Medication management: What do nurses think?

Plus:
- Cultural competency
- prn medication
- Female genital mutilation
- MHNA Update
- News review
- Resource reviews

MENTAL HEALTH NURSING
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Standing up for fair NHS pay: work to rule

Due to the impact that working to rule has had over a sustained period of time in providing back pressure on services, we have decided to continue with this action for eight weeks.

Members are telling us that the work to rule is enabling them to put their pens down at the end of the day, and is giving them permission to go home on time.

Some members have said that it is putting more pressure on them, to do more in less time. This is not the point of work to rule, nor is it safe.

**Guidance for managers on work to rule**

From continued surveying of Unite members, it has shown that members give eight hours unpaid overtime to the NHS a week. In the light that our members are not paid for these hours and are not getting a pay increase either, our members have determined that they will institute a ‘work to rule’.

We have balloted for Action Short of a Strike. This will commence at 00:01 am on 24 November and continue for eight weeks until 23:59 pm on 18 January.

The action we have asked our members to take is to arrive at work on time, leave work on time, and to take their meal breaks. Members will not exceed their contractual working arrangements.

We recognise that the NHS has become dependent on the ‘good will’ offered by our members, but this has now been legally withdrawn.

We would ask all managers to ensure that they abide with the action short of a strike and enable our members to work to rule. It is better for the wellbeing and work-life balance of your staff, and ultimately patient safety.

Managers should adjust workloads to ensure that additional pressure isn’t put on staff and that they can work in a safe way. The number of cases, patients in a clinic, volume of tests to be run, etc must be reviewed and adjustments must be made to enable staff to work their proper hours. We have learnt that this hasn’t happened in many workplaces and our members are being put under more pressure and expected to complete their work, although not providing unpaid overtime. This is not acceptable. We need all managers to review the service they provide in the light of the industrial action. Employers have a legal ‘duty of care’ to staff, and must not put staff under pressure and create work-related stress.

We are also telling our members, that they cannot write their notes out of hours, as this is work.

We are expecting our members to cease working at their contractual finish time and walk off the job. Handovers therefore need to be arranged in working hours.

Should there be emergency situations, then an employer may highlight these with the member, and request that they remain for an agreed period. If this is the case, the employer must also pay overtime to the employee. There will be no unpaid overtime on offer.

**Use of agency staff**

We would remind employers that it is not lawful to engage agency staff to provide cover for staff taking industrial action. Should an employer seek to introduce agency staff to provide cover, Unite will take legal action against the employer.

We recognise that services already employ agency staff, and therefore it is permissible under law that they continue to provide a service, but no additional cover can be.

Should agency staff be engaged to provide cover for future action, we will seek legal advice and take the recommended legal action.
Editorial

Donna Kemp
Care programme approach development manager, Leeds

User survey highlights peer support issues

‘Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?’

This is one of the new questions in the national NHS Community Mental Health Service User Survey. This is about people having been given information about peer support. This information being available in a range of ways, for example, having a discussion about it, accessible leaflets etc.

Better still is peer support being a routine element of a person’s care, support and treatment. But what is getting in the way of embedding peer support in practice?

- Access to peer support workers in mental health teams. How do we ensure this is equitable? A referral system to peer support workers within a team can highlight some interesting things. Peer support workers report that some care co-ordinators refer for peer support work and others don’t.
- Could it be said that most people have some lived experience of mental health issues, through their own life experiences? If so, then people are routinely being supported by peer support workers. Mission accomplished, box ticked. But this is not quite right – this is hitting the target but missing the point. It diminishes the experiences of people with mental health issues.
- Should recruitment to all posts actively encourage people with lived experience? Perhaps this is already happening but what about the person’s choice? Should people have to disclose their lived experience – and if they don’t, will they be discriminated against at selection?
- Peer support on social media? There is ever-growing peer support on social media channels. People regularly blog, tweet and share stories on Facebook about what is going on for them and it is reciprocal. Such support bypasses the ‘referral’ stage and is instant.
- The influence of national surveys in changing practice. The national survey question creates a standard and a measure. The danger is of it providing a minimum standard, and I would not want to see the current provision of actual peer support eroded due to a standard of providing information only.

People currently accessing mental health services are future peer support workers – the eco-system of peer support. People supporting others through sharing what they have learned along the way while achieving their own goals and ambitions.

To foster an equitable landscape there should be a balance between expert by experience and expert by education. MHN
Access to safe places for people experiencing a mental health crisis is crucial, urges CQC

The Care Quality Commission has called for urgent action to continue to improve access to and the operation of health-based places of safety for people experiencing a mental health crisis.

The CQC has found that too many health-based places of safety are turning people away because they are already full, and some are refusing to help people who are intoxicated or exhibiting disturbed behaviour.

The regulator has issued a series of recommendations aimed at providers and commissioners today alongside the findings from a survey of all NHS mental health trusts in England and two social enterprises providing health-based places of safety.

People detained by the police under section 136 of the Mental Health Act must be taken immediately to a safe place where a mental health assessment can be undertaken.

This should be a ‘health-based place of safety’, located in a mental health hospital or an emergency department at a general hospital. They should only be taken to a police station in exceptional circumstances.

Overall, CQC’s findings suggest that while some health-based places of safety are effective, others are less responsive to people’s needs and require far reaching improvements.

CQC’s key findings are:

- Too many health-based places of safety are turning people away or requiring them to wait for a long time with the police because they are already full or because there are staffing problems. A quarter of providers told CQC that they did not believe that the provision of health-based places of safety in their locality was sufficient.
- Too many providers are operating restrictions which exclude some people from specific groups from accessing a health-based place of safety. This includes young people, people who are intoxicated, and people exhibiting disturbed behaviour.
- Too many commissioners are not adequately fulfilling their oversight responsibilities in relation to people who are detained under section 136. This limits their awareness of a key issue which should inform their commissioning decisions.
- Too many providers are failing to monitor their service effectively, making it difficult to assess whether provision of health-based places of safety is meeting the needs of their localities. Many health based places of safety were unable to provide CQC with basic data about the use of their service or how often people were turned away or excluded.

Dr Paul Lelliott, CQC’s deputy chief inspector of hospitals (lead for mental health), said: ‘Since we carried out this survey earlier this year, we know that a great deal of work has been done nationally and locally to improve services for people who experience a mental health crisis and good progress is being made – but findings from our survey and recent inspections of mental health services show clearly that there is still more to do to improve health-based places of safety.

‘There is a range of services that can respond to people experiencing a mental health crisis, as well as services that can intervene early to prevent a crisis from happening in the first place.

‘However, if a crisis does escalate and the police do need to use section 136, people should be taken to a place of safety in a healthcare setting.

‘What our survey of health-based places of safety found is not good enough. There would be a national outcry if people experiencing a physical health crisis were treated in the same way.

‘Imagine if people who had had a heart attack or stroke were regularly turned away from an A&E department due to a lack of staff or beds, or if people who had been seriously injured in an accident or attacked were told they couldn’t receive care because they had been drinking or were showing signs of being disturbed.

‘We have found that people experiencing a mental health crisis are far more likely to end up in a police cell if a health-based place of safety is not available due to staffing or capacity problems, or has restrictions on access in place.

‘Police are left with no option but to take a person to the police station, which is unacceptable and likely to cause additional distress to an individual who is already in a vulnerable situation.

‘To give praise where it is due, we did find a number of providers with appropriate provision who were able to deliver a good service. We hope that those providers and their commissioners who were restricting access or not delivering as good a service will learn from those that are giving people the support that they need.

‘The issues we have identified around access to health-based places of safety show why it is so important that parity of esteem is achieved between physical and mental health.

‘We urge providers and commissioners of services and others to pay close attention to our findings and act on our recommendations.

‘This will help them to fulfil their responsibilities under the Mental Health Crisis Care Concordat, but – more importantly – will help those experiencing a crisis to get the support they need, whenever and wherever they need it.

‘The Concordat has encouraged many organisations to consider what more they can do in this area, both individually and by working with other agencies, and we are delighted to be a part of this.’

Lord Victor Adebowale CBE, chief executive of the charity Turning Point and chair of the Independent Commission on Mental Health and Policing, said: ‘This report reiterates how essential it is that we immediately improve the provision, availability and awareness of health-based places of safety so that people experiencing a mental health crisis can access support wherever they are in the country, without the use of police cells.

‘Given the correlation between psychosis and substance misuse, this support should not be dependent on whether someone is intoxicated or demonstrating disturbed behaviour, or subject to delays because beds are not available.

‘Additional care providers should be utilised to ensure there is a range of adequate places of safety available in any local area, for anyone requiring support.

‘The most pressing issue, however, is staff training and ensuring that all police officers and health professionals know their role within an effective crisis care pathway that saves people’s lives.’
NHS blueprint prompts questions on privatisation

Big questions need to be answered on how the new five-year blueprint to provide NHS services will be implemented, according to Unite, the country’s largest union.

Unite, which has 100,000 members in the health service, said that the crucial questions posed by The NHS Forward View are how is it going to be paid for with an increasingly ageing population and who was going to provide the new models of care outlined – the NHS or the private sector?

Unite head of health Rachael Maskell said: ‘The best investment that the government could make in the NHS is the immediate scrapping of the Health and Social Care Act, which has already squandered £3 billion in a pointless reorganisation.

‘Simon Stevens, the new chief executive of NHS England, makes precious little mention of the plummeting morale of the 1.3 million workforce, which is becoming a worrying pattern for this government with its continued failure to invest in skills, retention and development.

‘In the last four years the NHS has been battered by the funding crisis resulting in £20 billion being sucked out of the service during this parliament.

‘The picture remains very bleak and it is clear that the plan will not plug the predicted £30 billion financial black hole by 2020/21.

‘This will be impossible to deliver in five years – if you are talking about a real improvement in health prevention, retraining and realigning the roles of NHS staff, together with integration of health and social care.

‘The NHS has been also been hit by the helter-skelter dash to privatisate services with 56 per cent of new contracts going to private healthcare companies in the last year.

‘There is also the financial albatross of the private finance initiatives (PFI) which is bringing many hospitals to their knees.

‘One positive to take from this plan is that it will focus the minds of politicians of all parties for the need to provide a suitable financial framework to underpin the NHS.’

Unite is also calling for Stevens to disclose the legal advice the NHS and Department of Health has received on the potential impact of TTIP, the controversial US-EU trade deal, which could make the Tory sell-off of local services irreversible.

Unite general secretary Len McCluskey said: ‘We have consistently warned that TTIP means the irreversible privatisation of the NHS – what is the Department of Health trying to hide?’

Report shows £8bn cost of mental health problems in pregnancy

Perinatal mental health problems cost the UK £8.1 billion each year, according to a new report released by the London School of Economics and Political Science and the Centre for Mental Health.

The report calls for the NHS to spend £337 million a year to bring perinatal mental health care up to the level recommended in national guidance.

The Costs of Perinatal Mental Health Problems report is part of the Maternal Mental Health Alliance’s ‘Everyone’s Business’ campaign, which is appealing to government and health commissioners to ensure that all women throughout the UK who experience perinatal mental health problems receive the care they and their families need, wherever and whenever they need it.

The key findings of the report, led by Annette Bauer and Professor Martin Knapp from LSE’s Personal Social Services Research Unit (PSSRU) are:

• Perinatal depression, anxiety and psychosis together carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.
• Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.
• Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).
• Other costs include loss of earnings/impact on someone’s ability to work and quality of life effects.

