Research Demand Signalling for Mental Health Nursing

Research Question Preparation

This document will help you prepare for the formulation of research questions or ideas.

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Background

Demand signalling is a process used by NHS England to identify, prioritise, and articulate important health research priorities.

It generates research questions in high-level priority areas for research funders and policy makers and involves practitioners, researchers, NHS England policy leads, charities and people with lived experience.

Previous workshops determined seven priority topics:

1. Physical health promotion and prevention interventions delivered by mental health nurses for people with mental illness
2. Variation in restrictive practices by gender and/or ethnicity
3. Evidence on facilitators and barriers to care planning by mental health nurses and approaches to co production, and the effectiveness of care planning on patient experience and recovery outcomes
4. Understanding approaches and effectiveness in clinical safety management practices in suicide and self-harm prevention for patients with mental illness, in a variety of healthcare settings
5. Further education and training for mental health nurses that meets patients' mental health needs and physical healthcare
6. The impact of mental health Advanced Nurse Practitioners (ANPs) as part of the mental health nursing workforce, on patient outcomes
7. The impact of staffing models on experiences and outcomes of people with mental illness in a variety of healthcare settings

Preparation for suggesting research questions

The following slides outline summaries and evidence gaps for each topic. These are drawn from reviews undertaken by teams at University at Birmingham working with colleagues at Northumbria University and De Montfort University working with colleagues from University of Suffolk.

To submit suggestions for research questions in these topic areas please use the form, the link to this is below.

Health Care Professionals' Mental Health - Research Question Form and submit by **Friday 8 September** 2023

You may submit more than one question, but up to a maximum of three

A Glossary of Terms can be found on slide 34 .

For any queries, please contact England.researchcno@nhs.net

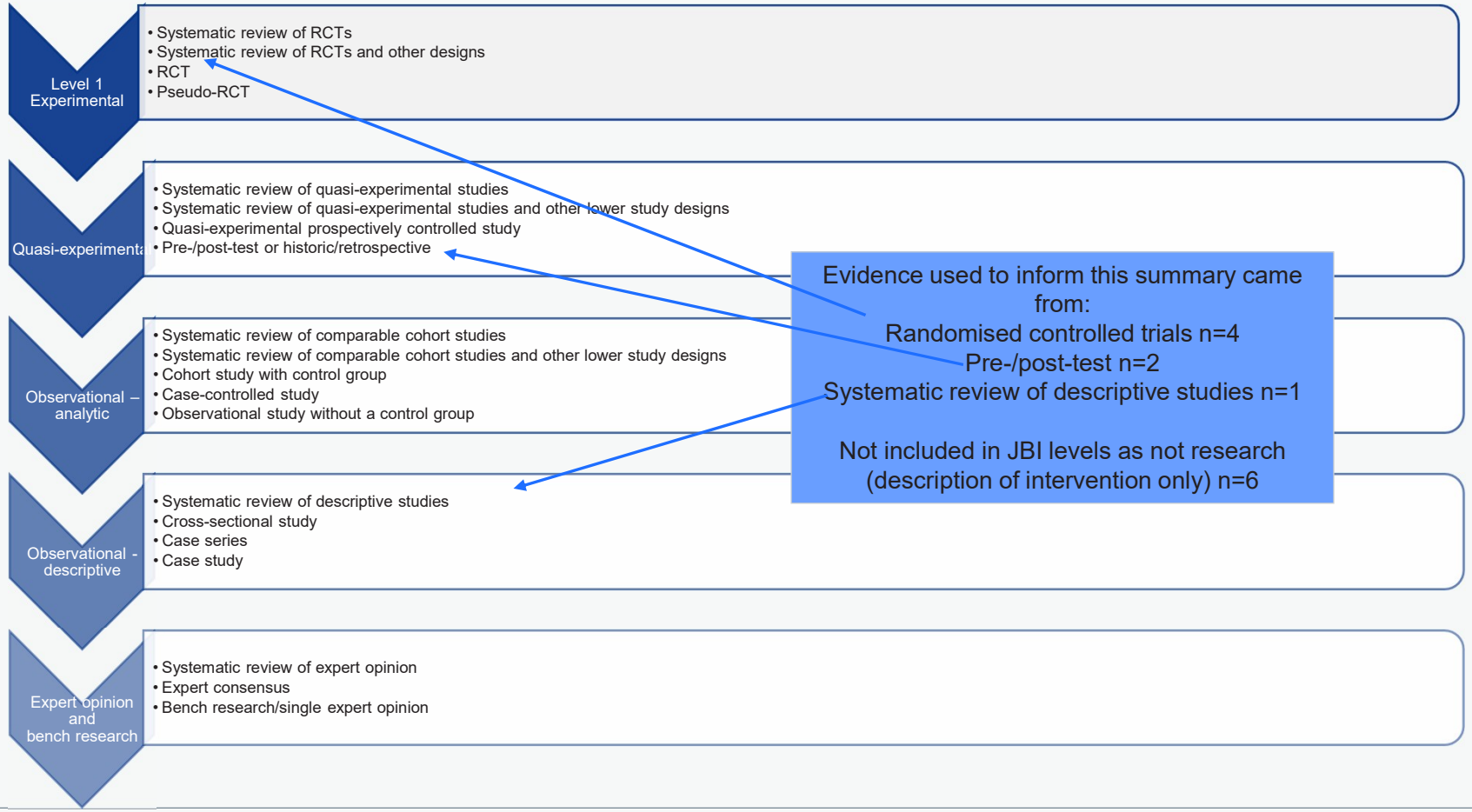
Physical health promotion and prevention interventions delivered by mental health nurses for people with mental illness

