Practice leadership in mental health and intellectual disability nursing

Note

Healthcare practice and knowledge are constantly changing and developing as new research and treatments, changes in procedures, drugs and equipment become available.

The editors and publishers have, as far as is possible, taken care to confirm that the information complies with the latest standards of practice and legislation.

Practice leadership in mental health and intellectual disability nursing

Edited by

Mark Jukes

Quay Books Division, MA Healthcare Ltd, St Jude's Church, Dulwich Road, London SE24 0PB

British Library Cataloguing-in-Publication Data
A catalogue record is available for this book

© MA Healthcare Limited 2013

ISBN-10: 1-85642-506-1
ISBN-13: 978-1-85642-506-3

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior permission from the publishers

Edited by Jessica Anderson

Printed by Mimeo, Huntingdon, Cambridgeshire

Contents

List of contributors *vii*
Foreword *ix*
Introduction *xi*

Section One: Policy context for leadership
1. Intellectual disability and mental health nursing in the 21st century 1
   Mark Jukes and Vicky Clarke

Section Two: Understanding the use of self in leadership
2. Self-awareness and personality 21
   Helen Goulding and Emma Lyall
3. Practice leadership and emotional intelligence 31
   Fred Ruddick

Section Three: Applying the trilogy to develop effective leadership
4. Reflective practice and its relationship to practice leadership 43
   Nicola Clarke
5. Maximising capacity and creativity through coaching 53
   Stephen Conlon and Dean-David Holyoake
6. Practice development: Mental health and learning disability 69
   Cheryl Chessum

Section Four: Leadership perspectives
7. Learning disability nursing in the UK: Issues and challenges 85
   Michael Brown and Karen Nankervis
8. Mental health: UK and international perspectives 99
   Mervyn Morris

Section Five: Leadership and strategies for change
9. Towards leadership and social inclusion 109
   Mark Jukes
10. Strategies for implementing and managing change 123
   Mark Jukes, Premchunlall Mohabeersingh and Paul Allen

Section Six: Practice challenges in learning disability nursing
11. Better care in hospitals: Care adjustments for equal treatment 139
Jim Blair
12. Learning disability intensive support teams 149
Jonathan Beebee
13. Practice leadership in community forensic learning disability services 167
Carl Benton and Rachael Garvey

Section Seven: Practice challenges in mental health nursing
14. Practice leadership and child and adolescent mental health 179
Paul Millwood, Jon Stringer, Josh Millward and Mike Jenkins
15. Crisis resolution and home treatment 189
Tom Casey
16. Role of the matron in a medium secure service 201
Stuart Guy, Lorraine Conlon and Sophia Nuala Fletcher

Section Eight: Leading in education and cultural diversity
17 Education and leadership 213
Paul Illingworth
18 Cultural diversity 223
Marion Johnson

Index 233

List of contributors

Editor

Mark Jukes – Reader in Learning/Intellectual Disabilities, Faculty of Health, Department of Mental Health and Learning Disabilities, City South Campus, Birmingham City University.

Contributors

Paul Allen – Senior Lecturer in Public Health, Department of Public Health, Faculty of Health, Birmingham City University.

Carl Benton – Associate Lecturer/Practitioner for Medium Secure Forensics For People With Intellectual/Learning Disabilities, South Birmingham Mental Health Foundation Trust and Birmingham City University.

Jim Blair – Consultant Nurse in Intellectual/Learning Disabilities, St Georges Hospital, London.

Jonathan Beebee – Team Leader for the Intensive Support Team, Intellectual/Learning Disabilities, Southampton.

Michael Brown – Nurse Consultant and Reader in Health and Social Care, Edinburgh Napier University, Edinburgh.

Tom Casey – Community Mental Health Nurse, Crisis Resolution and Home Treatment, Birmingham and Solihull Mental Health Foundation Trust.

Cheryl Chessum – Associate Lecturer/Practitioner, Birmingham Community Mental Health Trust and Birmingham City University.

Nicola Clarke – Senior Lecturer in Mental Health Nursing, Department of Mental Health and Learning Disabilities, Birmingham City University.

Vicky Clarke – Head of Department, Mental Health and Learning Disabilities, Birmingham City University.

Lorraine Conlon – Lead Nurse, Reaside Clinic, Specialist and Complex Care, Birmingham and Solihull Mental Health NHS Foundation Trust.

Stephen Conlon – Associate Lecturer/Practitioner in Solution Focused Practice, Birmingham City University and Longbridge Health and Community Centre, Birmingham.

Sophia Nuala Fletcher – Matron, Reaside Clinic, Specialist and Complex Care, Birmingham and Solihull Mental Health NHS Foundation Trust.

Rachael Garvey – Senior Community Forensic Nurse, Greenfields, Birmingham Community NHS Trust.

Helen Goulding – Lecturer in Learning Disabilities, Department of Mental Health and Learning Disabilities, Faculty of Health, Birmingham City University.

Stuart Guy – Matron, Reaside Clinic, Specialist and Complex Care, Birmingham and Solihull Mental Health NHS Foundation Trust.

Dean-David Holyoak – Senior Lecturer in Mental Health, University of Wolverhampton, West Midlands.

Paul Illingworth – Independent Nurse and Health, Social and Justice Sector Consultant, Targeted Health Integrated Solutions, Birmingham. Previously Head of School of Nursing, Faculty of Health, Birmingham City University.

Mike Jenkins – Clinical Nurse Specialist, Birmingham Child and Adolescent Mental Health Services.

Marion Johnson – Senior Lecturer in Mental Health, Department of Mental Health and Learning Disabilities, Faculty of Health, Birmingham City University.

Emma Lyall – Team Manager, Children's Services, Greenhill Lodge Children's Home, Worcester.

Josh Millwood – Patient Governor, Birmingham Childrens Hospital, Birmingham.

Paul Millwood – Senior Lecturer in Mental Health, Faculty of Health, Department of Mental Health and Learning Disabilities, Birmingham City University.

Premchunlall Mohabeersingh – Senior Academic, Faculty of Health, Department of Public Health, Birmingham City University.

Mervyn Morris – Professor of Mental Health, Director, Centre for Mental Health, Birmingham City University.