There is clear guidance from the National Institute for Health and Care Excellence (NICE) and other national bodies on the treatment of mental illness during and after pregnancy.

Yet the current provision is best described as patchy, with significant variations in coverage around the country:

• About half of all cases of perinatal depression and anxiety go undetected and many of those which are detected fail to receive evidence-based forms of treatment.
• Specialist perinatal mental health services are needed for women with complex or severe conditions, but less than 15% of localities provide these at the full level recommended in national guidance and more than 40% provide no service at all.

Annette Bauer, LSE research officer in PSSRU and lead author of the report said: ‘Our findings show that mothers’ mental health is vital to the economy and to society as a whole, particularly because of the potential negative impact that untreated maternal mental health problems may have on children.

‘In order to protect the family’s long-term health, intervention needs to start before the child is born, or shortly after because the potential benefits are very high and the costs could be fully recovered in a short time frame.’

Dr Alain Gregoire, Maternal Mental Health Alliance chair, said: ‘Perinatal mental health problems are common and costly.

‘They affect up to 20% of women at some point during pregnancy or in the year after childbirth and are a major public health issue impacting on both women and baby.’
It’s been a busy time since my last update. On Monday 13 October, English and Northern Irish NHS workers took strike action – the first in 30 years. The demand of striking workers is simple – fair pay in the NHS. I was on paternity leave when the strike happened so got to experience it from the side of a person receiving the services of the NHS.

On the day I heard a fascinating radio debate between a midwife and Edwina Currie. The midwife spoke very eloquently and with great compassion about why she’d been led to the really difficult decision of withdrawing her labour (and taking a cut in her pay packet) to defend the services that are being undermined. Edwina Currie then said she should be grateful to have a job and should think about all the people on much less pay who were being disadvantaged by her selfish actions.

All the while I wondered how much money flows into her account from her MP’s pension.

My colleague Rachael Maskell emphasised the issues when she said: ‘We urge Jeremy Hunt to heed his responsibility to the NHS workforce and patients and to start talking with the unions to discuss fair pay for the vital staff who would rather be caring for patients than having to fight their own poverty.

Health professionals are especially concerned that the health secretary implies that fair wages for them mean job losses, but he does nothing to curb pay excess by corporate chief executives or the horrific £3 billion cost of this government’s useless reorganisation of the NHS.

‘The health unions are calling for the government not to impose limits on what can be achieved for this essential workforce, but to come to the table prepared to negotiate in a meaningful way.’

With the continued failure of Jeremy Hunt to engage in talks with NHS staff over their declining pay, a further four-hour strike has been called in England on 24 November, followed by an eight-week work to rule starting on the same day and running until 19 January.

In Northern Ireland, Unite health members will continue to work to rule while the union organises further stoppages. This follows the announcement that there would be no cost of living pay rise for healthcare workers under the 2014/15 health budget.

In Wales, talks are continuing between the health unions and the devolved government and no industrial action is currently planned for 24 November.

In Scotland, the devolved government has agreed to pay the 1% pay rise to all staff as recommended by the pay review body and to implement the ‘living wage’ by paying an extra £300 to low-paid workers. Unite accepted this and therefore did not ballot its members in Scotland.

The campaign to reverse the cuts and privatisation agenda of the coalition government has continued. Unite has revealed that 71 coalition MPs who voted on the Health and Social Care Act have links to private healthcare companies. Since the Act was passed, over 70% of tendered contracts have been awarded to the private sector, amounting to over £13 billion worth of NHS services falling into private hands.

Unite found that £1.5 billion worth of contracts have been given to just 15 companies.

The disgraced 71 (64 Tory and seven Liberal Democrat MPs) includes senior coalition figures such as the prime minister and past and current health secretaries Andrew Lansley and Jeremy Hunt.

At the same time, we see the Transatlantic Trade and Investment Partnership (TTIP) being pushed forward despite strong opposition to the effects that it will have on our democracy and our ability to run the NHS. At the recent G20 in Australia, instead of David Cameron voicing the concerns on trade unions, campaign groups and large sections of the public, he vowed to ignore these concerns and state that he would ‘fast-track’ its progress.

On 21 November a bill by MP Clive Efford will receive its second reading. This is aimed at addressing the pro-privatisation agenda by rewriting the rules that force competitive tendering of NHS services. It aims to restore the responsibility to the secretary of state for health to provide a comprehensive health service, free at the point of delivery, and prevents foundation trusts from prioritising private income at the expense of NHS patients.

On to other news. The reception to the recent Mental Health Nursing dementia special edition was really positive. We made the issue open access and nonmembers can download a copy at: www.unitetheunion.org/MHNA.

The England dementia conference held in London in September was also excellent. If you didn’t get chance to come, you can find out more at: https://storify.com/UnitelnHealth/mhnaedc.

Unite lead professional officer Obi Amadi contributes an article in this edition on female genital mutilation. Obi has been recognised for her work by being placed on the Health Service Journal ‘BME Pioneers List’ for 2014.

Finally I wanted to congratulate two members of this journal’s editorial board, Emily Prescott and chair Mandy Bancroft. They were supported by Unite/MHNA to attend the recent Horatio conference in Malta, where Emily presented on the challenges facing newly qualified nurses and the importance of clinical supervision.

This was a great achievement as Emily is still ‘only’ a student mental health nurse, though having worked with Emily I’m not surprised. I’m looking forward to seeing more at her work in future editions of Mental Health Nursing.

I hope that all our members get the chance for at least a small break from work and have a good Christmas and New Year. See you in 2015. MHN
In praise of Twitter

Nicky Lambert outlines the possibilities and benefits of Twitter for mental health professionals

When a friend told me that Twitter would be perfect for me, I was a bit offended – I had dismissed it as a place for people with short attention spans, and for trolls.

However, when I understood the possibilities, I quickly grew to value and enjoy the online communities of practice that I found there. If you are resolutely opposed to Twitter I won’t try and convince you, but it is useful to be aware of what is available.

Anyone holding a professional registration should be sensible about how they engage online in exactly the same way they would in any other part of society.

For example, I use my own name and let people know I am a proud mental health nurse because I do in other parts of my life. I stay within the NMC Code of Conduct online just as I would in a supermarket or on a bus.

I advise people to set up a separate professional account in addition to their personal social media to keep some separation, but that is a personal choice.

It is simple enough to start just go to the Twitter site (www.twitter.com), register an account and upload an image that you have chosen to represent yourself.

This doesn’t have to be a photo of you, but it helps people to connect to you. The other option is to stick with the default image avatar – the ‘egg’.

It is a good idea personalise your avatar. If you add a short biography – even just a couple of lines – people are more likely to interact with you.

If you would like help in setting up an account and getting started, there is a website for health professionals (see www.wenurses.com/Resources/Twitterversity.php).

There are also links on this page to more advanced guidance.

So who is out there? The short answer is everyone – service user groups; staff from every speciality from child and adolescent mental health services to dementia care; people from all professional backgrounds, such as researchers and teachers; plus organisations such as unions, professional bodies, the voluntary sector and government departments; and campaigners and journals.

If you have a specific area of interest then someone else out there will share it. Here is a list of some people and organisations (in no special order) who are on Twitter with an interest in mental health:

- @Unite_MHFA – needs no introduction.
- There are Twitter chats run by @WeMHNurses fortnightly on Mondays at 8pm – follow online using #WeMHNs.
- Follow @Mental_Elf to keep up to date with interesting and reliable mental health research and guidance.
- Fiona (@FionaArt) is a @TimetoChange champion, a mental health activist and blogger.
- Mark Brown (@MarkOneinFour) edited ‘One in Four’, a national mental health and wellbeing magazine written by people who experience mental health difficulties.
- @WeNurses is a weekly Twitter chat aimed at nurses (of all flavours) and takes place every Thursday at 8pm on Twitter using #WeNurses.
- Insp. Michael Brown (@MentalHealthCOP) a police inspector – tweeting on policing, mental health and criminal justice.
- Alex Langford (@PsychiatrySHO) is a psychiatrist who is patient-centred and has an opinion (usually a healthily critical one) on most things.
- Nursing Students (@nursingSUni)

This account is an innovative partnership between nursing staff and nursing students at The University of Salford – they co-ordinate it and it gives both perspectives.

Take a look through their timelines. If they are commenting on areas that interest you, click and ‘follow’ them to see their posts in your timeline. You can look through their followers and who they follow. You can then build your own community of interest. If you find others you’d like to recommend then please let me know – I’m at @nialda.

Hashhtags (#) are used to group together information on a specific interest or to join a tweet chat.

I find Twitter especially useful for conferences, as you can follow the build-up to the event, see who else is active and connect with them before arriving. It can make the experience less daunting if you are attending alone.

You can share your thoughts as speakers are presenting and comment on other people’s responses, turning what could otherwise be a didactic experience into a lively debate.

Another benefit is it allows you to participate in conferences and groups that you can’t physically be present at. You can participate in and see slides from places that you can’t get to because of time and financial constraints.

You can also use it to make following tweet debates more readable. Don’t worry if multiple discussion threads are breaking out you can always go back and read them later – the spontaneity is part of the fun.

Apps like Buffer or Hootsuite can help you keep track of professional and personal Twitter streams, LinkedIn and Facebook. You can see all the activity at once and you can store tweets, for example to be posted when you are offline.

One issue to consider is that tweets you have stored will go out as planned unless you stop them.

I use planned posting to enhance my normal professional, collegiate friendships, for example I worked in Australia and have an interest in mental health there, but I am not always keen to get up in the middle of the night to participate in discussions. So when I find information that is of interest to that audience I store it and schedule it to reach them at their peak hours and I’ll respond with comments in the morning.

Twitter is just ‘other people’ and most of the time that’s what’s great about it, and like any part of society some people are challenging. The charity Mind offers guidance on staying safe on line that is aimed at service users, which is clear and practical (see www.mind.org.uk/information-support/tips-for-everyday-living/online-safety-and-support/introduction/?o=6863).

On Twitter you can block anyone who is abusive to you and report them, so you won’t see any more tweets from that sending account.

If you want to connect to other people passionate about all aspects of mental health, share good practice articles and hear about innovation, then Twitter is waiting for you.

Nicky Lambert is a senior lecturer at Middlesex University
Since Unite launched the Intercollegiate Group report *Tackling Female Genital Mutilation (FGM) in the UK*, in November 2013 (see www.equalitynow.org/sites/default/files/Intercollegiate_FGM_report.pdf) it seems to have taken off and gathered great momentum.

The document made nine priority recommendations for tackling FGM in the UK, which were:

1. *Treat it as child abuse:* FGM is a severe form of violence against women and girls. It is child abuse and must be integrated into all UK child safeguarding procedures in a systematic way.

2. *Document and collect information:* The NHS should document and collect information on FGM and its associated complications in a consistent and rigorous way.

3. *Share that information systematically:* The NHS should develop protocols for sharing information about girls at risk of — or girls who have already undergone — FGM with other health and social care agencies, the Department for Education and the police.

4. *Empower frontline professionals:* Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and protection of girls at risk of FGM. Also ensure that health professionals know how to provide quality care for girls and women who suffer complications of FGM.

5. *Identify girls at risk and refer them as part of child safeguarding obligation:* Health professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk.

6. *Report cases of FGM:* All girls and women presenting with FGM within the NHS must be considered as potential victims of crime, and should be referred to the police and support services.