Summary

- Little evidence about mental health nurse-delivered interventions aimed at the physical health of patients or health promotion from the UK (n=13)
- Available evidence mostly about general physical health (e.g. weight, exercise, diet) and/or health screening aimed at people in the community
- Most comprehensive intervention: Health Improvement Profile (HIP). A 27-item physical health risk assessment aimed at highlighting areas for additional support/treatment, including inc. Body Mass Index (BMI), blood pressure, cervical smear/prostate and testicles check, oral health, eyes, smoking, exercise, diet and sexual health. Cluster Randomised Controlled Trial (RCT) had low uptake with the suggestion that lengthy structured health checks may not be feasible in routine practice
- Of the few studies that examined intervention effectiveness (n=6) 4 found improvements in diet, activity levels and blood pressure. The other 2, both RCTs, found no improvement in smoking cessation at 12 months or oral health, respectively

Nature and Quality of Evidence

Joanna Briggs Institute (JBI) Levels of Evidence



The Gaps

- Mental health nurse-delivered health promotion and physical health interventions within inpatient settings including acute, rehabilitation, Psychiatric Intensive Care Units (PICU) and secure units
- Mental health nurse-delivered health promotion and physical health interventions in child and adolescent mental health settings (CAMHS)
- Mental health nurse delivered interventions aimed at blood-borne viruses, diabetes, oral health, sexual health/dysfunction, smoking cessation

How do restrictive practices vary by gender and/or ethnicity?

Summary - Seclusion

- Within the limited evidence base about restrictive interventions (RIs) (n=20), seclusion has received the most attention in relation to ethnicity and gender (n=8 about seclusion and n=8 about RIs and including seclusion)
- No differences in the rates or length of seclusion by ethnicity have been identified, particularly when broad ethnic categories, e.g. Black, White, Asian, Other, are used. One study found that patients described as Black African or Black other were more likely to be secluded than White patients
- The evidence about gender is similarly mixed, with studies finding that women are more likely to be secluded than men (n=3), men are more likely to be secluded than women (n=2) or that there is no difference (n=2)