Karen Nankervis – Centre Director and Chair, Behaviour Support, Centre of Excellence for Behaviour Support, University of Queensland, Australia

Fred Ruddick – Senior Lecturer in Mental Health, Cumbria University, Carlisle

Jon Stringer – Nurse Consultant, Walsall Child and Adolescent Mental Health Services, Walsall, Birmingham.

Foreword

I am delighted to write this foreword as there has never been a better time to address leadership in mental health and learning disability nursing. The authors, all experts in their field, tackle this ambitious task by focusing on leadership in the delivery of personalised care, support, and the promotion of wider inclusion.

With nursing leadership under the spotlight, this book gives us the opportunity to identify why it is important to strengthen nursing leadership and to understand its influence in shaping practice and improving the quality of care. In an open and transparent culture staff members share and reflect on their experiences, they are encouraged to speak up when they have concerns, to seek support when needed and are helped to build emotional resilience. It helps us explore the relationships between effective leadership and improved outcomes for patients. The book is a valuable resource for educators, employers, and nurses working in practice, particularly those who are ready for change and improvement but are unsure how to go about making those changes.

Providing high quality personalised care can be a challenge for those working within mental health and learning disability services, but the principles of respect, participation, choice and control must always be applied. We have to get to grips with the failings identified in recent reports, listen to and involve the people we care for and their families, and make sure that high quality person-centred care is the norm. This book promotes investment and engagement to develop nurse leaders, illustrating how their skills can change service provision, engage service users in their care planning and embed patient-centred care across the health and social care system.

Mental health nursing and learning disability nursing offer valued, fulfilling and rewarding careers. It is important that we promote these fields of nursing, recognising and celebrating the contribution that they make. We need to enable role models to exert their influence across the whole nursing community and tackle the institutionalised discrimination towards these vulnerable groups.

Developing strong and influential leaders within mental health and learning disability services is an essential part of practice development. Mental health nurses and learning disability nurses are at the forefront of transforming services, service development and improvement. They lead new ways of working, wherever people need their care, creating a culture where good practice becomes common practice.

This book explores how to create and nurture practice leaders in mental health and learning disability services, and how this will improve people's experience of care. It offers a reminder of why most of us come into the nursing professions: to make a difference; to care for people when they are at their most vulnerable; to help people stay healthy or help them recover from illness; to promote well-being and support independence; and to ensure they experience high quality care and the best possible health outcomes.

Ben Thomas
Professional Nursing Adviser for Mental Health and
Learning Disability Nursing
Department of Health, England

Introduction

The landscape of services and support for people with mental health needs and for those with intellectual disabilities has changed considerably, particularly over the past 20 years since the introduction of the NHS and Community Care Act. Services continue to evolve around the personalisation and social inclusion agenda.

People with an intellectual disability also experience mental health distress and require treatment within acute primary, secondary or tertiary mental health settings. This text will help readers to acquire further insights and understanding into a broadened agenda for practice. Mental health and intellectual disabilities nurses share commonalities in terms of legislation, human rights, the deleterious effects of marginalisation and exclusion, and similar nursing practice issues towards the promotion of personalisation, inclusion and person-centred care.

The past decade has seen the arrival of personalisation in the UK, and the processes and outcomes of a traditional service-led approach have lead to people not receiving the right help at the right time. For some this has meant being excluded from mainstream services, such as transport, leisure, education, housing and health, and opportunities for employment regardless of age or disability (Allen et al, 2009; Department of Health, 2001, 2009).

So, the question that needs to be asked is, what are the leadership challenges in transforming mental health and intellectual disability services so as to deliver more personalised support, inclusion and care choices?

Several factors mitigate against engaging with personalisation, including traditional service model design and professional hierarchies. Nurses tend to resist letting go of established forms of assessments and methods of intervention.

Additionally, traditional forms of decision making culminate in an inability or reluctance to let go of professional power differentials, which are perceived as paternalistic and retain control over people.

Further challenges that personalisation offers for people with mental health needs and for people with intellectual disabilities are the opportunities to break down stigma and institutionalisation. This creates opportunities for integration through increasing self-determination, engaging with and promoting empowerment, independence, choice and control.

There are, however, additional challenges for professionals, where augmenting inclusion means managing particular types of risk and fluctuations in individuals' abilities to gain mental capacity. Professionals also need to be able to facilitate best interests and screen for and prevent deprivation of liberties – all issues that are embedded within the Equality Act 2010. Personalisation is about giving people more choice and control over their lives in all settings, including healthcare.

Personalisation implies a paradigm shift in thinking and practice at a personal/professional, political and developmental level, and therefore implies a radical agenda for change which ultimately will stretch present leadership norms and expectations.

Leadership challenges include driving a values-led service, and service transformation which sustains cultural change within and across organisations, all achieved within public spending restrictions.

This text is about practice leadership towards personalisation and person-centred care, and is grounded in relationship building, the development of shared values across services, the encouragement of creativity, the capacity to influence others and the ability to facilitate collective inputs and energies rather than "direct" them.

These human-based interactional qualities and competencies require practitioners to have a renewed, robust sense of confidence with strong person-centred values and leadership ethics, rather than a traditional paternalistic, authoritarian and hierarchical style of leadership.

We have recently witnessed the NHS at crisis point with the devastating results of the Mid-Staffordshire Inquiry (Francis, 2013). The Inquiry identified a lack of management and leadership capacity and that medical and nursing values and care had been breached, the outcome of which was the de-humanisation of patients.

Chapters within this text are about identifying concepts relative to leadership and about where the rightful place for practice leadership should be, which is at the sharp end of practice. Front-line mental health and intellectual disability nurses must work as effective role models in promoting leadership and managing change, and enable environments in which they work to become dynamic and palpable sources of positive growth and change.

References

Allen R, Gilbert P, Onyett S (2009) *Leadership for personalisation and social inclusion in mental health*. Social Care Institute for Excellence, London

Department of Health (2001) *Valuing people: A new strategy for people with learning disabilities in the 21st Century.* HMSO, London

Department of Health (2009) *Valuing people now*. HMSO, London

Francis R (2013) *Report of the Mid-Staffordshire NHS Trust Public Inquiry (The Francis Report)*. HMSO, London

Note

The term practice leadership is used in this book rather than clinical leadership, as the latter tends to infer a medicalisation role and relationship. Practice leadership infers a collaborative process between practitioners and service users.

