

Chapter 4

Community mental health nursing care of a person with complex needs

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Learning outcomes

This chapter will assist you to:

- Demonstrate understanding of how a recovery approach might be used in practice with a person such as Anthony.
- Demonstrate awareness of the evidence base for the care given to a person with complex needs.
- Understand how care is planned and priorities set for a person such as Anthony.
- Consider the importance of good links with service users and their carers.
- Examine an example of holistic care planning taking into account relevant risk factors.
- Recognize the role of mental health nurses in improving a person's physical health care.
- Identify the effects that social exclusion may have upon a person and consider the role of the mental health nurse in helping to promote inclusion.

Introduction

In this chapter we will consider the care of a person living in the community with complex needs. In the past, the majority of people who suffered from severe and enduring mental health problems would almost certainly have spent their lives living in institutionalized care. Today, the majority of people with such problems live in the community, and the issue of how well (or not) they are supported is a critical one for those working as part of a community mental health team.

In this chapter we introduce 'Anthony', a service user who has a long history of mental health problems. Anthony lives alone, and apart from his brother David, he has little contact with other people. Anthony has been referred to mental health services following a long period in which he has been having a **depot injection** from the nurse at his GP's surgery. He has a complex range of problems including harassment from local youths, possible physical ill health, and housing problems, as well as a deterioration in his mental health state.

Institutions and community care

In the UK, the move from hospital-based care towards a more community-oriented model is a relatively recent one. Many of the care practices and attitudes you may encounter today have their roots in an institutionalized model.

From the 1840s onwards a system of 'lunatic asylums' was developed, the intention being that these should provide a humane and morally disciplined environment for those identified as needing care for mental health problems. They were often linked to

county asylums and workhouses and became associated in the public view with both poverty and ‘madness.’ For ordinary people at this time of great industrial and social change, working conditions were harsh and the asylum policy was intended to provide a degree of social control (Rogers and Pilgrim 2001). A popular ditty of the time illustrates some of the prevailing attitudes:

Outside the lunatic asylum, I was there and I was
breaking stones,
When up popped a lunatic and said to me ‘Good
morning Mr Jones,
How much a week do you get for doing that?’
‘Sixteen shillings’ I cried,
‘That’s not enough to keep a wife and six kids,
Step inside you silly fella, step inside’.
(Anon)

As interest in psychiatry evolved, there were developments in both theory and practice, and some changes occurred through new knowledge and ways of thinking about neurology, psychology, and psychoanalysis. Many major shifts and breakthroughs came about via conflict and trauma; the world wars led to significant examinations of mental problems, like ‘shell shock’ and neuroses, and the work of people like Bion and Foulkes on groups and therapeutic communities emerged following World War I (Harrison and Clarke 1992). When mental hospitals became the responsibility of the National Health Service (NHS Act 1946, incorporated 1948) there was a desire to see change. Inpatient populations were still growing but by 1960, with the work of people like Goffman (1987), ‘asylums’ and institutional care were being challenged and increasingly perceived as damaging and unhelpful. Government policy of the time started to refer to moving care into the community, but it wasn’t until Margaret Thatcher’s government of the 1980s implemented NHS reforms and community care policies that mental health services really felt an impact.

From the middle of the 1980s the closure of large psychiatric hospitals began with the replacement of

service provision shifting to a system of community-based care. This was partly because it was thought that this would be a cheaper system, but also because prevailing government philosophy held that mental health patients would become ‘consumers’ of this care, and market forces would hopefully drive change for the better (Nolan 1992).

Community care policy was thrown into crisis by a series of tragic incidents, culminating in the death in 1992 of the musician Jonathon Zito following an attack by a mental health service user called Christopher Clunis. The subsequent inquiry (HMSO 1994) highlighted failures in community mental health care, including poor communication and missed opportunities to properly care for Mr Clunis. A significant factor was lack of resources; staff were doing their best to cope within an overstretched and badly designed system.

Student activity 1

Read the extracts in the box below and consider what image of mental health care or service users reports such as these give?

When you read newspaper articles about people with mental illness, pay particular attention to the language they use and compare it to the style of writing used by charities and academics, such as in the excerpts below.

There is an ongoing debate surrounding the rights of people who have mental health problems. In England and Wales the *National Service Framework for mental health* (Department of Health 1999) states that:

“ Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

‘FEARS are growing over the number of murders by mentally ill offenders. It comes as new research reveals that “stranger killings”, often by mentally unstable people, have quadrupled in the last 30 years.’

Perry (2004) writing in the *Sunday Express*.

‘Homicides involving psychotics remain constant despite heightened fears about the effects of cuts in the number of NHS beds and a series of chilling murders...’

Timmins (1996) writing in *The Independent*. »

» 'The vast majority of violent crime and homicides are committed by people who do not have mental health problems. In fact, 95 per cent of homicides are committed by people who have not been diagnosed with a mental health problem.'

Contrary to popular belief, the incidence of homicide by people diagnosed with mental health problems has stayed at a fairly constant level since the 1990s at between 50 and 60 a year.'

MIND (2006)

'The *Confidential enquiry into homicides and suicides*' shows that serious mental disorders are rare, and affect only four out of every 1000 adults. Serious violence is even more rare – there are between 600 and 700 homicides each year, but few of them are carried out by people with mental health problems.'

The enquiry, which took place over a period of 33 months, identified only 39 homicides in England by people in contact with specialist mental health services in the previous year (between five and six per cent of all homicides).'

Royal College of Psychiatrists (1996)

From <http://www.mind.org.uk>.

In 2004, the *British Medical Journal* published a study that concluded:

'Stranger homicides have increased in the recent years, but the increase is not the result of homicides by mentally ill people and therefore the "care in the community" policy. Stranger homicides are more likely to be related to alcohol or drug misuse by young men.'

BMJ (2004) **328**, 734-37 (27 March)

Standard Three adds that they should be able to make round the clock contact with 'local services necessary to meet their needs and receive adequate care.'

Furthermore, Standard Six states that people caring for a mental health service user should have an assessment of their own physical and mental health needs as well as their own written care plan (Department of Health 1999).

It has been suggested that while service users are now much more likely to be involved in service planning (Commission for Health Improvement 2003) there remains a culture of coercive treatment. Furthermore, this treatment is likely to be oriented towards a medical model, despite suggestions that people often see their problems differently

(Sainsbury Centre for Mental Health 2005). Others have highlighted the effects of social exclusion and discrimination in denying access to opportunities that most people would consider to be a right (Repper and Perkins 2003). A study of service user experiences with clear relevance to Anthony's situation (Read and Baker 1996) found that as well as suffering high levels of abuse, 26 per cent of those surveyed had actually moved home to escape harassment. You may wish to reflect upon how community mental health service users are treated; for example, to what extent do they and the team agree about both the cause of their difficulties and any proposed strategies to help? Also, do service users you meet feel that they are working in partnership with services or are services imposed upon them?