Summary - Restraint

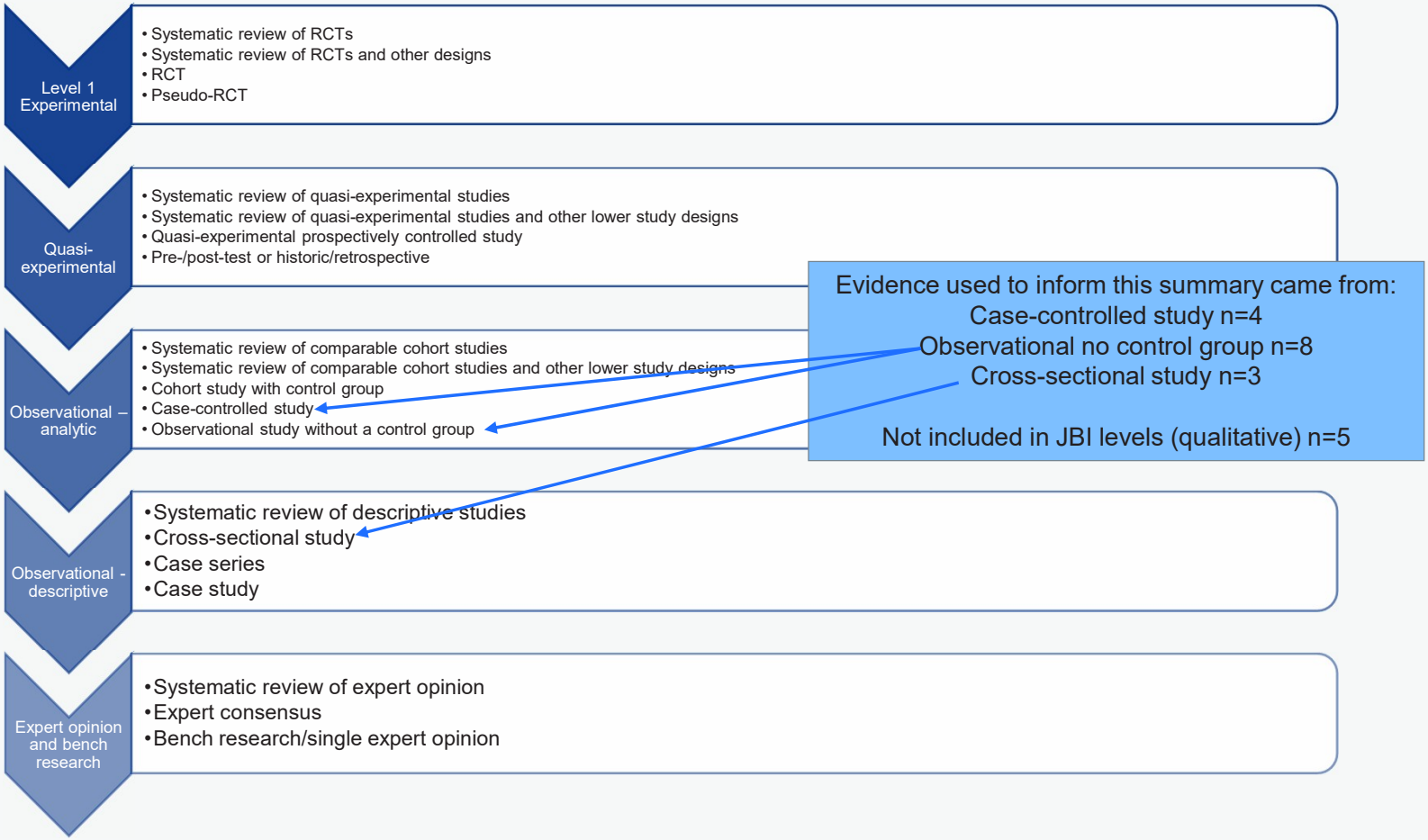
- Very little evidence (n=1 about restraint and n=8 about RIs and including restraint)
- One study found no difference by ethnicity in non-prone restraint when controlling for age but higher odds of prone restraint for Black Caribbean patients compared to white patients, while two further studies found no difference in restraint by ethnicity
- Only two studies provided data on restraint by gender; one found that there was no difference in coercive interventions, including restraint, by gender. The other found that male patients are more likely to physically restrained than female patients

Summary – Rapid Tranquillisation (RT)