The term intellectual disability is now becoming more commonly used internationally and within the research literature, and so has been adopted here. However, it is also acknowledged that the term learning disability is still used in the UK and so both terms will be found within the book.

Mark Jukes
Birmingham City University

Chapter 1

Intellectual disability and mental health nursing in the 21st century

Mark Jukes and Vicky Clarke

Introduction

This chapter focuses initially on the policy development that enshrines both mental health and intellectual disability nursing. A focus on these two fields of nursing then identifies why there is a need for effective leadership in these most challenging areas of contemporary practice, within a context of a sea of ideological and health and social care policy changes.

The past 20 years, in particular, have brought a raft of legislation and policy changes that have impacted on both service users/carers and nurses in these fields.

Emphasis on and ways of thinking about management and leadership have been favoured at certain times in our history and currently, mostly in response to critical incidents that have stemmed from policy implementation, and that have placed people with mental health and intellectual disability within the public spotlight.

Policy context and development

In 1971 and 1975 the *Better services* White papers were published by the Department of Health and Social Security for people with mental handicap and for those with mental illness. Since then there has been a gradual progression towards community care, which was at its peak during the 1980s, and which culminated in the introduction of the NHS Community Care Act 1990. Significant changes in policy over this period have also affected the way we communicate inter-professionally.

The review of the Mental Health Act, the introduction of the Mental Capacity Act, now the Equality Act 2010, coupled with the Deprivation of Liberty Safeguards, have compelled professionals to acquire and develop a sound value base, and have required nurses to be more self-aware and emotionally intelligent both in how they perceive themselves and their practice, and also when mediating and collaborating with other professionals and services that directly affect service users.

Recent health policies have emphasised social inclusion. In the UK in 2011, 22.7% of the population was considered to be at risk of poverty or social exclusion, equivalent to 14 million people (Office for National Statistics, 2013). People with mental health and intellectual disability are excluded from mainstream generic health, social, work, leisure and educational services. Professionals across these sectors are required to promote social inclusion for these groups of people.

We are in a policy age of citizenship and personalisation. The recovery approach has been developed for people with mental health needs by listening to service users about what they need to be able to manage their mental illness, to enable them to continue to live a meaningful life as purported by Repper and Perkins (2009). In intellectual disability, person-centred planning effectively means we are required to work with the individuals to maximise their opportunities and move towards the realisation of their aspirations and "dreams". Both the recovery approach and person-centred planning bring challenges not only to people with mental health and intellectual disability, but also to the professionals involved in their care. Contemporary policy that directly affects mental health practice includes the *Ten Essential Shared Capabilities* (Hope, 2004), and when compared with the values base for intellectual disability nursing, we can see that there are similarities in shared philosophy and practice (see *Table 1.1*).

Table 1.1. Ten Essential Shared Capabilities compared with the values base for intellectual disability nursing

Ten essential shared capabilities for guiding mental health practice (Hope, 2004)	*The values base for intellectual disability nursing (Scottish Government, 2012)*
1. *Working in partnership* with each other and with service users, carers and other agencies in order to develop an effective care plan. 2. *Respecting diversity* by addressing the different needs of individual people and their carers including differences in culture, age, sex, religion and race. It is not ignorant to discuss diversity with people but it can be harmful if we do not.	• *Human rights*: Place the individual at the centre, valuing choice, inclusion, citizenship and social justice. Incorporate equality, individuality, person-centred and strength-based approaches, empowerment, self-determination, dignity and anti-oppression. • *Personalisation*: Supporting the individual's control and choice over their own life and services through empowering people with intellectual disabilities, their families and carers and relinquishing "control".

3. *Practising ethically:* Ensuring that every individual has a chance to express his or her needs and not assuming that we always know best what other people's needs might be. 4. *Challenging inequality:* While it may be difficult at times we must always make sure that there is someone to advocate on behalf of people if they are unable to do so for themselves. 5. *Promoting recovery* by encouraging people to make decisions that maintain their hope and optimism in their individual needs being met. 6. *Identifying people's needs and strengths:* To encourage people along a recovery journey. 7. *Providing service user-centred care*: Working in collaboration at all times to identify and address needs. 8. *Making a difference* in helping people to identify and make choices without assuming that they know what is available to them. 9. *Promoting safety and positive risk taking* by identifying risks and working together to address them. 10. *Ensuring personal development and learning* by taking responsibility for our own learning and providing evidence that our practice is up to date.	• *Equality and inclusion:* Recognising diversity and challenging inequality and inequity by supporting people with intellectual disabilities to use the same services and have the same opportunities and entitlements as anyone else. • *Person-centred*: Meaningful engagement with people to identify goals significant to the person. • *Strengths-based*: Focusing on existing strengths, skills, talents and resources and increasing personal competence. • *Respect*: Valuing the whole person and the diversity of people who support and sustain him or her. Appreciating the contribution of families and carers and, where possible, enhancing the contribution of others. • *Partnerships*: Recognising that health and social outcomes are interdependent. • *Health-focused*: Focusing on the individual's health and well-being to enable inclusive lifestyles.

Intellectual disability nursing

Intellectual disability nursing has consistently been under threat and has at times been almost extinct since the NHS Act 1948 was enacted. Care for people with intellectual disabilities was previously in colonies or hospital and the development

of intellectual disability nursing has fractured as nurses moved out with their patients from the institutions.

The introduction of the NHS and Community Care Act 1990 divided services into health and social care. For intellectual disability nurses this brought about a dysfunctional split into what previously had been effective multi-professional team working in the form of community learning disability teams set up by the National Development Group for the Mentally Handicapped in 1976.

The implications of the Community Care Act resulted in social workers being absorbed into social care and intellectual disability nurses into health teams. For the latter this brought about an emphasis on health work and so these nurses were required to forge a specific health agenda and identity.

Health equality had been strived for from the mid-1980s (Howells, 1986) and disparities between the health of the general population and people with intellectual disabilities began to be well reported and subsequently highlighted in government reform on this issue (Department of Health, 1999, 2001).

More recently, a public health role for intellectual disability nurses has been pursued in England (Department of Health, 2007a), specifically relating to developing planning policy and leading service delivery for people with intellectual disabilities (Mufaba, 2009).