Clinical scenario: Anthony

In this chapter you will meet Anthony and his brother David following Anthony's referral to mental health services. You will find it useful to read the scenario first and then access the brief films that show both Anthony and his brother talking about the situation.

Anthony's story

Anthony is a 45-year-old man who lives alone in a rented flat in an inner city area. He was diagnosed

as suffering from schizophrenia when he was a young man and has had many previous admissions to psychiatric hospitals. He has been receiving a depot injection from the practice nurse at his GP's surgery for several years and has remained relatively stable throughout this time. He does not mix well with other people and at times lets himself become a little neglected. Anthony often appears to be hearing voices although he denies this; on occasions he hints to the practice nurse that the Internet is trying to control him.

Anthony has never worked and spends his time either alone in his flat or in the local library where he goes and spends most of his mornings, although recently he has been complaining that blurred vision is making it difficult to read the newspapers there. Anthony is quite overweight, smokes very heavily, and eats a diet that consists mostly of junk food; he often complains of feeling hungry and gets very thirsty, despite drinking nearly three litres of Coca-Cola and several pints of water on most days.

Because of the medication he has been taking over the past 20 years, Anthony has developed **tardive dyskinesia** and this makes him pull odd facial expressions. He also has a degree of akathisia and he is often restless. Anthony often feels tired and listless, which he blames on his medication, although recently his sleep has been disturbed by the need to pass water several times a night as well as more frequently during the day.

Anthony's most important source of support has been his brother, David, who although not living nearby tries to keep a bit of an eye on him and offers extra help when he needs it. He has a school friend who has kept in touch with him and who visits occasionally but apart from this he has no other social contacts.

For several months Anthony has been having problems with local youths who have spotted him in the street and begun tormenting him by calling after him and throwing things; they have now started hammering on his door and running away. Anthony has been quite upset at this treatment and his brother has noticed that he has been becoming more anxious, withdrawn, and suspicious of other people.

One day, David is contacted by Anthony's landlord to say that other tenants of the block of flats have been complaining because he has been shouting and

banging till late at night in his flat; also that people are concerned about his unkempt appearance and the fact he has been throwing rubbish out of his flat window. The landlord hints that he may try and force Anthony to move out of his flat if things don't settle down soon. Anthony's friend has also said that he showed him a toy gun that Anthony was intending to use to threaten the people who were tormenting him.

Anthony told his brother that he didn't think life was worth living any more, and David, understandably upset by this, went to Anthony's GP's surgery and told her about all of this; it was at this point that a referral for assessment was made to the local community mental health team.

You can see film of Anthony and his brother at:

 <http://www.oxfordtextbooks.co.uk/orc/clarke>

and choose the video link.

'Typical medication'

As you can see from the scenario, Anthony has been receiving an injection from the practice nurse at the GP's surgery. A 'depot' is an intramuscular injection, the effects of which usually last between two and four weeks, the advantage of this being that people don't have to remember to take lots of tablets (see Box 4.1). Unfortunately, this kind of medication has a range of unpleasant side effects and long-term problems (see Box 4.2). Did you notice any of these features when you looked at the film of Anthony?

Student activity 2

Before you read through Anthony's bio-psychosocial assessment, you may want to review the material in Chapter 2 on assessment.

Drug

Flupentixol decanoate (flupentixol decanoate)
Fluphenazine decanoate
Haloperidol decanoate
Pipotiazine palmitate (pipothiazine palmitate)
Zuclopentixol decanoate
Risperidone
Depot injections typically used in people identified as suffering from schizophrenia.

UK trade name

Depixol
Modecate
Haldol decanoate
Piportil Depot
Clopixol
Risperdal


Box 4.1 Typical medication

Tardive dyskinesia
 Dry mouth
 Blurred vision
 Flushing
 Urinary retention
 Constipation
 Ejaculatory inhibition
 Impotence
 Dizziness
 Unsteadiness
 Muscle spasms and stiffness – may include torticollis (spasms in head and neck) or oculogyric crisis (where a person's eyes roll up painfully).
 'Parkinson's'-type symptoms – i.e. limb rigidity, tremor, expressionless face, and shuffling gait.
 Akathisia – restlessness, agitated movements, person often feels uneasy and anxious.

Box 4.2 Some typical side effects/long-term problems

Assessment by CPN

We are going to show you a typical assessment profile for Anthony; this is based on conversation with Anthony as well as information provided by his brother David and a letter received from the practice nurse at the GP's surgery (see Figure 4.1).

 **Student activity 3**
 As you read through the practice nurse's letter and Anthony's assessment profile, consider the following questions:

- Do you agree with the content?
- Is there anything else you think should be considered?
- What sort of additional observations would you make?
- Are there any questions that you would ask of Anthony, David, and/or the practice nurse?

Please note that the authors would encourage you to adopt a critical and analytical approach to all of this; we don't expect that you will agree with everything we have written and we know that other CPNs will have different ways of approaching this. Your task as a student nurse is to think about what makes sense to you and consider why. Now, bearing the above in mind, read through the assessment profiles as you watch the interviews with Anthony and David on the website.

Psychological

Thinking

Patterns of thought: Anthony is demonstrating some negative and disjointed thinking. His thoughts seem to be distressing to him. He seems to be wary and suspicious.

Beliefs: Anthony has said he is misunderstood by his neighbours but wants to protect them. It is, though, important to stress that Anthony may be expressing delusional ideas about both his neighbours and the Internet.

Self-concept: Anthony demonstrates a mixture of both positive and negative notions of self. On the positive side he is motivated and engaged with the news, the Internet, and DIY; negatively, he is lonely and isolated.

Self-esteem: Anthony's self-esteem appears to be quite low. He has stated that 'life is not worth living any more'.

Self-awareness: Anthony lacks awareness of appropriate activities. For example, he has taken to carrying a toy gun with him and appears unaware of the dangers this presents. Anthony also pays less attention than necessary to his personal hygiene and appearance at times.

Dear Mental Health Team,

RE: Mr Anthony Harris

Anthony has been a patient of this surgery for the last 5 years and I have been seeing him to administer his injection (Depixol 200mg every 2 weeks).

He has a long history of Psychiatric care and treatment having been admitted to Bilberry Moor Hall Hospital 4 times since the age of 16 where he was diagnosed as suffering from Paranoid schizophrenia.

In recent years he has appeared to be fairly well on each occasion that he was seen, although he does sometimes look like he may be hearing voices and has hinted to me that he may be worried about the internet in some way.

We have been telephoned by his half-brother (David) who has become concerned about his brother's welfare. On visiting Anthony he does seem to have deteriorated somewhat, he is unkempt (more so than is usual), agitated and his flat is in a state of disarray.

