Mental Health Nursing Roles and Functions in Acute Inpatient Units: Caring for People with Intellectual Disability and Mental Health problems – A Literature Review

by

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Abstract:

The purpose of this paper is to review current national and international perspectives on the role and function of mental health nursing in dual disability within acute mental health inpatient settings. A universally accepted definition of the role and function of psychiatric nursing has been elusive. The role and function may be presumed to have core attributes that differ according to local conditions. The articulation of the role and function will contribute to the body of knowledge of psychiatric nursing and to improving the understanding of the nurse-patient relationship for those caring for people with dual disability in acute mental health inpatient facilities. The two identified key roles and functions of mental health nursing practice for people with intellectually disabilities within acute inpatient mental health facilities in Victoria will be discussed.

Key words: Nursing, Inpatient care, Intellectual disability, Role, Function, Mental health

Introduction:

Over recent decades, policy and legislative reforms have resulted in significant changes to the provision of mental health services in the State of Victoria (Australian Health Ministers' Conference, 1998; Human Rights and Equal Opportunity Commission, 1993; Mental Health Branch, 1994; New Directions for Psychiatric Services in Victoria, 1986). For people with intellectual disability in this State, an outcome of some of the earlier aspects of the process of policy reform has seen the separation of the social welfare elements of services from the more particular clinical focus of mental healthcare delivery. This reform has been subsequently reflected within State legislature, codified in the Intellectually Disabled Persons' Services Act (1986) and the Mental Health Act (1986), so that these two discrete pieces of legislation can be considered to respectively administer service provision and mental healthcare for people with intellectual disability.

Consistent with the current policy and legislation, mental healthcare has been sited for delivery within mainstream generic health services within Victoria. This has resulted in a shift in the allocation of resources so that spending reflects local need in terms of both community and
individual demands. Thus, people with intellectual disability and mental health needs turn to public mental health services for access to mental health treatment and care. Chaplin (2004) asserts that people with Intellectual Disability have reduced access to mainstream mental health services and that staff working in these services do not have sufficient training in the care of people with this dual diagnosis.

Mental health nurses account for approximately 53% of the public mental health workforce in Australia (Whiteford, 1998), and as such can be considered as playing a fundamental and essential role in mental health service delivery and in providing treatment and care for people experiencing a mental illness. A report on New Zealand Mental Health Services by Mellsop, Taumaepeau & Smith (1993) identified nursing as being the largest proportion of trained clinical professionals working in the health area, meaning that people experiencing mental health problems are likely to have significant contact with nurses if they are cared for by public mental health services. Therefore articulating the role of the psychiatric nurse is important in order to determine the benefits for the individual, the community and also for the profession itself. As greater understanding of the impact of mental ill health on particular populations occurs, it is necessary to reconsider the mental health nursing role to ensure that it remains relevant and contemporary. This is especially the case for vulnerable populations such as people with intellectual disability, who often rely on paid and unpaid carers to access mental health services on their behalf. Difficulties with communication and language skills can effectively create a barrier between themselves and the mental health practitioner (Hand, 1999; Thornton, 1999).

The available research suggests that most nurses do not feel confident in caring for people with intellectual disabilities and would prefer that a nurse with specialist qualifications in the nursing care of intellectually disabled people remains with them in the general hospital setting (Slevin & Sines, 1996; Vitiello & Behar, 1992). Naylor & Clifton (1994) and Chaplin (2004) also suggest that staff of mainstream health services do not have confidence in their ability to meet the needs of this population. No similar literature examining the attitudes of mental health nurses to caring for people with an intellectual disability could be found. The purpose of this article is to review the literature pertaining to the role and function of mental health nursing in dual disability within acute inpatient settings. The articulation of the nature of the facets of role and function will contribute to the body of knowledge of mental health nursing and contribute to improving the understanding of the nurse-patient relationship for those caring for people with dual disability in this domain of practice.

Intellectual Disability:

In the State of Victoria, Australia, the definition of intellectual disability (ID) is specified in the Intellectually Disabled Persons’ Services Act (1986) in accordance with the guidelines of the American Association on Mental Retardation, which requires that three separate diagnostic criteria be met. Firstly, the person has an Intelligence Quotient (IQ) that is more than two standard deviations below the mean on a norm-referenced measure of intelligence (equating to an IQ score of less than 70); secondly, the person experiences significant deficits in adaptive functioning in areas of day living, such as personal care or community access; and finally, these two criterion are both evident before 18 years of age.

