as healthcare assistants (HCAs) at two

different hospitals. The programme centred on various incidences of neglect that these journalists encountered within the wards. A report by the mental health charity Rethink (Hamilton 2010) has stated that service users report profound inadequacies in acute mental health care particularly in responding to emergencies. In these reports, services users were reportedly told that staff were unavailable for interaction. Taunting and verbal abuse directed at service users by staff was also reported.

As previously discussed, this situation is not restricted to mental health environments alone. Recently a senior Labour MP recollected on BBC radio 4 how her sick husband died in hospital "like a battery hen". The MP lamented the lack of compassion nurses demonstrated during her husband's stay in hospital. She described the "coldness, resentment, indifference and even contempt" of NHS nurses treating her late husband. She further asserted, "I really do feel he died from people who didn't care," Whether the lack of care and compassion is real or imaginary, the main issue at play here is that the public perception of nursing is unflattering and therefore something needs to change. To be able to do so, we need to understand what has led to this situation.

David McDaid suggests stigma and prejudice against mental health service users by the caring professions, is rife and is at the route of some of this undesirable treatment(McDaid 2008). This view is supported by a Swiss study that found that compared to the general population, stereotypical views about mental health patients was no more positive amongst mental health professionals(Lauber *et al.* 2006). Another possible factor that has contributed to the poor standards of care pertains to the culture in patient mental health environment. In my interaction with staff at the particular inpatient ward, there was sufficient reason to believe that nursing staff were not sufficiently aware of what was going in patients lives whilst on the ward. For example, although the staff informed me that my friend was recovering well, but after talking to my friend, I discovered that he was still depressed and had suicidal ideation. Furthermore, without staff knowledge, he had resorted to using alcohol to manage the depression and the boredom of inpatient life. This was aptly summed up in his own words, *'(you) say the right things to get out of here' and play the system, bringing in and hiding substances ...."*

If nurses promote a healthy therapeutic relationship with their patients, then one can argue that patients are more likely to take an active interest in their own treatment. Patients might actually believe that hospitals are for their benefit rather than places where they say the right things in order to get out. Past and contemporary literature has highlighted this inadequate therapeutic alliance between nurses and their patients (Royal College of Psychiatrists 2011; Evans 2009; Gijbels 1995), The charity, Rethink has reported that only 29% of service users in acute care receive talking therapies and little is done to help them recover(Hamilton 2010). The report also says that service users complain that nursing staff deny them access to outside space and within the ward, there is little to occupy them in a meaningful and therapeutic way. In another report, the charity MIND (2004) has equally expressed concern about this lack of interaction between patients and nurses

"You can be in the main office, walk through the back door round the back of the office into the kitchen, get yourself coffee and walk back. And all the patients are in one part while the rest of the staff is over there." "I do notice when I've been to visit a few people in hospital and they're stuck.

According to MIND, the hospital environment should ideally help some patients to recover but intense boredom can exacerbate existing difficulties and create new ones, subjecting patients to an environment that is inhumane where it should be therapeutic (Mind, 2004). In recognition of the problems beset by inpatient care, the Royal College of Psychiatrists have set standards for a good ward environment, unfortunately, these standards seem to have made little impact (Royal College of Psychiatrists 2011). It is evident areas of need remain in mental health inpatient nursing and remedial action need to be taken.

The way forward

A popular view is that poor patient care and attitudes is a consequence of deficits in education, prejudices and misperceptions regarding mental health nursing (Curtis 2007). Previous reports suggest that students are concerned and anxious about entering the mental health setting (Farrell & Carr 1996; Fisher 2002). Evidence consistently show that for those seeking a career in nursing, mental health is one of the least preferred areas (Happell and Gaskin 2013). For this reason, the mental health profession need to find ways of overcoming this challenge to enable it to

recruit well qualified enthusiastic people. Nurse educators have a leading role in this regard.

In addition to the recruitment of high calibre students, the bedrock of mental health nursing should be on attitudes and skills acquisition. A to an all graduate health in line with other disciplines like psychology should help to facilitate skill acquisition. Specific Cognitive Behavioural Therapy (CBT) and Motivational Interviewing techniques have the potential to benefit prospective nurses and improve patient care (Leahy, 2011). Over the past 10 years, various authorities have commented on the need to strengthen skills-based training/problem-based learning (PBL) with particular emphasis on these skills as they have a sound evidence base (Gournay *et al.* 2000; Rushworth and Happell 1998). Because of the shortcomings in current curriculum, anecdotal evidence suggest that when students do enter the mental health setting, some are so overwhelmed by their clinical placement that their only goal is to survive the experience without any focus skills acquisition(Curtis 2007). There are many shortcomings to the current curriculum but one pertains to student support. Some students report that they often feel isolated and unsupported by some clinical staff and this lead to inadequate skills acquisition. In this regard, there is a need for greater involvement of clinical tutors in the practice area.