He appears to be obsessed with the internet and has delusional ideas about local people who he feels are persecuting him. Apparently, the neighbours have actually complained to the landlord about his recent behaviour in which he has been shouting and banging in the flat and threw rubbish from the window into the shared courtyard.

It might be worthwhile you having a word with Anthony's brother who is complaining that there has been insufficient help and support given to his brother.
Once again, most grateful for your assistance,

Pat Raven RGN,
Practice Nurse.

Figure 4.1 Referral letter

Personal autonomy and capacity: Anthony has told his friend that he has taken to carrying a toy gun, intending to threaten people who he feels are threatening him. This may suggest that Anthony's capacity to respond appropriately in dangerous situations is compromised.

Feeling

Anthony's mood seems to indicate feelings of hopelessness, sadness, isolation, rejection, and loneliness. He can also be suspicious. He may appear quick-tempered and irritable at times.

Sensory perception

Touch, smell: Nothing unusual in these areas.

Taste: Anthony has indicated an increased thirst.

Vision: Anthony is currently experiencing blurred vision.

Hearing: There is evidence that Anthony may be hearing hallucinatory voices as reported by his practice nurse.

Reality

Anthony's awareness of time, place, and person appears to be appropriate.

Behaviours

Content of speech: Anthony's speech is focused on his felt problems; he mainly speaks about his problems with his physical symptoms and being bothered by local youths. He has stated that 'life is not worth living any more.'

Pace of speech: Anthony's speech is quite rapid at times and is sometimes difficult to understand.

Tone of speech: A little monotonous at times.

Volume of speech: Anthony's speech can be loud, particularly when he is talking about very important issues for him.

Flow of speech: Speech is sometimes disjointed, jumping between subject areas.

Proximity: Anthony remained seated during the interview.

Facial expression: Sometimes 'strange and bizarre' (grimaces at times).

Eye contact/movement: Anthony appears to engage with people well. He has good eye contact that is non-confrontational. When distressed he seems to avoid eye contact and when angry appears to stare.

Movements: Anthony exhibits some restlessness. There is evidence of tremor in both hands.

Social

Social and familial networks

Mother committed suicide when he was young. Anthony's half-brother David believes he was resented and blamed by his stepmother and says that he had a difficult early life. Anthony has occasional contact with an old school friend and his half-sister. Although David does not live locally he has regular contact with Anthony and is 'most important' to him. Anthony feels lonely and misunderstood by his neighbours but wants to 'protect them'.

Employment and engagement in meaningful activities

Anthony visits the library most mornings; he enjoys DIY at home in his flat. He has never held a full-time job.

Finance

It appears that Anthony is in receipt of Disability Living Allowance, which enables him to purchase

food, drink, and cigarettes for his personal use and to cover his monthly rent (although it is important to confirm this).

Housing

Anthony lives in a rented flat within the inner city. He shares the outside courtyard space with his neighbours. The flat contains only the most basic amenities and is otherwise sparsely furnished. Anthony's landlord is currently threatening to evict him because of his behaviour; other tenants have been complaining about his shouting and banging till late at night.

Interests

Anthony's identified interests are the Internet and DIY. He demonstrates an interest in the news and frequently uses the local library to read newspapers.

Physical

Current and past physical problems

Anthony states that he is often thirsty, is passing urine a great deal (more than usual), has a disturbed sleep pattern, and has blurred vision.

Current treatment for physical health conditions

He is not receiving any treatment for his physical health conditions currently.

Lifestyle issues relating to physical well-being

There are several lifestyle issues for Anthony at present. Anthony's diet consists predominantly of junk or fast foods; he drinks large amounts of (full sugar) fizzy drinks. Anthony also smokes at least 20 cigarettes per day. He does not take exercise although he frequently walks to his local library. At times, when his mental health deteriorates, Anthony neglects his personal hygiene.

Physical activity

Uses public transport and walks daily to the local public library (distance of journey unknown).

Pharmacist's view

Does the dose of flupentixol decanoate (Depixol) need to be increased? He has 200 mg every two weeks, but the dose could be increased to 300 mg – the usual maximum dose. (Some patients require up to 400 mg a week.)

Anthony has tardive dyskinesia, as shown by his facial movements. The severity should be carefully assessed, as it is potentially irreversible. The association between this side effect and antipsychotic drug use means that the lowest possible dose should be used. Tetrabenazine tablets could be given to treat the tardive dyskinesia.

The **antimuscarinic** drugs procyclidine, orphenadrine, and trihexyphenidyl (Benzhexol) do not

improve tardive dyskinesia and may make it worse. They may be used to treat other drug-induced **extrapyramidal symptoms** such as tremor, akathisia, and dystonia (abnormal face and body movements). Anthony has signs of tremor in both hands.

If the screen for diabetes shows that he has the disease, would it be better to change to risperidone injection, which is less likely to exacerbate or cause diabetes? Though Anthony may not want to have a different type of injection.

A useful reference that includes the BNF (British National Formulary) and other information on drugs and evidence-based reviews is:

<http://www.library.nhs.uk>.

Service user's view

Anthony

What Anthony says about himself describes very well what the experience of mental distress is like: he is very conscious of the loneliness and isolation, about people seeing him as strange, and about how the neighbours and local children react to him. He feels very deeply that people don't understand him, no one understands what it is like to be him, and is clearly distressed by that thought.

It would be too easy to dismiss what he is saying as nonsense, arising from paranoia and the symptoms of whatever diagnosis he has been given (if any). But perhaps he is giving clues as to what might help to alleviate his distress. What can be validated about what he says? Research does suggest that the use of mobile phones may in time cause damage to the brain; it is not illogical for Anthony to 'wonder' (he does not allege) whether the use of the Internet can be harmful.

Anthony does not appear to know that there may be service user groups in his area where he could go to talk to people who are experiencing similar problems.

David

What David says about his brother is a very good illustration of how important it is for practitioners to take the carer perspective into account and to value it. He has thought quite constructively about what his brother's problems might have stemmed from and is himself quite distressed at not being able to access help promptly and effectively for Anthony. He can see quite clearly how things will deteriorate if Anthony is not given help.

He is also distressed about the behaviour of the local children and at not being able to do anything about his brother being stigmatized for being different.

Marion Clark, service user

Sexual health

Anthony has no current partner – no issues were addressed in this area at this time.

Smoking

Anthony is described as a 'heavy' smoker.

Use of prescribed and non-prescribed drugs

Attends for his fortnightly depot injection of Depixol 200 mg. No current knowledge of illicit drug or alcohol use.

Side effects of current or previous medication

Anthony demonstrates some restlessness in his movements as well as tremor; at times his facial expressions can be 'strange'.

Significant histories of family illness

Mother committed suicide when Anthony was a young boy – history and background to this currently unknown.

Current nutritional status

While Anthony appears overweight, his diet indicates that his nutritional status is poor.