7. *Hold frontline professionals accountable:* The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor the progress of implementing these recommendations.

8. *Empower and support affected girls and young women (both those at risk and survivors):* This should be a priority public health consideration; health and education professionals should work together to integrate FGM into prevention messages (especially those focused on avoiding harm, e.g. the NSPCC ‘Pants’ campaign; personal, social and health education; and extracurricular activities for young people).

9. *Implement awareness campaign:* The government should implement a national public health and legal awareness publicity campaign on FGM, similar to previous domestic abuse and HIV campaigns.

We have politicians talking about it and are engaged in cross-party discussion.

Since April this year all NHS hospitals are required to record cases found in gynaecology, maternity and urology, so that we can be clear about the number of women affected in this country as the data is currently incomplete.

The Health and Social Care Information Centre (HSCIC) reported figures for the first time in October. In September 2014 there were 1,279 active cases and 46 newly identified cases. These are cases of FGM reported nationally. 125 of eligible trusts in England (78%) submitted signed off data. So the problem is significant.

The World Health Organization (WHO) defines FGM as ‘all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’. It has four classifications:

- **Type 1 (clitoridectomy),** which involves partial or total removal of the clitoris and, in rare cases, only the prepuce.
- **Type 2 (excision),** which involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
- **Type 3 (infibulation),** which involves narrowing of the vaginal opening through the creation of a covering seal, which is formed by cutting and repositioning the inner or outer labia, with or without excision of the labia majora.
- **Type 4 (other),** which comprises all other harmful procedures to the genitilia.
FGM has been a criminal offence here since 1985

Female genitalia for non-medical purposes, such as pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and/or labia; and cauterisation or burning of the clitoris and surrounding tissues.

FGM is usually carried out on girls between infancy and the age of 15, with the majority of cases occurring between the ages of five and eight.

It is also occasionally carried out on adult women, for example, reinfibulation following childbirth, or where a woman is forced into the procedure by her husband after marriage.

So now really is the time to act on the issue of FGM. The Home Affairs Select Committee report published on 3 July 2014 is very clear cut (see www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf).

The lastest harm FGM does to young girls and women in later life is at the forefront of public debate – and this MPs’ report has contributed positively to the discussion and planned future action.

However, this is a complex area with layers of cultural sensitivities that can’t be overlooked and which pose challenges to health and social care professionals, including health visitors, school nurses and mental health nurses.

At our recent FGM update event in June at the Royal College of Obstetrics and Gynaecology in London, both Norman Baker MP and Jane Ellison MP reported on the action they had taken so far and were committed to do in the future more data capture, more training for professionals, more to assist the police in securing convictions.

The issue of not having any successful prosecutions has meant that many are not deterred and so the practice goes on.

One new change to the law that will help change this situation will be the introduction of FGM protection orders similar to early forced marriage protection orders that will be placed on potential perpetrators, restricting their movement out of the country and lasting indefinitely.

The changes that will come will be big. With better identification of risk will come better reporting and we will achieve this in a number of ways, not least educating professionals to identify and report risk appropriately.

It is a safeguarding issue and is part of a professionals duty to identify, report and refer.

FGM has been a criminal offence in this country since 1985, but the way the law is constructed it puts some emphasis on the victim giving evidence against their parents or relatives, which they may be reluctant to do.

This needs to be changed as the child has suffered enough.

We must improve knowledge of all professionals working with children so that cultural understanding – or lack of it – is not an issue.

There must be no delay or hesitation when it comes to reporting – it is child abuse, pure and simple.

For those who have already been affected by FGM, we need to ensure they have access to the right specialist services to support them.

There are of course the physical symptoms that we think of first, however more importantly there is the psychological effect of this that has never been fully addressed – such as never being able to confront your parents, or having to travel long distances, sometimes alone as you can’t tell your family or community just to get to a specialist clinic.

This is not what these girls and women should be expected to do.

Health professionals need to really engage with this problem, and to use opportunities when in contact with women and children effectively.

Without the background understanding you may be missing the clues. Many victims say they wish that professionals had asked them so they can get help.

I was fortunate enough to have been able to attend the Prime Minister’s Girl Summit in July. The day was a joint initiative between the UK government and UNICEF, bringing together all nations to pledge and act to end FGM and child early forced marriage.

There were many pledges and announcements made on the day, including those for the UK – such as that mandatory reporting will be introduced, there will be training and education to support practice including e-learning training so that professionals will know how to recognise it, how to deal sensitively and confidently with the woman, and also how to record and report.

We need to support and ensure that professionals have the time and the skills to do this work sensitively and effectively.

If they need additional training and support they must be given it as we need to stop failing children and get this right.

It is child abuse and so a safeguarding issue for children. Confirmation it has occurred must be reported, and the law will be changing so that parents will be prosecuted for not protecting their children from having FGM. This is a positive step.

These harmful practices do more that cause physical and emotional pain – they destroy childhood and schooling and leave girls vulnerable and traumatised.

This continues on and then affects them as women.

Our actions now will protect children and their future health as women who should play a full role in society.

This is their basic human right. You have it so why shouldn’t they? MHN

Obi Amadi is lead professional officer for Unite
Why doesn’t the client listen to me? Challenging ethnocentricities through clinical supervision to promote cultural competencies

Kris Deering discusses the issues involved in ensuring culturally appropriate care

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Abstract
This paper aims to argue how developing self-awareness through clinical supervision may promote nurses’ cultural competencies in inpatient mental health care. Such capabilities include the ability to effectively work with those who may have differences in linguistics, beliefs and values within the contexts of different national, ethnic, religious, spiritual and/or social groups.

Key words
Clinical supervision, cultural competency, ethnicity, ethnocentrities, religion, spirituality

Reference

Introduction
Nurses’ awareness of their own ethnocentricity can be an important aspect of promoting cultural competency (Cary and Marques, 2007).

This may be described as using one’s own culture norms to evaluate others (Neuliep et al, 2005). Arguably, a recent example is the assumption that particular people immigrating to the UK might be perpetuating austerity (Helbling, 2013).

This paper will focus on how the philosophical values of western psychiatry could impede a client’s recovery if there is no consideration that the person might have different cultural views.

The concept of culturally competent care materialised as a mode of meeting the inequalities of minority groups experiencing mental health difficulties (Cary and Marques, 2007).

There are barriers, such as misunderstanding of differences, and these can restrict the effectiveness of care delivery (Kersey-Matusiak, 2012), for example by creating inadequate therapeutic relationships.

Deriving its ideas from the cross-cultural care paradigm, the foundation of cultural competent care lies in appreciating a person’s health beliefs, biopsychosocial views, illness explanation and collaboration on care planning (Oda et al, 2005).

Thomas and Bracken (2004) argue that the archetypal philosophy in psychiatry is positivist. This means actuality is noted through observation rather than interaction.

Conversely, Ingleby (2006) suggests there has been a move to post-positivistic thinking, signifying that human contact may have influence on the observed. However, the approach does not dispute the need to analyse behaviours, thoughts and feelings through measurable means (Hamati-Ataya 2012).

Anckarsäter (2010) adds that in psychiatry this implies the use of diagnostic tools or expert knowledge to gauge illness.

Potentially, this may interpret unfamiliar cultural views as being possibly delusional, magical in thinking or even dangerous (Nápoles-Springer et al, 2005).

Chambers (2013) argues that a focus on psychiatric epidemiology may promote clinical ethnocentrism, the supposition that clients are merely sums of their illness.

A possible example is adding diagnoses for behaviours that suggest irresponsibility for one’s own health, such as the extra labelling of personality disorder when it is not the person’s primary diagnosis (Crowe, 2008).

Paradoxically, particular cultural studies show that collectivistic attribution may develop through migration, where emphasis is on group unity and identity rather than individual attainment and culpability; in such circumstances families may have a great desire to take responsibility for others during ill health and the family member may wish to relinquish control (Willis, 2012).

Conceivably having family members assist with treatment within inpatient care may promote a client’s recovery, though such knowledge requires a curiosity to learn more from the person.

Language customs in psychiatry may include a sense of detachment for the purposes of...
Clinical supervision

objectivity (Boschma, 2007). Note writing can include the terms ‘client presentation’ or ‘the client presented as’ to promote distance, with the expression of ‘non-compliance’ being used to highlight a lack of acculturation to psychiatric cultural norms (Chua, 2012).

Gillett (2012) suggests such nonconformity is due to the absence of meaning to the client. The disciplining of diminished acclimatising may be noted through the process of objectification, which encourages people to act accordingly or at least to their labels (Vakirtzi and Bayliss, 2013; Foucault, 2002).

There are different forms of objectification. In ‘dividing practices’, clients are divided from their culture and further still their cultural identity, which may otherwise distract the clinician in identifying a psychiatric illness.

There are also ‘practices of classification’, in which the person’s behaviours are categorised into a scientific realm, illnesses are diagnosed and behaviour explained through symptomology, and the person acts accordingly (Foucault, 2002), such as by being non-compliant or passive in their care by agreeing to all instruction.

Foucault (2002) suggests that demonstrating ethical behaviour by being positive about human freedoms may encourage liberty of thought, in that such flexibility encourages the client to speak more freely about needs, which is then mirrored by the clinician who is attempting to understand more.

Contrary to ethnocentrism is cultural relativism. This approach argues that all differences seen through the lens of others are acceptable (Johnson, 2007).

However, dissimilarities in moral and ethical stances may promote irresolvable disputes, especially if the notions contravene a person’s human rights (Kathrani, 2012).

A further development of cultural relativism is transcultural care; a process demonstrating appreciation of all cultural beliefs and customs through the caring process while balancing ethics such as beneficence and non-maleficence (Kortmann, 2010).

The former refers to improving circumstances of others, while the latter is doing no harm (Beauchamp and Childress, 2013).

Campinha-Bacote (2002) suggests cultural desire is the motivation behind the transcultural process, and consequently is a significant factor of cultural competence.

If ethnocentric positions hinder cultural desire then self-awareness may develop nurses’ mindfulness to it.

Mirskey (2013) refers to this as cultural awareness, which is an introspective process of being aware of how one’s cultural views may affect another.

The promotion of self-awareness is a pertinent aspect of clinical supervision developing practitioners’ reflectivity on and after action. Schön (1983) describes this as developing skills through or after the moment to meet a client’s needs.

Positive discussion of fostering a cross-cultural therapeutic relationship requires the conveyance of knowledge, promotion of self-understanding and reviewing of power differentials (Young, 2004).

Such facilitation in clinical supervision requires the supervisor to investigate that there may be a meeting of different cultures without solely focusing on the initial information given on admission, for example the client’s race/ethnicity.

Bates (2004) suggests this may lead to theorising on presumed affiliations, for example food choices and religious beliefs, without having actual evidence.

A supervisee’s lack of meaning to learn may parallel the disconnection to the client being discussed (Ellis et al, 2014). The foundation of such learning is having awareness of the effect of our social construct on our view of reality, for example particular groups of people may act accordingly to how they are depicted by either themselves or others (Van der Linden, 2013).

Consequently this understanding could lead to reshaping such constructs to promote familiarity to the cultural needs of others.

The practicality of reforming social constructs may depend on how well one observes the disparities between individual realities.

Furthermore, using a distinct intervention during supervision may not only guide the supervisee but also assist novice supervisors by the transferability of the action.

The ladder of inference

Cary and Marques (2007) suggest both may be achieved by using the ladder of inference’s phased process of challenging one’s observations.