The first fracture occurred before the publication of the Jay report in 1979. In this report, Jay's concern was about the recommendations for further development and delivery of more effective services for people with intellectual disabilities. One recommendation proposed joining together intellectual disability nurses and social workers. In essence, this would expand the workforce across services. However, the report was not well received by nurses who saw it as a move towards the dissolution of intellectual disability nursing, to be replaced with a social care/worker model.

The *Nursing Mirror* (1978) reacted vehemently prior to the report recommendations being published, and the unions took to lobbying against it. As a consequence the Labour Government took a long time to release a response. Mitchell (2004) questions what would have happened to the Jay Report if a Conservative Government had not been put in power in 1979? What would services look like today, and what type of professional would exist in such services?

An alternative nursing syllabus was developed by the English National Board for Nursing, Health Visiting and Midwifery. This syllabus, which arrived in 1982, was orientated towards a social, educational ethos, with the nursing process and normalisation being a coherent thread throughout. It must be borne in mind, however, that intellectual disability nursing and services at this time were

predominantly still located in hospitals, and that the move to community care and the "ordinary living" model was yet to be fully realised. The mid-1980s could be seen as the point of transition for many services towards providing alternative residential options.

The Consensus conference 10 years later was the second fracture to impact on the future direction of intellectual disability nursing. This was where Brown (1994) coined the phrase "the consensus legacy", reflecting on the fact that the consensus was arrived at without proper consultation. One of the most radical suggestions was that intellectual disability nursing should become a post-registration option.

The profession reacted vociferously to the options proposed, and later there was a retraction of what could have been the death knell for intellectual disability nursing.

The report, *Continuing the commitment* (Kay et al, 1995) confirmed the government's commitment to intellectual disability nursing and began the journey of healing through celebrating and articulating the value and contribution of the specialty across health and social care. Within this report, examples of good practice captured some evidence that intellectual disability nurses provided a unique contribution to people with learning disabilities and their families.

What one can observe from these initial fracturing processes is the ability and presence that senior nurses, positioned within or having alliances with the Department of Health, have to mobilise themselves in times of threat and throw the weight of the profession behind them.

A third fracturing occurred after the announcement in 2005 that nursing would become an all-graduate profession, and that the four fields in nursing would remain. However, although this was positive news for intellectual disability nursing, and strengthened recognition of this field by the Nursing and Midwifery Council (2011), it occurred at a time when student admissions to intellectual disability nursing were declining. Universities offering courses in this field were also in decline and senior staff were openly dissuading students from pursuing the specialty (Parish, 2012).

Gates (2011) submitted a task-group report to the Professional and Advisory Board for Nursing and Midwifery giving an analysis of the results detailing the extent of decline in learning disability nursing courses and in student admissions. According to the Nursing and Midwifery Council (2011) there are just over 21 000 learning disability nurse registrants which represents just over 3% of the total workforce across intellectual disability services. This statistic indicates that the best value from these nurses occurs where direct effect is maximised, and that is within specialist NHS services for people with intellectual disabilities.

Abuse and poor care standards

Amid the periods of fracturing of intellectual disability nursing, and progressively since 1995, we have witnessed, through exposure in the media, blatant abuse of people with intellectual disabilities. In 1995 the BBC programme, *Panorama*, exposed the Longcare scandal in Buckinghamshire, and in 1999, on Channel 4, *MacIntyre undercover* exposed further abuse in residential social care through secret filming.

The Department of Health's (2001) publication, *Valuing people*, was timely. It had been 30 years since a government White paper had strategically addressed the way ahead in promoting a strategy for people with intellectual disabilities, their families and carers. However, although holistic in nature, *Valuing people* has been criticised for not being a National Service Framework which would afford, as with the Frameworks in mental health, a higher profile with more substantive investment (Styring and Grant, 2003).

In 2003, further abuse was exposed in social care on Channel 5, where *MacIntyre undercover* reported on the abuse of vulnerable people with intellectual disabilities with personal care needs who were inappropriately placed into supported living accommodation.

In 2006 the Healthcare Commission and Social Care Inspection had responded to complaints with regard to Cornwall Partnership NHS Trust's services for people with learning disabilities and found widespread poor standards of care in its assessment and treatment centres and in its residential care facilities – and this time involving learning disability nurses. In 2007 the Healthcare Commission inspected Sutton and Merton Primary Care Trust's services for people with a learning disability and once more found poor standards of care. Health inequalities and high rates of "unmet need", which may contribute to early death, were highlighted by the Disability Rights Commission (2006). This in turn brought into the political and societal consciousness what appeared to represent neglect in the NHS, and was followed by the damning report, *Death by indifference* (Mencap, 2007), which cited six unnecessary deaths of individuals with an intellectual disability in hospital. This has been further reported in the latest Mencap report (Mencap, 2012).

In May 2011, further shocking incidences of abuse were reported in the BBC *Panorama* programme on Winterbourne View. Acts of violence and systematic abuse to patients with intellectual disabilities were recorded within a private hospital, and intellectual disability nurses were culpable in this abuse.

In 2012 the Care Quality Commission inspection report identified that 50% of 150 services inspected were below standard.

Briefly reviewing this timeline of critical incidents specific to intellectual disability services presents a somewhat bleak picture in terms of what is going wrong. Given that we have a compendium of reforms that promote person-centred practice, which offers choices and works towards social inclusion, the evidence is undeniably that services and professionals are failing people and that what is required is clear leadership and change management skills at the sharp end of practice.

The Winterbourne View Serious Case Review Inquiry (Flynn and Citarella, 2012) has stated that there was a lack of leadership and supervision at the hospital, and that although it was nurse-led, there was a culture of support workers running shifts. There was little exposure to appropriate intellectual disability education and values-based training, and control and restraint techniques were dominant. It is clear that staff teams had been allowed to develop a subculture of deviance which contributed towards a decay in care services. Staff had become dysfunctional, directionless and caused harm to individuals who were vulnerable.

It is clear that intellectual disability nurses are in the minority within services across the NHS, and independent and third sectors (Gates, 2011), and, since the NHS and Community Care Act (1990), have not been the key influential professionals in the care, development and support of people and families with an intellectual disability. Additionally, they cannot be called to account for the majority of service failures that have been identified, rather it is the way in which services have been configured through multiple providers across sectors that is to blame.