Spiritual

Religious and/or spiritual needs and beliefs

Currently unknown

Risk

Risk of Self-harm

Anthony is currently stating that he feels 'life is not worth living anymore'.

Risk of self-neglect

When Anthony's mental state deteriorates, as it has currently, he neglects his hygiene and appearance.

Abuse from others

A gang of local youths are 'harassing' him whenever he goes out and also 'hammering' on his door.

Violence to others

Anthony is now carrying a toy gun; he has told his friend he is intending to threaten the people who are intimidating him.

Current physical, sexual, or emotional abuse

Currently being 'abused' by a local gang of youths, who are physically threatening. Also potentially now by neighbours seeking his eviction.

Past physical, sexual, or emotional abuse

David, Anthony's half-brother, indicates that his step-mother blamed and resented Anthony and he had a difficult early life.

Need for safeguarding children

Unclear status regarding 'gang of local youths'.

Substance misuse

Identify current, recent, and past use of prescribed and non-prescribed drugs

Current prescription Depixol 200mg fortnightly via intramuscular injection; otherwise no evidence or known past history of substance misuse.

Carers

Identify any carers

Some elements of caring from practice nurse. Closest to his half-brother David, who lives some distance away. Also has occasional contact with half-sister.

Assessment summary

The assessment profile clearly focuses on Anthony's view of his needs and the most important issues for him, but at the same time has to consider any risks from the situation and Anthony's **bio-psycho-social** state and behaviour. This leads nurses to identify specific priorities for care in negotiation and partnership with Anthony.

Anthony's care plan

Risk

Service User Need/Problem	Goals	Care Plan
<p>1. Possible self-harm. Anthony has said that 'life isn't worth living any more.'</p>	<p>Short-term goals Maintain Anthony's safety, contract agreed with Anthony that he will not self-harm but will follow crisis plan.</p> <p>Long-term goals Anthony will have renewed sense of hope and purpose in life.</p>	<p>Ascertain intent, plan (if any), previous attempts, and possible methods. Agree a crisis response plan with Anthony (see below). To promote recovery, encourage Anthony to develop support networks and strategies enabling him to anticipate problems and to respond in a more appropriate manner to his difficulties.</p> <p>Rationale: <i>Complies with Standards 1 and 7 of the National Service Framework for Mental Health (Department of Health 1999).</i></p>
<p>2. Self-neglect. Anthony's hygiene and appearance worsen as his mental health deteriorates.</p>	<p>Short-term goals Anthony will bathe/shower at least every other day. Anthony will change his clothes at least every other day.</p>	<p>Contractually agree to goals with Anthony. CPN to ensure that Anthony has access to wash his clothing and that his bathroom facilities are appropriate to his needs.</p> <p>Rationale: <i>Complies with duty of care requirements, Nursing and Midwifery Council (2004).</i></p>
<p>3. Abuse from others – see social care plan.</p>		
<p>4. Risk of violence to others. Anthony has been reported to have started carrying a toy gun with which he intends to threaten the people who are intimidating him.</p>	<p>Short-term goals Anthony will cease to carry the toy gun and will dispose of it in an appropriate place.</p> <p>Long-term goals Anthony will recognize the inappropriateness of carrying toy weapons and develop alternative approaches to perceived threats.</p>	<p>CPN to explain danger of using a toy gun, which could be seen as a 'real gun' by the people threatening him or by the police. CPN to discuss potentially fatal implications of this.</p> <p>Rationale: <i>Complies with legal requirements, Nursing and Midwifery Council (2004) Code of Professional Conduct, and risk management required by the Department of Health (1991 onwards) in accord with the Care Programme Approach.</i></p>

Anthony's crisis response plan

Anthony has stated that he feels 'life is not worth living any more.' The CPN will need to work with Anthony on agreeing what action both parties will take in the event that Anthony feels he is likely to endanger himself in any way.

Personal actions that the CPN could discuss with Anthony

- Relaxation strategies – deep breathing techniques, guided fantasy, muscle tensing/relaxing routine.
- Listening to music.
- Taking a walk, a bath, or a shower.
- Phoning family/friends for support.
- Access possible support from service users/survivors websites.
- Phone CPN's office line and indicate to secretarial support that some contact would be helpful.

A specific time limit needs to be agreed between Anthony and his CPN. For example if Anthony does ring the office the CPN may agree that they will contact him within three hours (See Hostick *et al.* 1997).

If Anthony does not feel in control after employing these strategies he will need to take the following action:

- Contact CPN on mobile telephone number and ask for support. CPN needs to identify specific contact number that will require an urgent response.
- In the event that the CPN is unavailable, for example out of hours, Anthony will contact crisis intervention/home treatment team – again, CPN needs to identify a specific number to ring for an urgent response.
- In a situation where Anthony feels unable to wait for help to get to him, he should be advised to access his GP, and in an emergency when the GP is closed, his local Accident and Emergency Services.

Social

Service User Need/Problem	Goals	Care Plan
1. To resolve current difficulties with neighbours and landlord.	Short-term goals For local neighbourhood officer to assist in conflict resolution.	CPN to liaise with local neighbourhood office. Organize a meeting with residents. Seek to get a housing officer allocated to Anthony's case. CPN to provide mental health awareness-raising and education at residents' meetings. CPN to attend residents' meetings with Anthony to provide him with support and encourage him to develop friendships with neighbours. CPN to access local service user groups and encourage Anthony to engage with these where appropriate.
	Long-term goals For Anthony to feel socially included within his neighbourhood.	
2. To reduce risk of harassment and abuse that Anthony is experiencing from a gang of local youths.	Short-term goals For Anthony to receive specific assistance from an appointed social worker as a vulnerable adult.	CPN to make urgent referral on Anthony's behalf for a social worker to be appointed to his case.

Service User Need/Problem	Goals	Care Plan
	<p>For local police to monitor situation and make increased 'safe and well' checks.</p> <p>Long-term goals For Anthony to feel safe in his own home.</p>	<p>CPN to work with police community liaison officer to make them aware of the situation and enlist their support in making regular 'safe and well' checks.</p> <p>If prescribed care fails to resolve difficulties, housing officer and social worker may need to collaborate on re-housing Anthony.</p>

The rationale for adopting this approach includes professional, ethical, and policy requirements for the mental health nurse, as well as service user direction in beginning the recovery process. Specific policy drivers include:

- The NMC (2004) and NSF Standard 1 for Mental Health (Department of Health 1999).
- National Institute for Mental Health in England (2004). 'Principle XI – Community involvement as defined by the user of service is central to the recovery process.'
- NHSU (2005). 'Working in Partnership: developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of

interest or aspiration that may arise between the partners in care. Challenging inequality: addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.'

- Department of Health (2006). 'Psycho-social care – Promote mental health and well being, enabling people to recover from debilitating mental health experiences and/or achieve their full potential, supporting them to develop and maintain social networks and relationships.'