Inferences are conclusions based on perceived experiences, with the ladder showing how actions may develop as one ascends it (Argyris, 1990).

At the base, facts are shaped on world views, facts are then interpreted to have meaning, assumptions are added without possible deliberation, conclusions are then drawn on interpretations and assumptions, and ultimately world views are based on those conclusions with the ladder being used again in a cyclic motion (Argyris, 1990).

Without interruption small misinterpretations can grow into larger actions that may eventually be deemed discriminatory without the clinician being overtly aware (Griffith, 2013).

The ladder of inference highlights how clinicians may draw conclusions based on ethnocentricities; this awareness may guide the supervisee to look at other data that was not considered before and elicit thoughts that were not present initially, for example cultural counter-transference, meaning the projecting of cultural judgements in response to interpretative experiential data.

Laitin (2010) suggests that Islamophobia is partly a product of such a process creating feelings of fear.

Images of the destruction of the World Trade Center in the US and the obliterated double-decker bus in London are representational in these cases; though if fear is present when caring for a Muslim client it would be extremely spurious to assume the person is a terrorist.

Arguably the attention of health services has recently been on performance management due to investigations such as the Francis enquiry (Nolan, 2013).

Understandably the public wish NHS staff to show compassion in their care, though executive/management focus appears to be on how to behave rather than the subtext driving it (Pope and Burned, 2013).

To appreciate and change drivers for ethnocentric actions may require dialogue without concern of being chastised. For example, clinical supervision sessions may begin with discussing a client with the supervisee not using politically correct terminologies, which Nairn et al (2012) describe as language that may exclude others.

However, if censorship occurs either by supervisor, supervisee or the organisation then this may neglect an opportunity for a more profound understanding on developing care practices (Avery and Steingard, 2008).

There is great challenge in implementing clinical supervision in inpatient psychiatry, let alone ensuring it focuses on cultural competent
Clinical supervision

care (Cleary et al, 2010).
As discussed there is a possible conflict between managerial and clinical need when focus is on performance (Cleary and Freeman, 2005).
Additionally there is an aspect of lack of time, with some believing that there already is adequate assistance through handovers and general support (Cleary et al 2010). The flexibility of ad hoc support perhaps requires further research.
Complexity theory considers the dynamic nature of multifaceted systems. In inpatient care this correlates to the unpredictability of human behaviour, which can alter the ward's dynamics by the smallest of actions (Semetsky, 2008).
A principle of complexity theory is the challenge of having specific moments in time rather than having time itself (Paley and Eva, 2011). Therefore, clinical supervision may not require precise planning, but might need an empathetic environment that notes that clinicians are struggling while allowances are made for private discussions (Sexton et al, 2013).
There is a prerequisite for training for all to promote cultural awareness so there is parity in the supervision given (Kersey-Matusiak, 2012). In common with the ladder of inference, complexity theory shows how one small misjudgement may affect a whole course of action. Ominously this may gradually expand the ward's cultural thinking about particular individuals, and without a critical eye, specific practices may eventually be deemed discriminatory.

Conclusion
The paper has focused on one component of promoting cultural competence through appreciating and challenging one's ethnocentricities.
Such awareness is arguably achievable through the clinical supervision process and by us the model of the ladder of inference. There is a drive within health services to demonstrate an undoing of past wrongs that have undoubtedly horrified the nation, but demonstrating cultural competence is more than adhering to a set of instructions on what constitutes good behaviour.
It requires using time and thinking flexibly to understand what drives our actions. Without it, there is a danger that we may witness other examples of substandard care. MHN

References
Acute mental health nursing and prn medication administration: a review of the literature

Emily-May Barlow presents the findings of a review into the use of ‘as required’ medication

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**Abstract**
This literature review examines the culture of prn medication within acute inpatient mental health settings. Administering medication on a prn basis largely falls to the judgement of qualified nurses. The themes explored are an overuse and reliance on prn medication, poor documentation surrounding this practice and the need for a standardised assessment. The implications of these are deliberated, including accountability, public image and media coverage (including the Francis Inquiry Report).

**Key words**
Medication, prn, acute mental health, inpatient, Francis Inquiry Report

**Reference**

**Introduction**
Pro re nata is a Latin phrase that translates to ‘in the circumstances’. Within nursing, this term relates to medications administered on an ‘as required’ basis.

Medication is a common treatment in acute inpatient settings, and acute wards continue to be a critical component of care for acute mental health services despite the ethos of mental health care moving to community based services (Healthcare Commission, 2008).

Within the first week of admission to an acute ward the majority of patients receive medication in accordance with the British National Formulary guidelines (Joint Formulary Committee, 2012). The choice to administer medication on a prn basis falls to the judgement of the qualified nurse as there are currently no specific national guidelines or policies for this routine practice.

As a newly qualified mental health nurse (who has relocated to a different country and is therefore working within different policies, guidelines and legislation), the author’s concern is that the care governance may not be ideal.

This is a relevant and thought-provoking topic professionally, considering that nursing conduct is accountable under Nursing and Midwifery Council (NMC, 2008) guidelines, which state: ‘You are personally accountable for your practice. This means you are answerable for your actions and omissions, regardless of advice or directions from another professional.’

In order to gain an understanding of the situation regarding prn medication within the acute environment a literature search was completed, from which several themes emerged. This paper aims to analyse the literature to establish the circumstances under which it is appropriate to administer prn medication to adults on an acute ward.

**Over-reliance on prn medication**
Current nursing practice relies on administering prn medication as a first line response to patient distress. Curtis et al (2007) report that prn medication is currently the primary intervention within acute inpatient care.

Baker et al (2006) found that factors such as time inhibit the use of non-pharmacological interventions. This qualitative study used semistructured interviews to explore mental health professionals’ opinions on prn medication and its large sample size of 59 involved professionals from four separate sites.

Curtis et al (2003) found there were more administrations of prn medication when wards were busy; suggesting that nurses rely on pharmacological interventions when time restraints prevent time-consuming alternatives. Curtis et al (2003) found there were less administrations of prn medication over the weekend, when ward environments are quieter (ie no ward rounds, and other departments are not on duty or requiring liaison).

Curtis et al (2003) also found that 11 patients (out of the 64 patients in the study) accounted for nearly half (46.4%) of the total of prn medication administrations. This was a small sample size for a quantitative study and the authors did not acknowledge this in their results. Other studies suggest there is an overuse of prn for a subset of patients (Stein-Parbury et al, 2008; Baker et al, 2007a).

Stein-Parbury et al found that a small subset of patients (18 from the 420 in their study) received more than 40 administrations of prn medication during their admission. This large-sample study found that these patients were more likely to present with psychotic symptoms, paranoid ideation, ‘bizarre behaviour’, elevated mood or physical aggression.
The authors suggest that patients who are more difficult to manage, because of their mental health presentation, are being overly medicated via prn.

Baker et al (2007a) found that three patients received over 50 administrations of prn medication each over a 10 week period. 35 patients participated in this study and 484 doses of psychotropic medication were administered in total within this time frame. Yet this study only included patients who were able to consent to medication administration, so it is possible the results would have been different if patients unable to consent had been included.

Documentation

One clear theme that emerged from the literature is the lack of nursing documentation when prn medication is administered. This was evident in a number of quantitative studies.

Baker et al (2007a) produced a times series design study to evaluate the impact of a good practice manual on professionals’ practice of psychotropic prn in acute mental health wards. The study found that prn medication was not documented at all in 38.2% of all administrations and that there was no evidence of documentation of side-effect monitoring at all throughout this study.

A disadvantage of this study is that bias was not eliminated: staff were recruited by the researchers themselves, only patients who could consent were included in the study, and the researchers scrutinised their own data to conclude their results. This suggests the methodology was flawed.

Both Curtis et al (2007) and Stein-Parbury et al (2008) found that the rationale for administering prn medication was lacking in the nursing documentation, for example Curtis et al (2007) found the rationale was documented in only 57.5% of administrations.

Both of these studies represent a cross-section of acute ward practice (being retrospective chart audit studies).

It could be suggested that other factors affected the results, such as the ward being short-staffed at the time of the study and consequently documentation around prn medication being less thorough.

In addition to the three quantitative studies above noting poor documentation around the use of prn, a thorough literature review on this subject by Molly et al (2012) researched the major nursing databases, and also supports this theme.

Standardised assessment

There appears to be inconsistencies in how prn medication is used within current nursing practice, and the need for a standardised assessment to eliminate such discrepancies is explicitly stated in the literature.

Baker et al (2007b) used a Delphi study to establish expert opinion and recommendations on the use of prn medication within acute services, with one recommendation being to implement a standardised protocol for prn practice.

To meet the criteria of an ‘expert opinion’, the participants had to have a professional healthcare background, hold a job at a senior clinical level, have publications on the use of prn medication, have been employed within acute care and have been recommended by a professional group such as the Royal College as Psychiatrists.

Chakrabarti et al (2012) attempted to complete a Cochrane review of any existing research to compare the effects of ‘as required’ medication regimens with regular regimens of medication for the treatment of psychotic symptoms or behavioural disturbance, thought to be secondary to psychotic illness.

This type of study is rigorous as it is able to establish cause and effect (Martin and Thompson, 2000) and systematic reviews of randomised control trials are valued as some of the highest-quality evidence available (Burns and Grove, 2001).

This review suggests that there is no trial-based evidence upon which prn medication is based, and without this scientific evaluation, the authors recommend the implementation of a protocol so this element of nursing is standardised.

It is not clear from the literature what form this should take and how it should be taken forward. It is reasonable to conclude there is a gap in practice, that practice varies, and that the methodology is flawed for some studies in the literature.

Discussion

This literature review highlights concerns with the practice of administering prn medication within acute environments. It is being used in some circumstances as a first response intervention, as opposed to therapeutic alternatives, and there is suggestion that a sub-group of patients are being overly administered prn medication.

The literature suggests that patients with more challenging characteristics (psychotic symptoms, paranoid ideation, ‘bizarre behaviour’, elevated mood or physical aggression), are more likely to be administered excessive amounts of prn medication (Stein-Parbury et al, 2008).

The UK’s national health system supports a recovery orientated approach (Department of Health, 2005). Relying on, and overusing, prn medication does not acknowledge the psychological, social or spiritual needs of an individual.

A recovery approach supports ‘person-centred care’ (Department of Health, 2010), i.e. the person should be placed at the forefront of care decisions. However, the evidence of staff relying on and overusing prn medication (because of limited skills and ward pressures) suggests a lack of person-centred care.

This topic is particularly relevant in the wake of the Francis Inquiry Report (2013) and the subsequent detrimental media coverage criticising the nursing profession for being uncaring and lacking compassion. Compassion has always underpinned nursing (Straughair, 2012), and the appropriate use of prn underpinned nursing practice, and is essential to the provision of person-centred care.

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mental health nurse are often criticised for being too uniform and thought of as tick-box exercises, for example, nurses often view risk assessments as being controlled by documentation that does not allow them to use their own initiative (Taylor et al, 2011).

The Francis Inquiry Report (2013) found standards of record keeping to be poor and inconsistent, reporting that ‘patient care and safety are prejudiced by such lapses’. Although documentation is a duty that does not require direct patient contact, failure to accurately keep records demonstrates a poor standard of patient care by nursing staff.