It is estimated that some 2% of the population will exhibit an IQ of less than 70 on a standardised score (American Psychiatric Association, 1994; Chang, Lee, Yang, & Wen, 2001). In Victoria this corresponds to approximately 80,000 people. However, the additional criterion for functional deficits reduces the number of people in Victoria who meet legal definition of intellectual ability to

approximately 40,000 or about 1% of the State's total population. The Department of Human Services (2000) estimates that approximately half of this number is registered as eligible for services, suggesting that the remainder are sufficiently supported or otherwise capable of living in the community.

Dual Disability:

Estimates on the prevalence of mental illness in people with intellectual disability vary considerably, although most studies suggest that they suffer the full range of mental disorders and that the rate of mental illness in this group exceeds that of the general population (Borthwick-Duffy, 1994; Holland, 1999; Jackobson, 1999; Moss, Emerson, Bouras, & Holland, 1997). A conservative prevalence rate of 14.4% for mental illness is reported by Deb, Thomas, & Bright (2001a) in a community-based sample of people with intellectual disability in the UK. A similar prevalence rate in Victoria would translate to about 5,700 people with intellectual disability also experiencing a mental illness. This number would equate to approximately the total caseload of one Victorian Area Mental Health Service. A severe behaviour disorder, which may be related to mental illness or disorder, is reported in 23.8% of participants in a parallel study by Deb, Thomas, & Bright (2001b). This would be equivalent to 3570 people if the same prevalence rate were applied in Victoria. This has significant implications for services, as the presence of mental disorders in people with ID is described as one of the main reasons for either loss of community placement or retention in institutional settings (Bouras, Holt, & Gravestock, 1995). Additional problems due to either the high rate of mental health problems related to co-morbid medical conditions (Beange, McElduff & Baker, 1995; Howells, 1985), or medical conditions themselves (Lennox et al, 2000) are well documented in the literature suggesting that this is a complex population, requiring a high level of support.

Method:

Key searches were conducted of the electronic databases MEDLINE, CINAHL, PsycINFO, the Cochrane Collaboration and EMBASE: Psychiatry and hand searches of library resources at St. Vincent's Hospital De Gruchy Library and the Melbourne Health Network Mental Health Library. The search terms used were nouns, verbs, adverbs and wild cards that are commonly utilised in domestic and international literature and were searched individually and in a variety of combinations, viz.: ‘nurs*’, ‘psychiatric nurs*’, ‘intellectual disabil*’, ‘role’, ‘function’, ‘mental* retard*’, ‘practice’, ‘inpatient’, ‘hospital’, ‘psychiat*’, ‘learning disabilit*’, ‘mental health’, ‘direct care’, ‘mental handicap’, ‘developmental disabili*’, and ‘developmental disorder’. Search results were consolidated so that the following criteria were fulfilled prior to abstracts being reviewed. English abstracts were selected only from articles published after 1980 in peer reviewed publications, opinions from professional journals or relevant conference proceedings. Abstracts were reviewed to determine the relevance of the article to the issue of mental health nursing roles and functions, with particular emphasis on the care of people with dual disability. Those articles that fulfilled these initial search criteria were procured by the authors for critical appraisal according to the specifications of the Centre for Evidence-based Nursing at the University of York.

A total of 42 articles were reviewed. A considerable body of the literature, 69% (n=29) originated from the United Kingdom (UK) and specifically related to the role of community nurses with people experiencing learning disability. These articles included little information regarding their role and function in mental health care for this population. Learning disability nursing in the UK encompasses both physical and mental health needs of people with intellectual disability and as such many of the articles refer to the nurse’s role in meeting the overall health care needs of this
population (Mobbs et al. 2002, Hallawel 2001, Minto 2001, Gilbert et al. 1998, Green 1998, Norman 1998). Of the remaining articles 19% (n=8) were from the USA, two from Canada and one each from Finland, Hong Kong and Ireland. No articles were located that originated from either Australia or New Zealand.