- Virtually no evidence (no studies about RT, few studies of RIs included detail about RT (n=3)
- Three studies found no difference in rates of rapid tranquillisation by ethnicity
- In relation to gender, one study found that women were more likely to receive forced medication than men while another found no difference

Nature and Quality of Evidence

Joanna Briggs Institute (JBI) Levels of Evidence



The Gaps

- Variation in restrictive practices by gender and ethnicity in secure mental health services
- Variation in restrictive practices by gender and ethnicity in child and adolescent mental health settings (CAMHS)
- Variation in restrictive practices by gender and ethnicity outside of London and the southeast of England
- Variation in types of restraint by gender or ethnicity
- Detail of ethnicity beyond broad categories in relation to variation in restrictive practices
- Reasons for variation in restrictive practices by gender and ethnicity.

Facilitators and barriers to care planning by mental health nurses and approaches to co production, and the effectiveness of care planning on patient experience and recovery outcomes

Summary

- Some evidence that involving patients in care planning processes leads to improved recovery outcomes
- Some evidence to help our understanding of the mental health nurse-health care professional related, system related, patient-related and mental health nurse-health care professional related factors that promote and inhibit effective collaborative care planning practices
- Some evidence mental health nurses and other health care professionals are unsure of the best approaches to implementing collaborative care planning
- Little evidence on approaches to personalising collaborative care planning in response to diverse patient needs and preferences
- Some evidence to suggest that involving a range of health care professionals in the collaborative care planning process can lead to better patient outcomes, but the most effective ways to achieve inter-professional communication during care planning activities is not yet well understood or evidenced

Nature and Quality of Evidence

Evidence used to inform this summary came from 31 studies:

- 17 primary research studies comprising 10 qualitative (largely interview or focus group), 5 quantitative (pre-post test, post test only, survey), 2 mixed methods studies
- 9 literature reviews (largely integrative reviews, narrative reviews or synthesis of qualitative studies)
- 4 systematic reviews (including a mixture of randomized controlled trials and quasi experimental designs, none with meta-analysis)
- 1 scoping review

The Gaps

- Effect of collaborative care planning on patient recovery outcomes
- Our understanding of what's involved in mental health nurses developing and sustaining high quality therapeutic relationships with patients and how best to measure/evaluate the efficacy and effectiveness of these relationships
- Structures and processes that enable effective collaborative care planning
- How might mental health nurses better understand and respond to diverse, individual patient needs as part of the care planning process
- Effectiveness of different approaches to undertaking joint care planning activities across a multi professional team and contribution of digital systems to these processes
- Effectiveness of different approaches to training (pre and post registration) mental health nurses to undertake collaborative care planning
- Our understanding of how mental health nurses can empower and involve patients, as equal partners, in the collaborative care planning process

Understanding approaches to and effectiveness of clinical safety management practices in suicide and self-harm prevention for patients with mental illness, in a variety of healthcare settings

Summary

- Little evidence on effectiveness of mental health nurse-led suicide safety planning self-care support such as apps (n=5), evidence based psychological therapies (n=6) or digital, interactive technology (n=5)
- There is limited evidence about efficacy of suicide risk assessment tools and approaches and suicide prevention programmes and how to manage risk as a person transitions from one service to another
- The evidence for involving families and caregivers in suicide safety plans and prevention programmes is limited (n=9) and focusses on nurse or healthcare professional perspective. Only 6 studies have investigated this area from the family or caregiver perspective
- Where there is evidence about how to involve patients and families in suicide safety planning (n=9) it does not address diversity in terms of ethnicity, gender or other protected characteristic groups
- There is some evidence about how to establish effective therapeutic nurse/patient relationships, but the evidence does not extend to how to support patients through periods of crisis or those experiencing suicidal thoughts

Nature and Quality of Evidence

Evidence used to inform this summary came from 15 papers:

- 1 primary research study (mixed methods)
- 3 systematic reviews with meta-analysis
- 7 systematic/integrative reviews
- 3 descriptive literature reviews
- 1 scoping review