There are differences between individual’s practice of prn medication administration (ward and time pressures, personal clinical experience) and therefore a standardised assessment is necessary to ameliorate these differences (Baker et al, 2007b; Chakrabarti et al, 2012).

Some guidance on prn administration is provided within local rapid tranquillisation policies (Mersey Care NHS Trust, 2010; Tees, Esk and Wear Valleys NHS Foundation Trust, 2011; Plymouth Community Healthcare, 2012), however this only relates to patients exhibiting signs of violence and aggression, despite these policies recognising that administering medications on a prn basis does not always apply to violent or aggressive scenarios.

As part of this literature review the author consulted the Consultant Nurse Network to enquire about any prn medication policies (that are not specifically for aggressive or violent scenarios) that may be available locally: this was unsuccessful.

The search for prn medication policies found that Baker (2007a) produced a ‘Good Practice Manual’ on how best to use prn medication, which suggests that some aspects of administering prn medication have been established on non-research-based practices. For example, it suggests that antipsychotic medication is often given prn because of its sedative effect, yet this is a side-effect and as such is not recommended.

A guideline would address such issues and provide a standardised approach to this practice. Furthermore, a guideline reflecting established values of the nursing profession would ensure that nurses nationwide are consistently upholding a caring and compassionate approach when administering prn medication. In turn, this would maintain the integrity and reputation of nursing.

As part of the National NHS efficiency reconfiguration, plans are in place to further reduce acute inpatient beds as care shifts to the community (Healthcare Commission, 2008). Resources on acute wards (such as staffing levels) are likely to be stretched further and administering prn medication could ultimately replace lengthier talk-based therapeutic interventions.

Additionally, ‘difficult’ patients, who required more intense nursing staff support, could be most vulnerable to excessive prn medication administrations due to insufficient numbers of nursing staff and a lack of time and resources to provide therapeutic alternatives.

This review demonstrates that there needs to be more research on a suitable protocol for prn medication practice. However, any research into prn medication must also recognise many other influences on administration, for example staff-patient ratios and ward mix of patients, and not just measure prn in isolation.

**Conclusion**

The available literature on prn medication within an acute ward suggests that documentation around this practice currently does not meet the necessary standards of record keeping.

This is not in accordance with professional benchmarks and does not reflect the strategic method of reporting required of the mental health nursing profession.

Additionally, there appears to be a culture of overuse of prn medication, which can be attributed to a variety of circumstances including a lack of knowledge, having a busy ward environment and time pressures, but ultimately this does not justify patients receiving a quick-fix treatment instead of more favourable options for long-term recovery. **MHN**

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**References**


Me and The Meds: A personal story of a dysfunctional relationship

Rachel Waddingham gives a personal account of her relationship with medication

Meet the matchmaker
The year is 1998. I'm sat in the office of a psychiatrist. I'm anxious, my eyes are fixed on the floor and I'm trying to work out if he can help me.

He seems OK, but given that I have an alien hiding inside me I know that appearances can be deceptive.

My Dad, shellshocked by this girl sitting next to him in the space his daughter used to inhabit, listened carefully as I poured out my reality and placed it at the doctor's feet.

I'd been keeping it secret for years and desperately wanted someone to save me.

The doctor smiled reassuringly and told me that it was OK, that I just needed to come in to hospital so they could give me the medication that would get me back to university in no time.

In relationship terms this is akin to being taken to a dating guru by your family when you all fear that you are destined for life-long loneliness.

Through the depths of despair, the guru ignites a tiny ember of hope as they tell you they can help you find true love.

This is how I was ‘match-made’ with ‘The Meds’. That night, on the ward, I was handed a measuring cup with a tiny pill inside.

The part of me that didn't trust the reassuring stranger was quickly silenced by my need to find an exit from this downward spiral. With a deep breath, I swallowed the tablet and waited for my salvation.

The first few dates
My first date with The Meds was a non-event, as was my second, third and fourth. I felt dazed and sedated, but the voices were still in full flow and I still felt hounded by the aliens.

I would have given up, if not for the conviction of those around me. Despite our initial lack of chemistry, they implored me to give The Meds time.

It must be love
Sure enough, a month or so later we started to hit it off.

I remember one day my parents came to visit me only to stare, open-mouthed, as I drank from a can of pop without painstakingly examining it for signs of tampering.

Over time the voices began to fade and I felt less bothered by the aliens.

The nurses told me I had a spring in my step and was a world away from the tortured soul they met on admission.

It was clear to everyone that I had found my soul mate, my missing piece – The Meds.

I never promised you a rose garden
All relationships have issues. As the ‘honeymoon’ phase ends, we often become aware of our partner’s annoying habits.

Snoring... leaving the toilet seat up... but if the benefits of the relationship outweigh the drawbacks we might file these issues as ‘endearing quirks’.

The ‘quirks’ I gratefully accepted included extreme sedation, weight gain, lactation, diabetes, oculogyric crisis and akathisia.

If questioned, I'd barely acknowledge their existence. I knew I was lucky to be with The Meds and I wasn’t going to jeopardise our relationship.

Setting down for life
Eight months later, I was finally discharged from hospital with the understanding that I must stick with The Meds for life, no matter what.

I quickly settled into a routine: taking 12 tablets a day and going back to bed after each dose to sleep off the worst of the sedation.

Having internalised the belief that I was a severely ill schizophrenic with a chemical imbalance, I felt that merely existing was the best I could hope for.

Eventually, things began to shift. The sedation, the feelings of detachment, the mind-numbing fatalism of the prospect of taking these pills for every single day of my life... all the ‘quirks’ that I'd gratefully accepted began to grate.

I flirted with the idea of breaking free, missing doses here and there. The resultant string of admissions further solidified beliefs about my ‘illness’ and the sense of dread my parents felt at the thought of me without meds.

Unable to acknowledge or articulate my ambivalence, I repeated this loop over 20 times.

Growing apart
Paradoxically, it was only when I fully accepted my fate that I was able to shift my energies from fighting with The Meds to getting the life that eventually helped me break free.

It was slow and complicated, but the highlights include meeting the Hearing Voices Network, volunteering, finding an amazing housing project (Network for Change), gigging as ‘Rai Studley’ on the Leicestershire music scene and meeting some amazing people who believed in my potential and refused to give up on me.

I started to embrace connections with others rather than fear them.

Through these human relationships, I began to see myself as a human being with a story to
tell – rather than a walking bag of pathology.

In 2007, I became manager of the London Hearing Voices Project at Mind in Camden. The working world was a shock to my meds-addled system and it became clear that I needed to make some changes if I was going to keep the job I was beginning to love.

I started to develop flexibility in the way I took my medication, slowly withdrawing from the Venlafaxine and taking less on the eve of particular early starts.

This, plus a flexible employer and a husband whose morning ritual involved pouring coffee and porridge down me in between snoozes, helped me get by.

Over the next few years my dose crept down and I began to find I had more energy to cope with the day.

I wasn’t consciously moving away from The Meds – I was moving towards life.

The idea of stopping completely didn’t occur to me, I was still haunted by the lingering ghosts of multiple hospital admissions and a deep-seated belief in my own illness. I was scared of going backwards and losing myself again.

The first was reading an article by Joanna Moncrieff that indicated long-term neuroleptic use was frightening to dismiss than the long-term damage my medication might have caused was frightening.

As useful as this was, I knew that its cost was far too high. I wanted my life back.

**The withdrawal**

Knowledge about ‘rebound psychosis’, I was careful to take it slowly.

Still, after taking my final pill I remember my husband’s shock at waking to up me sitting, wide-eyed, in bed.

This signified a new chapter in our lives together. Having only known me post-meds, the sedation was deeply woven into his mental picture of me.

Over the first month, Joel had the opportunity to get to know a different Rai – someone more alive and vivacious than the girl he’d wed. It was as if I’d finally let go of a concrete-filled backpack we’d originally thought was stuffed with feathers. I felt free.

**The aftershock**

Aside from having to re-learn the art of sleep, things went smoothly until three of my most critical voices returned.

The floodgates opened and I was soon beset by 10 other voices, body sensations and visions. Without the protection of my medication-fuelled emotional buffer, I was raw and vulnerable.

During this time my psychiatrist, with whom I was trying to be honest, struggled to cope.

They subjected me to risk assessments, read out dire predictions about my future and pleaded with me to accept their help.

I found myself under a medical microscope and it was too much to bear. My voices screamed and I began to feel people psychically operating on my brain.

It was as if they forgot to sew up the wounds they created and I noticed my thoughts leaking out to those around me.

Exposed, I became a vacant shell unable to hold on to what was inside my own head.

Joel, having never witnessed this before, felt as if he’d lost his wife. I was unrecognisable.

**Crawling my way back**

Joel was a lifesaver during this time. Having listened intently to my prior ways of making sense of voices, he was in an ideal position to help me develop some pragmatic strategies to find a foothold from which to begin crawling back to my life.

These strategies enabled me to return to work, essential in helping me rebuild my battered confidence and sense of agency.

It wasn’t easy, but I was beginning to find a way of living without meds.

**Living my life**

Over time, I regained my prior ability to see my experiences as symbolic signposts rather than concrete facts.

I sought out a therapist to help me make sense of it all and 18 months after my final pill I began to feel like I had a handle on things.

Looking back, I’d come to view The Meds as the enemy and believed that if I could beat them I’d get my life back.

In truth, The Meds were simply a plaster that obscured and dulled the problems that led me to such a toxic relationship in the first place.

Re-thinking my relationship with medication involved recognising the good parts as well as the bad.

The Meds helped dull my emotions, keeping traumatic memories safely tucked away.

They helped me sleep; giving me respite from the voices I was unable to listen to.

Most of all, they helped me feel like an expert knew how to fix what I felt was deeply wrong with me.

The Meds were a promise that it was impossible to make good on.

Coming off medication wasn’t the end of my story, as I’d originally imagined, it was me picking up where I’d left off a decade before.

Taking my last pill was like going through the gate of a protected, but deeply uncomfortable, paddock back out into the world in all its intensity.

As hard as this can be, it’s also something that I relish. This is MY life, MY pain and MY joy and it’s MY right to experience it directly.

My unhealthy relationship with medication was created by a system that tried so hard to alleviate my suffering when what I needed was the support to face it and understand its source. MHN

Rachel Waddingham is the manager of the London Hearing Voices Projects at Mind in Camden. For more details see the website www.behindthelabel.co.uk

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**Write for MHN!**

Speak up! is an informal opportunity to for you to write for Mental Health Nursing about anything relevant to you and your fellow members. It can be subjective, serious or light-hearted, and you won’t be expected to provide references.

If you have something to say, then just contact the editor to discuss style and deadlines. Email mhneditor@gmail.com
Medication management in mental health: nurses’ perceptions of their work with service users and carers

Steve Hemingway presents findings of a study exploring how mental health nurses implement medicines management

### Introduction

Mental health nurses’ medicine management interventions have the objective of addressing the needs of the person who is prescribed medication, including effect and side-effect assessment, management and information exchange (White, 2004). Whether the mental health nurse prescribes or includes medicine management in their role, the aim is ensure the service user (and carer) receives the optimal therapeutic effect of the medication while minimising any potential adverse reactions (Snowden, 2010).

Psychotropic medication remains a leading intervention despite opposition to it claiming its use is for the social control of people with symptoms of mental distress (Cutliffe and Happell, 2009; Gray et al, 2009).