What is clear from the inquiries and controversies is that frontline workers should have more robust training in learning disability – but what exactly does this mean? Both the Winterbourne View Serious Case Review Inquiry and the Francis Report (Mid-Staffordshire NHS Foundation Trust Inquiry, 2010) give clear messages about the necessity for values training, and both inquiries identified professionals' disregard for patients' humanity, and a lack of respect and compassion among staff. In fact it has been reported that management of Stafford Hospital exemplified a total distancing of managers and staff from what patients were experiencing (Moore, 2013). Is, then, what is required in our failing general hospitals today, what was required when long-stay institutions were closing, and staff and patients were transferring into the community – values training and education? What was thought a unique phenomenon to the asylum has now become a reality in the general acute provision of care – the dehumanisation of patients.

We should not disregard our past in terms of what intellectual disability workers have previously been exposed to in promoting a values-based relationship with

people and their families. In the 1980s, staff teams were exposed to what values represented. The 10 core themes of social role valorisation were not only articulated, but transplanted into services and individuals' practice. This included recognising how distancing can manifest itself into a person's unconciousness, thereby not allowing him or her to see the poverty that can exist within a relationship when people are not included within any form of decision making or choice. This is doing things *to* people instead of *with* people and not allowing them to have a voice.

Following on from Gates's (2011) *Strengthening the commitment*, the UK Modernising Learning Disabilities Nursing Review report was published (Scottish Government, 2012). In this report the four Chief Nursing Officers of the UK invested support for intellectual disability nursing. Currently, the response from each respective country to the report's 17 recommendations is awaited. Recommendations include action at a UK level, commissioning, and education at a service and individual practitioner level. The report has identified what intellectual disability nurses do that represents good practice, what other health professionals need to do better, and what learning disability nurses can do to extend their role (see *Box 1.1*).

The whole emphasis of *Strengthening the commitment* is a call for the strategic harnessing of intellectual disability nursing, and the recognition that as a field it should be maintained and developed. However, and paradoxically, a previous recommendation from the Department of Health (2007a) advocated regionalising centres of excellence. At a meeting of the recently formed Intellectual Disability Academic Nursing Network at the University of Nottingham, several speakers favoured regionalisation. This was in the absence of any evidence that this proposal is valid, where no discussion papers have been offered, and where there has been a lack of consultation among the profession, or indeed people with learning disabilities, their families and carers. For intellectual disability nursing, this option could potentially result in a fourth, and possibly final fracture and the demise of the profession, as a result of further fragmenting and marginalisation.

Recent developments since the publication of *Strengthening the commitment* include, in England, a multi-professional working party with key stakeholders and partners, and mapping against the six action areas from *Compassion in practice* (Department of Health, 2012).

Learning disability nurse consultants have developed an outcome framework based on the five determinants of health inequalities with the outcome of measuring effectiveness in tackling health inequalities for people with intellectual disabilities (Department of Health, 2013). The five broad determinants of health inequalities are:

Box 1.1.Existing and future competencies for practice

What learning disability nurses do well

- Encourage empowerment and participation.
- Promote communication skills, including accessible communication.
- Carry out health checks, support access to hospital and primary care, help with behaviour and teaching people about health.
- Help people to keep healthy and live in the community.
- Support access to general healthcare (liaison roles are highly valued).
- Raise awareness around learning disabilities through education and training for all professionals.

What learning disability nurses need to do better

- Some people with learning disabilities do not have good experiences in specialist assessment and treatment services. Learning disability nurses need to involve people more in their assessment and treatment in these settings and avoid restrictive practices.
- Learning disability nurses could support services to manage better children with very complex needs who are being excluded from education.
- Provide consistency: people prefer to have the same nurse/named nurse.
- Non-registered workers should have a more robust training in learning disabilities.

Where learning disability nurses want to be

- Supporting transition from children's to adult services: carers would value more involvement from learning disability nurses.
- Developing their role around discharge planning.
- Taking time to get to know people, building trust and recognising that the person is the expert.
- Allowing people with learning disabilities, their families and carers to be more involved in the selection of learning disability nurses, students and the non-registered workforce.
- Involving people with learning disabilities, their families and carers in nurse education for all fields of nursing. Other nurses still need more knowledge and skills in working with people with learning disabilities.
- Expanding their role into other areas, such as mental health and prisons.

Scottish Government (2012: 16–17)

- Social determinants of poorer health, such as poverty, poor housing, unemployment and social disconnectedness.
- Physical and mental health problems associated with specific genetic and biological conditions in learning disabilities.
- Communication difficulties and reduced health literacy.
- Personal health behaviour and lifestyle risks, such as diet, sexual health and exercise.
- Deficiencies in access to and the quality of healthcare and other service provision.

The need for effective practice leadership is required across all populations and sectors, where all workers involved have access to localised education and training in all geographical areas of provision, for all have a responsibility in providing effective support and delivery, and where provision is locally determined amidst a diverse demography.

Leadership

Given the political and social context above, and where intellectual disability nurses are located, there is no doubt that they have a clear impact, identity and influence as trailblazers and champions. This occurs particularly within the healthcare arena, where they promote and support health equality in access to generic mainstream services and acute liaison teams. It is at this interface of services where they are required to demonstrate their values, impacting on service users and services, and working towards a vision that empowers and motivates a workforce across sectors.

If intellectual disability nurses are directly supported through policy by the Department of Health, their presence will be of influence and have credibility with other providers. Commissioning bodies should also be required to acknowledge and have a clear commitment and vision towards the value of intellectual disability nurses' specialist roles in the development of innovations. Such examples are promoting person-centred thinking and planning, and assisting in facilitating accessibility beyond primary healthcare and acute services. Further leadership capacity would also extend into specialist secondary and tertiary services, such as specialist assessment and treatment centres. Further focus for leadership is in mental health (dual-diagnosis) acute services, where collaboration with mental health nurses will promote interprofessional working. Forensic services are an additional specialist area, where to implement a person-centred ethos creates additional challenges for nurses in terms of patients detained under the Mental Health Act 1983.

The General Medical Council, Nursing and Midwifery Council and the Royal College of Nursing have been openly criticised (Winnett, 2013) for not responding to the poor standards of care detailed in the Francis Report (Mid-Staffordshire NHS Foundation Trust Inquiry, 2010).