See also Piipo J and Aaltonen J (2004). Also, see discussion point below.

● Discussion point: Social inclusion

We debated whether it was appropriate and realistic to include the community mental health nurse in meeting the residents in Anthony's community to raise their awareness of mental health issues. One major concern was the issue of whether this strategy could compromise Anthony's confidentiality. We agreed that any such approach must be carried out with sensitivity to Anthony's rights and wishes at all times. One of the options we considered was that a CPN uninvolved with Anthony's direct care should take on the responsibility for promoting social inclusion and reducing stigma by providing the local community with mental health education; this would avoid any links being made to Anthony's association with mental health services. We also considered whether this type of education should be taken on by community mental health nurses in any circumstances,

because of their caseload pressures and requirements from their employing trusts to be involved in the delivery of service user care, not education of local communities.

We also discussed whether this is actually part of the community mental health nurse's role, or whether it should be referred to a social worker as an aspect of social care, not health. Eventually we agreed to disagree. There are clear policy guidelines and very specific drivers that indicate that the Department of Health and a range of government organizations have definite expectations that this aspect of promoting social inclusion for people with mental health problems will happen; however, the debate as to who ultimately has responsibility is one you are likely to come across during your community placements.

Physical needs

Service User Need/Problem	Goals	Care Plan
1. Anthony is concerned that he is often thirsty and passes urine more frequently.	<p>Short-term goals Find out cause of unusual thirst, and frequency of passing urine.</p> <p>Long-term goals Anthony will re-establish a 'normal' pattern of fluid intake and output, which is appropriate to his health status.</p>	<p>a) Screen for diabetes. b) Measure blood pressure and body mass indicators. c) Begin programme of health promotion: diet, exercise, smoking cessation. d) Ensure prescribed medication is reviewed as soon as possible. CPN to liaise with practice nurse at GP's surgery and ensure she is involved in the screening and health promotion process. See the separate boxes for plans to tackle diabetes, diet, exercise, and smoking.</p> <p>Rationale: <i>Interventions are based on existing ill health diagnostic criteria and the medical model.</i></p>
2. Anthony has disturbed sleep.	<p>Short-term goals Find out Anthony's current sleep pattern.</p> <p>Long-term goals Re-establish Anthony's preferred sleep pattern.</p>	<p>Ask Anthony why he thinks his sleep is disturbed now – has anything changed? What is his normal sleep pattern? Ask Anthony to monitor his sleep pattern. Give advice re: sleep hygiene.</p> <p>Rationale: <i>Interventions are based on existing ill health diagnostic criteria and the medical model.</i></p>
3. Anthony has blurred vision.	<p>Short-term goals Establish cause of blurred vision.</p> <p>Long-term goals Anthony will have clearer vision to a level satisfactory to him.</p>	<p>Ascertain if Anthony's blurred vision is due to: a) diabetes, b) prescribed medication, c) normal ageing.</p>

Service User Need/Problem	Goals	Care Plan
		<p>Encourage Anthony to have an eye test.</p> <p>Encourage him to monitor time spent at the computer, and educate about distance and breaks.</p> <p>Rationale: <i>Interventions are based on existing ill health diagnostic criteria and the medical model. Underpinned by and in accordance with national guidelines and policies.</i></p>
<p>4. Anthony experiences tremors, restlessness, and 'strange' expressions at times.</p>	<p>Short-term goals Establish cause of Anthony's problems.</p> <p>Long-term goals To reduce tremors, restlessness, and strange facial expressions to a level Anthony feels able to manage.</p>	<p>Discuss with Anthony the length of time he has been having these experiences.</p> <p>Assess their frequency, intensity, number of times they occur each day, and their duration.</p> <p>CPN to ask MDT to review medication to either exclude side effects or alter prescription as necessary to alleviate.</p> <p>Rationale: <i>Interventions are based on the medical model, which informs the specific choice of intervention.</i></p>

See also: Allen *et al.* (2004), Duffin (2005), and Olsen *et al.* (2005).

Anthony's Health promotion plan – diabetes

Typical NHS screening for diabetes (type 2, or late onset; see www.nhsdirect.nhs.uk/articles/alpha/index.aspx) would include the following battery of tests. You will find explanatory information on each of these tests on the relevant website.

- Abdominal obesity, waist to hip ratio, and body mass index assessments.

www.eatwell.gov.uk/healthydiet/healthyweight/bmicalculator

- Blood pressure measure to exclude or recognize hypertension.
www.netdoctor.co.uk/health_advice/examinations/measuringbloodpressure.htm
- Random blood glucose – finger prick test. If the results indicate that glucose levels are above 7 mmol per litre, this suggests that diabetes may well be present and further tests are required.
- Urine test for glycosuria.

- Lipid profile – blood testing for high LDL and cholesterol levels and low HDL to exclude or diagnose dyslipidaemia.
- Fasting blood glucose analysis.
- Glucose tolerance test.
- Baseline glycosylated haemoglobin (HBA 1C).

www.labtestsonline.org.uk/understanding/analytes/lipid/glance.html

The treatment of type 2 diabetes is largely centred around lifestyle changes, healthy diet, getting appropriate levels of exercise, and losing weight, but some people may require medication to help. This can include oral hypoglycaemic agents such as **glibenclamide**; and certain weight-reducing drugs are occasionally used, such as **orlistat**. The CPN working with Anthony would work with the **primary health care team** in order to establish a thorough and regular screening of Anthony within his GP practice setting.

They would also educate both Anthony and the team about Anthony's antipsychotic medication, as this can potentially cause weight gain, a key indicator in diabetes. At the same time they would raise awareness that some of the symptoms of diabetes, for example in Anthony's case thirst, polyuria, and blurred vision, are relatively common side effects of antipsychotics. Whether the outcome for Anthony is a diagnosis of diabetes or not, the CPN will still need to offer an appropriate programme of health promotion and education to Anthony and monitor the effectiveness of these sessions. According to his assessment and care plan, the CPN would need to offer Anthony specific sessions on the following areas: healthy diet; smoking cessation; getting exercise; and sleep hygiene. We have included some examples of what you could do with Anthony; however, these are not meant to be exhaustive and need to be adapted for individual service users' needs.

Health promotion session

1 – healthy eating

- **Stage 1** – Carry out a baseline assessment. Ask Anthony to keep a food and drink diary for one week and establish whether he would like to be weighed throughout the changes to see if this approach is helping him to lose weight.
- **Stage 2** – Start with minor and maintainable changes. Encourage Anthony to drink at least six glasses of water a day, drink less fizzy drinks, and add or maintain five portions of fruit and vegetables every day. Ask him to continue with his food and drink diary but also to include how he sleeps, how he feels, and what he's thinking about food.
- **Stage 3** – Encourage Anthony to eat at regular times during the day and to always have breakfast, lunch, and dinner. Encourage him to avoid big, heavy meals at the end of the day and not to eat after 7 p.m. If he gets hungry in between mealtimes, advise Anthony to have ready small, healthy snacks such as fresh fruit, seeds, and small portions of unsalted nuts. Discuss with him the constituents of a healthy diet; what should be incorporated into his daily intake.