There are questions about the long-term efficacy of psychotropic medication, for example antidepressants (Moncrieff, 2007) and antipsychotics (Leiberman et al, 2006, National Institute of Health and Care Excellence, 2008).

Indeed, rather than increasing wellbeing and life expectancy, antipsychotics (DeHert et al, 2010), some mood stabilisers and antidepressants can increase morbidity and subsequent mortality (McCloughen and Foster, 2011; Hemingway et al, 2014). This also applies to younger (McCloughen et al, 2012) and older people (Baker et al, 2008) diagnosed with a mental illness.

There have been calls to minimise the use of psychotropic medication as their supposed benefits in treating mental health conditions have been described as mythical (Barker and Buchanan-Barker, 2012). Other commentators have suggested mental health nurses need to be at least more critical of psychotropic medication they might administer and prescribe (Harris and Shatnell 2012).

More than 90% of people in the UK diagnosed with a mental illness are prescribed some form of psychotropic medication – with the figure being over 90% in an inpatient (Care Quality Commission 2009) and 80% in the community context (Care Quality Commission, 2013).

Psychotropic medications, either used alone or alongside psychological therapies, remain the mainstay for the ‘treatment’ of mental health problems (Wand, 2013).

Medicines management is also established as a major part of the mental health nursing role, including prescribing, and mental health nurses are the largest group of registered practitioners involved in the care of mental health service users (Snowden, 2010; Hemingway et al, 2011b; Mutstata 2011).

Mental health nurses are at the centre of medicines management interventions (Gray et al, 2005; Hemingway and Ely, 2009), as they administer oral medicines or intramuscular injections, prescribe medications, advise clients and carers, liaise with other healthcare practitioners on prescribing decisions and assess the outcomes of medicines taken.

### Aim and objectives

This study focused on exploring the medicines management interventions that mental health nurses undertake and their
subsequent interactions with service users and carers.

It was part of a wider study exploring the impact of training on clinical competence for mental health nurses in medicine management interventions.

Methods
A qualitative design was used with in-depth semi-structured interviews for mental health nurse participants to reconstruct their perceptions of medicine management education they had experienced and how these transferred to clinical practice.

Registered mental health nurses were sought who were graduates from the University of Huddersfield and who worked for South West Yorkshire Foundation NHS Trust.

Recruitment was done by a trust wide-email inviting interested nurses to take part, and ten participants were recruited to the study.

Written informed consent was obtained before interviews. Participants were informed they could withdraw from the study at any time without giving a reason.

In the interview the aim was to explore the social aspect of the participants’ medicine management role in the clinical setting. Therefore the researcher is positioned within the research process, not as an objective observer outside of it (Hoare et al, 2012).

The semi-structured interview data was subject to qualitative content analysis outlined by Newell and Burnard (2006) by the researcher. Qualitative content analysis is a research method that involves making replicable and valid inferences from data, with the purpose of providing new knowledge, insights and representation of real life, and a guide to future action (Elo and Kyngas, 2008).

For this study the intention was to investigate mental health nurse participant experiences of medicine management interventions.

Six steps were involved in the analysis process. Stage one involved taking notes and memos of ideas and impressions during the interview. Stage two involved the researcher forming general ideas about emerging categories. Stage three involved the start of categorisation and some text reduction. Stage four involved finding overlapping data, and collapsing and refining categories. Stage five involved putting categories in place and linking them ready for reporting. The final stage is this reporting of the findings.

The length of graduate experience ranged from one to four years. The roles of the sample were broad ranging, involving working with people from 14 years to old age. The clinical contexts included inpatient, clinic and community settings, typical of where mental health nurses in the UK work.

Findings
The participants’ responses identified three key themes: dialogue, education and information, and adherence issues.

Dialogue
Communication is central to the client and carer being at the centre of decisions about the medication they are prescribed. Narrative accounts from the mental health nurses in the sample provided evidence that dialogue is enacted in different ways.

The content and the timing of the conversations depend on the mental status of the client. One participant illustrated this: ‘We’ve got people who are so acutely unwell, and they’re so disturbed that they can’t even have a conversation about what they want to drink or eat.’

In more open acute wards interactions with service users increase as their mental state improves: ‘We do have those discussions with service users, but it tends to be as the admission progress rather than from the very beginning really. The dialogue just starts a little bit later in the care pathway.’

Medicine administration was described as an opportunity to talk to clients about medication and other issues. For example, one participant said of being on a busy older people’s inpatient environment: ‘You don’t always get chance to talk to people. It’s a couple of minutes where you can have a chat.’

A participant who worked in a low secure rehabilitation setting said the medication round is an important opportunity for different reason: ‘Medication time is an opportunity when I might ask them if they feel it’s working or if they’re experiencing side-effects. Because unless I ask clients do not generally talk about them.’

For a participant working in acute adult inpatient care, discussion of client experiences’ of medication is a major focus: ‘I always ask how they find it, if it works, if it helps, if they’ve experienced anything that they could report, just to make sure that they really get to grips with what we’re giving – not just giving things to people who don’t understand about how medication works.’

For an admiral nurse participant whose main focus is to support the carer of someone diagnosed with dementia, interactions often involved discussing the risks and benefits of medication for carers, and sometimes there is resistance: ‘Because they’ve not been in mental health services at any point in their life, they find it quite difficult sometimes to accept taking medications. So we discuss the risks and benefits of antidepressant medication.’

Education and information
Educating the client and carer increases their understanding of medication, and their involvement in decision-making can be more informed.

Education interventions are employed in different ways according to capacity of the client, context and motivation. In the acute adult inpatient setting one participant discussed the use of information to facilitate understanding: ‘We’re big on giving patients leaflets and advising them about any medication they are prescribed. We educate them on their medication so they know what to expect and the potential side-effects.’

Information is also used in the community setting for service users under the care of the early intervention service (EIS): ‘We use a lot of the trust information on the website for managing medications, such as information sheets. These have up-to-date information that increases understanding of what they are facing.’

The need to provide dedicated time to discuss medication-related issues was illustrated by one participant: ‘We’ve found from getting feedback from people that ward
Medication management

round isn't long enough for people to ask questions about side-effects, why they're taking a medication, what are the expected outcomes. So it's giving people that bit of follow up to then feel that they've got an arena to ask any questions that they might not have had time to do in ward round.'

The approach taken is determined by the specific situation. On the inpatient acute ward this appears relatively straightforward for one participant: 'It's all about knowing what side-effects are there and educating patients. We also need to know more about potential side-effects of medication and so do patients as well.'

Another participant, from a psychiatric intensive care unit (PICU), explained how it differed from the open acute ward: 'You can't have that extended and kind of in-depth information exchange with people because they can't take it in often. I suppose it's about adapting the way you deliver medication, you know, deliver that knowledge to people.'

In the PICU setting education for the carer or family member can take place when service user involvement is restricted: 'We spend a lot of time with carers, explaining treatment plans, change of medications, what we intend to happen when we change someone's medication.'

The participant from the low secure inpatient unit also said they make sure the client has some knowledge of the medication they are taking: 'Because sometimes they don't even know what it is, especially when they first come here, some of them didn’t even know what they were taking, I'm sure it has been explained to them in the past, but if they've been quite psychotic, the information's probably not sunk in properly.'

Information on medication as a therapeutic option is also used for carers where appropriate:

‘This is for the carers, because they're often quite reluctant, so we'll discuss the benefits, we'll discuss what side-effects they should be looking for, we'll discuss how long they should expect to stay on their medication, that's really more to kind of bridge that gap for them because quite often the talk in therapies can only go so far. If somebody's really at the bottom, they need some medication to try and pick them up, so that's what we'll do to try and move that on before we start doing some counselling.’

A participant working with adults in the community identified the importance of medication discussions in outpatient appointments: 'I think the ones that stand out are outpatient appointments. We discussed how the medication should be given, both on the ward, whilst under the care of the crisis team and now coming to an outpatient appointment. We've reduced some of the medication so then I can go every week to make sure that her mental health is ok and that the medication is still doing his job, but not too sedating. So hopefully that means that her quality of life's going to pick up.'

**Adherence**

Medication adherence has been highlighted as a major cause of poor therapeutic outcomes or relapse. However, this is a very normal occurrence as people may not take medication because they are reluctant, see it as an inconvenience or may forget.

The participant working on the inpatient ward for older people had experienced such situations: 'We do have some people who, because of mobility issues or whatever or they're just flat out refusing to come round, then we do have to go to them and maybe don't have the opportunity to spend as much time with them.'

The participant employed in an EIS involves young people with are self-conscious about their appearance, so finding out about potential side-effects can be frightening and this may affect adherence: 'They're on the internet, having a look, thinking oh my god, I can't take that because I'm going to be impotent and I'm going to have boobs when I'm a man and Olanzapine has weight gain. Because of our client group being so young, they're bothered, they want to know, and they want to be slim and fit.'

Discussing issues important to the service user and carer helps adherence: 'The medication that they receive will go alongside our one-to-one sessions that we have. We unpick things so that clients are able to understand it easier, like the thinking, the perception, the behaviours, everything that happens, in their thought process. We try and help them to understand this by having these discussions at their homes where they're comfortable, and then obviously with parents as well.'

For the memory service adherence issues are related to the capacity of service users, and reluctance to report side-effects can present a challenge: 'When you ring people directly, we've been told that everything's fine in the past and then, we'll find out that they haven't been taking them or they've not been able to get off the toilet or then sometimes we find that the spouse have noticed side-effects, but they're that keen at keeping people on the memory medication that they don't tell us. So but we've got to say something, it's about quality of life.'

Establishing successful collaboration with carers of people diagnosed with dementia is of crucial importance: 'I've just had a couple come back to me that they weren't taking it, they were taking it haphazardly, they'd deteriorated and we've got them back on the higher dose and they're doing really well because the family are involved now and they're making sure that they're taking it and it's about knowing what to put in place for that person.'

The memory nurse highlighted individualising interventions: 'If someone’s always had a role in doing their own medication, the old-fashioned way, by laying out stuff, we usually leave them to that because they're usually alright with that. Pill dispensers, they're brilliant, but they're not good for everyone that can't do with technology.'

Attitudes toward medication was identified as a reason for non-adherence. The admiral nurse participant said: ‘We also talk to carers who are feeling very low and because they've not been in mental health services at any point in their life, they find it quite difficult sometimes to, accept taking medications.’

Self-administration of psychotropic medication was also discussed. A participant in low secure services uses an approach that takes into account client independence but still needs to monitor the adherence to good practice and safety protocols: ‘You're being vigilant, you're making sure you're not interfering with them doing their thing, but

> They are on the internet thinking ‘oh my god I can’t take that because I'm going to be impotent’

"
you’re making sure they’re dispensing the correct medication as well and you do have to remind them to look at their card, they know what medication they’re on and they just dispense it. It’s getting them to pick up the good habits of looking at the meds card, looking at the back of the blister strip and making sure that the dosage is right.”

Discussion
This paper evidences the perceptions of mental health nurse interventions and subsequent interactions they have with mental health service users and carers. What emerged in the findings is that participants reported they actively tried to involve the service user in the management of their medication.

Comments on the themes of dialogue, information and education, and adherence show how in their daily interventions mental health nurses sought to make medication appropriate and in keeping with service users’ and carers’ wishes and needs, their capacity to understand, and the context of their care.

Studies involving mental health service users show that medication is recognised as the primary therapy in inpatient settings that contributes toward their recovery (Bowers, 2005; Gray et al, 2005; Piat et al, 2009).