The Royal College of Nursing was perceived as neither functional as a union nor as a professional body representing standards of good practice. Professional bodies such as the Royal College of Nursing regularly produce guidance documents and role descriptors for nursing, but are not seen as actively representing and supporting good practice initiatives.

As is the case in mental health nursing, intellectual disability nursing has no central representation at government level, minimal representation at the Nursing and Midwifery Council and is left to circumvent its cause and agenda within localised and national networks.

The UK Consultant Nurse Network in 2006 produced a vision for learning disability nursing which recommended that learning disability nurses should develop their leadership capability (Northway et al, 2006). More recently, *Strengthening the commitment* (Scottish Government, 2012) also recommended that it is essential for intellectual disability nurses to be supported through clear career pathways, and to be involved in succession planning to enable such leadership capability to develop and be sustained. Practice leadership education and training is about intellectual disability nurses developing capacity, resilience and having such opportunities available to further hone their skills as an integral part of undergraduate preparation for practice within safe educational environments. Preparing intellectual disability nurses psychologically in subjects such as self-awareness, personality development, emotional intelligence, conflict resolution with additional training and education in the adoption of interpersonal frameworks for effective intervention, are critical for competency-based practice. These concepts and skills are essential requirements within what, at times, is a harsh practice world, where professionals across sectors can be difficult to manage and can demonstrate inappropriate attitudes and values.

Intellectual disability networks are effective and important for communicating good practice and in supporting practice locally. However, such networks are in danger of acting like virtual academies of expertise, promoting interest groups among the converted, and this questions the impact in real terms across wider communities and sectors. For leadership, evidence suggests that intellectual disability nurses are required to break out of their professional boundaries, be more transparent across other sectors and professions, extol their capability in collaborative working and avoid becoming parochial.

Mental health nursing

It is an interesting and challenging time to be considering practice leadership in mental health nursing. In Britain we are experiencing yet another episode of legislative change, following on from the many identified earlier in this chapter. This change comes in the shape of the Health and Social Care Bill 2012 which is likely to have ramifications for mental health nursing well into the 21st century. This section reviews mental health nursing leadership, considers the strengths and weaknesses of the profession, discusses lessons to be learned in parallel with our colleagues in intellectual disability nursing and reflects on the opportunities for mental health nursing practice leadership in the future.

The traditions of mental health nursing have been well documented (see Nolan, 1993). The origins were set in the asylums of Victorian Britain and, as a group, mental health nurses were more typically working class (many were agricultural workers looking for "warmer/inside" winter work). Large numbers were men, although they were still overwhelming female, and during the 20th and early part of the 21st century they came from marginal immigrant population groups notably Irish, Mauritian, and Afro-Caribbean (Royal College of Nursing, 2007). Their work was predominantly to carry out doctors' instructions to keep the patients safe. Over time, mental health nursing began to develop its own theories and ideas of practice (Norman and Ryrie, 2009).

The Department of Health (2006a) focused on nursing moving towards becoming a "research-based profession". Training moved into higher education and, following the Butterworth Report (Department of Health, 1994), "psychiatric" nursing was rejected as an occupational title, being seen to be too illness-focused, and there was a new emphasis on and name for the profession – "mental health" nursing. This was supposed to refocus the profession onto recovery and evidence-based mental health nursing practice. While Barker and Buchanan Barker (2005) acknowledge the potential for positive changes, they illustrate how there have been no significant changes in mental health nursing itself. The practice of mental health nurses and the status of mental health nursing have not changed; there is no public representation of mental health nursing, and no mental health nurses are consulted by the media, politicians or even the Department of Health. In the National Institute for Health and Care Excellence (NICE) guidance to the NHS, rarely, if ever, do they refer to, let alone include, mental health nurses in their work on improving mental health services. For the first time, in 2012, a mental health nurse has been involved in developing guidelines with NICE (Cawthorne and Barron, 2012). Interestingly this individual is a Scottish mental health

nurse, perhaps reflecting that Scottish mental health legislation and policy are increasingly independent from the rest of the UK with the more central inclusion of mental health nurses and mental health service users. Peer support work has progressed more widely in Scotland. This has led to some de-professionalisation of mental health services, and while there is a clear potential for good, and alliance with principles of effective recovery for mental health service users, it does leave unanswered questions for the future of mental health nurses.

There have been significant differences in the progression of mental health nurses across the UK. Scotland did not roll out the *Improving access to psychological therapies* programme (Department of Health, 2007b), as their mental health focus tended to be on wider issues around poverty, social exclusion and addiction. In England, Wales and Northern Ireland, although mental health nursing staff will talk readily about excellent clinical leaders at a local level; this is much more nebular at a national level. Clinical mental health nursing staff appear to tie leadership at a national level to academic work. There is recognition of the excellent contribution made by Phil Barker, Kevin Gournay, Peter Nolan, Len Bowers and Liam Clarke to name a few, but these are colleagues recognised for their contribution to academic leadership in mental health nursing and, while their work has and continues to influence clinical practice, clinical mental health nurse leaders are difficult to identify with any real confidence.

Mental health nurses need to heed the lessons of their colleagues in learning disability. We are seeing the implementation of the "big society", the rolling back of health and social care. Mental health nurses are replaceable. In response to opportunities for them to embrace additional and/or expanded roles as nurse consultants, non-medical prescribers, therapists, or allied mental health professionals, or to take on the role of responsible clinician, they seem to have shied away or slowly seen the opportunity eroded through trust policy and practice (Department of Health, 2006b). In some areas these roles have been taken up by mental health nurses and often extremely well, but they are quickly lost in less affluent times. One trust in the West Midlands engaged well with the idea of nurse consultants in mental health, appointing five senior nurses to these posts. Sadly, in 2013, there is only one nurse consultant remaining following several reconfigurations, and that post is likely to be lost to retirement before the end of the year.