- **Stage 4** – Using Anthony's area of interest, the Internet, to encourage him to access relevant sites to promote self-help and autonomy in relation to a healthy diet. Encourage him to access sites such as:

www.eatwell.gov.uk

www.eatwell.gov.uk/healthydiet

www.eatwell.gov.uk/healthydiet/healthyweight

Encourage him to avoid foods high in saturated fats and fried foods and get him to recognize these foods by reading food labels. Advise him about the meaning of some food labels that are currently in use, such as the traffic light system (mainly green labels indicate go ahead, but always within reason; amber labels suggest some caution should be used when eating these foods; and mainly red labels indicate that these are foods to eat little of and rarely). Also advise him that most food labels will have some green, some amber, and some red sections. Encourage him to access www.eatwell.gov.uk/foodlabels/trafficlights.

Health promotion session

2 – getting moving

Before Anthony can be advised about exercising he would need to see his GP and determine appropriate levels of activity. As with any health promotion strategy, the idea is to start with minor and maintainable changes. In certain parts of the UK, GPs are now prescribing exercise for people and this can help to keep costs down. Many local council facilities will offer discounts for people on benefits or prescribed exercise programmes.

It is also useful to associate exercise with pleasurable activities. Anthony likes to go to the library; encouraging him to walk there or to use a library further away over time, which would increase his activity levels, could be a useful strategy. The CPN would need to ask Anthony what he enjoys doing and target those areas.

Starting off with simple and free activities is always useful and walking is an excellent first option. Many parks, in collaboration with the NHS, have measured walking areas to encourage people to get active; finding something local for Anthony is a useful start point. As his confidence grows, seeking to enhance his social

networks by joining walking associations could also be a useful approach. As previously observed, Anthony enjoys using the Internet so the CPN could encourage him to access the following websites to help him design his own exercise programme:

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthyLiving

www.mentalhealth.org.uk/html/content/exercise_depression_booklet_patient.pdf#search=22%exercise%22

http://hcd2.bupa.co.uk/fact_sheets/html/exercise.html

www.weightlossresources.co.uk/exercise/take_5_plan
www.ramblers.org.uk

www.nhs.direct.nhs.uk/articles/alphaindex.aspx
www.florahearts.co.uk

The CPN would be looking for 30 minutes of activity at least five times per week, and would then gradually build this up with Anthony to enhance his general health and fitness.

Health promotion session

3 – smoking cessation

- **Stage 1** – Carry out a baseline assessment. Ask Anthony to monitor when and where he smokes and record any triggers to his smoking. Also discuss with Anthony his health awareness and the dangers of smoking; encourage him to identify why it would be appropriate for him to stop. Discuss Anthony's preparedness and motivation to stop smoking. Identify strategies that Anthony would like to employ in stopping smoking. Consider whether he wants to stop, reduce the amount he smokes, use nicotine replacement therapy, or other alternatives such as hypnotherapy.
- **Stage 2** – Start with minor and maintainable changes. Encourage Anthony to have his first cigarette later in the day than usual; encourage him to clean his teeth before smoking and to drink a glass of water. Encourage Anthony to use simple

relaxation techniques such as slowed breathing instead of smoking. Motivate Anthony to set a target stop date, one that he chooses and feels confident in. For example some people will choose to give up on New Year's Eve to start the New Year smoke free. Try to establish a date of significance with Anthony that he can work towards.

- **Stage 3** – Using Anthony's interest in the Internet, encourage him to access relevant sites promoting autonomy and self-help in relation to stopping smoking, such as:

www.ash.org.uk

www.bupa.co.uk/health_information/asp/healthy_living/lifestyle/smoking/

A useful guide for nurses is provided in Percival (2006).

Health promotion session

4 – sleeping pattern

Anthony has stated that he is not sleeping well. There is a need to identify what exactly this means to Anthony. Encourage Anthony to record the following in a diary by his bed: what time he goes to bed; if he is awake for long periods in the night; and if his sleep is disturbed. Anthony has also complained of polyuria, which could be contributing to his perceived poor sleeping patterns.

Once the CPN has established some sort of baseline assessment of Anthony's sleeping pattern, it is essential that they determine what would be appropriate in sleep terms for Anthony. Simple changes like establishing a routine, going to bed and getting up at the same time each day, can help. Strategies employed could include sleep hygiene mechanisms such as removing

televisions, stereo equipment, phones, and computers from the bedroom so as to reduce distractions; all of these would be useful in Anthony's case. Limit caffeine drinks and nicotine intake before bed. Encourage Anthony to avoid heavy meals or exercise late in the evening. Also get Anthony to consider a winding down period before bed when he carries out relaxation and might have a warm bath. Some people recommend wearing warm socks to bed as this convinces the body that you are ready to sleep sooner because your feet are cosy – a cautionary note: it doesn't work for everyone. Several of the recommendations for exercise, diet, and smoking cessation should also assist Anthony in re-establishing appropriate sleeping patterns.



Student activity 4



<http://www.oxfordtextbooks.co.uk/orc/clarke>

and choose the video link.

Review the online video interview with Anthony; the priorities set are risk, social, and physical needs.

Would you agree with these priorities?

How would you try to help Anthony with his needs?

Care planning

Having done the assessment and identified the priorities of care, mental health nurses now need to try and develop a care plan in partnership with the client (note that this issue is explored further in Chapter 2). You should consider the care plans suggested for Anthony, bearing in mind that these are *suggestions* – ideally we hope that you will adopt a critical/analytical approach to these, using them as a starting point for your own plans.

You will see that in places, the content of the care plans overlap; in these circumstances there is no

need to duplicate planning. Also, we have not stuck rigidly to the same format in each case where this is not necessary; for instance, we couldn't identify long-term goals in each case. Care plans are meant to be practical guides to *help* the process of nursing care and shouldn't be treated as a bureaucratic exercise.

You will be busy enough preparing plans without making more work for yourself by doing the same thing twice!

Implementation

Implementing Anthony's care requires specific mental health nursing skills. Your assessor from practice will be expecting you to demonstrate certain standards as recommended by the Nursing and Midwifery Council (NMC), but as you will be working with people like Anthony in a community setting you must also demonstrate *safe, effective, and efficient* capabilities

in meeting these standards. This part of the chapter considers four of the NMC standards in relation to both Anthony and the work you are likely to be doing in a community mental health team setting and offers some examples of the necessary skills and example documentation.