However, the relationship service users have with mental health nurses can determine if they are adherent to what is prescribed, and if they feel they are part of the decisions about the management of their medication (Day et al, 2005; Gilburt et al, 2008; Piat et al, 2009).

If the service user is not included and feels that care is coercive and not inclusive, this can negate the chances of a therapeutic engagement (Happell, 2004; Cutliffe and Happell, 2009). It also goes against mental health nursing training, ethics and the code of practice.

Hemingway and Snowden (2012) and Wakefield (2013) discuss how approaches to medicines management interventions are determined by best interest and the law. In circumstances where the service user lacks capacity this may mean dialogue is kept to a minimum.

In other circumstances, as emerged in this study, it is the nurse who is the instigator of conversations regarding the outcomes of medication. In these cases the mental health nurse is acting in the service user’s best interest and thus using an informed approach (Haglund et al, 2004).

Nurses have been criticised for communicating while administering medicines, yet where quality time is not available it may be the one time the nurse can talk to the carer during a busy shift.

In contrast the participant who worked in an EIS talked about a purposeful approach to allow the service user to reflect on their understanding and perception of medicines.

Another participant from an inpatient unit included discussions about medicines so the service user understands about the medicines they are taking.

Such dialogue is recognised as central to successful outcomes (Day et al, 2005; Piat et al, 2009) and something service users see as central to establishing a therapeutic relationship (Duxbury et al, 2010).

Information sharing is seen as pivotal in engaging service users (Duxbury et al, 2010). The information and education category included aspects of how the mental health nurses use such interventions in their day-to-day work.

Leaflets about prescribed medication were used that are obtained from the trust website. The trust uses information from the choice and medication website originally developed by Professor Stephen Bazire and colleagues in East Anglia, which has information about 150 medicines used in mental health care (South West Yorkshire Partnership Foundation Trust 2014).

Process consent for service users taking psychotropic medication is highlighted as an essential medicines management intervention (Harris, 2009). This intervention seeks to empower the service user to be informed about the medicines they are prescribed. Thus the mental health nurse participants appear to be utilising such an approach.

Educating carers also emerged in this category. Carers are recognised as being key to optimum treatment outcomes and their engagement is crucial (Mutstata, 2011).

Adherence to medications is an important issue in the service user-mental health nurse interaction. Adherence, in terms of taking the dose of medication as prescribed, is the main factor in the prevention of relapse for the client certainly for people diagnosed with a severe mental illness (Gray et al, 2009; Hemingway et al, 2013).

However, episodic or total non-adherence with taking neuroleptic medication has led to increases in relapse rates, hospital admissions and higher rates of suicide (Valenstein et al, 2006; Norvick et al, 2010).

Non-adherence is a very normal fact when compared to people taking any form of prescribed medication. There is no one intervention or factor for any health condition or context that increases the likelihood of service users taking medication that is prescribed for them (National Institute of Health and Care Excellence, 2009).

NICE (2009) also concluded that the best approach is to engage the client with a person-centred approach that involves them to be informed and involved in decision-making about medicines.

There are significant factors that mental health nurses encounter that lead to non-adherence. One participant working in an inpatient older people’s environment pointed to problems with physical mobility as well as people avoiding being administered medicines.

Such difficulties are recognised in the research literature for the inpatient environment with an understanding problem-solving approach suggested (Happell, 2004; Duxbury et al, 2010).

A mental health nurse who worked with younger people with a mental illness related to the stark reality that antipsychotic medication side-effect profile is significant, for example weight gain is negative issue when personal image is so important to them.

Addressing non-adherence to treatment in early intervention services for psychosis is one intervention noted as a key factor in positive outcomes for clients. For the memory nurse memory problems or side-effects from taking cholinesterase medication may lead to non-adherence. The importance of educating service users and carers toward their condition and monitoring and managing...
Medication management

side-effects is a key intervention to promote adherence (Owby et al., 2006; Watts and Curran, 2013). Mental health nurses in this study used various adherence interventions. For the memory nurse the key to adherence is to collaborate with the carer when memory problems may lead to non-adherence (Smith and Hemingway, 2005; Stapleton, 2010).

Using a person-centred approach to tailor interventions to the service user’s particular outlook and abilities also increases the chances of successful treatment (Stapleton, 2010; Snowdny, 2010).

For the mental health nurse seeking to support the service user’s recovery in the early phases of psychosis, engaging them in medication decisions as one aspect of their treatment increases their feeling of control of their life (Roberts, 2007).

Establishing a therapeutic relationship allows for meaningful conversations to take place and a focus on adherence to medication can decrease relapse rates for people under the care of the EIS (Brown et al., 2013).

Ambivalence or an attitude against taking medication are identified as risk factors to taking medication (Harris 2009; McCann et al., 2008). Such attitudes are normal, and are issues to address in adherence interventions by the mental health nurses (Harris, 2009; Pat et al, 2009).

In the case of the admiral nurse the time spent on discussing the risks and benefits of medication for the family member is the key link in the care of the service user that could enhance the chances of an optimal outcome of antidepressant therapy (Chong et al, 2011; Scrandis and Watt, 2013).

Self-administration of medicines by service users can involved challenging the traditional medical model of nurses administering medications (Murray, 2011).

One participant described how they took a balanced approach that ensured safety but ensured the service user is in control of dispensing the medication. Mental health nurses’ assessment of the service user’s skill and capacity in self-administration is an important determinant in assessing future adherence to prescribed medication (Manias, 2004).

Although ultimately it is the service user’s choice if they take medication when they go home, education about what is prescribed and its risks and benefits can lead to improvements in satisfaction, knowledge and independence (Anderson et al, 2014).

Conclusion

This study sought the perspective of mental health nurses’ work with service users and carers involving psychotropic medication. Mental health nurses felt they implemented important activities that enable service users to get the optimum treatment outcome.

In a world where nurses are under increasing pressure to prove the value of their interventions, more emphasis is needed on how to implement evidence-based knowledge and skills in relation to medicines, which engage and involve the service user.

Medication can contribute toward a meaningful recovery. Medicines management very much remains an activity the mental health nurse undertakes and the growing case against the long-term use of psychotropic medication should not obscure the very real need for mental health nurses to have medicines knowledge and skill so that inherent issues can be discussed with the service user and carer so that choices can be made in an informed manner.

This study involved a small sample and claims of transferability need to be treated with caution. The participants were not asked to critique their own practice, so the findings may have been more positive about the mental health nurse role than might otherwise have been.

Participants in the study also volunteered with an apparent recognition that they saw medication as a major part of their role. Other mental health nurses may not have identified with it as comfortably.

Further research is needed to determine what skills and knowledge mental health nurses need to impact on health outcomes in terms of service context and service user need in relation to medication.

References


Medication management


George Coxon reacts to the latest report on the capital’s situation from The King’s Fund

The transformation of London’s mental health care

Introduction
We all regard The King’s Fund as a significant influencer of policy on health and social care issues.

We have seen and read the Mental Health Productivity Challenge work the organisation did and also the themes around the co-morbidity aspects of links between long-term conditions and mental health problems so we take a keen interest in all it says, particularly about mental health care.

The latest report, Transforming Mental Health Services – A Plan for London, offers a context and framework for the capital.

A read of this report’s 55 pages leaves me with some thoughts that I feel are worth sharing.

London’s particular challenge
The scene-setting data of facts and figures give us a picture that has challenged my initial opinion of ‘well, London is not really much different to anywhere else is it?’

Most striking was the description of the demographic mental health landscape – £7.5 billion total spend on London mental health care, and overall £26 billion health impact when taking account of loss of tax income due to work days lost resulting from mental health impact and other calculated costs, 88,000 carers of people with mental health problems and – most startling for me – 70% of those with psychotic disorder – most startling for me – 70% with mental health problems and costs, 88,000 carers of people with mental health problems and costs, 88,000 carers of people with mental health problems and costs, 88,000 carers of people with mental health problems and costs.

I was equally struck by the contrast for London compared to many other parts of the country of a low incidence and prevalence for depression and dementia yet high numbers of people with psychosis – leading me to reflect on my many trips to London where I witness a great many people living rough who, of those I speak to, always rather leave me ashamed of our collective dereliction of duty of care in not reaching the hard-to-reach and highly vulnerable people – mostly men often seeming tormented, dishevelled and hopeless.

The life expectancy gap
The report highlights the life expectancy gap for those people living with not just a diagnosis, symptoms and challenge associated with a serious enduring mental health problem, but also who have had a lifetime of treatment that has often caused co-morbidities such as lethargy, weight gain and difficulties with ordinary living such as being active and motivated, unable to get work and live life away from benefits.

Providing consistent services
With 32 clinical commissioning groups and 10 different specialist mental health provider trusts, there is a challenge too in providing a consistent service framework detailed enough to address some of the specific difficulties affecting London.

I missed any real reference in the report to the London population as I see it – but if I may hypothesise my observations as a non-Londoner the groupings of Londoners are as follows:

• The ‘haves’ – the 5% of people living well in nice houses, driving nice cars largely oblivious to the world of mental health struggle going on around them.
• The ‘aspirationalists’ – the 30% of often young upwardly mobile, ambitious keen professionals building their careers feeling intensely what we might regard as competitive positive pressure – but pressure nonetheless.
• The ‘workers’ – the 40% of the population that keep the city working – taxi drivers, retail workers, health and social care staff, infrastructure and maintenance workers – not without life difficulties – mostly not earning enough to live particularly comfortably but essential to the city’s functionality.
• The ‘transients’ – the 20% of visitors and tourists as well as business people in the city for short bursts, but who have their own stresses and tribulations and when in difficulty from a mental health perspective present often complex and unique challenges.
• The ‘have nots’ – the 5% of people living rough and struggling to cope, feeling disaffected and disenfranchised, with a high proportion disengaged from support and many with florid psychiatric morbidity, and highly vulnerable to desperate and tragic life.

All of the thoughts I have set out so far don’t exactly offer a ‘punch line’ as such – however, I do want to give one.

I have responded already to the report on the comment page of The King’s Fund report website – and I strongly recommend we all sign up to the regular news bulletins and automated email newsletters – my comment and those of others can be found using the link www.kingsfund.org.uk/publications/transforming-mental-health#comment-72037.

My comments, as you will see, talk of a missed opportunity to set out a commissioning tool that can raise the bar and address the inequities affecting mental health service investment, and I also say something about a lack of mention of integration between health and social care.

Getting involved
However, a real punchline for us mental health nurses must be that make sure we engage in receiving these types of reports with an open mind and a willingness to read and respond to them, and also to make sure we get involved more in the producing the reports too – reflecting the need for more protection and inclusion of mental health nurses in future-proofing best care and quality support to those needing it – whether in London or elsewhere.

George Coxon is chair, Unite/MHNA Organising Professional Committee; specialist mental health advisor – Nursing in Practice; Director, Classic Care Homes; and independent mental health and commissioning advisor

George Coxon is chair, Unite/MHNA Organising Professional Committee; specialist mental health advisor – Nursing in Practice; Director, Classic Care Homes; and independent mental health and commissioning advisor.
Part one provides strategies for the development of the care plan. The emphasis is on interaction skills between the professional and client.

The various teaching methods are demonstrated through the use of role plays and case studies, which is appealing.

Part two has a specific focus on key concepts of care. Again, from a student's perspective, it gives insight into the importance of the nurse-client relationship.