There are still opportunities for mental health nurses to lead but they need to adapt and be effective role models; to be positive, assertive and empowering towards mental health service users; to develop others; to promote autonomy; and to encourage independent and critical thinking not only for themselves but

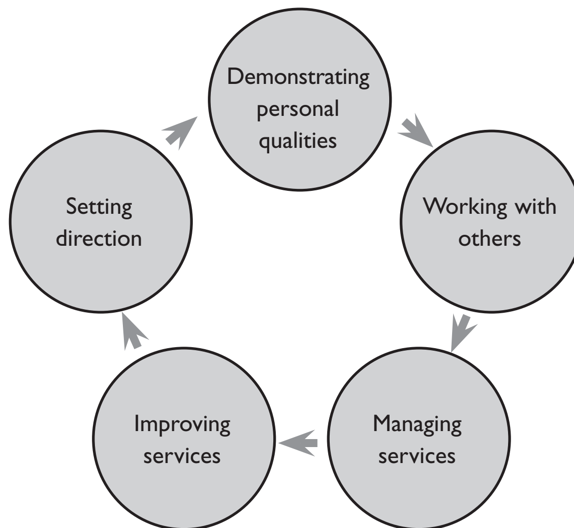

Figure 1.1. Clinical leadership framework (NHS Leadership Academy, 2011).

also in the next generations of mental health nurses; if these opportunities are to continue. In order to be a clinical leader it is necessary for mental health nurses to have a vision of what they are hoping to achieve, what they are trying to do and to understand why. They need to be visionary, not blindly following, and this means developing their own theories and evidence to support their clinical practice as mental health nurses.

The NHS has developed a clinical leadership framework (NHS Leadership Academy, 2011) (see *Figure 1.1*). The framework acknowledges that the necessary personal qualities of a clinical leader include self-awareness, managing yourself, continuing personal development, and acting with integrity. In order to work effectively with others, a clinical leader needs to develop networks, build and maintain relationships, encourage contribution, and work with teams. In managing services, an effective clinical leader must plan and manage resources, including people and their performance. If a clinical leader is working to improve services then he or she must ensure patient safety, evaluate critically, encourage improvement and innovation, and facilitate transformation. The framework also states that in setting direction it is important to identify the contexts for change, apply knowledge and evidence, make decisions, and evaluate the impact on services.

Concerns over the apparent lack of autonomy and initiative among the next generation of mental health nurses is apparent when colleagues report hearing nurses say, “Tell me what you want me to do”, rather than, “This is my vision

and is what I'm going to do". Mental health nurses are struggling to deal with increasingly complex needs within the mental health service user population alongside their own feelings of compassion fatigue and stress (Clarke, 2008; Taylor, 2011). Mental health nurse leaders need to engage with colleagues in a way that helps to build resilience and robustness and that provides effective clinical supervision with appropriate protective measures (White and Whitstanley, 2010).

Clinical leaders will need to help provide a space for mental health nurses to engage in reflexive practice and process supervision (Carthy et al, 2012). Part of this provision by leaders must be to enable nurses to care about and with service users. In order to capture the essence of how and why leadership seems inadequate to this task and why mental health nurses persistently fail to care, it is necessary to consider the perceived overwhelming need for care and attachment that people with mental health problems demonstrate. Faced with such neediness mental health nurses appear to retreat hastily into traditional and established patterns of behaviour such as excessive documentation, reliance on medication and physical treatments rather than carrying out interpersonal work with their service users (Clarke and Flanagan, 2003). The use of professional language, such as "boundaries", is much manipulated and has come to mean emotional distance and a lack of availability rather than working with service users in a way that is genuine, honest, person-centred and patient-focused. Claims of "confidentiality" also provide mental health nurses with the opportunity to avoid dealing with the emotional needs of families and carers of service users. Mental health service users respond well to small gestures of care and attention on one hand yet mental health nurses appear entrenched in a position of avoidance and distancing from this "burden" of excessive neediness. Is it due to fear of failing the service user, so we never even try? Is it that we fear we will be the only person fully committed to this so we pre-emptively resent others' lack of support and that we are doing more than them, and blame them for our inability to meet the demands of service users? Mental health nurses are used to expectations that they will carry the burden of emotional labour, that they will be with mental health service users more and will deal those with the greatest complexity of need more than any other health professional. Have they become so damaged, traumatised and fatigued that they have stopped caring? Do they feel so badly done to that they are now doing badly to others?

Mental health nursing leaders need to show the way in caring through role modelling good practice. Service users need time, but not every moment of the working day; leaders need to demonstrate how to give time effectively. One of the key ways to do this is through group processes that can help to meet service users'

needs in a way that promotes independence, social interaction and networking, which are all transferrable skills for successful inclusion in society (Perese and Wolf, 2005).

Clinical leaders in mental health nursing also need to remember the importance of the nurse–patient relationship (Peplau, 1988); washing a person and making sure they eat and drink enough. There needs to be an emphasis on the therapeutic use of self; being with the person in distress physically, emotionally and psychologically is essential if these specialist nurses are going to be part of mental health services in the 21st century and reflect the importance of care and caring (Royal College of Nursing, 2012).

Barker's (2009) Tidal Model is a useful metaphor for the current situation in mental health nursing. The sea around mental health nurses is not gently swaying, it is not static or frozen, rather there are huge swells (the challenge to mental health professionals from peer support workers, inter-professionalism, the Department of Health's [2011] *Payment by results*), whirlpools (the Mid-Staffordshire NHS Foundation Trust inquiries, 2010; stigma; rising demand for a high quality service with less and less resources), storms (the Health and Social Care Act 2012) and tidal waves (the global economic crisis) to contend with. How we weather these conditions will be largely dictated by how effective our clinical leaders can be. Now, more than ever, is the time to be with mental health service users, their families and friends and to offer real care. Hopefully mental health nursing will be swimming not drowning in the 21st century.

Acknowledgements

Mark would like to acknowledge the first 2010/11 student intake for the BSc(Hons) Learning Disability Nursing degree and Vicky would like to acknowledge Mayuri Senpati (Consultant Clinical Psychologist) and Rachel Clarke (RN:MH, and Senior Lecturer) for their invaluable contribution to this chapter.