The Gaps

- Effectiveness of suicide safety planning self-care supports interventions
- Effective of mental-health nurse delivered clinical safety programmes addressing suicide prevention in different mental health settings
- Approaches to effective involvement of families and caregivers in suicide safety plans
- Understanding of what approaches to use during suicide safety planning in order to meet needs and preferences of individuals and families from ethnically diverse groups, children and young people and individuals with other protected characteristics
- Approaches to building nurse/patient therapeutic relationships during crisis situations
- Lack of UK-based evidence

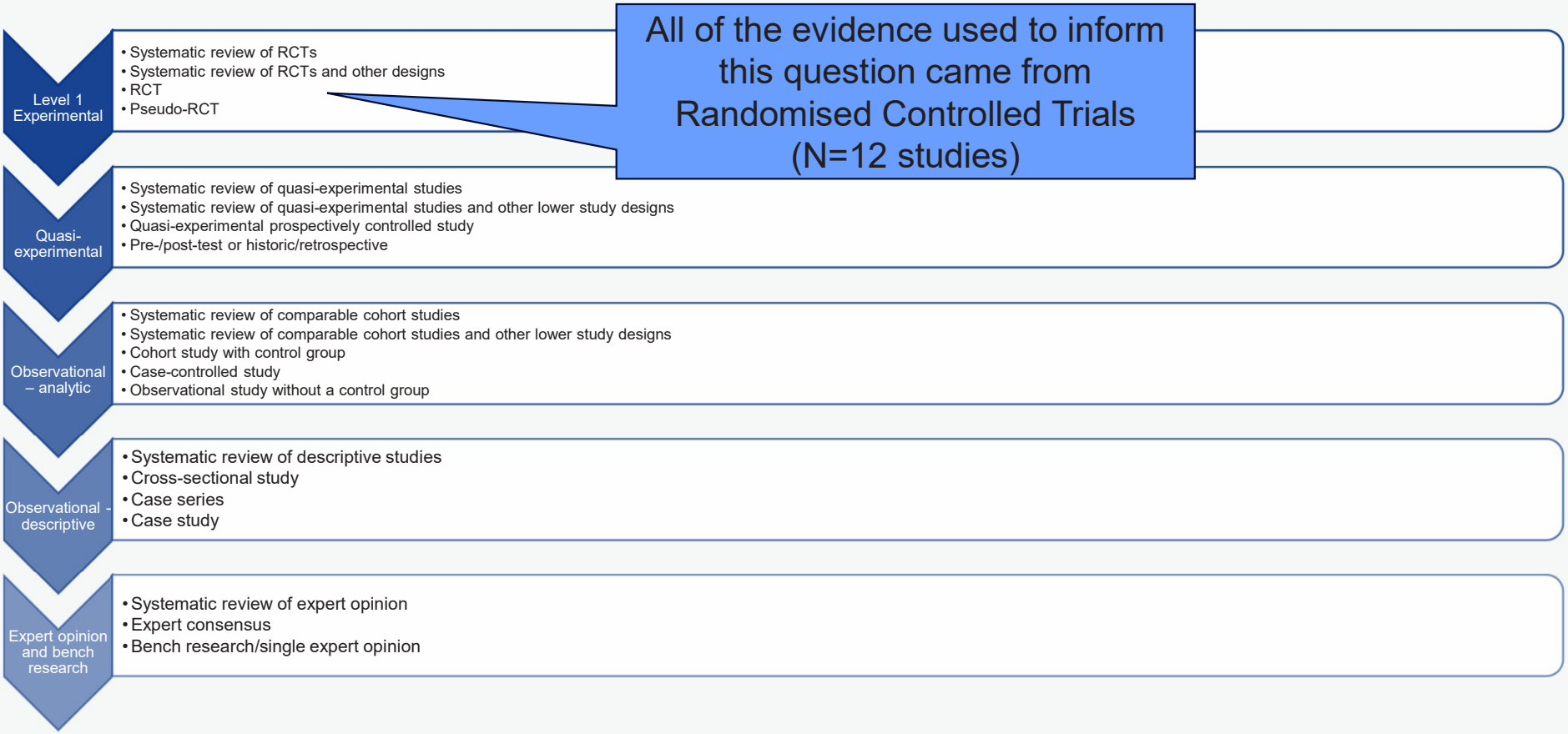
Further education for mental health nurses that meets patients' mental health needs and physical care.