A greater involvement by ‘clinical tutors/practice educators should help to bridge the theory practice gap(Evans 2009) and build a closer liaison between higher education and clinical practice. This closeness should build robust structures for monitoring student progress and aid communication between clinical areas and academic staff(Baillie *et al.* 2003).

Currently, there remains a lack of strategic management of the clinical role of nurse lecturers in higher education (Day 1998). Contemporary evidence suggests that student nurse learning in clinical placements is currently led by nurses in practice-based teaching roles such as mentors, clinical practice facilitators and practice educators while university based lecturers had become increasingly remote from clinical practice(Smith and Allan 2010). This uncoupling of education and practice has been reported previously and is attributed to many of the problems nurse education currently experiences. The demands within academia of teaching,

publishing, research activity, and grant income, protecting time for clinical practice has been found to be very problematic for nurse educators(Barrett 2007). Current literature suggests a valuable role for Lecturer Practitioners (LP). In particular LP were found to be flexible and maintained a credible status with students, and were generally rated highly (Fairbrother and Mathers 2004). In pre registration nursing, students have identified the LP as a useful source of information to consult (Hancock *et al.* 2007). Lecturer Practitioners have the potential to boost the confidence of undergraduate nursing students and able to bridge the practice theory gap and should strengthen the role of Continuous Professional Development for nurses.

The Department of Health defines CPD as, '*a process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential'* (DH, 1998). Evidence suggest that CPD as currently defined has had a limited positive impact on patient care due to poor analysis of training needs of staff and poor evaluation of training packages among other factors(Lee 2011). Other authors have identified heavy workload and covering for staff absence has prevented uptake of CPD (Shields 2002). This view is compatible with a previous study by the first author showing that many newly qualified staff on inpatient units had skills development needs within their chosen area of expertise (Kemp *et al.* 2009). Evidently, poor implementation of CPD has important ramifications for mental health nursing practice, some of which include poor knowledge, skills and attitudes that first author experienced. Although the need to improve CPD is critical, on its own, it is unlikely to yield tangible results without effective clinical supervision.

According to Fowler,, clinical supervision is a process of professional support and learning that assist nurses in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler 1996). Clinical supervision should provide empathetic support to nurses, improve therapeutic skills, transmit knowledge and facilitate reflective practice. The participants have an opportunity to evaluate, reflect and develop their own clinical practice and provide a support system to one another. However, clinical supervision remains one of the most misunderstood practices in modern nursing. Though mandatory under the

terms and condition of clinical governance, its correct application in clinical practice is questionable. As much as assessing attitudes and personal qualities is key to attracting the right individual in to the profession, careful nurturing and shaping during clinical supervision is also very important. For these reasons, our profession need to revisit this issue with view to reinstate the true and original purpose of clinical supervision.. Another and possibly contentious view blames the declining standards in care is a direct result of the application of market principles in healthcare.

It is possible to assert that the introduction of market principles in healthcare has distorted values in our profession and this has contributed to the current crisis. McCoy argues that if we see healthcare as a business in which we invest capital to enable business growth, then selling more goods and services more profitably than your competitors is the only criteria for success in the market. Unfortunately, in healthcare, this approach is unlikely to work because of the inherently complicated nature of health and healthcare. For example, a successful healthcare system should produce less health care demand and not more! The reported cases of poor practice may be a reflection of the intrinsic tendency for healthcare markets to fail and the damage that competition does to patient care, trust, and ethical practice(McCoy 2012). In short, we assert that health is not a commodity that we can produce by means of capital investment, deployment of capital and labour resources. It is more than that.

Conclusion

Poor practice and attitudes among nurses in inpatient mental health settings are being frequently reported and new strategies are needed to;(1) strengthen the founding principles of care and compassion, (2) facilitate a more positive attitude towards mental health nursing; and (ii) encourage more suitably qualified students to consider a career in mental health nursing. Lastly, it is important to recognise that there are more than 600,000 nurses on the UK professional register. The vast majority of these provide excellent care to their patients even under difficult conditions of long shifts, low staffing levels and the occasional rude or ungrateful patient. However, we should concern ourselves with a minority of nurses delivering

poor care as thousands of patients suffer needlessly. We therefore, have to speak out and find a way reclaiming our values as a profession.

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