References

Barker P (Ed) (2009) *Psychiatric and mental health nursing: The craft of caring*. (2nd edn). Hodder Arnold, London

Barker P, Buchanan-Barker P (2005) Still invisible after all these years: Mental health nursing on the margins. *Journal of Psychiatric and Mental Health Nursing* **12**: 255–6

Brown J (1994) *Analysis of responses to the Consensus Statement on the Future of the Specialist Nurse Practitioner in Learning Disabilities*. Department of Social Policy

and Social Work, University of York

Carthy J, Noak J, Wadey E (2012) Clinical supervision in a high secure hospital. *British Journal of Mental Health Nursing* **1**(1): 24–32

Cawthorne P, Barron DT (2012) Developing the new SIGN schizophrenia guidelines. *British Journal of Mental Health Nursing* **1**(1): 45–51

Clarke L, Flanagan T (2003) *Institutional breakdown: Exploring mental health nursing practice in acute in-patient settings*. APS Publishing, Wiltshire

Clarke V (2008) Working with survivors of trauma. *Mental Health Practice* **11**(7): 14–8

Department of Health (1994) *The Butterworth Report. Working in Partnership*. HMSO, London

Department of Health (1999) *Facing the facts.* Department of Health, London

Department of Health (2001) V*aluing people. A strategy for people with learning disabilities in the 21st Century*. Department of Health, London

Department of Health (2006a) *From values to action: The Chief Nursing Officer's review of mental health nursing.* Department of Health, London

Department of Health (2006b) *Modernising nursing careers. Setting the direction*. Department of Health, London

Department of Health (2007a) *Good practice guidelines for learning disability nursing*. Department of Health, London

Department of Health (2007b) *Improving access to psychological therapies*. Department of Health, London

Department of Health (2011) *Payment by results in mental health services*. Department of Health, London

Department of Health (2012) *Compassion in practice. Nursing, midwifery and care staff. Our vision and strategy.* Department of Health, London

Department of Health (2013) *The CNO Bulletin*. Issue 113, February 2013, Gateway No. 18809

Department of Health and Social Security (1971) *Better services for the mentally handicapped*. Department of Health and Social Security, London

Department of Health and Social Security (1975) *Better services for the mentally ill.* Department of Health and Social Security, London

Disability Rights Commission (2006) *Equal treatment: Closing the gap*. Disability Rights Commission, London

Flynn M, Citarella V (2012) *Winterbourne View Hospital. A serious case review.* South Gloucester Council, Gloucester

Gates B (2011) *Learning disability nursing: Task and Finish Group Report for the Professional and Advisory Board for Nursing and Midwifery*. University of Hertfordshire, Hatfield

Hope R (2004) *The ten essential shared capabilities: A Framework for the whole mental health workforce*. HMSO, London

Howells G (1986) Are the health needs of mentally handicapped adults being met? *Journal of the Royal College of General Practitioners* **36**: 449–53

Kay B, Rose S, Turnbull J (1995) *Continuing the commitment. Report of the Learning Disability Nursing Project*. Department of Health, London

Mencap (2007) *Death by indifference! Follow up of the Treat Me Right report*. Mencap, London

Mencap (2012) *Death by indifference! 74 deaths and counting*. Mencap, London

Mid-Staffordshire NHS Foundation Trust Inquiry (2010) *The Francis Report. Independent Inquiry into care provided by Mid-Staffordshire NHS Foundation Trust. January 2005–March 2009*. Stationery Office, London

Mitchell D (2004) The Jay Report: 25 years on. *Learning Disability Practice* 7(6): 20–3

Moore C (2013) Let's face the truth about our uncaring, selfish and cruel NHS. *Daily Telegraph* **Feb 9**: 26

Mufaba K (2009) The public health role of learning disability nurses. A review of the literature. *Learning Disability Practice* **12**(4): 33–7

NHS Leadership Academy (2011) *Leadership framework*. Available from: http:/www.leadershipacademy.nhs.uk/develop-your-leadership-skills/leadership-framework/supporting-tools-and-documents/documents-to-download

Nolan P (1993) *A history of mental health nursing*. Chapman & Hall, London

Norman I, Ryrie I (Eds) (2009) *The art and science of mental health nursing: A textbook of principles and practice* (2nd edn). Open University Press/McGraw Hill, Maidenhead

Northway R, Hutchinson C, Kingdon, A (eds) (2006) *Shaping the future: A vision for learning disability nursing*. UK Learning Disability Consultant Nurse Network, London

Nursing and Midwifery Council (2011) *Standards for competency*. Available from: http://standards.nmc-uk.org/PreRegNursing/statutory/competencies/Pages/Competencies.aspx

Nursing Mirror (1978) No way, Mrs. Jay. **June 29**: 1

Office for National Statistics (2013) *Poverty and social exclusion in the UK and EU, 2005-2011*. Office for National Statistics, London

Parish C (2012) Learning disability students "discouraged" by senior staff. *Learning Disability Practice* **15**(1): 5

Peplau H (1988) *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. Macmillan, London

Perese EF, Wolf M (2005) Combating loneliness among persons with severe mental illness: Social network interventions' characteristics, effectiveness and applicability. *Issues in Mental Health Nursing* **26**: 591–609

Repper J, Perkins R (2009) Recovery and social inclusion. In C.Brooker, J Repper (eds) *Mental health: From policy to practice* (pp 1–13). Elsevier, Oxford

Report of the Committee of Enquiry into Mental Handicap Nursing and Care (1979) *The Jay Report*. Department of Health and Social Security, London

Royal College of Nursing (2007) *Black and minority ethnic and internationally recruited nurses: Results from the RCN Employment/Working Well Surveys 2005 and 2002*. Royal College of Nursing, London

Royal College of Nursing (2012) *The Willis Report. Quality with compassion: The future of nursing education. Report of the Willis Commission on Nursing Education*. Royal College of Nursing, London

Scottish Government (2012) *Strengthening the commitment. Report of the UK modernising learning disabilities nursing review* (pp 16-17). Scottish Government, Edinburgh

Styring L, Grant G (2005) Maintaining a commitment to qualities In Grant et al (Eds) *Learning disability: A life cycle approach to valuing people*. Open University Press, Berkshire

Taylor R (2011) The interface between forensic psychiatry and general adult psychiatry. In Rubitel A, Reiss D (Eds) *Containment in the community: Supportive frameworks for thinking about antisocial behaviour and mental health*. Karnac Books, London

White E, Whitstanley J (2010) A randomised control trial of clinical supervision. Selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research Nursing* **15**(2): 151–67

Winnett R (2013) Minister calls for police enquiry into NHS. *Daily Telegraph* **Feb 9**: 1