Summary

- There is limited evidence about how programmes of pre- and post-registration education for mental health nurses subsequently impact on service users
- There is good evidence that training nurses to reduce conflict and containment in inpatient settings results in improved related outcomes over limited time periods
- Some good evidence that training nurses in medication management has positive outcomes for patients' mental health
- Studies have investigated educational interventions to promote recovery, shared decision making, physical health, and smoking cessation but their effectiveness has not been demonstrated
- Studies have also examined mental health nurse-delivered interventions including cognitive analytic therapy, problem-solving therapy, structured communication, and physical health assessment but have not demonstrated their effectiveness

Nature and Quality of Evidence

Joanna Briggs Institute (JBI) Levels of Evidence



The Gaps

- For training to reduce conflict and containment there is a gap about how improvements can be sustained over longer periods
- Whilst evidence from randomised controlled trials does not support the proposition that mental health nurse-delivered interventions are effective in improving recovery, shared decision-making, smoking cessation or physical health, there is a need for evidence on what might work
- There are gaps in all of these areas for patient reported outcomes as well as for clinician-recorded measures

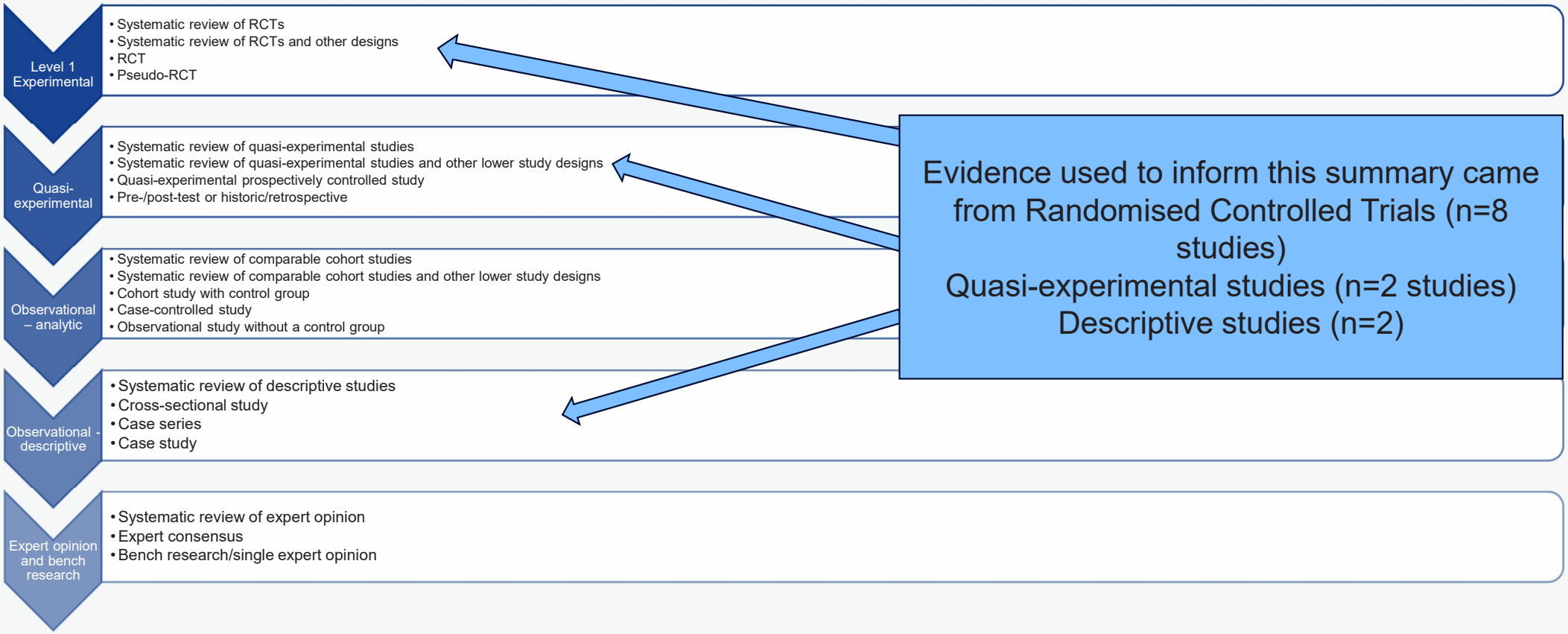
Impact of mental health Advanced Nurse Practitioners (ANPs) on patient outcomes