It allows the reader to focus on various aspects of the individual's life that need to be incorporated in the planning, implementation and evaluation of nursing care.

The main focus of part three is the nursing diagnosis and how this should be addressed in the format of a care plan.

This chapter is particularly useful as it is structured in a format that is clear and easy to understand.

It provides in-depth suggested nursing interventions that are evidence based, and gives readers a clear focus on the need for nursing interventions to be written in a format based on rationale for use.

The manual is written in a format that is easy for nursing students to understand.

It addresses all the outcomes in the nursing process and provides a range of learning tools, resources and further suggestions for up-to-date reading.

We both felt that some of the terminology used seemed to assume a more advanced level of understanding.

However, we both felt that this challenged our learning and widened our knowledge in relation to terminology.

We both agreed that the book will be beneficial to students who are in their final year of training.

The manual is most definitely one that we will continue to use throughout our nursing careers.

Sharon Baxter and Nina Hargreaves

Grandma Remember Me
(2014)
Az2B Theatre Company
Various locations
www.az2b.co.uk

Grandma Remember Me is a play written by Belinda Lazenby in order to highlight the impact of dementia on the person and their families.

The website describes it as a ‘beautiful story about a special relationship between a grandma and her granddaughter’, which ‘explores the importance of memories and relationships within our lives and how to keep and treasure them’.

The show was staged by the Az2B theatre company, which although based in Cornwall puts on shows across the country.

I was lucky enough to sit in on a production with a group of nursing students.

If you get the chance to see this play it will move you to tears and remind you of the impact of dementia on all who are involved.

Often on a busy ward at the end of a long shift it can be all too easy to forget the person behind the illness.

What Grandma Remember Me does for the students and the audience is remind them not to forget the person, and to try to understand them.

The play uses puppetry and combines this with acting that makes you immersed in the production.

It takes you through the stages of the illness, looking at the impact in a compassionate and thought-provoking way.

I urge you to try to see this play, whether you are training or have years of experience working with people and their families suffering from dementia.

It was a refreshing but realistic look at this important issue.

Some of the students’ comments that were fed back to the team included ‘touching’, ‘realistic’ and ‘passionate’, which testimony to an excellent play and one that I believe will have a significant impact on their learning.

For more information visit www.az2b.co.uk.

Many Bancroft

Psychopharmacology: Practice and Contexts
Karen-leigh Edward and Chris Alderman
Oxford University Press
(Australia & New Zealand)
(2013)
288 pages
£31.99

This book takes the reader from the history of psychopharmacology through to up-to-date knowledge and practice.

It is refreshing to see the healthcare professionals’ roles identified and the inclusion of pharmacists (although this may be a reflection on the fact that one of the authors is a pharmacist).

The authors manage to make the early chapters on pharmacokinetics and pharmacodynamics readable and readily understandable, making it a useful text for all pharmacology students.

As well as theory, there is
particular emphasis put on the
experience of the patient as they
move through the system.

Patient stories are introduced
early in the text and continue
throughout. These are powerful
and relate to the reader the
problems for the patients,
families and carers living with mental
health problems.

The book is written in three
sections. The first deals with
history, law and ethics and
therapeutics, while the second
gives an outline of the major
mental illness with therapeutics
included and a particular
reference on patient care.

Finally the third section covers
advanced nursing practice and
nurse prescribing.

As well as describing existing
therapies, the book also mentions
those that are in development.

It will be important to have
future editions updated with the
newest therapies and practice.

Although written for Australian
and New Zealand audience with
a focus on nursing practice, the
majority of information in the book
can be used internationally by all
mental healthcare professionals.

I particularly recommend the
book for pharmacists working
in psychiatry, all prescribers
in mental health, allied health
professionals and all mental health
nurses.

I was interested in the
differences in the care systems to
those in the England and, although
the majority of the drugs used are
the same, many of the licences
are different and the drugs vary
in popularity in the different
countries.

The use of a national
medication chart is identified as
valuable in reducing medication
errors. Although an all-Wales
medication inpatient chart has
been introduced, attempts to
produce a national medication
chart for use in inpatient mental
health facilities have fallen by the
wayside in England.

Sections of the text are ideally
suited for group work, peer and
multidisciplinary team working,
learning and review.

Aspects of the cases and
answers can be adapted to
support current caseload working.

Lynn Haygarth
Specialist pharmacy adviser, mental health

Social media and the MHNA

Stay informed online through the MHNA’s
social media connections.

Facebook: http://www.facebook.com/#!/UniteMHNA
Twitter: http://twitter.com/#!/Unite_MHNA (@Unite_MHNA)
Join Unite/MHNA!

As a trade union, Unite protects your rights, health, safety and wellbeing at work. Unite negotiates on your behalf with employers and the UK and European governments to get you a fair deal at work.

Why join?
There are many benefits to joining Unite/MHNA:
• Free, 24/7 access to our online journal Mental Health Nursing
• Indemnity insurance cover to £3m
• Online information and support at www.unitetheunion.org
• Advice and support exclusively from and for mental health nurses
• Opportunities to network with other mental health nurses
• Professional guidance on clinical and professional issues
• Full labour relations, legal and industrial support from the biggest union in the country

What are the workplace benefits?
Our aim is to get you the highest possible level of pay and the best terms and conditions of service, and to provide advice and support on any matter you may need related to your job. It is a proven fact that well organised, unionised workplaces have better terms and conditions than non-union workplaces:
• On average 6% higher basic rates of pay
• Less sexual or racial harassment
• Less bullying in the workplace
• Better health and safety performance
• More skills and training provision
• Better training representatives and effective procedures

Support and representation: You have the legal right to be accompanied by a trade union representative if you have a workplace grievance or if you are facing disciplinary action.

Legal support: You will get free legal support on any employment or work-related issue, once you have completed the minimum membership period (at the discretion of the Union’s Executive Council).

Campaigning: Support for your industry and company through campaigns and political lobbying.

How to join
You can join MHNA online by visiting our website at: www.unitetheunion.org/mhna and clicking on Join MHNA Online.
You can also join by completing the form on the journal’s back page and sending it to:

Unite Health Sector – MHNA
Unite the Union
128 Theobald’s Road
Freepost London WC1 8BR

Direct Debit Guarantee
This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society. If the amounts to be paid or the payment dates change, Unite the Union will notify you 10 working days in advance of your account being debited or as otherwise agreed. If an error is made by Unite the Union or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid. You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us. Alternatively, you can call our Member Services Team on: 0800 587 1222.

Data Protection Notice
By joining Unite the Union you are providing information which may be used for administrative purposes, the holding of elections and other statutory requirements. If you do not tick the box overleaf you consent to Unite the Union passing on your information for the promotion of membership services (e.g. Insurance). We may disclose your information to our service providers and agents for these purposes. However if we do disclose your information, we will put a contract in place to ensure it is protected.

We or they may contact you by post, telephone, (but not if you or the subscriber to a telephone line has registered with the Telephone Preference Service), e-mail, SMS Text or such other means as we may agree with you from time to time, to let you know about any goods, services or promotions that may be of interest to you. We may keep your information for a reasonable period to contact you about our services. We have the right to ask for a copy of your information (for which we charge a small fee) and to correct any inaccuracies. To make sure we follow your instructions correctly and to improve our service to you through training our staff, we may monitor or record communications.

Monthly rate | Annual rate
--- | ---
‘Core’ full time members | £13.86 | £166.32
‘Core’ part time members (10-20 hours per week) | £7.58 | £90.96
Special discounted rate | £3.42 | £41.04

The special discounted rate applies to members under 18, members not working who are in full time higher or further education, unemployed members of the community, members who are volunteers, members who normally work under 10 hours per week, members who are unemployed, or who have been prevented from working on medical grounds, or are on maternity/paternity leave, retired or permanently disabled members.
<table>
<thead>
<tr>
<th>Membership Form - GB</th>
<th>About You</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surname</strong></td>
<td>[ ], [ ], [ ]</td>
</tr>
<tr>
<td><strong>Forename</strong></td>
<td>[ ], [ ], [ ]</td>
</tr>
<tr>
<td><strong>NI No.</strong></td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>House No./Name</strong></td>
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<td><strong>City/Town</strong></td>
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<td><strong>Postcode</strong></td>
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<tr>
<td><strong>Home Tel.</strong></td>
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<td><strong>Email</strong></td>
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<tr>
<td><strong>About Your Job</strong></td>
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<tr>
<td><strong>Employer/Company Name</strong></td>
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<td><strong>Department</strong></td>
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<tr>
<td><strong>Job Title</strong></td>
<td>[ ] (MHNA)</td>
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<td><strong>Work Address</strong></td>
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<tr>
<td><strong>Postcode</strong></td>
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<td><strong>Work Tel.</strong></td>
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<td><strong>NMC No.</strong></td>
<td>[ ]</td>
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<tr>
<td><strong>Tick box only</strong></td>
<td>[ ]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Equal Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unite the Union is committed to the promotion of equal opportunities for all and it is the Union’s aim to provide services and support to members that is free of discrimination on the basis of race, gender, religion, sexual orientation or disability. What ethnic group do you belong to?</td>
</tr>
</tbody>
</table>

- [ ] White British
- [ ] Mixed White & Black Caribbean
- [ ] Asian or Asian British Pakistani
- [ ] Black or Black British African
- [ ] White Irish
- [ ] Mixed White & Black African
- [ ] Asian or Asian British Bangladeshi
- [ ] Black or Black British Other
- [ ] White Other
- [ ] Mixed Other
- [ ] Asian or Asian British Other
- [ ] Black or Black British Caribbean
- [ ] Black or Black British Other
- [ ] Mixed White & Asian
- [ ] Other/please specify [ ]

- [ ] Do you regard yourself as disabled? |

- [ ] For office use only (Member No.) [ ] [ ] [ ] [ ] |

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**Direct Debit Details**

**Instructions to your Bank or Building Society to pay by Direct Debit**

**Originators ID Number** [9, 7, 1, 4, 6, 7]

**Name of bank/building society**

**Town of the Bank**

**Sort Code** [ ] [ ] [ ] [ ] [ ] [ ] On the selected day of the month: [ ] [ ] [ ] [ ] [ ]

**Account Number** [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**Name(s) of Account Holder(s)**

**Instruction to your Bank or Building Society**

Please pay Unite the Union Direct Debit monthly from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with Unite the Union and, if so, details will be passed electronically to my Bank Building Society.

**Authorisation of deduction of your trade union contribution from your pay (check-off)**

**Note: Not all employers operate check-off.** I hereby authorise the deduction of Unite the Union subscriptions from my pay of such amounts as shall be notified to my employer on my behalf from time to time by Unite the Union. I also authorise my employer to inform Unite the Union of any changes of address.

- [ ] Paid weekly or monthly? [ ] Weekly [ ] Monthly [ ]

**Payroll No.**

**Please read the Data Protection notice.**

You have the right at any time to stop us using your details for third party marketing purposes. If you do not wish us to communicate with you or share your contact data for these purposes, please tick this box. Please note that this will preclude you from receiving our special offers or promotions.

I agree to abide by the union’s rules. I authorise the payment above.

- [ ] Signature(s) [ ] [ ] [ ] [ ]

- [ ] Date [ ] [ ] [ ]

**Equal Opportunities**

- [ ] White British
- [ ] Mixed White & Black Caribbean
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- [ ] Other/please specify [ ]

- [ ] Do you regard yourself as disabled? [ ]

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