Findings - Nursing and Intellectual Disability:

Studies of mainstream health services have examined nurses’ attitudes towards people with ID and found a general lack of confidence and a reluctance to work with this population (Barr, 1990, MeConkey 2000, Naylor & Clifton 1994). There is considerable debate as to whether provision can be satisfactorily met within generic mental health services, with the body of international expert opinion arguing that people with ID are both disadvantaged and vulnerable in generic treatment settings (Bouras & Holt, 2001; Day, 2001; Moss et al., 2000; Nottestad & Linaker, 1999; Raitasuo, 1999). Improving the health of people with ID has been identified as an important issue in the UK. Health of the Nation (Department of Health 1995) stresses the right of people with ID to use general health services. The difficulties for this population in accessing and using these services and the subsequent need for additional support, has however been identified. This is further emphasised in Signposts for Success (National Health Service Executive, 1998) that recommends partnerships between primary and specialist healthcare focused on health improvement. Health promotion and education as well as health surveillance schemes are identified as a key role for nurses in a survey of 136 community nurse managers in NHS Trusts in England (Mobbs et al., 2002). Nurses are well prepared for this role due to their health-based education and training.

Nursing roles and functions differ considerably between different geographical areas. Thiru (1994) describes the role of a specialist community service in London. She offers the opinion that both psychiatric and learning disability nurses are equipped to offer mental health care for people with intellectual disability but that the combination of both areas of training brings specialist expertise. Nurses are reported to play the lead role in the following areas: running outpatient nursing clinics; monitoring and evaluating treatment; providing counselling and education for patients, families and other professionals; designing behaviour management interventions; providing advice and support regarding behaviour management; running group interventions for anger and anxiety management and for psychosexual problems; and liaison with local agencies regarding vocational and social activities.

Similar roles were described in a survey of 50 nurses working with people who have ID in Northern Ireland, when asked to describe what they perceived as their key roles (Parahoo & Barr, 1996). The principal reasons for visiting community clients were physical care, epilepsy, aggression and mental health. Nurses responding to the survey identified their desired role as being more specialised, including early intervention, offering increased clinic based care and public education. The authors report a response rate of 72% (n= 35) but caution against generalising results due to a significant number of non responders and the speed of change in services. They present an argument for further studies to examine changes in the role.

Relationships were identified as a major theme, with the nurse’s ability to develop relationships with patients, families and other professionals considered an essential factor in delivering effective care. The importance of interpersonal skills and the therapeutic relationship is addressed in several articles (Culley & Genders, 1999; Norman, 1998; Raitasuo et al., 1999, Sharkey & Lipshutz, 1982). A study of outcomes for people with intellectual disability in a specialist psychiatric unit by Raitatsuo et al (1999) suggested a crucial role for nursing in establishing a relationship through human contact with the person. This view is consistent with the desires of community learning disability nurses for more client centred work, as demonstrated through the results of a survey.
conducted in Northern Ireland (Parahoo & Barr, 1996). Cutler (2001) and Nehring (2003) present reviews of mental health services for people with ID in the USA. The traditional role of the nurse is identified as one of providing physical care but changes in policy that emphasize de-institutionalisation and normalisation have resulted in greater use of generic services, which has radically altered the nurse’s role. The historical reluctance of mental health professionals to address the mental health needs of people with dual disability is highlighted, and it is suggested that this influenced by both lack of interest and a perception that the issues are too complex.

Nehring (2003) suggests that the nurse’s role should involve comprehensive clinical and educational input across the lifespan as well as providing leadership in this field. She argues that nursing care in this field is unique and states “for the most part, the average nurse in the US does not have adequate knowledge or experience with persons of any age with ID” (p. 22). This view is supported by Moore (2003) who highlights the role of nurses in changing and shaping mainstream health provision for this population. Cowman, Farrelly, & Gilheany (2001) conducted a study of 155 nurses, their data analysis revealed nine main categories of mental health nursing roles: assisting patient needs and evaluation of care; planning care; nurse/patient caring interactions; pharmaceutical interventions; education; documenting information; co-ordinating the services of nurses and other professionals for patients; communication with other professionals and other grades of staff; and administration/organisation of the clinical area (p. 749). Two categories had subordinate dimensions that further delineated the category in terms of its scope and relationship with other entities. For example, the category of nurse/patient caring interactions had safety, social, spiritual and self-determination elements. Green (1988) reports an approach to defining a nursing model that includes physical care; psychosocial care; skill development; activities of daily living removal of constraints/provision of appropriate environment; and reduction in undesirable behaviours.