Summary

- Advanced practice nursing involves complex, autonomous, expert roles. Unlike many other countries, the UK does not specifically regulate advanced practice
- Evidence about the impact of mental health advanced practice nurse roles comes largely from outside of the UK, chiefly from Australia and the US
- There have been some advances about ANP practice with adults with severe mental illness in terms of their psychological symptoms, physical health, medication adherence, and family functioning

Nature and Quality of Evidence

Joanna Briggs Institute (JBI) Levels of Evidence



The Gaps

- There is an absence of evidence investigating the effectiveness of any mental health advanced practice nurse training programme in relation to patient outcomes
- There is a lack of evidence about the impact of ANP-delivered interventions associated with new roles in the UK such as prescribing or Approved Clinician status
- There is a lack of evidence about the impact of the ANP role with children, older people, or groups such as forensic patients

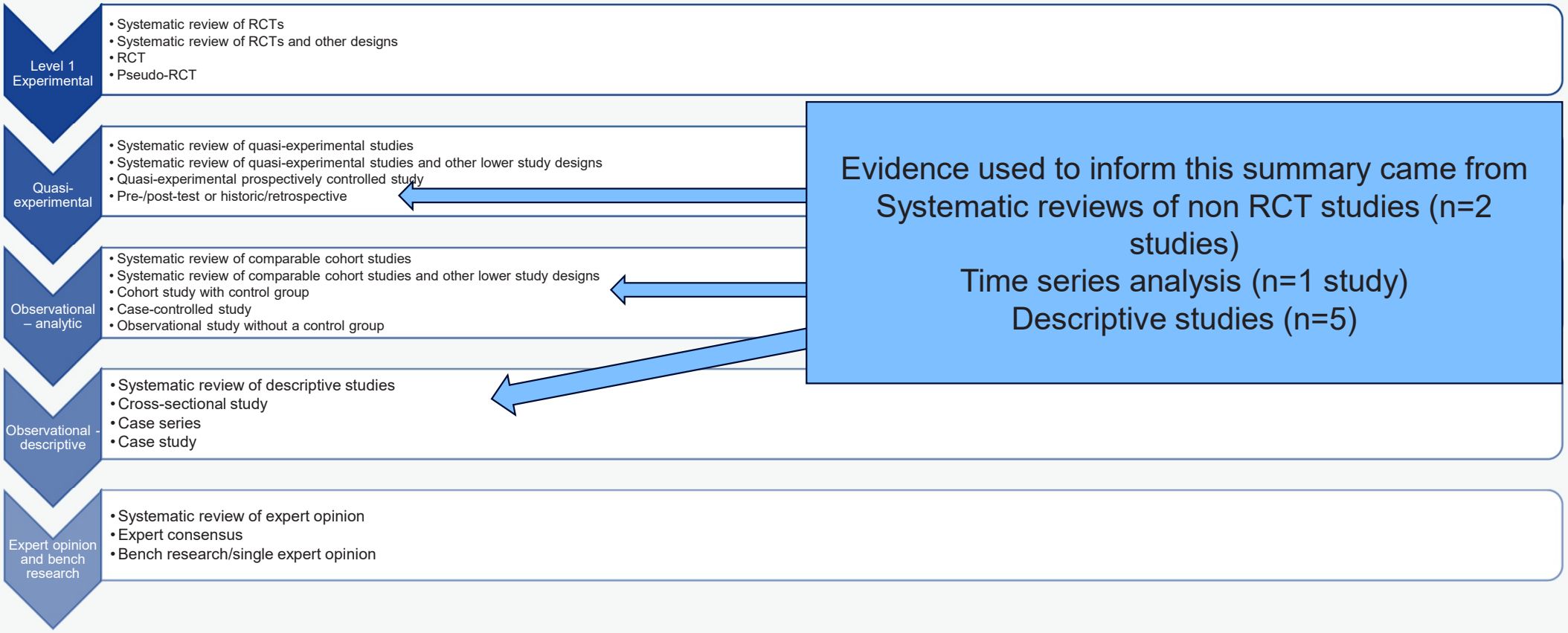
The impact of different staffing models on mental health patient outcomes