NMC Standard D

“ Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills. ”

Important mental health nursing skills that you need to demonstrate include the core conditions as recommended by Rogers (1951): empathy, warmth, genuineness, and **unconditional positive regard**. You also need to demonstrate listening and attending skills (Egan 2002). Your facial expression should show warmth and concern and you should smile where appropriate to the circumstances. Good use of eye contact helps to show that you are listening but it is important that this isn't too intense as staring makes people feel uncomfortable. Your gestures need to be calm and relaxed and you need to avoid making the service user feel that their personal space is being invaded. Although what you say is important, it is also necessary to consider *how* you say it; for instance, consider the effect that your pace, pitch, and tone of speech can have on an interaction. Calm and clear is effective and you should vary this as determined by the service user's needs.

↙ **Student activity 5**
Basic communication skills are identified in Chapter 2 on p. 29–33; review the section on basic aspects of engagement. Consider the following questions and make a note of your ideas:

- How will you encourage Anthony to trust you?
- How will you demonstrate to Anthony that you are genuinely interested in him?

NMC Standard E

“ Create and utilize opportunities to promote the health and well-being of patients, clients and groups. ”

Practice

You would need to show both Anthony and your mentor that you are honest, reliable, and can behave professionally; for example being punctual is important, as lateness may be seen as trivializing people's concerns.

You should also consider your general approach, for example, do people feel that they can speak to

↙ **Student activity 6**
Review the material provided on Anthony in relation to smoking cessation, healthy eating, and exercising. Pick an example from your clinical placement and work on a health promotion package for that service user. You can use this material as supporting evidence for your clinical assessor and in your portfolio; make sure that if you do so, you ensure service user confidentiality.

NMC Standard F

“ Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities. ”

NMC Standard G

“ Formulate and document a plan of nursing care, where possible, in partnership with patients, clients, their carers and family and friends, within a framework of informed consent. ”

↙ **Student activity 7**
Review the assessment and care plans provided on Anthony as this will be useful preparation for practice. It might be useful to practice both your assessment and care planning skills with your clinical assessor and in partnership with a service user. Again, this work is appropriate supporting evidence for your clinical assessor and your portfolio; ensure that service user confidentiality is maintained.

you? How might you show you are listening and showing concern? Learning to reflect on your practice (see the following section) is essential if you are to fully develop your skills as a mental health nurse.

What your clinical assessor may expect from you when working in the community

Consider the following while working with the community mental health team.

Preparation

Before visiting any service user(s), be prepared:

- Be self-aware; consider what message you are sending in terms of your general appearance and approach.
- As a student you need to read through any existing information about the service user(s).

Consider:

- Why are we visiting this service user?
- Are any interventions required?
- Ask your assessor what is expected of you during the visit.
- Are there any approaches that this service user dislikes/prefers?
- Is there any risk that you need to be aware of? (Your placement area should have a 'lone worker' policy in place and you should make yourself aware of this.)
- Are there any intended outcomes from this visit?

Once there:

- Always adopt a courteous, formal approach; ask permission to enter the service user's home (have your identity card ready), don't sit until asked, and make sure you know what they prefer to be called.

- Sometimes CPNs are required to carry emergency mobile phones for urgent calls. If this is the case, ensure that the service user is aware of this potential disruption before commencing any interventions; otherwise ensure that all mobile phones are switched off.
- Many CPNs make notes as the visit progresses, although some find this distracting – you might be advised to discuss this with the CPN you are working with. These can help to show that you are taking seriously what is being said; however, do be careful to ensure that the service user is aware of what you are doing and be prepared to share these notes.
- Carry out appropriate activity and ensure that this is within a time frame to suit the service user. Always work with respect and in partnership, and before finishing summarize the visit and anything that has been agreed together.
- Remember that any care plans should be mutually agreed and shared between the service user and CPN.
- Finally, set a date and time for your next appointment if this is appropriate.

After visiting:

- Record the details of the visit in the service user records and discuss intervention/action with your assessor.
- Feedback the relevant information to the appropriate multi-professional team members. This may be verbally or in written form, for example a letter to the service user's GP.

Two practising CPNs suggested a list of Dos and Don'ts (Box 4.3, p. 88).

Evaluation

In this part of the chapter you are encouraged to reflect upon and analyse your clinical practice in relation to service user satisfaction and its effectiveness. We will also provide some consideration of what your personal tutor and university lecturers will expect from you once your clinical placement is completed.

Student activity 8 Reflection

After completing a community visit with your assessor, carry out the following activity. Analyse what you did

with the service user, employing a simple SWOT analysis approach (see Box 4.4).

Analysing clinical work in this way helps you to become a reflective practitioner (see especially Schön 1987). This means that you always consider what you've done and why and whether you could have done things differently. The following activity encourages reflection, placing the service user as advisor and expert, while showing your desire to work in partnership.

Dos

Be prepared
 Plan what you will do
 Ensure your personal safety
 Consider 'risk'
 Promote independence
 Discuss time-limited nature of relationship
 Maintain existing support networks
 Ask questions of the CPN – show interest
 Research/study around the problems you encounter

Don'ts

Clock watch
 Fidget
 Look bored or disinterested
 Overstay your welcome
 Promote dependency
 Worry about admitting you don't know something

Box 4.3 Dos and Don'ts**Strengths**

- What did you do well with this service user?
- What were you particularly happy with in your work with this service user?

Weaknesses

- Where did you feel that you could have improved in your work with this service user?
- Was there anything lacking in your approach?

Opportunities

- What do you need to know to do things better?
- Is there any research or reading that you could do to improve your knowledge and approach to assist this service user?

Threats

- Was there anything you wished you had done differently?
- Did you feel out of control?
- Did you feel uncertain of what to do at any time?

Box 4.4 SWOT analysis**Student activity 9***Service user feedback*

Try asking the following questions of the service user:

- Do you feel that I have understood what you've told us?
- I would like us to work together in trying to deal with your problems. Is there anything I can do to make you feel we are partners in this?
- As a student nurse, what do you think I could do to improve?

Student activity 10

Effectiveness

Having previously documented an assessment and formulated a care plan, from this analyse each of the care plan segments for their effectiveness. Consider whether the element of care is:

- Prescribed in accordance with national policies and guidelines.

- Utilizing a specific theoretical model to inform the approach, for example psycho-social interventions.
- Based on existing mental health diagnostic criteria.
- Underpinned by specific published research suggesting that this is the best approach.

Discussion points

Risk

You will have noticed, both from reading this book and from reflection on your clinical experience, that risk and risk management are important aspects of mental health nursing. In this chapter we have introduced you to specific issues around risk in the context of caring for Anthony. It is worth reiterating that as a minimum when you think about risk in a nursing context, you should consider the following basic components in Figure 4.2.

In analysing the care prescribed for Anthony we should consider the implications of the mental health nurse's action or inaction. The harm Anthony is experiencing from a gang of youths has led to his readiness to carry an imitation gun. This presents us with a serious dilemma. On one hand, we may live in areas of increasing violence and crime where self-defence is seen as acceptable within that context. Asking Anthony to destroy his imitation gun may leave him feeling increasingly vulnerable and unable to defend himself against a perceived violent threat. In any future conflict with this gang, if Anthony is hurt or seriously injured or worse, could we, in part, be

responsible for this outcome?

On the other hand, the likely escalation of any potentially violent encounter, the possibility of police involvement (including armed response teams) and the need to uphold the law of the land would lead the mental health nurse to agree to the action prescribed on Anthony's care plan.

However, we are presented with additional dilemmas. If Anthony refuses to destroy the imitation gun, whom do we inform? Do we have a responsibility to inform the police, considering Anthony is not planning to commit violence but rather to defend himself if necessary? As mental health nurses, we need to develop alternative response strategies with Anthony. We could encourage him to adopt a range of personal safety measures to enhance his feelings of safety, for example carrying a mobile phone, or travelling at different times and by different routes to avoid contact. However, to some extent it does sound as if this 'gang' may well be targeting Anthony; his encounters with them seem to be increasing and the level of threat he perceives also seems to be worsening.

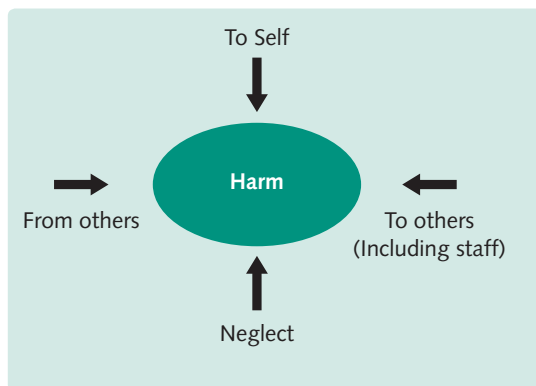


Figure 4.2 Basic components of risk

Social exclusion

“ Social exclusion happens when people or places suffer from a series of problems such as unemployment, poor skills, low incomes, poor housing, high poor health and family breakdown.

Social Exclusion Unit, Office of the Deputy Prime Minister 2004. ”

If you briefly pause to consider the above definition in terms of Anthony's situation, it is easy to see how he might be considered to be experiencing social isolation. Faulkner and Biddle (2002) remind us that as long ago as 1796, the founders of the York Retreat considered physical well-being as essential to the care of

people with mental health problems, but we might reasonably ask how much consideration is given to this matter in modern mental health care. It should be noted that mental health services have been criticized for not paying sufficient attention to the physical care needs of our clients (Muir-Cochrane 2006).

In the UK, the Black report attempted to draw attention to the powerful evidence for links between ill health and poverty (Townsend *et al.* 1988, see also Wilkinson 1996). At the time of its initial publication it would be fair to say that this report was received unenthusiastically (Morris 1995) but in recent years the issue of health inequalities has at least been achieving a higher policy profile. In an attempt to address this problem, the UK Government established the Social Exclusion Unit (Office of the Deputy Prime Minister 2004) with the intention of trying to consider policy solutions across different government departments.

In terms of mental health, the *National Service Framework for mental health* (Department of Health 1999) highlights figures that suggest that people living with mental health problems also have high rates of physical morbidity, and that people with schizophrenia, for example, may have mortality levels 1.6 times that of the general population (Harris and Barraclough 1998).

More recently, the Chief Nursing Officer's review of mental health nursing (Department of Health 2006) identified one of the ten essential shared capabilities for mental health nurses as being the ability to 'Promote physical health and well-being for people with mental health problems.' Obviously we should consider these factors when meeting with a client such as Anthony (see 'physical needs' section of the care plan, p. 81).

Summary

This chapter has introduced you to some of the important issues in mental health nursing practice; it builds on ideas introduced in the first chapters, such as the recovery approach and engagement skills. You have had an opportunity to explore typically encountered mental health nursing approaches to the care of people such as Anthony and his brother. It is intended that this chapter will help you to understand the complexity of a person's needs and the likelihood of multiple issues arising in people with mental health problems. It clearly demonstrates the need for mental health nurses to use a bio-psycho-social perspective

Evaluating the service

If you are undertaking final year clinical experiences you will probably be involved in a range of strategies that the team/service use to evaluate their provision. It would be useful for you to familiarize yourself with clinical governance strategies, including audit and service user surveys. It is appropriate for you to discuss with your assessor any ideas you may have to improve the service and/or experience for other students. Most clinical assessors will expect senior students to demonstrate a move towards independence and autonomy and evidence of thinking as a qualified nurse; similarly your personal tutor and university lecturers expect you to demonstrate a proactive approach to learning at this stage.

Evaluating yourself

Preparing your portfolio for review

Universities recognize the need for all students to be lifelong learners and maintaining a portfolio of learning is a strategy frequently employed. The NMC recommends that all nurses keep a portfolio of evidence of their ongoing professional development and learning.

Student activity 11 – Portfolio review

Consider the following questions as you read through and check your portfolio.

What should be in your portfolio?

Where should it be in your portfolio?

How should it be presented in your portfolio?

Have I included all of the correct materials?

Have I provided sufficient evidence to support my claims of learning?

when working in partnership to help people. You have also been introduced to the changing environment of mental health nursing and the move to community mental health care.

The necessity of considering a person's physical health has been stressed, as well as the importance of holistic health promotion.

This is the first of our clinical chapters in which you are introduced to the films of our 'service users'; these are intended to give you an idea of how people really express their problems. Obviously these cannot replace real life experience and we would recommend

that if you really want to understand people then you must take every opportunity to spend time with mental health service users. The materials in this chapter provide you with the opportunity to begin reflecting on and applying this learning in your clinical practice. It is essential that you broaden and deepen your knowledge and to aid you in this we have identified some further appropriate reading.

You may also find it helpful to work through our short online scenario, intended to help you to consider and actively work through issues raised by Anthony's case.

 <http://www.oxfordtextbooks.co.uk/orc/clarke>

and choose the online resources for this chapter.

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Useful web links

Mental Health Foundation

<http://www.mentalhealth.org.uk/>

National Library for Health

'Aims to be the best health library and information service in the world.' You will need an ATHENS ID to fully access this, which your librarian will be able to advise you about.

<http://www.library.nhs.uk/?autoLogin=0>

Rethink website

http://www.rethink.org/how_we_can_help/campaigning_for_change/physical_health/whats_the.html

The Sainsbury Centre for Mental Health

'We work to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services.'

<http://www.scmh.org.uk/80256FBD004F6342/vWeb/wpKHAL6S2HVE>

Sources of help and advice

Be-frienders Worldwide

<http://www.befrienders.org>

MIND

<http://www.mind.org.uk>

Samaritans

<http://www.samaritans.org.uk>

Further reading

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