Identifying the role of the mental health nurse in intellectual disability:

Nurses are identified as comprising the majority of the workforce caring for individuals with intellectual disability in acute inpatient mental health settings (Baily & Cooper 1997). This is consistent with the previous findings of (Whiteford, 1998) and (Mellsop et al., 1993). However, despite this finding, there is surprisingly little available literature that comprehensively explicated the role of the nurse in this area of practice. More generally, there is a paucity of published nursing research in the whole area of nursing and dual disability. This theme is consistent with a comprehensive review of service provision for adults with intellectual disability in several European countries (Holt, Costello, Bouras, Diareme, Hillery, Moss, Rodriguez-Blazquez, Salvador, Tsiantis, Weber, & Dimitrakaki, 2000), which reported that there is no systematic information on service delivery for people with dual disability.

Much of the available literature on the role of the nurse for people with intellectual disability relates to community nursing or is limited to institutions for people with intellectual disability. The majority of the articles are opinion based with few research-based studies found. Significant differences in nurse education and service models both internationally and regionally, make comparisons difficult and there is a wide variation in practice. These findings support those derived from a comprehensive review of the literature on the role of the community learning disability nurse (CNLD) by Parahoo and Barr in 1996 in which they comment on the lack of good quality research in this area.

The variation in the perceived role of nurses in the care of people with intellectual disability is illustrated by the responses of other health professionals reported in several studies. It is suggested
that the difference in professional makeup of teams may influence the role of nurses in a particular area (Mobbs et al., 2002). Occupational Therapists are reported to view the role of the nurse in ID as liaison and health promotion (Lillywhite & Atwal 2003) whereas teachers saw the nurse's role as one of support for families, and managers emphasised nurses' strengths in behaviour management (Stewart & Todd, 2001).

Managing personal disturbances, particularly aggression is seen by non-nurses as a significant area of the nurse's expertise (Gijbels, 1995). Learning disability nurses are seen as providing specialist input relating to challenging behaviour and mental health but were frequently seen to fill in for other professionals such as psychologists or social workers when these positions were vacant, giving an impression of the nurse as a generalist with limited skills or a 'Jack of all Trades' (Farrelly & Gilheany, 2001). In contrast, a study of nurses' perceptions (Department of Health, 1995) found that while they also saw themselves as having a breadth of skills and knowledge they considered that they also had specialist knowledge and expertise, which allowed them to understand the complex needs of people with intellectual disability.

Whilst there is a clear focus on clinical care of the patient and distinction between specific nursing care and more general social or occupational issues, the nurse also has a responsibility to the family of the individual, and to the wider service system, including their colleagues and peers. The nurse has a key role within the multidisciplinary team, in terms of the assessment planning, implementation and evaluation of healthcare delivery to support the patient in optimising their biological, psychological and social health status, with due regard paid to cultural and spiritual factors.

Advocacy and Leadership:

Advocacy is cited as a role for nurses when working with people who have intellectual disability because the existence of a disability may also increase vulnerability (UKCC, 1999). However there is potential for the creation of dependency. A study of the role of mental health and learning disability nurses across six sites in England (three mental health, and three learning disability) used a multiple case study approach to obtain the views of stakeholders (Norman, 1998). There was widespread agreement that service should be needs led and that users and carers need to be involved in service planning and delivery. Respondents were divided between those who regard the nurse as having a role as an advocate and opposing views that regard this as incompatible with the nurse's position as a service provider.

Jenkins and Northway (2002) examine the role of nurses in acting as advocates for people with intellectual disability. They present a logical argument that nurses may not be the best placed to take on this function and suggest the nurse should promote self advocacy and independent advocacy rather than directly advocate for the individual. This view is also expressed by Kwok (2001) who describes the nurse as playing an important role in developing personal autonomy. In this situation the nurse would aim to promote self-determination by supporting the individual to develop the necessary skills to exercise control over their own lives. This may include developing the person's assertiveness and problem solving skills or liaising with advocacy groups. Nurses may be ideally placed to provide practical help for the person with ID in providing information and assisting the person in contacting and dealing with relevant agencies or services.

Several authors suggest nurses as having an advisory role in policy-making and service design with increased input into service planning (Mitchell, 2004; Moore, 2003; Nehring, 2004). Cutler (2001) presents a logical and coherent argument for an advanced practice mental health nurse to assume a
leadership role in clinical care. The proposed role moves away from the traditional view of the nurse as primarily part of a team of care providers, to assume a leadership role in clinical care, service co-ordination and co-ordinating cross-system care (termed integrative practice), education and advocacy for individuals and families. In Norman’s study nurses were perceived as specialist advisors on issues relating to intellectual disability and it is suggested they require knowledge and skills in presenting arguments and public presentation to develop this role.