Summary

- Available evidence is limited in scope. Available studies examine links between the number of registered nurses and health care assistants on shift and conflict and containment outcomes such as violence, seclusion, and restraint
- Two systematic reviews have been published. One reviewed the link between staffing and seclusion but no studies were identified for inclusion and the other reported on very old evidence
- More recent study established that increased numbers of registered nurses on shift reliably precedes small but statistically significant increases in conflict and containment incidents
- In contrast, qualitative research suggests that nurses and patients believe reductions in restraint are unachievable with insufficient staff. They believe that staff shortage impacts on staff-patient relationships and communication resulting in failure of efforts to reduce conflict
- Appears to be growing consensus that a simple relationship solely between number and status of staff on shift in inpatient mental health settings and patient outcomes is inadequate to explain the complexity of the issue
- Other factors, including the characteristics of the nursing staff, the presence of non-nursing staff, environment/ward design, leadership, and staff flexibility, need to be considered

Nature and Quality of Evidence

Joanna Briggs Institute (JBI) Levels of Evidence



The Gaps

- Current evidence is only about relationships between the number and status (qualified/unqualified; permanent/temporary) of nurses and patient outcomes
- The only outcomes examined relate to conflict and containment and not, for example, patient wellbeing or recovery
- There is a lack of evidence about how factors including characteristics of nursing staff, the presence of non-nursing staff, environment/ward design, leadership, and staff organisation impact on patient outcomes
- There is a lack of evidence about why increased qualified nurse numbers precede increased incidents of conflict and containment, and whether interventions can reverse this

Glossary of Terms

Term	Description
Advanced Practice Nurses (APN)	Nurses who are educated at master's Level in clinical practice and have been assessed as competent in practice using their expert clinical knowledge and skills in their specialist area of practice
Care planning	Care planning is about the process of negotiation, discussion and decision-making that takes place between a medical practitioner and a patient
Clinical safety management practices	(Safety as a concept in the mental health setting can be broadly defined) Practices that support suicide prevention and management of suicide and self-harm of patients with pre-existing mental health illness under the care of mental health teams
Co-production in mental health care planning	The inclusion of people with lived experience of mental illness, as well as their partners, family and friends (who are all "Experts by Experience") in the commissioning, planning and delivery of services as equal partners with service providers and professionals (also referred to as **Partnership** in planning)
Mental health nurse	Registered mental health nurses working with and supporting people experiencing mental health difficulties
PPI(E)	Patient and public involvement (& engagement); Public Contributors with Lived Experience
Protected characteristics	9 protected characteristics refer to groups of people that are protected under the Equality Act (2010). Age, Disability, Race, Religion or belief, Gender, Pregnancy and maternity, Sexual orientation, Gender reassignment, Marriage and civil partnership
Restrictive Interventions (RI)	Also referred to as Restrictive Practices. Deliberate acts that restrict a patient's movement, liberty and/or freedom to act independently to manage aggressive or disturbed behaviour and for the safety of the patient and/others. Includes seclusion, physical restraint, rapid tranquillisation
Risk assessment	Identifying aspects of a service which could lead to injury to a patient
Risk management	Changing aspects of a service that could lead to injury to a patient
Seclusion	The practice of confining a person in a room from which the person cannot exit freely, to manage aggressive and disturbed behaviour, with no access to own property
Service users of mental health services	Also referred to as patients; people with mental health illness
Shared decision making	A collaborative process through which a clinician supports a patient to reach a decision about their treatment

Acknowledgements

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Thank You

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