**Educator:**

People with intellectual disability have higher rates of both physical and mental illness when compared to the general population. They are more likely to require ongoing medical interventions and are more likely to be taking prescribed medication (Broda, 2004; Crabbe, 1994; Jansen, Krol, Groothoff & Post, 2004; Lennox, 2000). Despite these findings they consult their GP less often, do not receive regular medication review and the level of health screenimg is erratic and poorly accessed. Good quality health surveillance and maintenance can have a significant impact on the general health of people with intellectual disability (Whittaker & McIntosh, 2000). In a discussion of primary healthcare for this population, Powrie (2001) identifies significant gaps in service delivery and suggests a lead role for nurses in providing education for people with ID and their carers in relation to their health needs and in organising and coordinating relevant screening or interventions.

Jukes (1994) identified a significant role for nurses in educating primary health care staff about the specific problems and needs of people with ID as well as contributing to curriculum development in this area. This role is further explored by Jukes in 2002 in an article about the introduction of the concept of Health Facilitators for people with ID in the UK. In this role the nurse is described as a facilitator of learning in areas of intellectual disability across professional boundaries. A strong emphasis is placed on health promotion and education, particularly relating to life events and the reality of community living for this population that can precipitate mental illness.

**Discussion and Conclusions:**

The review of the literature, although varying, clearly demonstrates that the prevalence of dual disability is significant (Borthwick-Duffy, 1994; Moss et al, 1997; Holland, 1999; Jacobson, 1999). In view of nurses constituting the largest professional group within the mental health workforce (Whiteford 1998), there is a need for a clearly defined role for the mental health nurse to provide care for people with an intellectual disability who are also experiencing a mental illness. In light of this, the paucity of literature articulating the role and function of the mental health nurse in relation to dual disability within the acute mental health setting is of concern. This review of the limited available literature supports the importance of a mental health nursing role in the dual disability area, particularly in view of the specific needs and vulnerabilities of people experiencing a dual disability (Bouras & Holt, 2001; Moss et al, 2000; Nottestad & Linaker, 1999; Raitasuo, 1999). Nurses are described as suitably placed to perform the roles required in order to meet the needs of people experiencing both a mental illness and an intellectual disability, with communication skills and therapeutic relationships being described as two crucial elements in providing care for this population. Indeed these roles constitute the essence of mental health nursing practice (Norman, 1998; Raitasuo et al, 1999; Culley & Genders, 1999; Sharkey & Lipshutz, 1982).
The ability to accurately describe the role of the nurse in the dual disability area is severely limited by international differences in service delivery settings and educational approaches (Parahoo & Barr, 1996). This lack of clarity has influenced the perspectives of the multidisciplinary team towards nurses as well as for nurses towards themselves (Lillywhite & Atwal, 2003; Mobbs et al, 2002; Stewart & Todd, 2001). However, in articulating the role of the nurse in dual disability, the therapeutic relationship was identified as crucial. Human contact and trust was viewed as a necessary component to providing client centred care (Parahoo & Barr, 1996; Raitatsuo et al, 1999). Other functions acknowledged included the management of behavioural disturbances, most notably aggression, which was particularly attributed to the nursing role by allied health professionals (Gijbels, 1995).

From the literature it is evident that nurses consider their role to comprise a number of broad functions including physical care; psychosocial care; skill development; activities of daily living and removal of constraints/provision of appropriate environment (Green, 1988). However, the limited literature suggests that nurses consider themselves to have the specialist skills and knowledge to understand, and therefore provide care for, the complex needs of people experiencing a dual disability (Department of Health, 1995). The importance of this latter point has led to the identification of two particularly pertinent roles, that of advocacy and leadership, and the role of the educator (Broda, 2004; Jenkins & Northway, 2002; Kwok, 2001; Mitchell, 2004; Moore, 2003; Nehring, 2003, Wittaker & McIntosh, 2000).

The articulation and further development of these roles is urgently required if the specific and complex needs of people experiencing both a mental illness and an intellectual disability are to be met (Lennox, 2000). However despite recognition of the need for nursing skills, the literature demonstrates that nurses have a lack of confidence and reluctance to work with this population (Barr, 1990; McConkey, 2000; Naylor & Clifton, 1994). In seeking to contribute to the body of knowledge in this area, this paper has identified a substantial lack of literature. If the needs of this extremely vulnerable group of people are to be met, further research regarding the role of the nurse is crucial.

References:


