The Changing Face of Psychiatric Nursing – Care or Control?

The Changing Face of Psychiatric Nursing – Care or Control?

ePsychNurse.Net – Towards Improved Quality – Improving Nurses' Continuing Vocational Training in Psychiatric Hospitals and Inpatient Units

Välimäki M, Scott A, Lahti M & Chambers M (eds.)

Department of Nursing Science
University of Turku, Turku
ISBN: 978 – 951 – 29 – 3576 – 5

Preface

This report has been written as part of the project "Toward improved quality – developing nurse's continuing vocational training in hospitals and inpatient units". Its overall goal is to ensure high quality, ethically appropriate and therapeutically effective interventions to enable nurses to manage distressed and disturbed patients in European psychiatric hospitals and inpatient units. In this large-scale, multinational projects there are all together six European countries involved: Finland, Ireland, England, Portugal, Italy and Lithuania. The project work plan were during autumn 2006 and spring 2007.

The content of this publication was produced in the first stage of the project aiming to collect the preliminary source material for the project. The literature review was carried out in the project stage, providing the groundwork for the next steps for the project. This project aims to develop an interactive multinational portal with training material. Therefore, it is important to share an understanding of basic information, psychiatric nurse's continuing vocational education, laws and ethical codes and patient restriction used in mental health care. In this publication, the purpose of the material produced here is to understand nurses' educational need related to vocational continuing education and to be used in further project stages as an empirical data collection. The data were collected as a preliminary source material for latter phases where nurse's perceptions of the current practice, nurse's attitudes to mental illness, prevalence of use of seclusion room and existing and desired vocational training provision will be collected in six different European countries.

The following organisations are involved in this project: University of Turku, Dublin City University, St. Vincent Hospital, National Council for the Professional Development of Nursing and Midwifery, University of Padova, Klaipeda College - Health Faculty, Klaipeda Psychiatric Hospital, Escola Superior de Enfermagem de Lisboa, Centro Hospitalar Psiquiátrico de Lisboa, Omnia Vocational Institution the Espoo Region, Kellokoski psychiatric hospital, Hyvinkää hospital area, Pirkanmaa Hospital District, Kingston University & St. George's Medical School and South West London & St. George's Mental Health NHS Trust. A wide variety of different countries, organisations and individuals in this project give us a strong confidence that theoretical, practical, ethical and political issues around the topic of interest will be taken account during this project lifetime.

We are aware the content of this book will be partially outdated almost as soon as it has been published. We still hope that this publication will encourage nurses and different professions working in mental health care field to have a basic understanding of similarities and differences between different European countries related in mental health care. We also hope that this publication will inspirate and motivate nurses in maintaining and developing the quality of psychiatric care in Europe.

29 October, 2007, Turku, Finland

Maritta Välimäki, Professor
Co-ordinator of ePsychNurse.Net project

This project has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

BACKGROUND……..8

Baseline information from Finland: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Finland

INTRODUCTION 12
DESCRIPTION OF FINNISH POPULATION AND HEALTH STATISTICS 12
Population statistics 12
Health statistics 13
THE FINNISH HEALTH CARE SYSTEM 13
General 13
Mental health services 14
NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE……..…..15
Degree education 15
Vocational continuing education 16
Nurses role in mental health services 17
LEGAL NORMS AND ETHICAL CODES IN FINLAND RELATED TO PATIENT RESTRICTIONS……...18
Legal norms related to patient restrictions 18
Ethical codes related to patient restrictions 19
Professional codes related to patient restrictions 19
PATIENTS RESTRICTION IN FIELD OF MENTAL HEALTH CARE IN FINLAND……..20
CONCLUSIONS 21
REFERENCES 22
ACKNOWLEDGMENTS 24

Baseline information from Ireland: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Ireland

INTRODUCTION 25
DESCRIPTION OF IRISH POPULATION AND HEALTH STATISTICS 25
Population statistics 25
Health statistics 27
THE IRISH HEALTH CARE SYSTEM 28
General 28
Mental health services 30
NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN IRELAND 31
Degree education 31
Vocational continuing education 32
Nurses' role in mental health services 32

LEGAL NORMS AND ETHICAL CODES IN IRELAND RELATED TO PATIENT RESTRICTIONS.....33

Legal norms related to patient restrictions.....33
Ethical norms related to patient restrictions.....34
Professional codes related to patient restrictions.....35

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN IRELAND.....36

Mental health statistics and patient restrictions used.....36
Management of distressed and disturbed patients.....36

CONCLUSIONS.....37

REFERENCES.....38

Baseline information from Italy: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Italy

INTRODUCTION.....40

DESCRIPTION OF ITALIAN POPULATION AND HEALTH STATISTICS.....41

Population statistics.....41
Health statistics.....42

THE ITALIAN HEALTH CARE SYSTEM.....43

General.....43
Mental health services.....45
Understanding the psychiatric model in Italy.....47

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH SERVICES IN ITALY.....48

Degree education.....48
Vocational continuing education.....48
Nurses' role in mental health services and multidisciplinary team.....49

LEGAL NORMS AND ETHICAL CODES IN ITALY RELATED TO PATIENT RESTRICTIONS.....51

Legal norms related to patient restrictions.....51
Ethical codes related to patient restrictions.....53

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN ITALY.....53

Mental health statistics and patient restrictions used.....53
Management of distressed and disturbed patients.....54

CONCLUSIONS.....56

REFERENCES.....57

Baseline information from England: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in England

INTRODUCTION 60
DESCRIPTION OF ENGLISH POPULATION AND HEALTH STATISTICS 61
Population statistics 61
Health Statistics 62
THE ENGLISH HEALTH CARE SYSTEM 65
General 65
Mental health services 66
NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN ENGLAND 66
Degree education 66
Vocational continuing education 67
Nurses' role in mental health services 67
LEGAL NORMS AND ETHICAL CODES IN ENGLAND RELATED TO PATIENT RESTRICTIONS 68
Legal norms related to patient restrictions 69
Formal admissions under the Mental Health Act 1983 69
Professional codes related to patient restrictions 69
PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN ENGLAND 70
Mental health statistics and patient restrictions used 70
Ethnic minority mental health statistics 71
Management of distressed and disturbed patients 72
CONCLUSIONS 72
REFERENCES 73

Baseline information from Lithuania: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Lithuania

INTRODUCTION 77
DESCRIPTION OF LITHUANIA POPULATION AND HEALTH STATISTICS 78
Population statistics 78
Health statistics 79
THE LITHUANIAN HEALTH CARE SYSTEM 82
General 82
Mental health services 84
NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN LITHUANIA 84
Degree education 84
Vocational continuing education 85
Nurses role in mental health services 85

LEGAL AND ETHICAL NORMS RELATED TO PATIENT RESTRICTIONS IN LITHUANIA……85

Legal norms related to patient restrictions 85
Ethical norms related to patient restrictions 86
Professional codes related to patient restrictions..... 86

PATIENTS RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN LITHUANIA……86

Health statistics and patient restrictions used 86
Management of distressed and disturbed patients 86

CONCLUSIONS..... 86

REFERENCES..... 87

Baseline information from Portugal: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Portugal

INTRODUCTION 89

DESCRIPTION OF PORTUGUESE POPULATION AND HEALTH STATISTICS……89

Population statistics 89
Health statistics..... 90

THE PORTUGESE HEALTH CARE SYSTEM..... 90

General 90
Mental health services 92

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN PORTUGAL……93

Degree Education 93
Vocational continuing education..... 93
Nurses' Role in mental health services 94

LEGAL NORMS AND ETHICAL CODES IN PORTUGAL RELATED TO PATIENT RESTRICTIONS……95

Legal norms related to patient restrictions 95
Ethical codes related to patient restrictions 96
Professional codes related to patient restrictions..... 96

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN PORTUGAL……97

Mental health statistics and patient restrictions used……97
Management of distressed and disturbed patients……97

CONCLUSIONS..... ……97

REFERENCES 98

DISCUSSION……...100
REFERENCES……105

BACKGROUND

Mental health problems are an international and national concern. More than 27% of adult Europeans are estimated to experience at least one form of mental ill health during any one year (Wittchen & Jacob 2005). The increased demands in mental health care services have caused stress and pressures in health personnel (Xianyu & Lambert 2006). Younger and well educated employees have particularly found their work to be more stressed and emotionally exhausted in mental health care area (Laijärvi et al. 2006). Occurrence of psychic and somatic symptoms or sleep disorders among employers has increased (Ministry of Social Affairs and Health 2004). Stress (Mann & Cowburn 2005) and burnout (Pompili et al. 2006) among health care personnel is also a reality. A serious problem is personnel's threat of patient violence (Ashmore et al. 2006, Needham et al. 2005).

Despite the development of out-patient psychiatric care, a number of patients needs inpatient psychiatric care due to the nature of mental illness; a patient may be a danger to him or herself or to other people (Salize & Dressing 2004). These patients may also be hospitalized against their will, their right to self-determination may be restricted or they may be subjected to restrictions or coercive interventions during a treatment period (Kaltiala-Heino & Välimäki 2001, Salize 2002, Tuori 2002, Tuohimäki ym. 2004). Such interventions include the use of the seclusion room, physical restraint by tying up patients' hands and/or ankles, physical holding, forced medication, restrictions on movement inside or outside the hospital ward, or inspection of patients' belongings (Välimäki et al. 2001). These are ethically sensitive interventions violating human rights and dignity during psychiatric hospital stays. At the same time, evidence is still missing for the evidence of effectiveness of coercive interventions in managing patient aggressive behaviour (Wright 2003) or serious mental disorders (Sailas & Fenton 2000, Sailas & Wahlbeck 2005).

Questions of ethics have been attracting increasing attention in the health care debate. There is accordingly a growing need for ethical discussion of the use of coercive measures and patient violence and aggression in psychiatric care in Europe. Together with the working life and intersection of the information society has been largely researched in various health care sectors. However, a lack of structured and evidence-based good practices and guidelines increase pressures and ethical dilemmas among nurses (Marangos-Frost ym. 2000, Kuosmanen ym. 2006, Olofsson & Nordberg 2005).

Stigmatisation, discrimination, disrespect for the human rights, and the dignity of mentally ill and disabled people still persists, challenging core European values (European Commission 2005). Despite their differences, national health systems in European Union countries place the same rights of patient, consumers, users, family members, health care staff, vulnerable populations and ordinary people at risk. The Council of Europe Convention on human rights and biomedicine (1997), the Declaration on the promotion of patient' rights in Europe, endorsed in Amsterdam in 1994, The Ljubljana Charter on reforming health care and the European Charter of Patient rights (2002) all highlight the requirement to respect patients as human beings and to ensure their privacy and dignity is protected. This report furthers this aim in a particularly vulnerable group of people suffering from mental health problems and their careers at psychiatric health care organisations.

The shortcomings of continuing vocational training are detrimental to the quality of health care services and cause problems for both employees and employers (Ministry of Finnish Social Affairs and Health 2002). In addition to the technological development during the last few years, nurses are required to demonstrate new ethical sensitivity to avoid stigmatisation caused by illness when encountering people suffering from mental health problems (WHO 2005). The lack of professional competence may also affect the equal treatment of patients. There may be qualified nurses who are not able to recognise the meaning of the compulsory interventions to a patient or nurses who do not perceive the ethical implications of interventions related to restrictions. (WHO 2005, Olofsson & Norberg 2001, Marangos-Frost & Wells 2000, Olofsson et al.1998). One reason for this may be the staff's attitudes towards their fundamental task in working with people with mental health illness (Tuori 1999).

Continuing vocational training is an effective method to maintain professional competence in health care. However, the Systematic Review (Thomson et al. 2001) has shown that training sessions alone are unlikely to change professional practice, while interactive workshops can result in moderately large changes in practice. Therefore, it is important to develop a high quality and systematic continuing vocational training using a variety of different and innovative methods to increase European qualified nurses' professional skills. This would increase and maintain the quality of nursing in psychiatric hospitals and inpatient units and also increase the attractiveness of the work. We are already able to see that there is lack of competent qualified nurses in psychiatric area and young people are not willing to educate themselves for the field of mental health care.

The problems of work and well-being in changing mental health services are not still fully understood in European society. As rapid and wide-ranging changes occurs in social and health care system across Europe. The psychiatric nursing profession need to display a new and comprehensive vision for the role of psychiatric nurses and its commitment to patients and co-workers. To maintain and increase attractiveness of mental health services, a deeper understanding of working life and new solution to resolve problems in work are also needed. It is therefore important to systematically develop a high quality and innovative educational methods to increase European qualified nurses' work and professional skills to work pressured and demanding environments. It has been shown that multiple organisational and social intervention has a positive effect to health care staff's work satisfaction, moral and well-being and further the quality of patient care (Gilbody ym. 2006).

The project focuses on human rights and dignity in mental health care area. Qualified nurses in different European countries share the problems of psychiatric nursing and education. National and international collaboration among different health care and education organisations, however, is slight. Ensuring high quality, ethically sensitive nursing care especially in the management of distressed and disturbed patients is necessitates a critical appraisal of these interventions. (Kisely et al. 2005) Therefore, alternative ways of dealing with unwanted or harmful behaviours need to be developed and continuing use of seclusion or restraint must therefore be questioned (Sailas & Fenton 2005). This project creates new opportunities to discuss and develop the quality of continuing vocational training in Europe.

References

Ashmore R, Jones J, Jackson A & Smoyak S. (2006) A survey of mental health nurses' experiences of stalking. Journal of Psychiatric and Mental Health Nursing 13, 562-569.

Gilbody S, Cahill J, Barkham M, Richards D, Bee P & Glanville J. (2006) Can we improve the morale of staff working in psychiatric units? A Systematic Review. Journal of Mental Health 15 (1), 7-17.

European Commission (2005) Green paper. Improving the mental health of the population: towards a strategy on mental health for the European Union. Health and Consumer Protection. Directorate-General. Brussels, 14.10.2005, COM(2005)484. Brussel.

Kaltiala-Heino R & Välimäki M. (2001) Involuntary commitment in health care. An analysis of the status and rights of involuntarily treated psychiatric patients in comparison with patients treated involuntarily under other acts. European Journal of Health Law 8, 299-316.

Kisely S, Campbell L-A & Preston N. (2005) Compulsory community and involuntary outpatient treatment for people with severe mental disorders. The Cochrane Database of Systematic Reviews 2005 Issue 3. The Cochrane Collaboration. Published by John Wiley & Sons, Ltd, UK.

Laijärvi H, Pääkkönen T, Välimäki M & Pukuri T. (2006) Stressi ja työuupumus akuuttipsykiatrisessa hoitoympäristössä. Hoitotiede 18 (5), 245-254.

Mann S & Cowburn J. (2005) Emotional labor and stress within mental health nursing. Journal of Psychiatric and Mental Health Nursing 12, 154-162.

Marangos-Frost S & Wells D. (2000) Psychiatric nurses' thoughts and feelings about restraint use: a decision dilemma. Journal of Advanced Nursing 31 (2), 362-369.

Ministry of Social Affairs and Health (2004) Health care in Finland. Brochures of the Ministry of Social Affairs and Health 2004:11. Ministry of Social Affairs and Health, Helsinki.

Ministry of Finnish Social Affairs and Health (2002) Decision in Principle by the Council of State on Securing the Future of Health Care. (http://www.terveyshanke.fi/eng.pdf), Helsinki. (Accessed 13.6.2008)

Needham I, Abderhalden C, Halfens R.J.G, Dassen T, Haug H-J & Fischer J.E. (2005) The Impact of Patient Agssion on Carers Scale: instrument derivation and psychometric testing. Scandinavian Journal of Caring Sciences 19, 296-300.

Olofsson B, Gilje F & Jacobsson L. (1998) Nurses' narratives about using coercion in psychiatric care. Journal of Advanced Nursing 28 (1), 45-53.

Olofsson B & Norberg A. (2001) Experiences of coercion in psychiatric care as narrated by patients, nurses and physicians. Journal of Advanced Nursing 33 (1), 89-97.

Pompili M, Rinaldi G, Lester D, Girardi P, Ruberto A & Tatarelli R. (2006) Hopelessness and Suicide Risk Emerge in Psychiatric Nurses Suffering From Burnout and Using Specific Defence Mechanisms. Archives of Psychiatric Nursing 20, 135-143.

Salize J & Dressing H. (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. British Journal of Psychiatry 184, 163-168.

Sailas E & Fenton M. (2000) Seclusion and restraint for people with serious mental illnesses.

Cochrane Database of Systematic Reviews 2000, Issue 1. Art. No.: CD001163. DOI: 10.1002/14651858.CD001163.

Sailas E & Wahlbeck K. (2005) Restraint and seclusion in psychiatric inpatient wards. Current Opinion in Psychiatry. 18 (5), 555-559.

Salize H. (2002) Compulsory admission and involuntary treatment of mentally ill patients – legislation and practice in EU-member states. Mannheim: European Comission, Health and Consumer Protection Directorate-General.

Tuohimäki C, Kaltiala-Heino R, Korkeila J, Tuori T, Lehtinen V & Joukamaa M. (2004) Deprivation of liberty in Finnish psychiatric inpatients. International Journal of Law and Psychiatry 27, 193-205.

Tuori T. (1999) Pakkotoimet Suomen psykiatrisissa sairaaloissa vuonna 1996. Kirjassa Kaltiala-heino, R. & Välimäki, M. (toim.) Rajoitetaanko rajoittamista – eristys ja lepositeet psykiatrisessa hoidossa. Tampereen yliopisto. Terveystieteen laitos. Julkaisuja 2. Tampereen yliopistopaino Oy, Tampere. 25-33.

Tuori T. (2002) Psykiatrinen sairaalahoito Suomessa. Sairaanhoitopiiri- ja sairaalakohtaista vertailutietoa vuosilta 1999 ja 2000. Aiheita 5, Stakes. Helsinki.

O'Brien MA, Freemantle N, Oxman AD, Wolf F, Davis DA, Herrin J. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2001, Issue 1. Art. No.: CD003030. DOI: 10.1002/14651858.CD003030.

Välimäki M, Taipale J & Kaltiala-Heino R. (2001) Deprivation of liberty in psychiatric treatment: a Finnish perspective. Nursing Ethics 8 (6), 522-32.

WHO (2005) Mental Health Declaration for Europe. Facing the Challenges, Building Solutions. WHO European Ministerial Conference on Mental Health. Helsinki, Finland 12-15 January, 2005, Helsinki.

Wittchen H-U & Jacobi F. (2005) Size and burden of mental disorders in Europe – a critical review and appraisal of 27 studies. European Neuropsychopharmacology 15, 357-367.

Wright S. (2003) Control and restraint techniques in the management of violence in inpatient psychiatry: a critical review. Medical Science Law 43, 31-38.

Xianyu Y & Lambert V.A. (2006) Investigation of the relationships among workplace stressors, ways of coping, and the mental health of Chinese head nurses. Nursing and Health Sciences 8 (3), 147-155.

Baseline information from Finland: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Finland

Välimäki M, Makkonen P, Kuosmanen L, Anttila M, Jakobsson T, Kontio R.
University of Turku, Department of Nursing Science, Finland

INTRODUCTION

This chapter focuses on the mental health care system in Finland. Specifically, it presents an overview of the laws, policies and practices in place in relation to the care and treatment of distressed and disturbed (often referred to as violent and aggressive) services users. This is an area that has been the subject of considerable recent debate in this country, with contributors from various interest organizations as well as government agencies.

DESCRIPTION OF FINNISH POPULATION AND HEALTH STATISTICS

Population statistics

Finland declared its independence in 1917, and today Finland is a democratic republic with a semi-presidential system and parliamentarism. Finland joined the European Union together with Sweden and Austria at the beginning of 1995 (Ministry for Foreign Affairs of Finland 2007). A population of 5.3 million people is spread over more than 330,000 km², making it the most sparsely populated country in the European Union. Of the two official languages in Finland, Finnish is spoken by 92% and Swedish by 5.5% of the population. Finland's foreign community, only 1.99 per cent of the population, is very small in comparison to other European countries; approximately 40% is from the former Soviet Union. Over 83% of the population belong to Evangelical Lutheran Church of Finland (Evangelical Lutheran Church of Finland 2006).

Finnish people have a high standard of education. Young people, in particular, have been rated very highly in international comparisons. The OECD Programme for International Student Assessment (PISA), placed Finland among the top countries in 2001. (Ministry for Foreign Affairs of Finland 2007). The current most important creators of employment are the electronic industry, forestry, business services, social and health services as well as trade. These branches of the employment sector are also growing the fastest. Jobs are still decreasing in the food and textile industries. (Statistics Finland 2007.)

Health statistics

Life expectancy among women is 82 years and among men 75 years, respectively. The infant mortality rate is among the lowest in the world. Cardiovascular disease (CVD) account for 41%, cancer for 22% and external causes about 10% of all deaths. Ischemic heart disease is the single biggest killer in Finland. (WHO 2005a, 2005b.)

Table 1. Core Health Indicators in Finland from WHO sources

Indicator	Value (year)
Life expectancy at birth (years) males	75.0 (2004)
Life expectancy at birth (years) females	82.0 (2004)
Healthy life expectancy (HALE) at birth (years) males	68.7 (2002)
Healthy life expectancy (HALE) at birth (years) females	73.5 (2002)
Probability of dying (per 1 000 population) between 15 and 60 years (adult mortality rate) males	137 (2004)
Probability of dying (per 1 000 population) between 15 and 60 years (adult mortality rate) females	62 (2004)
Probability of dying (per 1 000 population) under five years of age (under-5 mortality rate) males	5 (2004)
Probability of dying (per 1 000 population) under five years of age (under-5 mortality rate) females	3 (2004)
Total expenditure on health as percentage of gross domestic product	7.4 (2003)
Per capita total expenditure on health at international dollar rate	2,108 (2003)
Population (in thousands) total	5,249 (2005)
Per capita GDP in international dollars	30,415 (2004)

Reference: WHO 2005a

THE FINNISH HEALTH CARE SYSTEM

General

Finland has a compulsory, tax-based health care system, which provides comprehensive coverage for the entire resident population. The state and municipalities levy taxes for health care. In 2002 about 43% of total health care costs were financed by the municipalities, 17% by the state, 16% by the national health insurance (NHI) and about 24% by private sources. In 2002, total health expenditure comprised 7.3% of the gross domestic product (GDP) in Finland: the lowest level among the Nordic countries and lower than the Eur-A average. Despite this fact the health care system provides high-quality care; it is fairly efficient compared with systems in other countries, and the Finns are satisfied with it. (WHO 2006).

Public primary health care is delivered through health centres. Municipalities (n = 416 in Finland) can have their own health centre or form joint municipal boards with health centres serving the participating municipalities. (The Association of Finnish Local and Regional Authorities 2007). Central functions of the health care centre are: to provide guidance in health matters and to carry out prevention of disease, to organise medical examinations and

screenings for local people, to run maternity and child health clinics, to arrange for school, student and occupational health care services, and to organize the provision of dental health care (Ministry of Social Affairs and Health 2004.) The personal doctor system in which doctors are obliged to accommodate consultations with their patients within three days and medical salaries becoming more workload-related, was introduced in the 1980s. It resulted in improved access to general practitioners (GPs) and reduced waiting times. (WHO 2006).

Specialized medical care for residents is offered by hospital districts (n = 20). The largest hospital district in terms of population base has over 1.4 million inhabitants, while the smallest has over 65,000. Each hospital district has a central hospital and other units. Five of these are university hospitals offering more demanding forms of specialized medical care. More than quarter of Finnish people (1, 5 million) use the services of hospital districts in the course of a year. (Ministry of Social Affairs and Health 2004.) Public health provision is supplemented by private health care services. Less than 10 per cent of physicians work exclusively in the private sector, but many public health service doctors hold private surgeries outside their regular working hours. There are also a few private hospitals in Finland. Patients can reclaim part of the fees charged by private doctors from the national health insurance system; a similar system also applies to private dental charges. (Ministry of Social Affairs and Health 2002.)

Mental health services

Psychiatric care in Finland has undergone an extensive transformation in the last quarter of a century. Since the early 1990s, there has been a major shift away from institutional inpatient care for psychiatric patients toward out-patient community care. In 1980 there were 4.2 beds for psychiatric patients per 1,000 inhabitants. By 1994, the ratio was 1.3 per 1,000 inhabitants. Correspondingly, outpatient visits rose from 520,000 in 1980 to 1,290,000 in 1997. In the 1990s the most dramatic economic recession ever to hit an industrialized country detracted from the smooth transition to community-based care. Resources were cut and the tight financial situation of municipal economies meant that greater priority was given to somatic, general health services. More recently additional allocations to mental health services have been granted by government to support the development of the sector. (Ministry of Social Affairs and Health 2005.) In addition, Quality Recommendations for Mental Health Services were launched at 2001 (Ministry of Social Affairs and Health 2001).

The mental health care system in Finland is decentralized. It is organized at local level within the country's 416 municipalities. Municipalities are responsible for organizing outpatient mental health care and rehabilitation services. Specialized mental health care is organized by hospital district and it comprises inpatient services arranged through hospital districts, as well as part of outpatient services. (Ministry of Social Affairs and Health 2005.) The main challenge for the mental health care service system is to diminish regional disparities in the quality and availability of services and to ensure comprehensive mental health planning at local levels.

The prevalence of diagnosed mental disorders and of depression in particular, has risen markedly in Finland during the past decades. Currently, mental disorders are the most frequent group of disease causing disability. There are many reasons for the increase in the

incidence of mental disorders. These include the economic recession of the early 1990s, high unemployment, improved recognition, and changes in the diagnostic system. (International Labor Office 2000.)

The most common mental disorders from the public health point of view, include mood disorder (6.5%), anxiety disorder (4.2%), and substance use disorders (4.3%). (Pirkola & Sohlman 2005). In psychiatric hospitals in 2005, the most common diagnosis was schizophrenia (F20-29) and mood disorders (F30-39). The average length of hospital stay was 40 days and number of involuntary admissions were 11 321, which is 35% of all admissions. (National Research and Development Centre for Welfare and Health 2006).

Suicide is of particular concern in Finland, since the country has traditionally had a high suicide rate compared with other countries. In 1994, Finland ranked eighth internationally in terms of male and female suicides (43.6 male suicides and 11.8 female suicides per 100 000 inhabitants). The figures for young men are particularly high: one in four suicides is committed by a man under the age of 35. Fortunately, the number of suicides, notably for men, has been declining steadily since their peak in 1999.(International Labor Office 2000).

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE

Degree education

Today, the Finnish higher education system consists of two sectors: universities and polytechnics. The polytechnics are more practically oriented, training professionals for expert and development posts. There are 29 polytechnics in Finland; most of them are multidisciplinary, regional institutions, which give particular weight to contacts with business and industry. The Ministry of Education confers professional qualifications degrees, the degree programmes and the number of new students. The polytechnics award professionally oriented higher education degrees, which take 3.5 or 4 years. (Ministry of Education 2007).

The entry requirements are either an upper secondary school certificate or a vocational diploma. At present about 70 % of all entrants are matriculated students and 30% vocational graduates. There is no tuition fee for degree studies (Ministry of Education 2007). Polytechnics are developed as part of the national and international higher education community, with special emphasis on their expertise in working life and its development. The polytechnics also carry out research and development (R&D) relevant to their teaching and to the world of work.

University level masters degrees (in general the compulsory prerequisite for registered nursing licence) are offered at the universities of Tampere, Kuopio, Oulu, Turku and Åbo Academi (Vaasa). University education leads to the qualification of Bachelor and Master of Nursing Science (MNSc), which is a higher academic degree. The Masters degree consists of 240 ECTS credits. Previous vocational education is acceptable as a substitute for a proportion of the coursework. The departments also offer postgraduate programmes leading to licentiate's or doctor's degree. There is a national doctoral programme in nursing, which is run jointly by all Universities.

Vocational continuing education

Vocational upper secondary education and training is provided in vocational schools and is a form of apprenticeship training in the following fields of education: Social and Health Care Services and Physical Education Practical Nurse Education 120 cr (1cr/40 hours/week). The programme consists of academic studies and practical studies. The study time takes about 2.5 years studying full-time. After completion of 1.5 year's basic studies you can continue studies for a further year in a specialist area, for example mental health and substance abuse work**. (**Ministry of Education 2004, 2006b.)

Adult education policy is designed to provide a wide range of study opportunities for the adult population. Finland offers excellent conditions for lifelong learning. Different institutions provide a great variety of courses and programs for adults at all levels of formal education, and the provision of liberal adult education is extensive. The annual number of participants in adult education and training is 1.7 million, which makes up half of the working age population. This is a very high figure in international terms. The aim is to raise the participation rate in adult education and training to 60 % by 2008. (Ministry of Education 2007). Adult education is given by independent sponsoring organizations, evening schools, vocational institutions, and universities. Per year proximately 54 % of adults take part in some kind of adult education. In public health services professionals have a legal updating training/education obligation. (Ministry of Education 2004, 2006b.)

The Health Care Professionals Act (559/1994) also prescribes a continuing training/education obligation. According to the law health care professionals are obliged to maintain and develop their professional knowledge and skills and must be acquainted with the rules and regulations to their profession. It is the employers' duty to enable employees to participate in education (Ministry of Social Affairs and Health 2001). Work on the National Healthcare Project (2003) expressed changes to legislation to improve follow-up training arrangements. Regulations concerning the responsibilities of employers and employees in the supplementary training of healthcare professionals were harmonised and incorporated into legislation on public health and specialised medical care. The amendments to the laws took effect from the beginning of 2004. It means that the local authority clusters of health centres and hospital districts ensure that sufficient and appropriate supplementary training is arranged for healthcare professionals. This will be done in line with regulations made by The Ministry of Social Affairs and Health concerning the content, quality, extent and organisation of supplementary training. (Ministry of Social Affairs and Health 2003a, b.)

A total of 146, 000 students attend initial vocational training every year. Of them, 4, 500 attend access courses preparing for initial vocational training. The largest fields are Technology and Transport (c. 36%), Business and Administration (19%) and Health and Social Services (17%). The other fields are Tourism, Catering and Home Economics (13%), Culture (7%), Natural Resources (6%) and Leisure and Physical Education (2%). There are 119 study programs leading to 53 different vocational qualifications confirmed by the Ministry of Education. The number of further and specialist qualifications, which are taken as competence,-based qualifications is 305 (Ministry of Education 2007).

Nurses role in mental health services

In 2002, (31 December), all together 56,458 registered nurses lived in Finland (Stakes 2003). The number of qualified nurses, i.e. registered nurses and mental health nurses working in psychiatric hospitals in Finland have decreased from 5399 in 1990 to 3984 in 2005 (Ailasmaa 2007). The decreasing numbers are a clear outcome of the decreased number of psychiatric hospital beds in Finland.

Nursing education in Finland is now carried out in the polytechnics (AMK). The last entry into colleges of nursing was in 1988, with only a few places available. The degree programs of the polytechnics are approved by the Ministry of Education. There are three options in the nursing program of the AMK: nurse, public health nurse and midwife. Registered nurses tend to work mostly in hospitals, whereas the registered public health nurses tend to work in community health centers and schools. The practical nurse is a lower level nurse and is capable of working autonomously at certain basic tasks, but often works with the general care nurse at hospitals. In 1995 a new basic examination leading to a vocational qualification in social and health care for practical nurses commenced. Practical nurses take care, support and promote the growth and rehabilitation of people from various age groups and in various life situations. (European Commission 2007).

Professionals in health care are prescribed by The Act on Health Care Professionals (559/1994) and the Decree on Health Care Professionals (564/1994). The function of the Health Care Professionals Act is to promote patient security and quality of services in health care. The law seeks to ensure that health care personnel have an appropriate professional education that ensures adequate professional competence and fitness for the role of health professional. The Health Care Professionals Act defines a health care professional, which is a person who has got a right to practise as a registered or licensed professional health care practitioner or a person who has the right to use the title of health professional (Ministry of Social Affairs and Health 2001).

Psychotherapy has traditionally been provided by self-employed persons in the private sector, whose customers or patients have been reimbursed for their treatment by the Social Insurance Institution; or in some cases by private insurance institution against a justifiable application. (Pirkola & Sohlman 2005.)

In the field of nursing, the nurse's role is to promote health, prevent diseases, care and rehabilitate. A nurse for example plans and carries out nursing care, monitors the patient, administers medication and informs, guides and supports patients, customers and relatives. Nurses work both independently and in multi professional teams. (Finnish Nurses Association 2007, Ministry of Social Affairs and Health 2001). Their professional expertise is based on knowing how to work ethically, making decisions in nursing, co-operating with the multi-disciplinary team, developing leadership, nursing multi-culturally, working socially and nursing clinically. (Ministry of Education 2006a.)

The nurses' role in Finland is independent and nurses are responsible for the decisions they make in daily nursing care. Nurses are working in multi-professional teams. They have the most direct interrelations with patients and their relatives. In the field of psychiatric nursing, the nurses' basic role is to take care of the health and well-being of individuals and groups and to support them to manage daily health problems which are encountered as a result of their illness (Välimäki et al. 2000.)

LEGAL NORMS AND ETHICAL CODES IN FINLAND RELATED TO PATIENT RESTRICTIONS

Legal norms related to patient restrictions

There are several acts in Finland regulating the rights and status of patients in health care. Based on The Constitution of Finland (Section 7 – The right to life, personal liberty and integrity) everyone has the right to life, personal liberty, integrity and security. The personal integrity of the individual shall not be violated, nor shall anyone be imposed only a court of law. (The constitution of Finland 1999). However, perhaps the most fundamental is the Act regarding the Status and Rights of Patients (785/1992). The Act came into effect on March 1, 1993, and Finland was thus the first country in Europe to implement an act on patient's rights. (Leino-Kilpi et al. 1999). The Act attempted to clarify and strengthen those rights of patients that in everyday clinical practice seem to have caused them anxiety, and resulted in varying interpretations and complaints to supervisory authorities. According to the Act, the care of the patient has to be arranged so that human dignity is not violated and that confidentiality and privacy are respected (Välimäki et al. 2003).

In psychiatric treatment, compulsory treatment is an option, unlike in health care in general. The Finnish Mental Health Act (1116/1990) states:

> *"A person can be taken into involuntary psychiatric treatment (exact translation: treatment independently of the patient's will) only if 1) she/he is mentally ill (this is understood as referring to psychotic conditions), and 2) due to her/his mental illness is in need of treatment because not treating would result in deterioration of the mental illness or would seriously endanger her/his health or safety or other people's health or safety, and 3) no other mental health services are appropriate or adequate."*

The Amendment of the Mental Health Act (1423/2001) came into force on 1 June, 2002. The amendments especially concern the restriction of patients' fundamental rights during involuntary treatment or examination. The right to self-determination and other basic rights can be restricted only if required by the treatment of illness, the patient's safety or by the protection of other interests. All procedures must be performed as safely as possible and with respect for the patient's human dignity. Treatment procedures that affect the patient's integrity seriously or irrevocably can only be performed with the written consent of the patient, except if the procedure is necessary for the prevention of a danger to his/her life. Decisions about involuntary treatments, examinations and restrictive measures are made by a doctor (The Amendment of the Mental Health Act 2001).

There are also restrictions on freedom of movement that patients must accept. These are prohibition to leave the hospital or ward premises or preventing a patient from leaving. Patient may also be involuntarily isolated from other patients, if a patient causes injury to him/herself or to others, impedes the treatment of others or damages property or for other serious treatment-related reasons. The decision about continuation and termination is made by a doctor. A secluded or restrained patient should have a named nurse, and an interested party or legal representative must be informed about seclusion exceeding 12 hours, or restraint exceeding 8 hours. The Amendment also describes patients' rights and obligations related to confiscation of property, inspection of possessions or correspondence, bodily

search, and restrictions on communication. Every hospital must have guidelines for implementing restrictions, and the restrictions must be listed accordingly. A patient ombudsman must be appointed for health care units.

The patient ombudsman may also be shared by two or more units. The tasks of a patient ombudsman are: 1) to advise patients on issues concerning the application of this Act; 2) to help patients in the matters referred to in subsections 1 and 3 in Section 10; 3) to inform patients of their rights; and 4) to act also otherwise for the promotion and implementation of patients' rights (Välimäki et al. 2003).

Ethical codes related to patient restrictions

In Finland, there are ethical codes for many professions, and most of the codes have been revised in the 1980s and 1990s, and new ones are under preparation. These codes are rather similar in content, but they differ in emphasis. Nursing codes in Finland are based on the ICN Code (1973). Ethical Guidelines of Nursing have been approved by the Assembly of the Finnish Federation of Nurses in September 28, 1996. The aim of the ethical guidelines is to support nurses, midwives and public health nurses in their everyday decision-making involving ethical question. (Leino-Kilpi et al. 2000.)

The nurse should respect the autonomy and self-determination of the patient and give him an opportunity to participate in decisions concerning his own care. The nurse should realize that all the information given by the patient is confidential and she should use judgment in sharing this information with other people involved in nursing. The nurse should treat the patient as a fellow human being; she should listen to the patient and empathize with him. The relationship between nurse and patient should be based upon open interaction and mutual trust (The Finnish Nurses Association 1996)..

The Finnish Union of Practical Nurses called Super has also drafted ethical guidelines for practical nurses and practical mental health nurses. The principle of self-determination based on the belief that each person is the best expert on his/her own life lies at the centre of these guidelines. Customers or patients should to be able to make decision about different services, alternative methods of treatment and their effects. The ethical guidelines make it clear that an autonomous person is capable of independent reflection and decision-making. The person also has the right to follow the course of action determined by his/her reflections and to receive appropriate assistance (Leino-Kilpi et al. 2000).

Professional codes related to patient restrictions

A number of professional groups are involved in providing mental health services. They include general practitioners, psychiatrists, psychiatric nurses, psychologists, social workers, public health nurses, occupational health nurses and also occupational therapists and other experts. The National Board of Medicolegal Affairs (TEO) grants the licences for health care professionals and keeps a register of licence holders in Finland (Pirkola & Sohlman 2005).

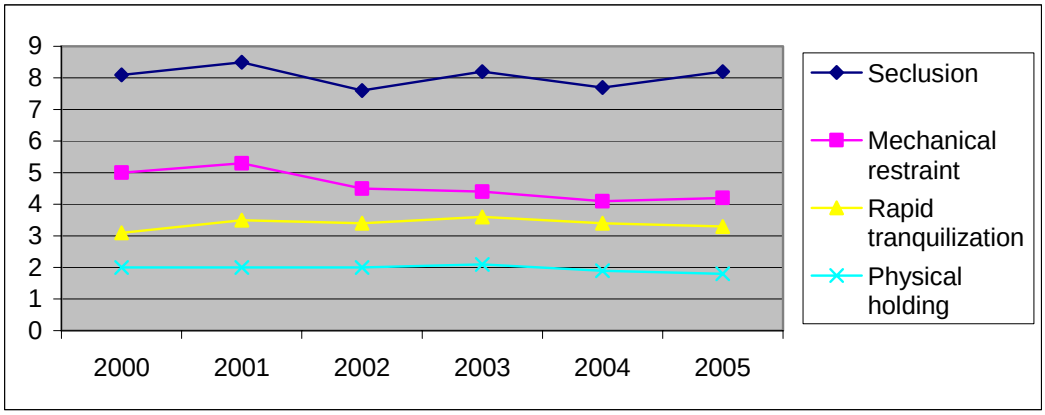
The National Authority for Medicolegal Affairs keeps a central register of health care professionals (TERHIKKI), which contains data on the right to practice a profession of over

300 000 health care professionals. Health care professionals are described prescribed in Act (559/1994) and Decree (564/1994) on Health Care Professionals. Licensed professionals who are given the right to practice a profession by virtue of law include: physician, dentist, head dispenser, psychologist, speech therapist, dietitian, pharmacist, nurse, midwife, public health nurse, physiotherapist, medical laboratory technologist, radiographer, dental hygienist, occupational therapist, optician and dental technician (17 titles) (National Authority for Medicolegal Affairs 2007).

PATIENTS RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN FINLAND

In 2005 all together 32,054 patients have been treated in psychiatric specialties; of these, 2,617 had been secluded, 1,333 mechanically restrained, 1,068 compulsorily medicated and 587 physically restrained during the inpatient treatment (National Research and Development Centre for Welfare and Health 2006).

Table 2. Coercive measures in Finnish psychiatric inpatient care 2000-2005



Reference: STAKES 2006

Preparing nurses to manage distressed and disturbed patients

In Finland undergraduate (student nurse) training includes a few areas in management of distressed and disturbed patients. These are nursing interventions and methods of rehabilitation, the therapeutic relationship and identification, assessment and support of a person and significant other(s) in crisis. Training in management of distressed and disturbed patients is mainly organized in continuing vocational training provision in each health care organization. There are several similar training programs variously named, such as MAPA; management of actual or potential aggression, VETH; prevention of aggression and safer care of aggressive patients, AHHA; therapeutic management of aggression, HRF; controlled physical restriction. (Curriculum of AHHA, Pirkamaa Hospital District; Curriculum of MAPA, Kellokoski Psychiatric Hospital; Curriculum of VETH, Kellokoski Psychiatric Hospital; Nursing syllabus, Stadia Helsinki polytechnic).

CONCLUSIONS

Finland is a sparsely populated country, Finnish people have high standard of education and total health expenditure is at rather a low level. The health care system provides high-quality care, is fairly efficient and the Finns are satisfied with it. In the last quarter of a century there has been a major shift toward out patient community care in the field of psychiatry and the number of qualified nurses working in psychiatric hospitals has decreased as a clear outcome of this shift in care provision. However, the prevalence of diagnosed mental disorders has risen markedly during the past decades and mental disorders are the most frequent group of diseases causing disability.

In 2001, quality guidelines for mental health care services were negotiated and approved to facilitate the development of community care, in parallel with rapid reductions of capacity in the hospital sector. In the same year, a national programme of health promotion was approved: it sets guidelines for the next 15 years based on the WHO policy for health for all. Some challenges that need to be further addressed include: increasing access to care and the system's responsiveness to patients' preferences, addressing the limited freedom to choose a GP and hospital, improving the coordination between primary and secondary health care, and addressing the shortage of personnel and increase in out-of-pocket payments. Correspondingly, health care systems need to shift toward the prevention and management of chronic diseases and more formal long-term care. Since people are living longer, measures to improve health and prevent disease need to focus on people of working age (WHO 2006).

In public health services professionals have legal continuing training/education obligations in Finland. It is important as the role of the nurse is independent and nurses are responsible for decisions made in daily nursing care. There are also ethical codes for many professions whose aim is to support staff in their everyday decision-making. Undergraduate training includes a few areas in management of distressed and disturbed patients. At the moment training is mainly organized in continuing vocational training provision in each health care organization, so there are several similar training programs variously named. There should be institutional guidelines in all the psychiatric hospitals regarding the use of restraint and education in control and restraint of aggressive behaviours must be provided for health care personnel (Välimäki et al. 2000).

The right to self-determination and other basic rights can be restricted only if required by the treatment of illness, the patients' safety or to protect other interests. Human dignity, which emphasises persons' uniqueness, freedom, responsibility and right to self-determination should be respected. Special attention has been paid to the development of effective interventions to manage patients' aggressive behaviour, and to decrease the use of restraint and seclusion. Supplemental education is also a good way for a nurse to get information in situations where in-patient treatments are short and there is a lack of qualified personnel.

References

Ailasmaa R. (2007) Personal information. Stakes. Helsinki.

The Amendment of the Mental Health Act (2001) 1423/2001. 22b.§
http://www.gov.im/lib/docs/infocentre/acts/mhaa2001.pdf (Accessed 10.5.2007)

The Association of Finnish Local and Regional Authorities (2007) Localfinland.fi.
http://www.kunnat.net/k_etusivu.asp?path=1;161;279 (Accessed 9.5.2007)

Evangelical Lutheran Church of Finland (2006) Church statistics. http://www.evl.fi/english/ 9/5/2007

European Commission (2007) Nursing in Finland.
http://europe.eu.int/comm/internal_market/qualifications/docs/nurses/2000-study/nurses_finland_en.pdf. (Accessed 9.5.2007)

The constitution of Finland (1999) 731/1999
http://www.om.fi/uploads/54begu60narbnv_1.pdf (Accessed 10.5.2007)

Finnish Nurses Association (1996) Ethical Guidelines of Nursing.
http://www.sairaanhoitajaliitto.fi/sairaanhoitajan_tyo/ohjeita_ja_suosituksia/sairaanhoitajan_eettiset_ohjeet/ethical_guidelines_of_nursing/ (Accessed 10.5.2007)

Finnish Nurses Association (2007) Nurses' work. [Sairaanhoitajan työ.]
http://www.sairaanhoitajaliitto.fi/sairaanhoitajan_tyo/ (Accessed 9.5.2007)

International Labour Office (2000) Mental health in the workplace. Situation analysis Finland. International Labour Organization. Switzerland.

Leino-Kilpi H, Välimäki M, Dassen T, Gasull M, Lemonidou C, Scott A.P & Arndt M. (1999) Patients' autonomy and privacy in nursing interventions. Nursing Ethics 6(4), 337-338.

Leino-Kilpi H, Välimäki M, Arndt M, Dassen T, Gasull M, Lemonidou C, Scott A.P, Bansemir G, Cabrera E, Papaevangelou H & Mc Parland J. (2000) Patient's autonomy, privacy and informed consent. European Commission Directorate –General XII Science, Research and Development. Biomedical and Health Research, 40. IOS Press, Netherlands.

Ministery of Education. (2004) Education and Research 2003-2008. Publication 8. Ministery of Education, Helsinki.

Ministery of Education (2006a) From the polytechnics to the health care. Qualified nurses professional competence, essential studies and minimum credits. [Ammattikorkeakoulusta terveydenhuoltoon. Koulutuksesta valmistuvien ammatillinen osaaminen, keskeiset opinnot ja vähimmäisopintopisteet.] Opetusministeriön työryhmämuistioita ja selvityksiä 2006:24. Ministery of Education, Helsinki.

Ministery of Education (2006b) Education and Science in Finland. Publication 15. Ministery of Education, Helsinki.

Ministery of Education (2007) Vocational education and training.
http://www.minedu.fi/OPM/Koulutus/ammatillinen_koulutus/?lang=en (Accessed 9.5.2007)

Ministry for Foreign Affairs of Finland (2007) Virtual Finland.fi.
http://virtual.finland.fi/netcomm/news/showarticle.asp?intNWSAID=25876 (Accessed 9.5.2007)

Ministry of Social Affairs and Health (2001) Nurses', public health nurses' and midwifes' competence requirements in health care. Essential elements in practising health care. [Sairaanhoitajan, terveydenhoitajan ja kätilön osaamisvaatimukset terveydenhuollossa. Terveydenhuollon ammatinharjoittamisen kannalta keskeisiä näkökohtia.] Brochures 2000:15. Ministry of Social Affairs and Health, Helsinki.

Ministry of Social Affairs and Health (2002) Decision in principle by the council of state on securing the future of health care. Brochures of the Ministry of Social Affairs and Health 2002:6 eng. Ministry of Social Affairs and Health, Helsinki.

Ministry of Social Affairs and Health (2003a) Improvements due for supplementary healthcare training. Announcement 19/2003.
http://www.stm.fi/Resource.phx/publishing/documents/1135/index.htx9 (Accessed 9.5.2007)

Ministry of Social Affairs and Health. (2003b) The National Healthcare Project.
http://www.stm.fi/Resource.phx./hankk/hankt/terveysprojekti.htx (Accessed 9.5.2007)

Ministry of Social Affairs and Health (2004) Health care in Finland. Brochures of the Ministry of Social Affairs and Health 2004:11. Ministry of Social Affairs and Health, Helsinki.

Ministry of Social Affairs and Health (2005) Mental Health in Finland. Brochures of the Ministry of Social Affairs and Health 2005:1. Ministry of Social Affairs and Health, Helsinki.

National Authority for Medicolegal Affairs (2007) The tasks of the National Authority for Medicolegal Affairs.
http://www.teo.fi/uusi/engl_1.htm. (Accessed 9.5.2007)

National Research and Development Centre for Welfare and Health (2006) Inpatient care within the medical speciality of psychiatry. Care Report Statistics on Health Care 24/2006. Helsinki.

Pirkola S & Sohlman B. (2005) Atlas of Mental Health. Statistics from Finland. National Research and Development Centre for Welfare and Health. STAKES. Helsinki.

Statistics Finland (2007) Population.
http://www.stat.fi/til/vrm_en.html (Accessed 9.5.2007)

STAKES (2006) Inpatient care within the medical speciality of psychiatry in 2005. National Research and Development Centre for Welfare and Health (STAKES). Care Report Statistics on Health Care 24/2006. Helsinki.

STAKES (2003) Health Care Professionals 31.12.2002. Stakes Statistics 8/2003. Helsinki.

Välimäki M, Holopainen A & Jokinen M. (2000) Psychiatric Nursing in Ateration. [Psykiatrinen hoitotyö muutoksessa]. WSOY, Juva.

Välimäki M, Kaltiala-Heino R & Kjervik D. (2003) The rights of patients with mental problems in Finland. Journal of Nursing Law 9 (2), 17-28.

WHO (2005a) Core Health Indicators from WHO sources.
http://www3.who.int/whosis/core/core_select.cfm?strISO3_select=fin&strIndicator_select=healthpersonnel&intYear_select=all&language=english (Accessed 10.5.2007)

WHO (2005b) The European health report 2005. Preventing NCDs in Finland.
http://www.euro.who.int/ehr2005/parttwo/20050816_7 (Accessed 10.5.2007)

WHO (2006) Highlights on health in Finland 2004.
http://www.euro.who.int/document/e88101.pdf (Accessed 10.5.2007)

Acknowledgments

The authors thank the persons who helped to collect the data.

Baseline information from Ireland: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Ireland

Scott PA, Cocoman A, Matthews AM.
Dublin City University, School of Nursing, Ireland

INTRODUCTION

Psychiatric/ mental health nursing in Ireland has a rich history that has led to the profession's willingness to meet the complex challenges of practice in the last 20 years. Until the 1970s, psychiatric nursing was conducted mainly in large institutions providing custodial care to those with mental illness. New psychological interventions together with a changing philosophy of care instigated the period of community based mental health care which began in the 1970s. Students entering psychiatric nursing must undertake a four-year bachelor's degree program offering 343 places each year in twelve universities throughout Ireland. The demand for recovery focused mental health care has meant that new education and training was needed to develop these skills. To improve the quality of care delivery psychiatric nurses are currently trained in developing specialist knowledge and skills in cognitive behavior therapy, risk assessment, and numerous other treatments of acute and enduring illness in children, adolescents and older people. Psychiatric /mental health nurses currently work with patients /service users with serious mental illness who are predominantly in secondary and tertiary settings, in either inpatient or community mental health settings.

DESCRIPTION OF IRISH POPULATION AND HEALTH STATISTICS

Population statistics

The population of the Republic of Ireland rose from 2.8 million in 1961 to 3.6 million in 1996, and to 4,234,925 million in 2006 (Central Statistics Office 2006). For population health and health service delivery purposes Ireland is divided into four Health Service Executive regions (See Figure 1). The Health Services Executive (2006) area Dublin Mid Leinster has the greatest share of the population at 28.7%, followed by HSE South at 25.5%, HSE West at 23.9% and HSE Dublin North East at 21.9%. The overall population growth is 8.1% since 2002 and is the largest population growth in the EU.

Figure 1. Map of Ireland showing the four administrative areas of the Health Service Executive

Ireland joined the European Economic Community in 1973, which resulted in a substantial inflow of EU funds that speeded the modernization of the island. Over the past ten years Ireland has enjoyed an astonishing economic growth. While agriculture was the leading economic means of income, tourism and industries are in recent years making substantial inroads. Electronic, chemical and pharmaceutical multinationals are now the main industrial employers, drawn to Ireland by substantial state aid agencies. Exports account for three-quarters of national output, which is a level unique in Europe. That success has been in large measure due to the contribution of overseas companies, which have found Ireland to be a highly competitive location from which to sell to international markets. Ireland offers a well-managed and stable economy that has achieved high growth in a consistently low inflation, low cost and low corporate tax environment. That is why this "Celtic Tiger" of Europe wins close to a quarter of all available US manufacturing investment in Europe, although it accounts for just 1% of the population.

The Irish based Economic and Social Research Institute (ESRI) has warned that the boom years of the Celtic Tiger have passed but the outlook remains good. Ireland's unemployment rate in 2004 was 4.4 per cent, with 13,000 unemployed. This is the second lowest unemployment rate in the EU. These figures show that despite recent job loss announcements Ireland still continues to outperform many of EU partners. In an increasingly competitive global economy, industrialists are aware of the competitiveness issues facing the Irish economy, and of the need to ensure that Irish business is in a position to embrace the enormous opportunities for future growth and development (Economic and Social Research Institute 2006).

Ireland has a long tradition in education. Successive governments have continued to regard education as a key priority and investments in this area have been sustained for a long period. As a result of a sustained investment in this area Ireland now has one of the highest educational participation rates in the world - 81% of Irish students complete second-level and approx 60% go on to higher education (O'Connell et al 2006). This in turn, has had positive implications for the strong economic growth, and development of the country. This

dynamic, educated population has made its mark at home and abroad with international companies looking to Ireland when hiring graduates for top class positions.

During the last decade there is a consistent increase in the numbers of students from overseas coming to study in Ireland. There is a substantial and growing third-level education sector that draws mainly from the economically advantaged levels of society. The Irish Government, through the Higher Education Authority, has a policy and a number of initiatives focused on broadening access into higher education. The government has invested in three branches chemistry, pharmaceutics and computer technology. At the same time bachelor programmes were developed to prepare students for jobs in these sectors. This success story has seen a substantial increase in school leavers accessing third level education in the last 27 years. The growth in tertiary education in Ireland has been extraordinary with the age participation rate rising from 11% in 1965, 20% in 1980 to an estimated 60% in 2006 (Enterprise-Ireland 2006).

Health statistics

Irish people are living longer. In the 1960s the average Irish man could expect to live to about 68 years; now he should be around to celebrate his 73rd birthday. Women fare much better with a life expectancy of 71 years in the 1960s. This had risen to 78 years in 1996.

Table 1. Life expectancy in Ireland

At Age	0	10	20	35	55	65	75
			Males				
1926	57.4	55.2	46.4	34.4	19.1	12.8	7.7
2002	75.1	65.7	56.0	41.8	23.4	15.4	8.9
At Age	0	10	20	35	55	65	75
			Females				
1926	57.9	54,9	46,4	34,7	19,6	13,4	8,4
2002	80.3	70.8	60.9	46.2	27.4	18.7	11.2

Reference: Central Statistics Office 2002

The number of births in Ireland has fallen since the heady days of the 1950s (62,558 babies were born here in 1953). Ireland still boasts the highest birth rate in Europe. See Statistics of births deaths and marriages

Suicide in Ireland and internationally, is now recognized as a major public health problem. In 1998, seven times as many men as women took their own lives in Ireland, the highest ratio in the world. The Central Statistics Office in Ireland recorded the number of suicides that were registered in 2004 as 457. The Irish Association of Suicidology reported 189 suicides of people under 35, an 11% decrease on the 2003 figures. However, there were 268 suicides for those aged 35 and over, a 16% increase on 2003 figures. The National Suicide Research Foundation, Ireland, claims that suicide remains the single biggest killer of young Irish men (Cocoran et al 2006). Female suicides have remained stable for twenty years, while male suicide has risen sharply. Males represented 78% of those who died by suicide, while females represented 22% (Cocoran et al 2006).

Table 2. Number of births, deaths and marriages [1]

Years	Marriages		Births		Deaths	
	No.	Rates[2]	No.	Rates[2]	No.	Rates[2]
1950	16,018	5.4	63,565	21.4	37,741	12.7
1960	15,465	5.5	60,735	21.5	32,660	11.5
1970	20,778	7.0	64,284	21.8	33,686	11.4
1980	21,792	6.4	74,064	21.8	33,472	9.8
1990	17,838	5.1	53,044	15.1	31,370	9.0
2000	19,168	5.1	54,789	14.5	31,391	8.3
2005	20,723	5.0	61,042	14.8	27,441	6.6

Reference: Central Statistics Office 2002

[1] Data for marriages are by year of Registration. 1997-2001 & 2003-2004 data are provisional. Births and deaths data up to and including 2003 are year of occurrence, 2004 and 2005 data are year of registration; [2] % Rates per 1,000 of the estimated population

THE IRISH HEALTH CARE SYSTEM

General

Health policy in Ireland is guided by the current national health strategy, Quality and Fairness: A Health System for You (Department of Health and Children 2001a). The principles underpinning the strategy are equity and fairness, a people-centred service, quality of care and clear accountability. The goals of the strategy were identified as: better health for everyone, fair access, responsive and appropriate care delivery and high performance. Specifically in relation to mental health, the strategy proposed a new action plan for mental health. This included the establishment of the Mental Health Commission and the development of a new policy framework for mental health services. The Commission was subsequently established and the Report of the Expert Group on Mental Health Policy, A Vision for Change (Department of Health and Children 2006a) proposes a ten-year policy framework for mental health services.

Subsequent to the publication of the national health strategy in 2001, the primary care strategy Primary Care - A New Direction was also published (Department of Health and Children 2001b). This provided a more detailed account of the primary care component of the health strategy. Its aims were to strengthen the capacity of the primary care system and enhance the quality of primary care services. It proposed new primary care teams and networks, which are slowly being developed.

The 2001 Health Strategy also identified the need for organisational reform and planned for an audit of structures and functions of the entire health system. This review was carried out and published in 2003 (Department of Health and Children 2003a). In that same year the Commission on Financial Management and Control Systems in the Health Service published its findings (Department of Health and Children 2003b). Both reports recommended the creation of a unified management structure for the health service, in place

of the health board/authority structures[1] which were in place at the time. These publications informed the reform programme which was announced in June 2003. Its central component was the creation of a single unified executive body with responsibility for all service management, the Health Service Executive (HSE). The HSE was formally established in January 2005. The HSE both directly employs staff and provides services and also funds other service providers including voluntary organisations, voluntary hospitals[2] and private providers. With a budget of approximately €15 billion in 2007 it has the largest budget of any public sector organization in the country.

The HSE's four administrative areas cover the country geographically, as shown in Figure 1. The main pillars of the HSE are the National Hospitals Office, the Primary, Community and Continuing Care Directorate and the Population Health Directorate. Population Health promotes and protects the health of the entire population, Primary, Community and Continuing Care (PCCC) delivers care in the community and the National Hospitals Office (NHO) provides acute hospital and ambulance services. There are ten hospital networks, four regional networks and 32 Local Health Offices sited around the country. The local health offices are the entry point to community health and personal social services. A wide range of services are provided through Local Health Offices and from health centers, general practitioner services, public health nursing, child health services, community welfare, chiropody, ophthalmic, speech therapy, social work, addiction counseling and treatment, physiotherapy, occupational therapy, psychiatric services and home help.

The other major component of reform has been the creation of an independent statutory Health Information and Quality Authority (HIQA) (Department of Health and Children 2006b) with responsibility for health information, standards and quality issues. The Department of Health and Children still sets overall policy for the health service. However, the Health Act (2004) devolved responsibility for the management of the health and personal social service of Ireland to the Health Services Executive (HSE).

The HSE's Transformation Programme 2007-2010 has given a new impetus to the health reform programme (Health Service Executive 2006). It states the fundamental purpose of the HSE as enabling people to live healthier and more fulfilled lives and aims for easy access to high quality care, public confidence in services, and staff pride in services. Six transformation priorities are outlined and these include the development of integrated services across all stages of the care journey with the optimal configuration of primary and hospital based services, a focus on chronic disease prevention and management, standards-based performance measurement and management and the engagement of all staff in the transformation process. These apply to all aspects of the health services, including mental health services.

The current reform programme has not altered the ways in which healthcare is financed in Ireland. It is financed primarily by general taxation, which includes an income tax health levy. Thereafter public health care is in theory free at the point of use. However there exist a number of charges (for General Practitioner services, for hospital in-patient beds) that

[1] From 1970 to 2000, eight health boards managed health services regionally across Ireland. In 2000, to take account of the large eastern population, the Eastern Regional health Authority and three constituent Area Health Boards replaced the Eastern Regional Health Board.

[2] The establishment of voluntary hospitals by religious orders in Ireland dates back to the eighteenth century, before state provision of health services. These public hospitals have their own Boards of management, though staff are paid by the state.

individuals pay, unless they are covered by the General Medical Scheme. Under this Scheme, a third of the population is covered because they are either over 65 years of age or are eligible on the basis of income means-testing. In addition, just over half the population (52%) have private health insurance cover, mostly to expedite access to specialist consultants and in-patient admission to hospital (Health Insurance Authority 2005). Private health insurance in Ireland encompasses community rating, within which all subscribers are offered equal subscription rates regardless of age or medical history. This involves risk equalisation between insurance providers in order to balance the risks associated with having older subscribers. The private health insurance market is currently under review in Ireland.

Mental health services

The government mental health strategy Vision for Change (Department of Health and Children 2006a) replaced the previous policy document called Planning for the Future (Department of Health 1984). Vision for Change is a visionary document that paves the way for creating a more broadly focused community service. It also includes the closure of the custodial psychiatric institutions. The emphasis now, for those with mental illness, is to move care from large institutions to smaller community centers or small admission units attached to general hospitals.

The Vision for Change (Department of Health and Children 2006a) strategy outlines an exciting vision for the future of Mental Health services. It recommends a holistic approach to mental illness addressed by multidisciplinary teams in the community and delivered on the basis of the mental health and wellbeing of the population as a whole. Planning for the Future (Department of Health 1984) recommended that each sector have a multidisciplinary team and that each team should have a psychiatrist, psychiatric nurses, psychologist, social worker, occupational therapist and a health administrator. A multidisciplinary team enables patients to benefit from a variety of approaches and receive continuity of care. The term ‘sectorisation’ is used to describe the process of providing a comprehensive psychiatric service for each sector of the catchment area. It was agreed in Planning for the Future (Department of Health 1984) that each catchment area must have an acute inpatient facility and each sector should provide day care, home care, outpatient care and community-based residences.

Decisions around the extent of inpatient and community care depended on local circumstances and ideologies.

Despite recommendations from successive reports for the movement from traditional in-patient care to more community-based services, there is a lack of national information on community mental health services, this is problematic and results in difficulty establishing how many of the recommendations outlined in Planning for the Future (Department of Health 1984) have actually happened. The Vision for Change (Department of Health and Children 2006a) document however has an independent monitoring group established by the Department of Health and Children to monitor progress on the implementation of the recommendations in "A Vision for Change".

A Vision for Change (Department of Health and Children 2006a) emphasizes the importance of service user’s dignity and citizenship by offering, where possible, home-

based support to treating acute mental illness. Treatment will be offered by home-based nurses and visiting doctors. Social workers and psychologists will help families understand illness better and the social difficulties and conflicts will become much more obvious - and therefore better managed. It is important to say that despite optimal medication and psycho educational treatments, many patients with schizophrenia do relapse and need readmission. This "revolving door" phenomenon of re admissions appears to arise from the interaction of a wide range of features related to disease severity, poor compliance with medication and additional factors such as substance abuse. It is difficult to accurately identify all the factors that contribute to patterns of readmission, however clinicians and service planners need to further assess those patients who require repeated admissions to ensure the allocation of appropriate resources for those patients in order to reduce their need for inpatient stays.

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN IRELAND

Nurse Education programs are governed by criteria laid down by the Irish Nursing Board, (An Bord Altranais 2000a). The pre-registration nurse education programs are inclusive of European Union regulations for the education and training of nurses. Nurse education in Ireland has changed radically in the last decade. Entry to the nursing profession was via one of five separate divisions of the Irish nursing register and was initially facilitated by a three-year hospital based certificate program. Then in the mid nineteen-nineties a conjoined Diploma in Nursing Program, run jointly between the health care providers and affiliated third level institutions was introduced. These diploma programs may have educated the student nurse in general nursing, psychiatric nursing or intellectual disability nursing. Assuming successful completion of both the academic and practice components of the diploma program the student nurse could then register on the relevant division of the Irish nursing register; and thus become a Registered General Nurse, a Registered Psychiatric Nurse or a Registered Nurse for the Mentally Handicapped.

Degree education

In Ireland, nursing registration is a regulatory mechanism enshrined in An Bord Altranais. Registration as a nurse confers the right to practice as a registered nurse on those who have acquired the appropriate education, clinical experiences and qualifications (Nurses Act 1985). To ensure the integrity of the registration process all nursing students must be indexed at the commencement of their nursing education program. All those successful in completing a program of nurse education are entitled to apply to an Bord Altranais to have their names entered onto the An Bord Altranais nursing register. In order to practice as a registered nurse in Ireland a person must then be registered on the nursing register. All schools of nursing and midwifery and their respective third level institutes must comply with the requirements of the Nurses Act 1985.

Following the recommendations of the Commission of Nursing (Department of Health and Children 1998) and the development of a strategy to guide this process (Government of Ireland 2000), entry to the nursing profession in Ireland moved to graduate level. The four – year honors Bachelor of Science in Nursing Degree (BSc Nursing) commenced nationally in 2002 as the only means of obtaining the pre-registration education necessary to qualify

one to enter the Irish nursing register as a Registered General Nurse, Registered Psychiatric Nurse or a Registered Nursing for the Mentally Handicapped. The midwifery registration program is now, since September 2006, also a four-year honors degree program in Ireland. Entry to the paediatric nursing division of the An Bord Altranais Register is also since September 2006 a combined 4 and a half-year integrated honors BSc in Paediatric and General Nursing. Prior to September 2006 the nurse education program for entry to the Sick Children's and Midwifery divisions of the register continued as conjoined post-graduate diploma programs.

Vocational continuing education

An Bord Altranais is empowered with internal control of nursing through self-regulation; consequently An Bord Altranais is obliged to assure high quality nursing care through the continual reformulation and updating of standards of practice and education. This is necessary to ensure that professional programs of nurse education achieve a continuous improvement in nursing practice to enhance patient care. There are thirteen higher education institutions involved in nursing education with post-graduate education emerging to the fore in recent years. The Report of the Commission on Nursing: A Blueprint for the Future (Department of Health and Children 1998) recommended the establishment of a clinical career pathway for staff nurses/midwives to develop towards clinical nurse specialist and advanced nurse practitioners. Consequently, the Nursing and Midwifery Planning and Development Unit, Health Service Executive, and the National Council for the Professional Development of Nursing and Midwifery, secured funding to support the development and delivery of a range of postgraduate programmes in specialist practice. Many programs are available nationwide; these have been developed in response to local needs and are also of benefit in retention of staff.

Nurses' role in mental health services

Psychiatric/mental health nursing is often like a house divided (Forchuk 2001). In Ireland this double name is commonly used to describe the specialty of psychiatric/mental health nursing and reflects possible ambivalence or duality of purpose for the role. The Irish Department of Health & Children, in 2004, set up a forum to examine the possibility of a name change from Registered Psychiatric Nurse (RPN) to Registered Mental Health Nurse for the Psychiatric Nurses Division of the Register held by An Bord Altranais. The Board developed a questionnaire and sent it to 10% of all nurses registered as RPNs to ascertain nurse's views. The majority of nurses surveyed favored the title change to Registered Mental Health Nurse indicating that this title would help ensure that clients be viewed as individuals with altered mental health rather then a person with a psychiatric illness. Publication of these findings caused considerable dissent with the nurses unions and they called for further consultation with practicing nurses before any change of name of the Register take place. To date no name change has taken place hence the term "psychiatric nurse" is used for consistency with the Registered Psychiatric Nurse Division of the Register maintained by An Bord Altranais.

The role of nurses in the field of mental health care varies across the different mental health setting in which the nurses work. Psychiatric nurses work with individuals from child to adult through to old age, as staff nurses, managers, to specialist nurses in psychiatric home

health and community mental health settings, to primary care providers and as providers of psychotherapies to individuals, groups and families. Psychiatric nurses are expert at evaluating psychiatric, substance abuse and the physical health needs and problems of patients. Their primary role is to assess and treat psychosocial consequences of psychiatric illness.

LEGAL NORMS AND ETHICAL CODES IN IRELAND RELATED TO PATIENT RESTRICTIONS

Legal norms related to patient restrictions

Legal protection for patients and staff in restraining and secluding a patient can be found in the Mental Health Treatment Act (1945), the Mental Treatment Regulations (1961), the Mental Health Act 2001 and in common law. The use of seclusion and restraint without due authority is a violation of a person's civil rights and may constitute a criminal offence.

Mental Health Act (2001) brought changes to the existing rules (under the 1945 Act) on the involuntary detention of people for psychiatric care and treatment. It established an independent review procedure in the case of all involuntary detentions with the establishment of a Mental Health Commission, Mental Health Review Tribunals and an Inspector of Mental Health Services. These bodies monitor and regulate the standards of care and treatment in psychiatric hospitals and facilities, and ensure the protection of the legal rights of patients.

Rules on patient seclusion and restraint have currently being reviewed by the newly established Mental Health Commission (Mental Health Commission 2005, Dunne 2006) and are in keeping with the European Convention for the Protection of Human Rights & Fundamental Freedoms (Convention for the protection of human rights and fundamental freedoms 1950). This has brought Irish law in line with the European Convention on Human Rights Within this context there is specific reference to the UN Principles for the Protection of Persons with Mental Illness. The Mental Health Treatment Act 1945 was enacted over 50 years ago. There have been no major changes until the most recent legislation, the Mental Health Act (2001), was enacted in 2006. This legislation offers further safeguards for patients, in line with the European Convention on human rights (Convention for the protection of human rights and fundamental freedoms 1950) and the modern concepts of autonomy. The ethical basis of admitting and treating patients against their will has been and will continue to be challenged until a balance is reached for the need to treat in the least restrictive environment while respecting a patient's right to autonomy. This challenge will always rest on the patient's ability to reason and make decisions in their own best interest. If the patient's actions displays an inability to self govern or direct their own life, they cannot be treated as autonomous persons and may require an advocate to safeguard their dignity and rights.

The Mental Health Act (2001) was written into the Irish statute books in July 2001, however it was not until the 1st November 2006, when all sections of the Act came into force following the signing of a commencement order by the Minister for Health. The Act provides for: changes to the existing rules on the involuntary detention of people for

psychiatric care and treatment, an independent review procedure in the case of all involuntary detentions. The establishment of a Mental Health Commission, Mental Health Review Tribunals and an Inspector of Mental Health Services, the monitoring and regulation of the standards of care and treatment in psychiatric hospitals and facilities and the legal rights of patients. It is unlawful in Ireland to detain a person involuntarily in an Approved Centre solely because that person is: suffering from a personality disorder, or is socially deviant, or is addicted to drugs or intoxicants. Explicit inclusion criteria for an involuntary admission (Mental Health Act 2001) to an approved centre (psychiatric hospital or unit) are outlined as:

> *"because of an illness, dementia or disability: there is a serious likelihood of the person concerned causing immediate & serious harm to himself or herself or other persons, or because of the severity of the illness, dementia or disability: the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration of his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission and the reception, detention and treatment of the person concerned would be likely to benefit or alleviate the condition of that person to a material extent (Mental Health Act 2001 Section8).*

The Mental Health Commission is the statutory body responsible for promoting high standards for the delivery of mental health services and protecting the interests of those detained in approved centres. The psychiatric services in Ireland are scrutinized every year by an Inspector of Mental Hospitals; a function embedded in the Mental Health Commission. The 2004 annual report by the Mental Health Commission (Mental Health Commission 2005) highlighted the lack of any clear strategy for the mental health services since Planning for the Future (Department of Health 1984). In the Mental Health Commission (2005) report the Inspector of Mental Health Hospitals stated that Irish mental health services are in need of radical reform at all levels. While this inspection showed some areas of high quality practice it has also revealed unacceptable levels of care. The variation in indices of service development, service resources and service provision is a cause of real concern, revealing as it does no agreed minimum standard of care nationally. This is not unexpected given the absence of a modern national mental health strategy. (Mental Health Commission 2005).

Ethical norms related to patient restrictions

Professional codes play an important role in standard setting and are seen as being a valuable mechanism for imparting appropriate values and behaviors both to health care practitioners and the general public. Ethical codes relating to patient restrictions in Ireland comply with International Ethical codes such as the Nuremberg Code and the Helsinki Declaration. The Nuremberg Code (1947) was aimed at outlawing abuses of human beings in medical research for 'public good'. Emphasis was placed upon the necessity of gaining consent of the human subject for all participation in research. No explicit reference was made to use of personal information constituting research, however 'prevention of 'unnecessary mental suffering' might be interpreted broadly enough to cover use of personal of information.

The Declaration of Helsinki (1964/2004) developed a statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects. Medical research involving human subjects includes research on identifiable human material or identifiable data. It is the duty of the physician in medical research to protect the life, health, privacy, and dignity of the human subject. The right of research subjects to safeguard their integrity must always be respected. Every precaution should be taken to respect the privacy of the subject, the confidentiality of the patient's information and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

Professional codes related to patient restrictions

An Bord Altranais is the statutory body which provides for the registration of nurses in Ireland. The purpose of this board is to provide a framework to assist the nurse to make professional decisions, to carry out his/her responsibilities and to promote high standards of professional conduct. The Nurses Act (1985) is responsible for standards of professional education and training and professional conduct among nurses. Under the Act, a nurse is defined as a woman or a man whose name is entered in the register. Under rules made in accordance with that Act there are seven divisions of the register, general nursing, psychiatric nursing, mental handicap nursing, sick children's nursing, public health nursing, midwifery and registered nurse tutor.

An Bord Altranais (2000b) developed a Code of Professional Conduct for nurses which provides guidelines on professional behavior for its members and emphasizes that each registered nurse is accountable for his or her practice. The nursing board can take appropriate action as defined in Part V of the Nurses Act (1985) where nurses fail to meet the code of conduct requirements. An Bord Altranais (2000b) considers that the following values should underpin nursing practice and provide for the formulation of a philosophy of nursing:

- The best interests of the patient/client and the importance of promoting and maintaining the highest standards of quality health services should be foremost.
- Nursing care should be delivered in a way that respects the uniqueness of each patient/client regardless of culture or religion.
- Fundamental to nursing practice is the therapeutic relationship between the nurse and the patient/client that is based on trust, understanding, compassion, support and serves to empower the patient/client to make life choices.
- Nursing practice involves advocacy for the individual patient/client and for his/her family. It also involves advocacy on behalf of nursing within the organizational and management structures within which it is delivered.
- Nursing practice is based on the best available evidence.
- Nursing practice should always be based on the principles of professional conduct as outlined in the Code of Professional Conduct for each Nurse and Midwife approved by the board of An Bord Altranais (An Bord Altranais 2000b).

The Irish nursing profession has adopted the International Council of Nurses (ICN) Code of ethics to ensure ethical behavior. The ICN Code of Ethics for Nurses (2000) affirms that nurses have four fundamental responsibilities: promoting health, preventing illness, restoring health and alleviating suffering. The ICN Code asserts that "inherent in nursing is

respect for human rights, including the right to life, to dignity and to be treated with respect" (International Council of Nurses 2000).

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN IRELAND

Mental health statistics and patient restrictions used

The Health Research Board is responsible for managing a number of national information systems including the Activities of Irish psychiatric hospitals and units. Mental health statistics is sourced from the National Psychiatric In-Patient Reporting System (NPIRS). This database is the only national psychiatric in-patient database in Ireland and was established on the recommendation of the Commission of Enquiry on Mental Illness (Department of Health 1966). It has been maintained by the Medico-Social Research Board (MSRB), and subsequently by the Health Research Board (HRB), since 1971. Since 1965, annual reports are published (Activities of Irish Psychiatric Services) from the NPIRS data and play a central role in the planning of service delivery. National and regional newsletters, capturing data from the HSE administrative areas, are also produced from the database. This information system provides high quality information for the planning, monitoring, and evaluation of mental health services and is an invaluable source of information.

The study entitled "Activities of Irish psychiatric hospitals and units" (Daly et al 2005) reported that there were 21,253 admissions in 2005, down from 22,400 in 2004 a decrease of 5.1%. Re-admissions constituted 72% of all admissions. There was no decline in the proportion of non-voluntary admissions, which represented 11% of all admissions and 12% of first admissions. Only 4% of admissions to private hospitals were non-voluntary. The overall statistics revealed that: males account for just over half of all admissions (51%) and first admissions (55%). The 45–54 year age group had the highest rate of all admissions, at 901.0 per 100,000 of the population aged 16 and over, while the 20-24 year age group had the highest rate of first admission (211.4 per 100,000). Divorced persons had the highest rate of all admissions (947.0 per 100,00and first admissions (273.8 per 100,000). In keeping with the pattern of previous years, the unskilled occupational group had the highest rate of all admissions (1,249.7 per 100,000) and first admissions (269.3 per 100,000). Depressive disorders accounted for almost one-third (31%) of all admissions, schizophrenia accounted for 20%, alcoholic disorders for 14% and mania accounted for 13%.

Management of distressed and disturbed patients

Employers of health care staff have a legal responsibility under Section 6 of the (Safety, Health and Welfare at Work Act 2005) to take reasonable steps to secure the health and safety of their workforce. They are obliged to undertake risk assessments of potential hazards. This implies that employers must anticipate situations where patients may act in a way that threatens the safety of others and devise appropriate methods to minimize risk to staff. The Mental Health Commission (Dunne 2006) suggest that staff employed in the psychiatric services should be provided with adequate training and support in the

management of distressed and disturbed patients, in order to ensure that they are equipped to use seclusion and restraints in a safe approved and appropriate fashion.

Risk assessment and management is the initial focus in the management of distressed patients. It allows practitioners to focus on taking a full history of challenging behaviors (if any), including the patient's own view of his or her history or potential for unsafe behaviors and views with regard to how best to manage his or her individual needs. The United Kingdom National Institute for Clinical Excellence guide line, suggests that a risk assessment should also include a detailed assessment of secondary indicators that may highlight the potential of the patient for unsafe behavior (The National Institute for Clinical Excellence 2005).

De-escalation techniques have been shown to be a useful in the management of distressed patients and assist in the reduction of seclusion and restraint. De-escalation techniques are used extensively in Ireland in the management of distressed and disturbed patients. De-escalation allows the staff member to use a range of strategies focusing on his / her own verbal and non verbal skills, ability to monitor the care environment and an understanding of the sequence of escalation which leads towards unsafe behaviour. The National Institute for Clinical Excellence (2005) suggest that de-escalation techniques help staff to intervene early in the cycle of unsafe behavior in order to minimize the impact and duration of such behavior without the use of physical restraint.

Break-away techniques are taught both at undergraduate and post graduate level nursing in Ireland and are widely used by clinical staff nurses in the management of distressed and disturbed patients when a treat of violence occurs. These techniques allow nursing staff to free themselves quickly and non-aggressively from unwanted physical contact. Restraint techniques are taught to all qualified psychiatric mental health nurses and should only be used when all other method of managing the distressed and disturbed patient have failed (Dunne 2006). Restraint should be carried out by nurses who are skilled in restraint techniques; who have a proficiency in restraint techniques designed specifically for use as a point of last resort with vulnerable patients. The training itself should have a primary focus on de-escalation.

CONCLUSIONS

The above short chapter gives an overview of the structure of the Irish health service in general, including an overview of the Irish mental health services. This is a period of reform and development across all health service provision in Ireland. Psychiatric nursing has changed significantly over the past 20 years along with the move to a community focus of care delivery. The education and training of nurses has also undergone a fundamental shift to graduate training with a focus on psychosocial interventions and specialist case management.

It can be seen there is much strength and value in the current public service provision. However, there is also much that can be improved in order to ensure greater equity of access and an enhanced health service for the growing, and increasingly heterogeneous, population of the Republic of Ireland.

References

An Bord Altranais (2000a) Requirements and Standards for Nurse Registration Education Programmes. 2nd Edition. An Bord Altranais, Dublin.

An Bord Altranais (2000b) The code of professional conduct for each nurse and midwife. An Bord Altranais, Dublin.

Central Statistics Office (2006) Census 2006: Preliminary Report. Stationary Office, Dublin.

Central Statistics Office (2002) Census 2002: Preliminary Report. Stationary Office, Dublin.

Cocoran P, Arensen E, O'Mahony D. (2006) Suicide and other external – cause mortality statistics in Ireland. Crisis 27 (3), 130-134.

Convention for the protection of human rights and fundamental freedoms (1950) Council of Europe, European Treaties, ETS No 5, Rome 4.XL.1950. Amended by Protocol No. 11 (ETS) No. 155 of may 1994. Council of Europe, European Treaties. European Commission.

Daly A, Walsh D, Ward M, Moran R. (2005) Activities of Irish psychiatric units and hospitals 2005. Health Research Board, Dublin.

Declaration of Helsinki, Adopted by the 1st World Medial Assembly, Helsinki, Finland, June 1964, and amended in Tokyo, 1975, in Venice, 1983, in Hong Kong, 1989 in South Africa, 1996, in Edinburgh 2000, in Washington 2002, and in Tokyo 2004.

Department of Health (1966) Commission of Enquiry on Mental Illness. Stationary Office, Dublin.

Department of Health (1984) Psychiatric services: planning for the future. Stationary Office, Dublin.

Department of Health and Children (1998) Report of the Commission on Nursing: a Blueprint for the Future. Stationary Office, Dublin.

Department of Health and Children (2001a) Quality and Fairness A Health System for you Health Strategy: Department of Health and Children, Dublin.

Department of Health and Children (2001b) Primary Care A New Direction. Stationary Office, Dublin.

Department of Health and Children (2003a) Audit of Structures and Functions in the Health System. Stationary Office, Dublin.

Department of Health and Children (2003b) Report of the Commission on Financial Management and Control Systems in the Health Service. Dublin: Stationary Office, Dublin.

Department of Health and Children (2006a) A vision for change: report of the expert group on mental health policy. Stationary Office, Dublin. ISBN: 0755773764.

Department of Health and Children (2006b) Health Services Reform Programme Available at: http://healthreform.ie/structures/hiqa.html (Accessed 9.11.2007)

Dunne EA (2006) The views of adult users of the public sector mental health services: report of a survey for the Mental Health Commission. Mental Health Commission, Dublin.

Economic and Social Research Institute (2006) Quarterly Economic Commentary http://www.esri.ie/news_events/latest_pess_releases/quarterly_economic_commen_3/index.xml (Accessed on 15.2.2007)

Enterprise-Ireland (2006) Releasing the Hidden Strength of your Enterprise http://www.enterprise-ireland.com/innovation (Accessed on 15.2.2007)

Forchuk C (2001) Evidence-Based Mental Health 4, 39-40. Online Evidence-Based Mental Health Journal.

Government of Ireland (2000) A Strategy for a Pre-Registration Nursing Education Degree Programme Report of the Nursing Education Forum. Stationery Office, Dublin.

Health Act (2004) 42/2004. Stationary Office, Dublin.

Health Insurance Authority (2005) The private health insurance market in Ireland. A Market Review. Prepared by Insight statistical consulting. The Health Insurance Authority, Dublin.

Health Service Executive (2006) Transformation Programme 2007-2010. Health Service Executive, Dublin. http://www.hse.ie/en/Publications/HSEPublications/FiletoUpload,2602,en.pdf. (Accessed on 22.1.2007)

International Council of Nurses (2000) The ICN code of ethics for nurses. Geneva, Switzerland.

Mental Health Act (2001) Stationery Office, Dublin.

Mental Health Commission (2005) Annual Report 2004. Dublin.

Mental Health Treatment Act (1945) Stationery Office, Dublin.

Mental Treatment Regulations (1961) Stationery Office, Dublin.

National Institute of Clinical Excellence (2005) Violence: The short-term management of disturbed/violent behavior in in-patient psychiatric settings and emergency departments. Clinical Guideline 25, February 2005. Developed by the National Collaborating Centre for Nursing and Supportive Care. NICE, London. www.nice.org.uk/pdf/cg025niceguideline.pdf. (Accessed 02.06.2007.)

Nurses Act (1985) Stationary Office, Dublin.

O'Connell P, Clancey D, McCoy S. (2006) Who went to college in 2004: a national survey of new entrants into higher education. Higher Education Authority (HEA), Dublin.

Safety, Health and Welfare at Work Act (2005) Stationary Office, Dublin.

The Nuremberg Code (1947) In: Mitscherlich A, Mielke F. Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman, 1949: xxiii-xxv.

Baseline information from Italy: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Italy

Camuccio C.A
University of Padua, University of Udine,
Department of Environmental Medicine and Public Health, Italy

INTRODUCTION

In this chapter we will examine the psychiatric system in Italy: its organisation and structures, the legal and ethicals norms related to the restriction of patients and the nursing management of the distressed patient.

A description of the Italian psychiatric system should consider the great importance given to its reform of 1978 with the law 180 (Legge 13 maggio 1978). Many authors, Italian and non-Italian, start their description of psychiatry in Italy just introducing the reform (Rissmiller & Rissmiller 2006, Sharp 2004, De Girolamo et al. 2002, Fioritti et al. 1997). This law, 180, has had a big impact on the psychiatric care system and it remains very controversial.

This reform closed all the psychiatric hospitals in Italy and focused psychiatric care in the community. Prior to 1978 the only psychiatric care available was hospital-based (apart from some hospital – dependant, outreach services focused mainly on the follow –up of discharged patients). It is clear that this 1978 reform tried to institute a major change – in organisational, epistemological and in cultural terms. The epistemological change has been the introduction of psychiatric care based on a social psychiatry model, which had emerged during the '60s and '70s. This was the spirit of the law. However large numbers of psychiatrists and psychiatric service personnel who had been educated to work within the psychiatric hospital system were not well equipped for this change. Probably for this reason, among others, the law, 180, has been implemented in a very patchy manner throughout the country; alongside excellent services coexisted (and still coexist) other services that applied the reform only at a minimum level (Sharp 2004). The Italian reform required not only a re-organisation of services, but also a cultural change within those services and the personnel who work within them. This has not happened in a comprehensive manner throughout the country. (Sharp 2004).

Another aspect of the Italian psychiatric system, is the lack of studies on the outcomes of the reform and of Italian psychiatric care in general (Sharp 2004, De Girolamo & Cozza 2000). As is clear from the descriptions below, the individual regions in Italy are responsible for the policies on Mental Health, within the framework of the national law 180. One can find studies on the outcomes of care at regional level but not at a national level. Here at this latter level we find only quantitative data and statistics related, for example, to the number of bed or compulsory treatments, etc.

Mental health nursing in Italy has been very influenced by the patchy implementation of the mental health reforms. This has left mental health nurses very confused about their role in community care; while at the same time giving nurses much scope for autonomy and autonomous practice. (Mislej 2006). Nursing education has largely borrowed from sociology, phenomenology, psychiatry and psychology. This is common also in other countries (Geanellos 2004) but in Italy nursing is a young discipline and it is only since the 1980s that international general nursing theories have been slowly introduced into Italian nursing education. The unique aspects of the contribution of mental health nursing to mental health care: the development of the therapeutic relationship, self involvement, problem of role, etc. (Cutcliffe & Goward 2000; Burns et al. 2001) did not find a proper space in nursing education which has focused on the generic role of the nurse. The patchy implementation of psychiatric services in Italy has not helped Italian mental health nursing to find either a proper theoretical, or conceptual basis, or a clear operational role for a long time now, as we will see in the following paragraphs, the specific psychiatric education of nurses has been carried out by psychiatrists together with experienced mental health nurses who were educated in the schools of the Psychiatric Hospitals.

Is it correct then to speak of "mental health nurses" in Italy? Yes, because mental health nurses are nurses who work in Mental Health Services and have acquired specific competences.

But there is also an ambiguity that nurses feel in the term "mental health nurse" because they have been educated as generalist nurses. After a university education the nurse is ready to work in every unit of every part of the health service. If they work in a Psychiatric Department at the same time they could work in another department as nurses, for example in a critical care unit. We will now move on to a description of the Italian health care system including the Italian mental health services.

DESCRIPTION OF ITALIAN POPULATION AND HEALTH STATISTICS

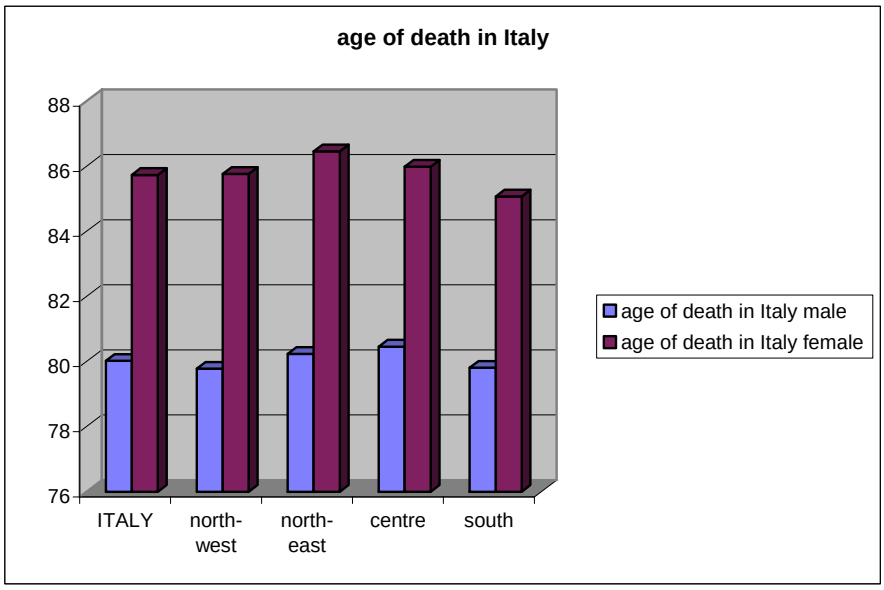
Population statistics

Italy is a country of the European Union: its area is approximately 300 sq. km. It is a country very expanded in length; its area goes from the 47th parallel to the 37th. The Italian population as of the 1st January 2004 is 57,888,245. Of this figure there are 29,819,637 women – females thus form 51.1% of the whole population, while the 28,068,608 males form just under 48% of the total population. The proportion of population under the age of 15 years is 14 % and the proportion of population above the age of 60 years 24%.

The sources of livelihood are primarily based on the service sectors; since the middle of the 80s industry is no longer the largest employer in Italy. Today, half of Italian citizen's source of livelihood comes from service sector (50,5%), while the rest comes from industry (46,3%), and 3% from agriculture. For example the Veneto Region - which contains the psychiatric service that we are analyzing - is based on industrial districts where little industry prevails. The unemployment rate in the whole of Italy is 8.4%. In the southern region this rate is higher and in the northern regions it is about 3-4%. In Padua (main city in the Veneto Region) the unemployment rate is 3% (National Institute of Statistic 2007).

Health statistics

Life expectancy at birth is 76.8 years for males and 82.5 years for females. As we can see from the Figure 1 below, this datum varies across different areas of Italy (north-west, north-east, centre and south with Sicily and Sardinia) (National Institute of Statistic 2007).

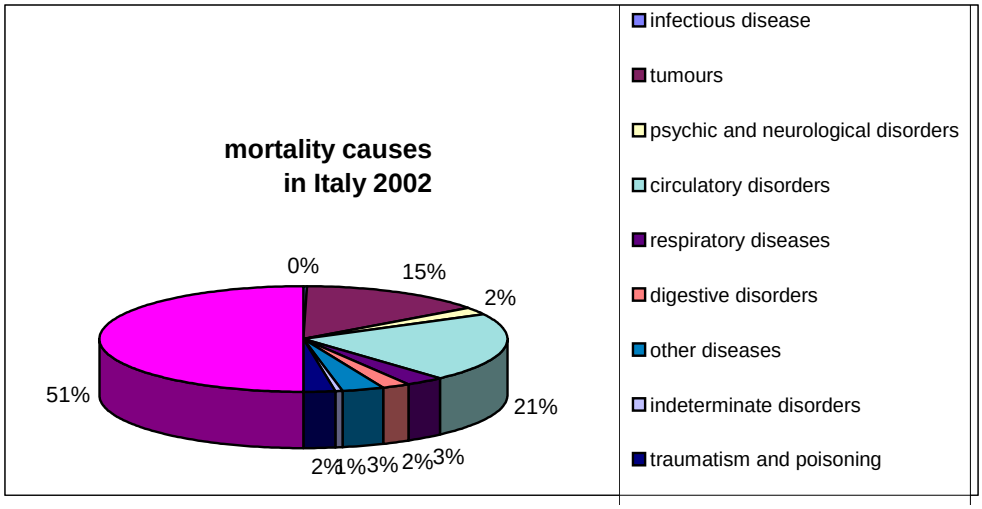


Reference: National Institute of Statistics 2007

Figure 1. Age of death in Italy in different areas

In Figure 2 different mortally causes in Italy are described.

Briefly, the most common mental health problems among the Italian population are the major depressions and phobias. The data from the National Institute of Statistic are not disaggregated enough to give clear data. However the most common diagnosis that we can find in psychiatric acute wards are in the classes of psychosis and personality disorders. The number of beds for acute psychiatric care in Italy is 3,992, plus 162 beds that are in University wards. The average length of stay in the acute ward is 15.51 days; this is a little longer in case of diagnosis of psychosis (Ministry of Health 2007).



Reference: National Institute of Statistics 2007

Figure 2. Mortaly causes in Italy

THE ITALIAN HEALTH CARE SYSTEM

General

The Italian Constitution gives to the Republic the duty of preserving health *"as fundamental right of the man and as public interest"* (art. N°32). (La Costituzione della Repubblica Italiana, 2007). The legislator has provided that this duty be met by passing the national Act n° 833\1978, which established the National Health Service (Servizio Sanitario Nazionale, Ssn), replacing a health insurance system. The basic principles of this law are: solidarity, universality and the public nature of the health system. That is to say that the Ssn must ensure health care for all the citizens without distinction. The citizens are free to choose treatment in any part of Italy, in public or private parts of the health system (but these latter must have an authorization by the Ssn).

The 1978 Act has been reformed during the 90s with many Government Decrees (502/1992, 229/1999) and with further National Acts (3/2001, 405/2001). The general principles of the Act establishing the Ssn are always confirmed, but the later acts and decrees introduced some innovation. The underlying principles are:

- Regionalization of the health service
- Rationalization of the Ssn costs
- Administrative, accounting, and financial autonomy to the Local Units
- A system of partial competition between the public and private health structures
- Great attention to quality and appropriateness of the health service
- Great attention to the integration between the sanitary and the social needs

The National Health Service has been established with the Act 833/1978. The NHS has three level of governance. First, the Ministry of Health has the responsibility of national planning, decides the level of performance of the services and decides the professional

profiles. Second, the Regions make their own laws in accordance with the national acts. And third, the Local Sanitary Units (Uls) have responsibility to operationalise the aims of the NHS. The Uls are at a local level, for example, Venice city is one Uls. The NHS is financed by general taxation including both direct and indirect taxation. Furthermore, the Local Units can finance themselves with income from prescription charges (Ministry of Health, 2007).

Italy is not a federal state, but is comprised of 21 regions that have a large degree of autonomy in many areas (Figure 3). However these regions are under the governance of the National laws; the local government has always to follow the national law and guidelines.

Figure 3. A map of Italy with 21 regions

The National Health Service has been established with the Act 833/1978. The NHS had three level of governance:

1. The Ministery for Health has responsibility of national planning, decides the level of performance of the Services and decides the professional profiles.
2. The Regions make their own laws in accordance with the national acts
3. The Local Sanitary Units (Uls) have responsibility to operationalise the aims of the NHS. The Uls are at a local level: for example, Venice city is one Uls.

One of the areas where the Regions have more autonomy is in the Health Systems: the regions here have a large degree of financial and managerial autonomy, although they have to guarantee the citizens the basic level of health care (L.E.A) defined by the State. In this system the Local Sanitary Units (Uls) have to develop and operationalise the Ssn aims. The Ssn has a political planning function of the health care while the Uls supply directly the

health care to the citizen with hospitals, services, etc. The Uls are at local level: they can have jurisdiction on a county or in a part of a city: for example in Padua there is only one Uls, but in Rome or Milan, big cities, there are several Uls. Psychiatric care can differ only marginally between different regions. This is an area where the regional health policies cannot vary to any significant degree. The national law governs the provision of psychiatric care very strictly with laws and decrees.

The law that governs psychiatric care is the n° 180/1978 Act. (Legge 23 Dicembre 1978) This law has been totally incorporated as a part of the law that established the National Health System (NHS). The 180/1978 is also called "Basaglia" from the name of the psychiatrist that was the leader of the psychiatric reform' movement. This law is a general policy law, except where compulsory treatment is described: this treatment is described in the 33rd and 34th article and is very detailed. The point is that this law is a general policy one, however it has been and continues to be implemented differently in different parts of Italy, even in the same region the policy may be implemented differently (Fioritti et al. 1997). This law has been fiercely thwarted by many psychiatrists, supported also by large parts of public opinion. So in many cases the law is enforced in clinical practice and the organization of the psychiatric services, only in a formal way, but the clinical practice remains unchanged (Giannichedda 2005).

The real application of the law requires a different perception of the psychiatric patient: it needs a cultural and epistemological change regarding perceptions of the patient and of mental illness. This will be explained further below, however it is important to remember that the law 180 substituted a law of 1904 (partially amended in 1968, but not in its essence); the first article of this law stated the obligation to cure and guard (Agenzia per i Servizi Sanitari Regionali 2007):

> *"...into the mental hospitals the persons suffering of any cause of mental alienation, in case they are for a danger to themselves or to others or motive of public scandal*".

The 1978 law turned this upside down emphasising the autonomy of the psychiatric patient and the voluntary nature of his / her request for treatment (Canosa 2005).

The psychiatric services in Italy only deal with psychiatric patient from age 18 to 65 years: patients under age, or drug-addicted- alcoholic, or patients with organic mental damages are treated in other, normally specialist services.

Mental health services

The Department for Mental Health (Dsm) is a complex structure comprised of networks and units to give an answer to various needs of the psychiatric patient. All these structures are directed by a central staff lead by a Director of Department. Every mental health unit is led by a psychiatrist. Only in very rare cases in Italy is a psychologist or sociologist in lead position.

Mental health services are governed strictly by national and regional laws: the kinds of things that the law regulates are the number of patients that a service can have, the number

of staff, the hours of opening of the service, ect. This is under the control of the Local Sanitary Unit (Uls) (Ministry of Health 2007).

In the acute hospital ward, the patient are usually in an acute and emergency psychiatric state.The number of beds that the ward can have is 1 for every 10,000 inhabitants to a maximum of 15 beds. That is to say that Rome does not have a big Spdc with hundred of beds, but several small Spdc.

Mental Health Centre (Csm) is the heart of the community mental health services . It is outside of the hospital and the opening hours are determinated by law. It is the heart of the Dsm because the therapeutic équipe of the Csm is responsible for the treatment of the patient in all the various structures of the Dsm. For example: it is this équipe that decides to hospitalize the patient in Spdc, or send him/her to a community service, or a Day Hospital. The Csm plan and define the therapeutic programme for the patient, and follow him in all the structures of the Dsm. This is a basic point of the Italian psychiatric service: the therapeutic continuity and the Csm interventions in the community. It is also responsible for the coordination with other agencies such as geriatric, drugs addiction, etc. It must be opened at least 12 hours a day for 6 days a week (Cianbrello et al. 2003).

The intermediate structure of mental health services includes daytime centres, rehabilitation centres, accommodation houses, day hospitals (Girolamo et al. 2002). Daytime centres are facilities dedicated to patients that have need of medium term rehabilitation. It is not a hospital or an in-patient facility. The patient comes with a fully developed programme directed by the équipe. So the activities, even if sometimes seems playful, always has determined therapeutic and rehabilitative aims. The activities are normally carried out in groups and may include psychotherapy, music therapy, art therapy and so on. The Day centre is often a place of training for integration into society and the world of labour. It is placed often into the Csm, never in the hospital.

Rehabilitation centre (Therapeutical Protected Residential House, Ctrp) is a therapeutic community, usually a protected house, where severely disturbed patients, usually young people, are cared for far from their family. They follow a programme of intensive rehabilitation inside the house usually focused on recovery of social and self care skills. The treatment is personalized even if life in the Ctrp follows group rules. There are a maximum of twelve beds per facility. Many Ctrp are placed in old buildings that were former psychiatric hospitals.

Accommodation house (Casa Alloggio, CA) provides community-based housing to a maximum of 15 beds where the rehabilitation needs are not so strong as in the Ctrp. Often patients who have had medium - long term intensive rehabilitation in a Ctrp are admitted to Casa Allogio, as a type of step-down facility or half-way house prior to returning to their home and social environment. These facilities are only staffed in the daytime. Many CA are placed in old closed Psychiatric Hospitals.

In the day hospital (DH) patients usually have injection therapies. In some departments the therapeutic focus is a social one: that is to say that the therapies are focused on one-to –one counseling and psychotherapy and on group therapy, mirroring the approach of a day centre. The Dh is often located in the hospital but may also be located in the Csm.

Understanding the psychiatric model in Italy

The new paradigm in Italy has its rational basis in the law 180/1978. The paradigm has disassembled the linear causality of the clinical paradigm, which analyses madness and the psychiatric patient as an object with a mechanic relational cause-effect characteristic (Morin 1993). Psychiatric movement in Italy is based on Franco Basaglia's ideas. The psychiatrist was a leader of the reform of mental health services, which is commonly known as "Basaglia act". The idea was to 'put mental illness in a parenthesis' (Basaglia 1974, Borgna 1996). This means that a priority is given to meaning of patients; what he/she shows or tells and not what we suppose to be manifestation of the disease. Patients' behaviour is not automatically a manifestation of the disease and patients are not labelled automatically due to their mental illness. This is the "suspension of the judgment" that allows reality, and gives concreteness to the phenomenas (Calzigna 2004, Colucci 2003).

The new paradigm indicates that if we think and analyze institutions for what they are said to be, we will not understand them. The Psychiatric hospital tells us that its function was curing patients. This was not true. Total transformation of the institutions could be a very slow process or quick and unforeseen (Basaglia 1969).

How did psychiatric hospitals in Italy close; which methods have been used in the past to de-institutionalized psychiatry in Italy?

1. Putting mental illness in parentheses.
2. Full respect for (listening to the patient without prejudice) the words of the patient
3. Full respect for patients' time
4. All resources must be given to patients
5. Join theory and practice

This last point leads to another subject which is cognitive destructuring or cognitive de-institutionalization. In community psychiatry, psychiatry not focused on the hospital but on the patient's environment, there has been discussion regarding the clinical rationalistic paradigm "solution–focused therapy". This paradigm tends to refine the problem by starting from the solution.

The "presa in carico" is a working method, a model, born within community psychiatry (Mislej 2006). The basic ideas are:

1. Precise territorial jurisdiction, proportionate to the service's resources.
2. The patients do not have to be selected, the service accepts everybody.
3. Therapeutic continuity, the patient has to be followed by the same team in all areas and structures of the service (or Department).
4. The service must be open 24 hours a day
5. The choice to not use the clinical paradigm (diagnosis-prognosis-therapy) that is the linear causality. The diagnosis is important (medical or nursing) but it is not the "compass" of the treatment (Dall'Acqua 1996, Mislej 2006).

The "presa in carico" includes holistic view of the patient in context (undertaking of all the needs and questions of the patient, with all the social involvement connected with their suffering.) The patient in this model is a subject, and as a subject he has bargaining power.

In fact we commonly speak of a ‘therapeutic contract’ between the patient and the service. The crisis of the patient is the crisis of this contract, so by extension, the crisis of the service. Talking at an operational level, the crisis of the patient has to be responded to flexibly by the service. Crisis is a common word used in Italian psychiatry to mean the distressed behaviour of the patient (Paloscia & Pasini 2005) ‘Crisis’ come from the Greek word ”krìsis” and the verb ”krìnein”. It means ”to distinguish, to recognize, to decide”. (Ferla et al. 1994, Online etymology dictionary 2007)

NURSING EDUCATION AND NURSES’ ROLE IN MENTAL HEALTH SERVICES IN ITALY

Degree education

There is no specific education for psychiatric nurses. Some universities have developed a 1st level degree masters in mental health nursing (where to be admitted you need 3-5 years of practice in a psychiatric department); you get a master after the first three years of the bachelor course (but there is not a formal role for this figure in the Nhs). This course, as in the majority of the European countries, prepares a nurse without a specialized grounding (Ministry of University and Research 2007): this nurse is able to work in all the wards. So the assignment to a psychiatric unit is usually casual and does not follow any educational criterion. The other two years of 2nd level degree education does not follow a clinical path but a managerial one. A clinical 2nd level degree is planned for the future.

Vocational continuing education

The education of the nurses that are working in a psychiatric department follows the same rules as those for the other sanitary areas. In Italy there is a system called “Continuous Education in Medicine” (Ecm). All nurses (but also all the sanitary staff) must attend some courses every year to achieve a number of obligatory credits (30 credits per year). The sanction for not attending may range from a reduction of the wage to removal from the nursing register (Ministry of Health 2007). The courses may require a fee or may be free. In the later case such courses are usually organised by the psychiatric department. (Such course are to up-skill nurses in specific areas of psychiatric nursing care, and help make up from the lack of requirement of a specialist focus on psychiatric nursing in pre-registration nursing education programmes.)

The educational courses for the staff of the psychiatric acute units are not usually focused on the management of the aggressive patient. For example, you will not see pictures or photographs showing the use of restraint techniques on a patient in Italian nursing test books. Even if management of the aggressive patient is the topic, the approach shown will be a relational one. All courses focusing on the management of aggressive patients focus on de-escalation techniques and support or sometimes on the juridical problems of restraint. These courses do not teach physical or mechanical restraint techniques. This seems an important point and in our opinion it comes from a series of reasons detailed below.

However, in many acute psychiatric units the nursing staff is composed of nursing staff who were training under the old traditional system of psychiatric care. These are nurses who trained in psychiatric hospitals prior to 1978. They received a three-month training course in a psychiatric hospitals school. They were entered onto the Nurses Register by law, but they could only work in a psychiatric department. They are not obliged to participate in continuous professional education (Ministry of Health 2007).

Nurses' role in mental health services and multidisciplinary team

In Italy, multidisciplinary team work forms the basis for psychiatric care. On our opinion, we can not describe the mental health nursing role without a description of the teamwork in its typological shape (Cantelmi et al. 2003).

The group has many roles:

- Organizational (how care and day structure have been organised)
- Political (policy of mental health)
- Epistemological (basic ideology in mental health care, different models, paradigms, can live in the same group)
- Psychodynamic (how to manage daily issues, how to cooperate with a patient, how the group with individual persons and different professions and competences work together, a living environment).

For the severely disturbed psychiatric patient who has a fragmented mental state, the team can represent a modality of integration of those fragmented part of identity. The patient establishes a unique therapeutic relationship with every member of the team which is a reflection of a single fragment of their inner reality. In the debate between the members of the team, every professional will give his or her opinion of the patient state, in accordance with their function and within their level of competence. This will serve to provide a more comprehensive framework for the psychological functioning of the patient and their needs, permitting the planning of a more personal and targeted therapeutic programme (Cantelmi et al., 2003).

No single psychiatric clinician can deal with a severely ill patient with the same efficiency as a multidisciplinary team. In this group (or multiprofessional team) we see a permanent crisis of professional competences, which means that the genuine relationship with the other (the patient) can be helped by this professional competence, but not completely (Cantelmi et al., 2003) . The relationship with a nurse can be more efficient, because it could be more true and genuine than the relationship with a psychologist or a psychiatrist.

The nursing role in psychiatry is not clear and defined: nurses have different approaches according with the contexts, the structure, organisation and "school of thought" (Burns et al. 2001) of the Department of Mental Health they operate within.

Mental health nursing in Italy does not have national standard guidelines and also at local level the use of a standard line of action is very low. In Italy the supply of physicians is great and their social status, unlike the nurses one, is high so they usually guide mental health nurses as well the other professional figures of the Dsm. The clinical responsibility is

left almost entirely to the physician (Burns et al. 2001). We have to say that this situation is similar to all the other kinds of nursing in Italy.
At the end, a nurse in psychiatry could be one that merely carries out orders or one that has large autonomy. This fact depends, as we just mentioned, from the "school of though" of the Dsm, from the structure where the nurse operates and from the personality of the single nurse. It is also true that nursing in Italy has problems such as: the lack of standardisation, the inadequate aptitude to record performance and activities of the nurse. These are problems that do not help an homogeneous growth of the profession, especially in a branch of nursing like mental health where the techniques and the standardisations are not always easy and possible. We remember that there is not a dedicated education during the university programme (only 20-25 hours and the practice is optional).

In our opinion the risk (and what is slowly happening in some Italian services) is the uncritical introduction into nursing practice of protocols and guidelines that do not give enough importance and relief to the personal needs of the patient, because they are introduced directly from others branches of nursing. In fact many authors are talking of reinstitutionalisation (Priebe et al. 2005), that is both new beds for inpatients but also an approach to the patient that is less personalized.

We mentioned above that the nurse's role changes according to the structure within which she/he operates. In every structure teamwork is the operational principle of clinical work, in most cases the psychiatrist is the person responsible for the teamwork. Within the context of teamwork the nurse can find large spaces of autonomy and clinical responsibility, but at the same time she/he can be "pushed" by other roles (psychiatrists, social workers, psychologists, psychiatric educators) if she/he is not well prepared clinically and/or aware of his/her competences. Obviously apart from the work context, also the typology of patient is important to determining the possibilities for autonomy.

In general we can identify three departmental areas with three typologies of mental health nursing: the hospital, the intermediate structures and the mental health centre. In all of this areas nurses work almost entirely with severely distressed patients, usually with a diagnosis of psychosis.

Nurses operating in the hospital have usually a technical approach to the care; great attention is paid to the therapy, to risk assessment and to the management of the distressed patient. In the acute units the length of stay has an average of 15 days (18 for psychosis). In the hospital the patient is in an acute phase of illness and other phases of the treatment such as rehabilitation are performed by other structures of the Dsm. In the majority of the Acute Units nursing education is focused on the development of relationship attitudes (Barelli & Spagnolli 2004).

In the intermediate structures nurses help the patient to recover positive relationship and to rebuild the skills required to meet their daily needs. There are activities such as social skill training and coping skill training provided. In these structures the patient has strong rehabilitation needs. Here the nursing role can be different according with the "school of though". For example: some day-hospital are focused on the infusive therapy while others are focused on relationship and rehabilitation programmes based on psychotherapeutic groups and workshops (Barelli 2003). The same nurse in these two different situations, but with the same typology of patient, could have different tasks and different levels of autonomy and responsibility.

The work of the community nurses is different. They have to operate with a patient living in his social and familiar background. Nurses operate in the social milieu of the patient supporting him in his relationship with the social environment (neighbourhood for example but also social services, etc.) and the family network, especially this latter one. The monitoring of the therapy, and often its administration, is another important task of the community nurse in Italy. It is clear how these latter "technical" activities are all connected with the others, we mentioned above. So community nurses (as professionals working in a team work) have a function of joint connection between the patient and his social relations.

LEGAL NORMS AND ETHICAL CODES IN ITALY RELATED TO PATIENT RESTRICTIONS

Legal norms related to patient restrictions

It is affirmed in first article of the Law 180/1978 that treatments are always voluntary. The patient has freedom of choice regarding treatment. This Act ordered the closure of psychiatric hospitals replacing them with local (Uls) Mental Health units focused on the community care. The only exception to the nature of treatment provided for by this law is the Tso (Compulsory Sanitary Treatment). (Ministry of Health 2007)

> *If a person is judged mentally incompetent he is not responsible for any crime committed and he is acquitted. However, if a psychiatric examination affirms that the person is a danger to himself or another person he can be brought to hospital for compulsory detainment. It is not the psychiatrist that decides the internment but the Judge following examination by and advice from the psychiatrist. There are 6 Psychiatric Hospital of this kind in Italy and they are called judicial psychiatric hospitals (Bondioli 2007). Subsequent Presidential Decrees (1994-1998-2002) have specified the structural standards and guidelines regarding treatments, the organization, the personnel, the number of bed of each service unit in the mental health service in Italy.(Ministry of Health 2007)*

The main Act legislating for patient's restriction is that contained in the law 180/1978 in the part referring to compulsory treatment (Tso) and compulsory assessment (Aso). There are no other acts or guidelines that have prescriptive strength, regarding compulsory treatment. The Tso is strictly regulated by the law 180/1978 and its procedure is complicated and strict.

There are three conditions for compulsory treatment (tso) (Barelli & Spagnoli 2004):

> Mental disorders so severe to need an urgent treatment
> The treatment is not accepted by the patient
> There are not possibilities of any assistance outside the hospital structures

Compulsory treatment (Tso) is requested by a physician. Another physician (but working in the National Health Service) must validate this first request (both have to check the presence of the three pre conditions, so they have to visit the patient). The request, with all

the personal data of the patient and the diagnosis, is sent to the Mayor of the town who gives permission to admit the patient to the psychiatric ward of a public hospital, as an involuntary patient. The patient is forced to go to the hospital by the police together with the personnel of the Emergency Service of the hospital (in some Uls there is also a psychiatric staff who accompanies the police to transport the patient to the hospital). During the Tso the patient can receive therapy and is not considered responsible for his acts under the law. (Peruga 2005)

Meantime, after the Mayor signed the Tso request, within 48 hours the Tso is sent to the Tribunal where a Tutelary Judge controls and can confirm or recind the tso. If the judge replies in the negative, the Tso is cancelled. The Tso lasts 7 days but can be renewed following the same procedure. During the duration of the Tso the patient can appeal against the Tso to the Tribunal. (Ministry of Health 2007)

If the condition of the patient is not clear and the physician has doubts about its severity he/she can ask for an Aso; that is a Compulsory verification of the mental state. The procedure is the same as that for a Tso, but it needs only to be requested by one public physician. The patient is taken by the police (always with health personnel) and brought to the Psychiatric ward where he is assessed. Following the assessment the doctor can decide to seek for a Tso, or can decide to send the patient home.

> *As indicated above no other guideline has the same normative power. Local guidelines have been developed usually at Department of Psychiatry level; that is the level of a Local Sanitary Unit. In many acute psychiatric units the guidelines regarding restraint have banned mechanical restraint or they concern the relations with other units, like the emergency one, or with the police. (Attanasio & Gabriele 2005).*

The Ministry for Health (1992) state that sanitary personnel cannot use compulsory methods during the execution of a Tso, this function is given to the police (Benci 2005). But this is a theoretical debate because in the majority of the Italian units restraint measures taken during the Tso, especially in the ward, are taken by the nurses (even if the patient restrained is under a compulsory treatment order) (Schiavon & Camuccio 2006).

There is no distinction made in law between physical and mechanical restriction, or the use of seclusion room. They are all included under the notion of compulsory treatment. But every method of restraint requires medical prescription, because they are considered therapeutic acts. But while in other areas of health care (geriatric, intensive care, ect.) this therapeuticity is more clearly understood, in the psychiatric area it remains a highly controversial topic (Benci 2005).

In our opinion, the use of restraint in psychiatric area has control as its major function. In fact the normative reference in case of legal actions is article n° 54 of the criminal code (Grassi & Ramacciotti 2005) about the “state of necessity” (“necessity knows no law”). We remember that in the Italian juridical system (the roman system) the ruling of the courts do not have strength of law, but also considering this they can mark a tendency (Benci 2005).

Ethical codes related to patient restrictions

The grey area surrounding the use of restraint in psychiatric care can also be seen in many ethical statement; the National Bioetic Commitee said in 1999 *(*Agrimi & Spinogatti 2005):

> *"...the use of seclusion and mechanical restrain should not be for long periods of time, and should only be used in exceptional circumstances, and only when there is not any other remedy to the situation."*

The deontological code for physicians states the following: *"...the physician must desist from diagnostical and\or clinical act because medical treatment against the person's will is not permitted..."* (National Medical Association 2007) The Code of Conduct for Italian Nurses states (National Nursing Association 2007):

> *"Nurse will strive to ensure that the use of chemical or mechanical restrictions be in extraordinary and justifiable cases only, and not the usual way of caring. The nurse should consider the use of restraint a justifiable choice when there is advantage for the patient, but unacceptable when it is the answer to istitutional needs*."

Italian ethical statements show that there is an absence of any mention to the psychiatric patient, only restraint in general.

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN ITALY

Mental health statistics and patient restrictions used

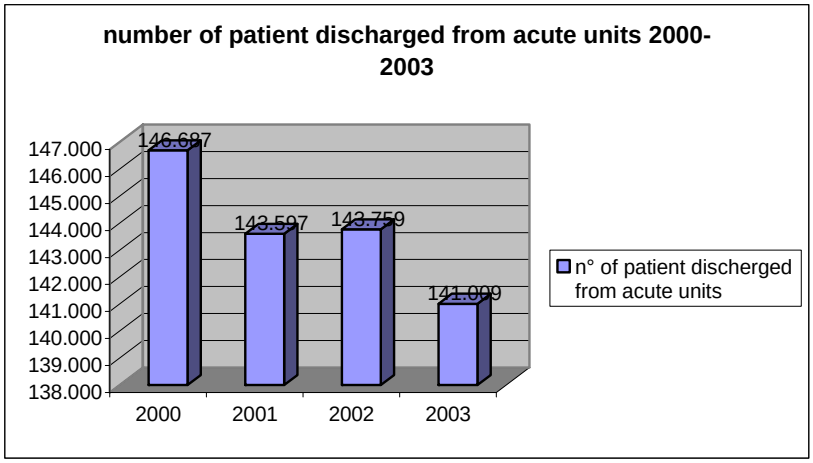
In Table 1, Health statistics related to mental health issues in Italy in being described (Table 1).

Table 1. Health statistics related to mental health issues in Italy

Most common mental health problems among population	Major-phobias (no percentages are available)
Most common diagnosis psychiatric services for diagnosis and cure	1. psychosis 2. personality disorders
Number of psychiatric service organizations for diagnosis and cure	321+8
Number of beds in psychiatric services	3,997+162(University units)
Number of staff	data not available for psychiatric hospitals
Number on involuntary treatment	data not available
Average hospital days and length of hospital stay	15.51 (18.22 for psychosis)

Reference: Ministry of Health 2007

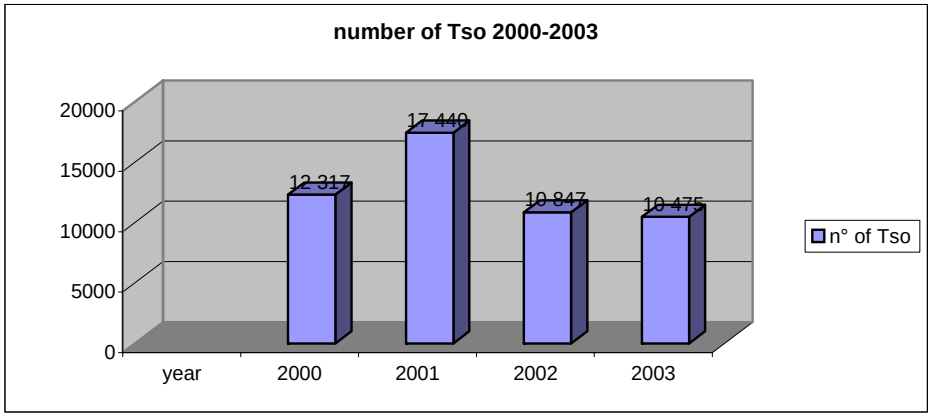
The Figure 3 below indicates some data regarding patient discharges from psychiatric acute wards.



Reference: National Institute of Statistics 2007 (see also for further data Priebe 2005)

Figure 3. Number of patient discharged from acute units 2000-2003

The number of patients under compulsory treatment (Tso) is being described in Figure 4.



Reference: National Institute of Statistics 2007

Figure 4. Number of patients under compulsory treatment

Management of distressed and disturbed patients

When confronted by a distressed or/and aggressive patient nurses and nursing practice has to be guided by the law of the land. The law, as indicated above, is very strict in some areas, but at the same time is not clear about mechanical or other kinds of restriction methods such as holding or seclusion.

The result is that the practice of nurses is very influenced by the psychiatrist "school of thought" (Burns et al. 2001) and therefore from the psychiatric paradigm that predominates in that Dsm. In Italy any restriction method can be made without the doctor order only in case of severe urgency when there is high risk of danger to the patient himself or to others. In such circumstances nurses can restrain a patient without medical prescription. But in this case the only type of restraint possible is physical restraint, or in some cases the use of the seclusion room, when nurses cannot manage the situation. In any case these restrictive acts are only temporary measure used while a waiting the arrival of the doctor to the unit (in particular during the night shift) and his/her prescription. Therefore the situation in the Acute Units is confused: in some Units mechanical restraint is very common, in others it is very rare but nonetheless occasionally it is used, in other again it is banned by, for example, a specific protocol. At the same time the seclusion room is not used in many wards while in others it is used, and may be used with mechanical restraint.

The preliminary results of some focus group discussions conducted with nurses in Italy and preliminary analysis of two Units of the Dsm of Venice illustrate this situation quite effectively: in Venice one unit, for the past thirty years, has banned any kind of mechanical restriction or use of seclusion rooms; the other Acute unit of the Dsm of Venice uses it rarely (and does not have seclusion room).

In the Units of Camposampiero and Cittadella the use of seclusion rooms is permitted but the door must remain open and a nurse monitors the patient in the room. In Cittadella this is the case only for the past two years because there is a new Director of that Dsm. But in Padua's units there are no guidelines, not even informal guidelines, on the use of restraint. Many nurses stated that the use of restraint depends on the approach of the psychiatrist on the particular shift – therefore it may vary from one shift to another. In this confusion only one point is clear: the only kind of patient that can be restrained with mechanical restraint or seclusion is a patient in compulsory treatment (Tso). Only in case of extreme danger can a voluntary patient be restrained.

However, generally, there is a common approach to the use of restraint among nurses: First the intervention must be carried out as part of a team and not by an individual nurse; working alone is considered dangerous and ineffective. This team has to be coordinated by the psychiatrist, he is considered the natural coordinator of these kinds of interventions, but usually nurses call him only when they cannot manage the situation any longer – thus calling the psychiatrist is seen as the last resort.

Indeed, nurses state that there is a sequence of interventions: first one tries talking to the patients in an attempt to "talk him / her down" and thus de-escalate the situation, then if talking does not work the second line in approach is pharmacological treatment, then, in the end, if the interventions mentioned above fail, physical and/or mechanical restrain is used. Usually nurses call the psychiatrist at the end of the talking/de-escalation phase. The first phase has been described in many ways, but all these ways can be summed up in a comment made during a focus group: "the art of waiting". It is a way to describe the forbearing attempts to solve the crisis of the patient without physical acts.

CONCLUSIONS

During more than ten-year experience of mentorship in a Department of Mental Health I have noted that when student nurses arrive in a psychiatric service they often spend the first days firmly taking possession of the nursing room where the therapy is administered. And, even if un-necessary, they do their best to put everything in order: drugs, forms, drawers and cupboards. This happens without any nurse's request - in the first days of practice the task of the student is to observe and listen to the patients.

The same thing happens when a new staff nurse is assigned to a psychiatric service: even if the role of registered nurse, not a student anymore, equips him /her to suggest new projects of rearrangement of the "sanitary" part of the nursing room.

I do not know if this little anecdote would help, but maybe it provides an example of how the nursing area of mental health has spaces of uncertainty and ambiguity for nurses especially for those not used to working in a psychiatric context (Cutcliffe & Goward 2000).

As indicated in the introduction, in Italy the patchy development of the Psychiatric Services has not helped nursing or mental health nurses to manage the uncertainty that is integral to mental health nursing practice. Similarly the current education also does not equip nurse well for the mental health practice context. Italian universities have not developed a second level degree in clinical nursing, and to date only a few dozen Italian nurses have taken the 1st level masters degree Nurses know very well what they are going to do, and to be, if they are assigned to a "general" ward. This is not the case if they are assigned to a psychiatric service (Cutcliffe & Goward 2000).

One of the challenges for mental health nursing is to manage this uncertainty and ambiguity, in managing the complexity of care for the psychiatric patient (Morin E. 1993; Cutcliffe & Goward 2000).

This management is not helped if nursing practice continues to depend on the "school of though" of the psychiatrist. This is a cause, but also a consequence, of the weakness of alian nursing that undermines the ability of nurses to provide a good level of care for the patient; in particular the seriously distressed and disturbed patient (Agrimi & Spinogatti 2005).

This does not mean that the nurses are not able to manage a crisis. Nurses who work in the mental health services are usually experienced nurses (the mean number of years of nursing experience in the Mental Health field in the services we analysed is 13.1 years). Our impression, is that Italian mental health nurses apply many techniques (de-escalation, risk assessment, etc.) but not in a structured way, without the necessary evidence base. To sum up, mental health nursing in Italy has at its core the seeds of innovation because during the past 30 years of community nursing work nurses have developed expertise in many methodologies of nursing work that only now are spreading in other areas of nursing practice (Mislej 2006). These are methodologies such as: teamwork/équipe andmulti-disciplinary team working, the "presa in carico", nurse – led case therapeutic relationship, relationship based on equality with the patient, the use of the self as care instrument, autonomy and discretionary power (Mislej 2006).

All these competencies need to be systematized and structured in a way that permits the identification of the appropriate evidence base and common frames of reference for the provision of all nursing care.

References

Dall'Acqua Giuseppe. (1996) Trieste vent'anni dopo dalla critica alle istituzioni della psichiatria alle istituzioni della salute mentale. http://www.triestesalutementale.it/letteratura/testi/12trieste.htm (Accessed 25.7.2007)

Agenzia per i Servizi Sanitari Regionali (Assr). (2007) Legge 14 Febbraio 1904, n. 36. Disposizioni sui manicomi e sugli alienati. http://www.assr.it/dsm/laws%5Citalia%5CN-L-36-1904-IN.pdf (Accessed 20.05.2007)

Agrimi E. & Spinogatti F. (2005) Il sottile filo rosso-Violenza e malattia mentale. Cic. Roma,Italy.

Attanasio L. & Gabriele G. (2005) Il Valore etico del cambiamento e l'abolizione della contenzione Into: Spdc aperti e senza contenzioni. by Lorenzo Torresini. Centro di Documentazione di Pistoia Editrice. Pistoia,Italy.

Basaglia F. (1967) Che cos'è la psichiatria. http://www.frosinone.org/oltreloccidente/testi_oo/c_salutementale/basaglia_cosa_psichiatria.pdf (Accessed 25.07.2007)

Basaglia Franco (1974) Introduzione generale ed esposizione riassuntiva dei vari gruppi di lavori (Internet) http://www.triestesalutementale.it/basaglia/citazioni_07.htm (Accessed 25.07.2007)

Barelli P. (2003) Ruolo dell'infermiere nella riabilitazione Into: Infermieristica Clinica in salute Mentale. Cea, Milano.Italy.

Barelli P. & Spagnoli E. (2004) Nursing di Salute Mentale. Carocci Faber, Roma.Italy.

Benci L. (2005) Aspetti giuridici della professione infermieristica. McGraw-Hill. Milano. Italy.

Bondioli C. (2007) Appunti sulle questioni relative all'Opg. http://www.psichiatriademocratica.com/opg1.htm (Accessed 20.05.2007)

Borgna E. (1996) C'è ancora un senso nella psicopatologia? http://www.psychomedia.it/pm/modpsy/psypat/borgna.htm (Accessed 25.07.2007)

Burns T, Fioritti A, Holloway F, Malm U. & Rosler W. (2001) Case Management and Assertive Community Treatment in Europe. http://ps.psychiatryonline.org/cgi/content/full/52/5/631 (Accessed 30.07.2007)

Calzigna M. (2004) Soggetti e Follia. Un approccio storico-epistemiologico. http://www.pol-it.org/ital/docustoria12.htm (Accessed 1.08.2007)

Canosa R. (2005) Lo Scandalo della Contenzione. Into: Spdc aperti e senza contenzioni. by Lorenzo Torresini. Collana dei fogli di informazione. Centro di Documentazione di Pistoia Editrice. Pistoia,Italy.

Cantelmi T, Ciambrello C, Stendardo V. & Marra F. (2003) Il lavoro d'équipe Into: Infermieristica Clinica in salute Mentale. Cea, Milano. Italy.

Colucci M. (2003) Franco Basaglia e la clinica della mente. http://www.triestesalutementale.it/letteratura/testi/colucci_2003_francobasagliaelaclinica-ecc.pdf (Accessed 01.08.2007)

La Costituzione della Repubblica Italiana (2007) Italian Costitution, art n° 32. http://www.quirinale.it/costituzione/costituzione.htm (Accessed 25.7.2007)

Cutcliffe J. & Coward P. (2000) Mental health nurses and qualitative research methods: a mutual attraction? http://www.blackwell-synergy.com/toc/jan/31/3 (Accessed 14.08.2007)

Ferla M, Mittino F, Boca B. & Morelli S. (1994) Urgenza in psichiatria. Valutazione clinico-epidemiologica delle visite effettuate presso il pronto soccorso dell'ospedale maggiore di Novara nel 1993. http://www.pol-it.org/ital/riviste/quaderni/urgenza.htm (Accessed 31.07.2007)

Fioritti A, Lo Russo L. & Melega V. (1997) Reform Said or Done? The case of Emilia Romagna within the Italian Psychiatric Context. http://ajp.psychiatryonline.org/cgi/reprint/154/1/94 (Accessed 29.07.2007)

Geanellos R. (2004) Nursing based evidence: moving beyond evidence –based practice in mental health nursing. http://www.blackwell-synergy.com/toc/jep/10/2 (Accessed 17.08.2007)

Giannichedda M,G. (2005) Il quadro Generale. Into: in Salute e territorio, rivista bimestrale di politica socio-sanitaria. Giunta regionale Toscana, Firenze. Novembre –December, 340-343.

De Girolamo G., Cozza M. (2000) The Italian Psychiatric Reform: a 20-years perspective Into: International Journal of Law and Psychiatry, 23, (3-4), 197-214.

De Girolamo G, Micciolo R, Faloon I, Fioritti A. & Morosini P. (2002) Residential Care in Italy. http://bjp.rcpsych.org/cgi/content/full/181/3/220 (Accessed 30.07.2007)

Grassi L. & Ramacciotti F. (2005) La Contenzione. Into: Spdc aperti e senza contenzioni. By Lorenzo Torresini. Centro di Documentazione di Pistoia Editrice. Pistoia, Italy.
Legge 23 Dicembre 1978, n° 833 Istituzione del Servizio Sanitario Nazionale (1978). http://www.pol-it.org/ital/180/833.htm#principi (Accessed 24.7.2007)

Legge 13 maggio 1978, n° 180. (1978) Accertamenti e trattamenti sanitari volontari e obbligatori, Art. 3. Procedimento relativo agli accertamenti e trattamenti sanitari obbligatori in condizzioni di degenza ospedaliere per malattia mentale.
http://www.ministerosalute.it/imgs/C_17_normativa_888_allegato.pdf (Accessed 22.07.2007)

Ministery of Health (2007) Elenco codici ICD9CM per le Diagnosi.
http://www.ministerosalute.it/programmazione/sdo/ric_codice/homepage_capitoli.jsp (Accessed 20.5.2007)

Ministery of University and Research (2007) Decreto interministeriale 2 Aprile 2001, Determinazioni delle classi delle lauree delle professioni sanitarie, Classe delle lauree nelle professioni sanitarie infermieristiche e professione sanitaria ostetrica. .
http://www.miur.it/0006Menu_C/0012Docume/0015Atti_M/1421CLASSE_cf2.htm (Accessed 30.07.2007)

Mislej M. (2006) Nursing Abilitante. L'arte di compromettersi con la presa in carico. Roma, Italy. Carocci Faber, 72-77.

Morin E. (1993). Introduzione al pensiero complesso. Sperling & Kupfer Editori Spa, Milano. Italy.

National Institute of Statistics (On general statistics) (2007) 14° Censimento generale della popolazione e delle abitazioni. http://dawinci.istat.it/daWinci/jsp/MD/dawinciMD.jsp (Accessed 20.05.2007)

National Institute of Statistics (On Discharged patients from acute Units) (2007) L'ospedalizzazione di pazienti affetti da disturbi psichici Trattamenti sanitari obbligatori (Tso) in regime ordinario per sesso, classe di età e Aggregati clinici di codici (Acc) - Anni 2000-2003 - Totale. http://www.istat.it/dati/dataset/20061206_00/ (Accessed 30.07.2007)

National Institute of Statistics (On compulsory treatments) (2007) L'ospedalizzazione di pazienti affetti da disturbi psichici Istituti di cura e dimissioni ospedaliere di pazienti affetti da disturbi psichici per regime di ricovero, tipo di attività e tipo di istituto – Anni 2000-2003 http://www.istat.it/sanita/Health/ (Accessed 30.07.2007)

National Medical Association. (2007) Codice di deontologia medica, articolo n. 35. http://portale.fnomceo.it/Jcmsfnomceo/cmsfile/attach_3819.pdf (Accessed 20.05.2007)

National Nursing Association (Ipasvi) (2007) Il codice deontologico degli infermieri. Articolo 4.10. http://www.ipasvi.it/professione/content.asp?ID=19 www.ipasvi.it/pubblicazioni/ (Accessed 20.05 .2007)

Online etymology dictionary (2007) Crisis http://www.etymonline.com/index.php?search=crisis&searchmode=none (Accessed 31.7.2007)

Paloscia C.,Pasini A. (2003) Disturbi mentali nel setting di medicina generale. Into Infermieristica clinica in igiene mentale. CEA Milano

Peruga D. (2005) Accertamento e trattamento sanitario obbligatorio. http://www.diritto.it/art.php?file=/archivio/21191.html (Accessed 30.07.2007)

Priebe S, Alli B, Fioritti A, Hansson L, Kilian R, Gonzales-Torres F, Turner T. & Wiesrma D. (2005) Reistitutionalisation in mental health care: comparison provision from six European countries. http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=15567803 (Accessed 30.07.2007)

Rissmiller D. & Rissmiller J. (2006) Evolution of the Antipsychiatry Movement into Mental Health Consumerism. http://ps.psychiatryonline.org/cgi/reprint/57/6/863 (Accessed 30.07.2007)

Schiavon L. & Camuccio C, A. (2006). Aggressione in Spdc. Into: Spazio Aperto Journal of the National Nursing Association of Venice's Province, 21-23. Venice, Italy.

Sharp D. (2004) Return to asylum: the search for clients with enduring mental health problems in Italy. http://www.blackwell-synergy.com/toc/jpm/11/5 (Accessed 14.08.2007)

Baseline information from England: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in England

Guise V, Chambers M.
Kingston University and St George's, University of London,
Faculty of Health and Social Care Sciences, United Kingdom

INTRODUCTION

This chapter focuses on the mental health care system in England. Specifically, it presents an overview of the laws, policies and practices in place in relation to the care and treatment of distressed and disturbed (often referred to as violent and aggressive) services users. This is an area that has been the subject of considerable recent debate in this country, with contributors from various interest organizations as well as government agencies.

Over the past decade or so, mental health has featured as one of the top priorities of the government's health and social care policy (Department of Health 1998, Department of Health 1999). Consequently, within this time, mental health services have undergone a number of major changes. The government's current mental health policy, set out in the National Service Framework for Mental Health (Department of Health 1999), addresses the mental health needs of adults up to 65 years of age. It details national standards, defines service models, provides support to underpinning programs for local action and implementation, and establishes a series of national milestones and performance indicators to assure progress and reform of mental health care in England.

One such milestone is to develop positive practice to support the safe and therapeutic management of aggression and violence in (mental health) in-patient settings (NIMHE 2004). There are now several initiatives under way on how to best address concerns regarding the prevention and management of violence and aggression within the English health care system. These developments were in part set in motion by a number of reports and inquiries that have focused on the management of violence within mental health care settings. According to Dale, O'Hare and Rae (2006), the most influential of these publications was the Independent inquiry into the death of David Bennett (Sallah et al 2003), after David Bennett, a patient at a medium secure unit died in October 1998 whilst being restrained in a face-down prone position.

One of the outcomes of this inquiry was the establishment of a project team consisting of the country's main organizations concerned with the prevention and management of violence and aggression. This group is responsible for "improving policy, training, practice including the use of technology, and public confidence in the management of mental health emergencies and in particular, aggression and violence" (Dale et al. 2006). The project team have since scrutinized a number of publications and identified key areas of concerns that contribute to increased levels of violence and aggression, including insufficient staffing levels, poor staff attitudes, lack of leadership and support, increased acuity on the part of patients, and poor environments on wards (Dale et al. 2006).

In light of such findings, it is clear that a number of significant developments are needed with regard to the prevention and management of violent and aggressive incidents within mental health care services in England. This chapter will look at some of the initiatives already taking place, such as attempts at streamlining management of violence and aggression training courses. It will also indicate how the proposed outcomes of the ePsychNurse.Net project will contribute to the broader national and international efforts to re-examine and enhance best practice in this important area of mental health care.

The chapter is structured into three parts. Part one starts by presenting various socio-demographic statistics, covering the ethnic make-up of the population, educational attainment and unemployment, to give an idea of the broader context of mental health care in England. England has a significant black and minority ethnic population. This group tends to be overrepresented in mental health statistics, especially statistics on formal admissions and the use of hands-on physical restraint techniques and seclusion. It has been argued that ethnicity remains a "key determinant of mental ill health and a critical influence on access to care and quality of mental health service experience" (NIMHE 2002).

Following discussion of the socio-demographic factors a brief description of the English health care system, with a focus on mental health services will be considered. This is followed by a short overview of the structure of nursing education in this country, covering an outline of the format of pre-registration courses as well as the minimum requirements for continuing professional education for registered nurses. The first part of the chapter ends with a brief note on mental health nurses' role and significance within the mental heath care system.

The chapter's second part focuses on English mental health law and the professional codes of conduct governing mental health nursing, whereas the third and last part looks at common management practices, formal restrictions used in mental health care in England and figures relating to formal admissions and use of physical restraint and seclusion. The concluding section offers an overview of current issues and future directions in the management of distressed and disturbed patients in England.

DESCRIPTION OF ENGLISH POPULATION AND HEALTH STATISTICS

Population statistics

In mid 2005 England's population was estimated to be 50,431,700, which constitutes over 83% of the total population of the United Kingdom (NSO 2007c). Although almost 91% of the population is white, England has a significant multicultural population, as is evidenced by Table 1 below.[3]

[3] The ethnic groups are as defined in the 2001 Census (NSO 2007d). White includes British, Scottish, Irish and Other British and Other White sub-categories. Mixed includes the sub-categories White and Black Caribbean, White and Black African, White and Asian and Other mixed.

Table 1. Different ethnic groups in England

Ethnic group	Percentage England	Percentage Total
White	90.9 %	
Indian	2.1%	Total Asian 4.6%
Pakistani	1.4%	
Bangladeshi	0.6%	
Other Asian	0.5%	
Black African	1%	Total Black 2.3%
Black Caribbean	1.1%	
Other Black	0.2%	
Mixed	1.3%	
Chinese	0.5%	
Other	0.5%	

Reference: NSO 2007d

Figures from 2006 show that 28.1% of the English working age population[4] hold a degree or equivalent qualification, and 59.5% have a qualification below degree level, whereas 12.4% have no qualifications (see Table 2) (Department for Skills and Education 2007). Table 2 also shows the ethnic differences in qualification attainments, with figures in the main indicating very similar findings for all ethnic groups. The biggest discrepancies are found in the Chinese population, where close to 50% have a degree or equivalent qualification, and in the Asian or Asian British population, where almost 20% are without qualifications.

The most recent unemployment figures for the United Kingdom, which are for the September-November quarter of 2006, show a rate of 5.5% for England (NSO 2007b). The ethnic minority population have higher unemployment levels for both women and men, with the 2004 figures for the UK as a whole showing that the unemployment rates for these groups are two to three times higher compared with rates for the majority white population (NSO 2007a).

Health Statistics

At any one time in England, one in six people of working age will have a mental health problem, most likely anxiety or depression, whereas one in 200 will suffer a psychotic illness such as bipolar disorder or schizophrenia (Department of Health 1999). According to the National Psychiatric Morbidity Survey (Singleton et al. 2001), the most common mental health problem among adults[5] in England is a combination of anxiety and depression (see Table 3).

[4] Males aged 16 to 64 and females aged 16 to 59.
[5] People aged 16 to 74.

Table 2. The English working age population

Personal characteristics	All people of working age[2] (thousands)	Percentage of people of working age qualified at each level[6]					
		Level 7-8	Level 4-6	Level 3	Level 2	Below Level 2	No qualifications
England total	**30,709**	**6.3**	**21.8**	**19.2**	**22.1**	**18.2**	**12.4**
Males	15,812	6.7	21.2	21.9	21.2	16.9	12.0
Females	14,897	5.8	22.4	16.3	23.1	19.6	12.8
White	27,084	6.1	21.8	19.8	22.5	17.9	11.9
Non-white	3,610	7.5	21.7	15.0	19.2	20.4	16.2
of which:							
Mixed	259	5.8	21.2	21.8	24.8	15.1	11.3
Asian or Asian British	1,730	7.5	19.9	13.9	18.4	20.4	19.8
Black or Black British	884	5.8	24.8	16.1	20.3	21.3	11.7
Chinese	154	18.6	31.2	11.4	13.7	15.1	9.9
Other	583	7.7	20.1	14.3	18.7	23.1	16.1

Reference: Department for Skills and Education 2007

Table 3. The most common mental health problem among adults[7] in England

Diagnosis	Percentage
Mixed anxiety & depressive disorder	8.8%
Generalized anxiety disorder	4.4
Depressive episode	2.6%
Phobias	1.8%
Obsessive compulsive disorder	1.1%
Panic disorder	0.7%
Any neurotic disorder	16.4%
Any personality disorder	4.4%
Any psychotic disorder	0.5%

Reference: Singleton et al. 2001

[6] Level 7-8: higher degrees and postgraduate level professional qualifications and NVQ level 5. Level 4-6: foundation or first degrees, recognised degree-level professional qualifications, NVQ level 4, teaching or nursing qualifications, HE diploma, HNC/HND or equivalent vocational qualification. Level 3: either 2 A-levels grades A-E, 4 AS levels graded A-E, an advanced GNVQ or NVQ level 3 or equivalent vocational qualification. Level 2: either 5 GCSEs grades A*-C (or equivalent), an Intermediate GNVQ, two AS levels, an NVQ level 2 or equivalent vocational qualification. Below level 2: one or more GCSE grade G or equivalent, BTEC general certificates, YT certificates, other RSA certificates, other City and Guilds certificates or NVQ level 1; Key Skills and Basic Skills qualifications are also classified here.

[7] People aged 16 to 74.

The type and prevalence of diagnoses among in-patients is slightly different. Figures for the 2005-06 period show that the most common psychiatric diagnoses of those admitted to NHS hospitals in England are substance abuse related disorders, followed by mood disorders; schizophrenia, schizotypal and delusional disorders; and neurotic, behavioral and personality disorders (see Table 4) (Hospital Episode Statistics 2006). The coding classification used is that of the ICD-10.

The number of beds available in mental health units in England per 2006 was 29,802 (with an occupancy rate of 85.6%), and there were 3,927 beds within learning disabilities units (with an occupancy rate 83.8%) (Department of Health 2006a). Staffing figures from 2005 show that of the 381,257 nursing staff[8] working in the NHS, 89 percent were female and 18.9 percent were from an ethnic minority (Department of Health 2006b). The number of nursing staff working in psychiatric hospitals was 57,377, with 48,553 working in mental health units and 8,824 in learning disabilities units (Department of Health 2006b).

Table 4. The most common psychiatric diagnoses of those admitted to NHS hospitals in England (people aged 16 to 74)

Diagnosis	Number of admissions	Percentage of total admissions	Average length of stay (days)
F00-F03 Dementia	19.214	10.2	68.3
F004-F09 Other organic mental disorders incl. symptomatic disorders	4.281	2.3	37.3
F10-F19 Disorders related to psychoactive substance abuse	47.854	25.6	8.7
F20-F29 Schizophrenia, schizotypal and delusional disorders	30.930	16.5	109.4
F30-F39 Mood (affective) disorders	39.421	21.1	45.8
F40-F69 Neurotic, behavioral and personality disorders	24.946	13.3	28.4
F70-F79 Mental retardation	10.945	5.9	154.4
F80-F99 Other mental and behavioral disorders	9.503	5.1	101.9
Totals	**187.094**	**100**	**69.3**

Reference: Hospital Episode Statistics 2006

[8] This is defined as "qualified nurses and health visiting staff" (DH 2006b).

THE ENGLISH HEALTH CARE SYSTEM

General

The majority of health care in England (and the rest of the UK) is delivered through the National Health Service, known as the NHS and governed by the Department of Health. It provides free treatment on entry within all areas of health care, including general practice, accident & emergency, and mental health. The NHS employs the majority of doctors and nurses working in hospitals. In addition, the current government encourages the NHS to commission healthcare services from the private sector. Contracted services mostly cover those provided by general practitioners (GPs), dentists and opticians.

Since it was established in 1948, the NHS has undergone several organizational and political changes. With the introduction of the NHS & Community Care Act 1990, health care provision became decentralized and has since then been delivered through independent and competing trusts. Strategic Health Authorities (SHAs) were established in 2002 as the link between the Department of Health and the NHS to better manage health care services on a local level (NHS 2007c). There are currently ten SHAs across England and within each of these a variety of trusts run the various local health care services. The different Trust types are Acute Trusts, Ambulance Trusts, Care Trusts, Primary Care Trusts (PCTs) and Mental Health Trusts (NHS 2007a).

Table 5. The ethnic groups of all inpatients as at the end of March 2006

Ethnic Category Code	Percentage	Totals
White British	77.6%	Total White 83.2%
White Irish	1.8%	
Other White	3.8%	
White and Black Caribbean	0.9%	Total Mixed 2.2%
White and Black African	0.3%	
White and Asian	0.4%	
Other mixed	0.6%	
Indian	1.4%	Total Asian 4%
Pakistani	1.2%	
Bangladeshi	0.5%	
Other Asian	0.9%	
Black Caribbean	4.2%	Total Black 8.2%
Black African	2.2%	
Other Black	1.8%	
Chinese	0.3%	
Other	1.1%	
Invalid / Not stated	1.1%	
Grand Total	**100.0%**	

Reference: Mental Health Act Commission et al. 2007 (© 2007 Commission for Healthcare Audit and Inspection Count Me In census)

Mental health services

Mental health services in England are first and foremost delivered through GPs and other primary services but around ten percent will be referred on to specialist services for assessment and/or treatment (Department of Health 1999). Specialist care is usually provided by Mental Health Trusts (or mental health provider Trusts), of which there are around 70 across England, or local council social services departments (NHS 2007b). Over the past decades, there has been a significant move towards community care, and the "closure of asylums and institutions for the mentally ill. Government policies have focused on reducing the number of hospital beds for people with severe mental illness in favour of providing care in a variety of non-hospital settings" (Tyrer et al. 1998). Therefore, the majority of mental health services now offered by Mental Health Trusts are mainly provided in the community through multi-disciplinary Community Mental Health Teams (CMHTs), in addition to traditional in-patient services.

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN ENGLAND

Degree education

Nursing education and training in England underwent major changes in the early 1990s. To be come a registered nurse students undertake a minimum three-year degree or diploma course delivered through a higher education institution. There are no national entry requirements as each higher education institute sets its own minimum criteria[9] (NHS Careers 2007a).

A Diploma of Higher Education in nursing (DipHE nursing) is a three-year program, and students are awarded an academic as well as professional qualification, whereas a degree course or a pre-registration nursing degree is a three to four year program (NHS Careers 2007b). All programs consist of fifty percent theory and fifty percent practice, with supervised placements in local hospital and community settings (Royal College of Nursing 2006). The first year of a course is usually delivered as a Common Foundation Program (CFP) and introduces basic principles of nursing. From the second year on, students specialize and follow a branch of adult, children's, mental health or learning disability nursing. There is also an option of completing a modified diploma program for those who already hold a health related degree, which is at least two years long and split over the CFP and the chosen branch program (NHS Careers 2007b).

When a student graduates, he or she must register their qualification with the Nursing and Midwifery Council (NMC) to be able to practice. Registration must be renewed every three years. In order to do so, there needs to be evidence of ongoing professional development during the previous three-year period.

[9] However, according to NHS Careers (2007a), these are generally around five GCSEs or equivalent at grade C or above in English language or literature and a science subject for a Diploma programme and five GCSEs plus two A-levels or equivalent for a Degree programme. All applicants must be able to demonstrate evidence of literacy, numeracy and good character.

Vocational continuing education

Lifelong learning and continuing professional development (CPD) is seen as an integral part of nursing training and practice across the UK. Keeping one's knowledge and skills up to date is seen as a "duty" that health care professionals have to the public (Royal College of Nursing 2002). CPD within nursing is principally governed by the NMC and the NHS Knowledge and Skills Framework (NHS KFS). The NMC stipulates that practitioners must re-register every three years. In order to do so, nurses must declare that they have met the legally required post-registration education and practice (PREP) standards for registration. Two separate PREP standards govern registration: The PREP (practice) standard which involves the completion of a minimum 450 hours of practice in the three years previous, and the PREP (continuing professional development) standard, involving the undertaking of at least five days (35 hours) of learning (though not necessarily obtaining a formal qualification) (Nursing and Midwifery Council 2004b).

The NHS KFS is the governmental framework that defines the knowledge and skills that all NHS staff require in order to deliver quality services (Department of Health 2004b). It is the main national guideline on continuing professional development (CPD) within the NHS providing a comprehensive framework for the review, development and evaluation of staff competencies at all levels. At its base is the belief that by "supporting staff to develop, the services offered by the NHS to patients and the public will also improve" (Department of Health 2004b). It is founded on the principles of lifelong learning and a desire for every staff member to have equal opportunities for learning and development appropriate to their position. The NHS KFS covers on-the-job as well as off-the-job teaching and learning, whether undertaken alone or with others. Its implementation is the joint responsibility of the employing organization, which should provide opportunities for learning and development, and all staff must take their own learning and development seriously.

The Royal College of Nursing (RCN), the UK's largest professional organisation representing nurses and nursing interests, stresses that "the primary responsibility for maintaining competence to practice remains with the individual" (Royal College of Nursing 2004). However, the RCN has committed itself to lobbying for every health service provider to have a strategic plan for CPD, as it argues that CPD cannot be achieved without employers' support and recognition of the value of CPD, and the provision of access to flexible practice development programmes (Royal College of Nursing 2002). A number of health service providers now offer CPD courses for nurses, often in conjunction with universities.

Nurses' role in mental health services

While it is the norm for mental health nurses to be part of multidisciplinary teams, they provide the majority of direct care across a number of settings. According to the Department of Health's Chief Nursing Officer, mental health nurses are the largest profession currently working in the mental health services (Department of Health 2006c).

The government has long been committed to strengthen and maximize the contribution that nursing, midwifery and health visiting makes to the health care sector (Department of Health 1997). Recently published best practice guidelines for the continued development of mental health nursing state that the core aim of mental health nursing in England is to

improve the outcomes and experiences of care for service users and carers (Department of Health 2006c).

LEGAL NORMS AND ETHICAL CODES IN ENGLAND RELATED TO PATIENT RESTRICTIONS

Legal norms related to patient restrictions

Mental health care in England is first and foremost governed by the Mental Health Act 1983 (the Act). The Act covers provision for the detention and compulsory treatment in hospital of those with a mental disorder. People can be placed under the various sections of the Act (which cover civil detentions (Part II) as well as court disposals and prison transfers (Part III), in the interest of their own or others' health, safety and protection (Islam & Hall 2006). A 1999 amendment of the Act, the Mental Health Act Code of Practice (1999), provides guidance for mental health professionals and others concerned with the admission of patients under the Act. In addition, mental health care provision in England also comes under the jurisdiction of The Mental Health (Patients in the Community) Act (1995/1996)[10], the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 (amended 1997)[11], as well as Common Law and the Human Right's Act.

The interests of those detained under the Act are safeguarded by the Mental Health Act Commission. This organization is responsible for reviewing the implementation of the Act (and the Code of Practice). Representatives of the Commission visit detained patients and provide Second Opinion Appointed Doctors when required.

In order to update the Act and make it more amenable to modern community care settings, the government drafted a new Mental Health Bill in 2002 and again in 2004 (Department of Health 2004a). However, in March 2006, the government abandoned its attempt at developing a completely new Act after considerable resistance from various mental health care advocacy groups, including mental health professionals. The third Bill to be presented to the House of Commons was finally passed in July 2007, after an eight year review process (Butcher 2007). This amended Bill reflects the shift in the majority of mental health care provision from an institutional to a community setting, with the introduction of community treatment orders (CTOs). CTOs allow those service users who have previously been sectioned in hospital to be formally treated in the community (Butcher 2007).

Other updates to the Act through this Bill include: making services more focused on the needs of the individual service user, addressing public safety concerns, improving services for children and young people, and being more compatible with the European Convention on Human Rights (Department of Health 2007).

---

[10] This covers after-care under supervision once someone leaves hospital, and the amendment of the law relating to patient leave of absence from hospital and absence without leave.

[11] This is the principal regulation dealing with the implementation of compulsory powers in respect of persons liable to be detained in hospital or subject to guardianship under the Mental Health Act 1983. It covers, amongst other things, the procedure for admission to hospital; transfer between hospitals; functions of guardians and nearest relatives of patients; and consent to treatments other than those specified in the MHA.

Formal admissions under the Mental Health Act 1983

A Statistical Bulletin on the Mental Health Act 1983 (Islam & Hall 2006) shows that there were 46,673 detentions under the Act to NHS facilities and independent hospitals in 2004-05. 26,752 of these detentions were formal admissions and 19,921 which were detentions subsequent to admission. Most were admissions under Part II of the Act (94%), and most were admissions to an NHS facility (94%). According to this bulletin, on 31st March 2005 there were 14,700 patients detained under the Act residing in mental health facilities, 83% of which were in NHS facilities. The majority of these patients had a mental illness (79%), whereas three percent had a psychopathic disorder. In independent hospitals, 72% of patients had a mental illness and ten percent had a psychopathic disorder.

When patients' ethnicity is considered, figures show that the majority of all the ethnic minority patients were formally admitted (Black or Black British: 66.4%; Asian or Asian British: 51%; Mixed: 60.9%; other: 52.7%), whereas only 36.8% of White patients have been subjected to a formal admission (Mental Health Act Commission et al. 2007)[12]. The considerable discrepancies in numbers of formal admissions between ethnic groups have been the subject of significant debate in this country, sparking recent government response to reform the racial inequalities found within English mental health care facilities (see Department of Health 2003a, Department of Health 2005).

Professional codes related to patient restrictions

The mental health care delivered by nurses in England is in principle governed by two ethical codes, the International Council of Nurses' Code of ethics for nurses (International Council of Nurses 2006), and the NMC Code of professional conduct (Nursing and Midwifery Council 2004a), which is the UK's key nursing standard, underpinning public protection (Nursing and Midwifery Council 2007). These documents both state the importance of maintaining high standards of personal and professional conduct, first and foremost through the promotion of the human rights, values and beliefs of the individual service user. They also stress the need for the utmost regard for the confidentiality of patients' personal information.

The NMC Code of professional conduct stresses the following points:

- Nursing is a practice-based profession
- Patient and client well-being and respect for individuals is key
- Evidence-based practice is to be achieved through integration of relevant knowledge
- Students are to be actively involved in delivery of nursing care, under supervision
- The NMC Code of professional conduct applies to all practice interventions
- Skills and knowledge should be transferable
- Research underpins practice, and
- The importance of lifelong learning and continuing professional development.

[12] Census groups are: White – British, Irish, Other White; Mixed – White and Black Caribbean, White and Black African, White and Asian, Other mixed; Asian and Asian British – Indian, Pakistani, Bangladeshi, Other Asian; Black and Black British – Caribbean African Other Black; Other – Chinese and Other.

The NMC Code of professional conduct also has an emphasis on the need to always obtain informed consent before giving care or treatment, a principle that applies equally to people with mental illnesses, including those patients involuntarily detained under the Mental Health Act 1983. Nurses "must ensure that [they] know the circumstances and safeguards needed for providing treatment and care without consent" (Nursing and Midwifery Council 2004a). Recently, the NMC Code of professional conduct has been deemed somewhat out of date and is currently under review to ensure that the advice and guidance provided is kept relevant to the changing needs of modern nursing practice (Nursing and Midwifery Council 2007).

In addition to the above guidelines, the Chief Nursing Officer (CNO) document Freedom to Practice (Department of Health 2003b) was developed as "a resource to nurses, therapists, healthcare professionals, managers, and directors to clarify what nurses and allied health professionals are allowed and able to do within their Codes of Practice."

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN ENGLAND

Mental health statistics and patient restrictions used

As is stipulated in the government's mental health policy (DH 1999), all mental health care providers, including Mental Health Trusts, must have sound strategies and policies for the management of violent and aggressive service users, as stipulated by the NHS Litigation Authority (2006). These should include policies addressing the recommended approaches to prevent and manage aggression and violence, such as risk-assessment, time-out, observation, rapid tranquillisation, physical restraint (Control and Restraint or C&R), and seclusion.[13]

The Count Me In census (Mental Health Act Commission et al. 2007) collected information on incidences of control and restraint (physical restraint) and seclusion in addition to data on ethnicity. Of the 29,906 people surveyed, 2,511 people, or 8.4%, had been subjected to control and restraint on at least one occasion within the three months leading up to the census date, while 826 people, or 2.7%, had experienced one or more incidents of seclusion within the three months leading up to the census date (see Table 6).

[13] Mechanical restraint can legally be prescribed for patients in the UK but this rarely if ever happens and there has been some debate as to its ethical and therapeutic implications for current practice (Dale et al. 2006).

Table 6. Incidents of control and restraint (physical restraint) and seclusion

Number of incidents per patient	Percentage of patients who have experienced control and restraint	Percentage of patients who have experienced seclusion
1	3.7%	1.6%
2	1.6%	0.5%
3-6	2.0%	0.5%
7-10	0.5%	0.0%
11+	0.6%	0.1%
Total	**8.4%**	**2.7%**

Reference: Mental Health Act Commission et al. 2007 (© 2007 Commission for Healthcare Audit and Inspection Count Me In census)

Ethnic minority mental health statistics

Several studies have shown that in comparison with the White majority population, mental illness rates are higher for people from ethnic minorities, both when neurotic and psychotic disorders are considered (Sproston & Nazroo 2002). However, as Sproston and Nazroo (2002) argue, measurements of the prevalence, incidence and outcome rates for mental illness among ethnic minority populations are complex, and the subject of considerable contention due to such factors as the nature of sampling procedures, the assessment tools used, cultural differences in the expression on distress, and the socio-demographic characteristics of the population samples. It is therefore unclear whether or not findings showing higher rates of mental illness for people from ethnic minorities are simply a consequence of the methodologies used, reflecting high treatment rates as opposed to actual illness rates (Sproston & Nazroo 2002).

On the 31st of March 2006, the Mental Health Act Commission, the Healthcare Commission, the Care Services Improvement Partnership, and the National Institute for Mental Health in England conducted its second national census of inpatients in hospitals and other facilities in England and Wales. The Count Me In census (Mental Health Act Commission et al. 2007) was undertaken first and foremost to obtain baseline figures on the ethnic make-up of the inpatient population in the two countries, and to be able to ascertain any significant ethnic differences in the experience of inpatients[14].

Data were collected on 29,906 inpatients across England and information on the ethnic groups of all inpatients as at the end of March 2006 is presented in Table 5. According to the report, the results are very similar to those found in the 2005 census. The data shows that patients from Black (by 5.9%), Asian (by 0.6%), Mixed (by 0.9%) and other (by 0.6%) groups are overrepresented in comparison with total population figures (see Table 1), whereas White (by 7.7%) and Chinese (by 0.2%) are underrepresented. The data also shows that ethnic minority patients are more likely to be involuntarily admitted and to be on Acute or Psychiatric Intensive Care Units (PICU) wards, i.e. they are given more serious diagnoses (Mental Health Act Commission et al. 2007).

[14] Information on ethnicity was available for 98.8% of inpatients. The majority (75%) of reported ethnicity in this survey was self-assessed.

Management of distressed and disturbed patients

The way distressed and disturbed patients are managed within English mental health services is an area that has received a lot of recent attention from both governmental and non-governmental organizations and interest groups. Over the past decade a number of reviews of and inquiries into the management of violence and aggression within mental health care have been published, and recommendations for fundamental change and improvement have been emphasized (see e.g. Gournay 2001, Royal College of Nursing 2003, NIMHE 2004, McGeorge 2006).

The most comprehensive guideline in the wake of these reviews is the NICE[15] guideline on the management of violent and disturbed behaviour (NICE 2005). These guidelines include recommendations on how to manage disturbed and violent patients, staff training and reviews of training strategies, how wards and units should be organised and staffed, and what policies should be in place in each clinical setting. In addition, a policy implementation guide was published to help the development of positive practice regarding the safe and therapeutic management of aggression and violence (NIMHE 2004). To complement this guide, a national syllabus has also been launched to ensure that all frontline staff in mental health and learning disabilities services receive the same national standard of training in the non-physical management of violence and aggression (NHS Security Management Service 2005).

However, a recent report addressing the status of the management of distressed and disturbed mental health service users concludes that the present lack of a uniform national standard of training and accreditation in the prevention and management of violence and aggression remains one of the biggest current challenge facing England's mental health services (Dale et al. 2006). An evaluation of the effectiveness of current violence and aggression training programs across a range of healthcare settings in England showed that there is still a lack of common criteria for the measurement of the value and impact of available violence and aggression training (Zarola & Leather 2006).

This latter report concludes that there is a need to develop such common benchmarks to assess all courses independently of their focus, content or delivery method; and that there is a need for tools that will allow trainers and managers to assess appropriate levels of training for their staff. Above all, the report stresses that "[t]raining cannot and must not be seen as a standalone solution to violence. The measures taken to control violence and aggression must be considered within the wider context of an integrated organisational response" (Zarola & Leather 2006:x). It is clear therefore, that there is still important progress to be made in the development of broad focused safe and therapeutic practices in the management of distressed and disturbed patients within the mental health care sector.

CONCLUSIONS

Mental health services in England have gone through a lot of change and reform during the past ten years. The changes are ongoing and cover all aspects of care and services, such as mental health policy, mental health law, the education and training of health professionals,

[15] NICE, or the National Institute for Clinical Excellence, is part of the NHS and is responsible for providing national guidance for healthcare professionals, patients and carers on treatments and care.

and the code of conduct that health professionals must abide by. More recently, there have been the beginnings of reform in the way that untoward incidents such as violence and aggression are managed, with a specific focus on mental health services, though significant progress is yet to be made. The number of recorded physical assaults is higher in mental health services than in all other areas of patient care (Dale et al. 2006). Figures show that almost as many as eight in ten nurses working on mental health and learning disability wards and units have experienced some form of violent attack or aggressive threat, whereas a third of service users have experiences the same (RCP 2005). Thorough and effective management practices that are in the best interest of staff as well as patients are needed.

The work being undertaken in the E-PsychNurse.Net project and specifically its overall goal to ensure ethically appropriate and therapeutically effective interventions for nurses to utilise in the management of distressed and disturbed patients corresponds with ongoing national aims concerning the prevention and management of violence and aggression within mental health services. By investigating nurses knowledge and opinions of the clinical management methods available in their current practice and their needs and desires for alternative approaches and related training and support, will contribute to the development of best practice based on actual clinical requirements. The project also contributes to the provision of sound and relevant opportunities in the field of continuing professional development for mental health nurses, improving practice and, in turn, improving work environments for health care professionals and outcomes for service users.

References

Butcher, James (2007) Controversial Mental Health Bill reaches the finishing line. The Lancet, vol. 370, (7)14,117.

Dale C, O'Hare G. & Rae M. (2006) The NIMHE/NPSA project on the prevention and management of aggression and violence in mental health services: final report. NIMHE & NPSA, London.

Department for Skills and Education (2007) The level of highest qualification held by adults: England 2006. Department for Education and Skills, London.

Department of Health (1997) Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare. Department of Health, London.

Department of Health (1998) Modernising mental health services: safe, sound and supportive. Department of Health, London.

Department of Health (1999) National Service Framework for mental health: modern standards and service models. Department of Health, London.

Department of Health (2003a) Delivering race equality: A framework for action. Department of Health, London.

Department of Health (2003b) Freedom to practice: Dispelling the myths. Department of Health, London.

Department of Health (2004a) Improving mental health law – towards a new Mental Health Act. Department of Health, London.

Department of Health (2004b) NHS Knowledge and Skills Framework (NHS KSF) and the development review process. Department of Health, London.

Department of Health (2005) Delivering race equality in mental health care, an Action Plan for reform inside and outside services; and the Government's response to the independent inquiry into the death of David Bennett. Department of Health, London.

Department of Health (2006a) Hospital Activity Statistics. Average daily number of available and occupied beds by sector, NHS organizations in England, 2005-06. http://www.performance.doh.gov.uk/hospitalactivity/data_requests/beds_open_overnight.htm (Accessed 18.9.2007)

Department of Health (2006b) The Information Centre. NHS Hospital and Community Staff (HCHS): Non-Medical England: 1995-2005. http://www.ic.nhs.uk/pubs/nhsstaff (Accessed 18.9.2007)

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

Department of Health (2007) Press releases notices. Government welcomes passing of Mental Health Bill as vital to community care**.** http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=297132&NewsAreaID=2&NavigatedFromDepartment=False (Accessed 18.9.2007)

Gournay K. (2001) The recognition, prevention and therapeutic management of violence in mental health care. UKCC, London.

Hospital Episode Statistics (2006) Primary diagnosis: summary 2005-06. The Information Centre, Leeds.

International Council of Nurses (2006) The ICN Code of ethics for nurses. International Council of Nurses, Geneva.

Islam S. & Hall T. (eds.) (2006) Statistical Bulletin: In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1994-95 to 2004-05. The Information Centre, Mental Health Statistics, London.

McGeorge M. (2006) The Healthcare Commission-funded national audit of violence: Report of work April 2005 – March 2006. Royal College of Psychiatrists, London.

Mental Health Act Commission, Care Services Improvement Partnership, National Institute for Mental Health in England, and the Healthcare Commission. (2007) Count me in: results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales. Commission for Healthcare Audit and Inspection, London.

National Centre for Clinical Excellence (2005) Violence – NICE guidelines on the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE, London.

National Institute for Mental Health in England (2002) Inside Outside: Improving mental health services for Black and Minority Ethnic communities in England. NIMHE for the Department of Health, London.

National Institute for Mental Health in England (2004) Developing positive practice to support the safe and therapeutic management of aggression and violence in mental health in-patient settings: Mental health policy implementation guide. NIMHE, London.

NHS (2007a) NHS in England. Authorities and Trusts. http://www.nhs.uk/England/AuthoritiesTrusts/Default.cmsx (Accessed 18.9.2007)

NHS (2007b) NHS in England. Mental Health Trusts. http://www.nhs.uk/England/AuthoritiesTrusts/MentalHealth/Default.aspx (Accessed 18.9.2007)

NHS (2007c) NHS in England. Strategic Health Authorities. http://www.nhs.uk/England/AuthoritiesTrusts/Sha/Default.aspx (Accessed 18.9.2007)

NHS Careers (2007a) Nursing. Entry requirements for nursing. http://www.nhscareers.nhs.uk/nursing_entry.shtml (Accessed 18.9.2007)

NHS Careers (2007b) Nursing programmes. http://www.nhscareers.nhs.uk/details/Default.aspx?Id=125 (Accessed 18.9.2007)

NHS Litigation Authority (2006) Clinical Negligence Scheme for Trusts: mental health and learning disability clinical risk management standards. NHS LA, London.

NHS Security Management Service (2005) Promoting safer and therapeutic services: implementing the national syllabus in mental health and learning disability services. NHS SMS, London.

NSO (2007a) National Statistics Online. Ethnicity and identity: Labour market: Non-White unemployment highest. http://www.statistics.gov.uk/cci/nugget.asp?id=462 (Accessed 18.9.2007)

NSO (2007b) National Statistics Online. Labour market statistics: January 2007: London. http://www.statistics.gov.uk/pdfdir/lmslond0107.pdf (Accessed 18.9.2007)

NSO (2007c) National Statistics Online. Population estimates. http://www.statistics.gov.uk/CCI/nugget.asp?ID=6&Pos=3&ColRank=1&Rank=128 (Accessed 18.9.2007)

NSO (2007d) National Statistics Online. Resident population by ethnic group, 2001. http://www.statistics.gov.uk/STATBASE/Expodata/Spreadsheets/D7666.xls (Accessed 18.9.2007)

Nursing and Midwifery Council (2004a) The NMC Code of professional conduct: standards for conduct, performance and ethics. NMC, London.

Nursing and Midwifery Council (2004b) Standards of proficiency for pre-registration nursing education. NMC, London.

Nursing and Midwifery Council (2007) The code is evolving. http://www.nmc-uk.org/aSection.aspx?SectionID=45 (Accessed 18.9.2007)

Royal College of Nursing (2002) Quality education for quality care: a position statement for nursing education. RCN, London.

Royal College pf Nursing (2003) Restraining, holding still and containing young people: guidance for nursing staff. RCN, London.

Royal College of Nursing (2004) Quality education for quality care: priorities and actions. RCN, London.

Royal College of Nursing (2006) Becoming a nurse or midwife. Nurse and midwife education. http://www.rcn.org.uk/resources/becomenurse.php (Accessed 18.9.2007)

Royal College of Psychiatrists' Audit Team (2005) The Healthcare Commission National Audit of Violence (2003-2005): final report. Royal College of Psychiatrists, London.

Sallah D, Saahidharan S, Stone R, Struthers J & Blofield J. (2003) Independent inquiry into the death of David Bennett. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, Cambridge.

Singleton N, Bumpstead R, O'Brien M, Lee A & Meltzer H. (2001) Psychiatric morbidity among adults living in private households, 2000. The Stationary Office, London.

Sproston K & Nazroo J. (eds.) (2002) Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – quantitative report. The Stationery Office, Norwich.

Tyrer P, Coid J, Simmonds S, Joseph P & Marriott S. (1998) Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. Cochrane Database of Systematic Reviews 1998, issue 4. Art. No.: CD000270.

Zarola A & Leather P. (2006) Violence and aggression management for trainers and managers: a national evaluation of the training provision in healthcare settings. Part 1: research report. University of Nottingham for the Health and Safety Executive, Nottingham.

Baseline information from Lithuania: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Lithuania

Staniuliene V.
Health Klaipeda College, Health Faculty, Lithuania

INTRODUCTION

After re-establishment of Lithuania's independence, health policy makers focused on structural and organizational changes, market mechanisms, development of the health insurance system and a new approach to public health. Aspects of implemented reforms of the Lithuanian health care sector are: development of primary health care, mother and child protection, restructuring of health care institutions, legalization and development of private medical practice, preparation of qualified specialists, disease prevention, modern methods of diagnostics and treatment. (Health Care in Lithuania 2006).

Over the last decade the world has been undergoing a process of resolving in essence the principles of values and scientific knowledge to be used as a basis for settlement of mental health problems in modern society. The Mental Health Declaration for Europe adopted at the 2005 WHO Ministerial Conference as well as the documents of the Helsinki conference signed by Lithuania; oblige Lithuania to take new steps in mental health policy. The project on developing a strategy towards mental health care is evidence that we are resolved to tackle this problem in a contemporary way, trying to organize a coalition open for all the stakeholders (Lithuanian state mental health strategy 2005-2010).

The Lithuanian Health Program 1997 – 2010 (www.euro.who.int/document/e699920) declares an intention to reduce the differences in health and health care between the different socio-economic groups in the country by 25% by 2010. The state program on the Prevention of Mental Disorders aims to:

- Bring mental health care closer to communities through the establishment of mental health care centers within municipalities by 2005.
- Create an effective community level network of social psychiatric structures by including non-governmental organizations in service provision.
- The Health Program emphasizes that these reform steps should be evaluated using scientifically based methods, but the program on the prevention of mental disorders does not set out any mechanisms for assessment of efficacy or quality (Puras et al. 2004). In line with the Lithuanian Health Program 1997 – 2010 (www.euro.who.int/document/e699920) participation in Leonardo da Vinci project "Towards improved quality- developing nurses continuing vocational training in psychiatric hospitals and inpatient units", will help us:
- To identify qualified nurses' educational needs, and existing educational provision in Lithuania, regarding the management of distressed and disturbed patients in psychiatric hospitals and inpatients units.

- To reform continuing vocational training in the area of mental health care by developing a new multinational portal and training program for use in psychiatric hospitals, inpatients units, and nursing education.
- To develop national and international collaborative networks involving nursing, education and administration in order to improve the transparency, quality assessment, and to promote co-operation between education and working life in different European countries.

DESCRIPTION OF LITHUANIA POPULATION AND HEALTH STATISTICS

Population statistics

The formation of the Lithuanian State began in the 13th century, with the establishment of the Grand Duchy of Lithuania by the first King of Lithuania, Mindaugas, crowned in 1253. Geographical location: on the eastern shore of the Baltic Sea. In 1989, the French National Geographic Institute established the geographical centre of Europe 24 km northwest of Vilnius. Its area is 65,303 sq. km with a population of 3.4 million inhabitants (Department of Statistics 2006)

Ethnic groups varies in Lithuania as follows: Lithuanian 83.4%, Polish 6.7%, Russian 6.3%, other 3.5%. People of 115 different ethnic backgrounds live in Lithuania. Official language is Lithuanian. Most of the population is fluent in English, Russian, Polish, German and other languages. Type of government is Parliamentary republic, Unicameral Parliament. Head of the State is the President, who is elected directly. Restoration of independence was 11 March 1990. Lithuania is a member of the UN, EU and NATO. Majority are Roman Catholic. Other denominations include Russian Orthodox, Evangelical Lutherans, Evangelical Reformers, Old Believers, Judaists, Sunni Muslims, and Karaims. National currency is the Litas (LTL). The capital of Lithuania is Vilnius. Human Development Index (HDI): 0.842, Lithuania is ranked 41st among 177 countries by HDI. Lithuania's economy has been growing at one of the highest rates in Europe in recent years. In 2005, GDP grew steadily by 7.3%, as compared to 2004, amounting to LTL 70,763 million. GDP per capita equaled LTL 20,659 (Health care in Lithuania 2006.) Location of Lithuania is described in Figure 1.

Figure 1. Location of Lithuania in Europe

Health statistics

Health statistics indicators of Lithuania are described in Table 1.

Table 1. Selected health statistics indicators (1997 – 2006)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Average number of inhabitants (thous.)	**3575.1**	**3549.3**	**3524.2**	**3499.5**	**3481.3**	**3469.1**	**3454.2**	**3435.6**	**3414.3**	**3394.1**
Live births	**37812**	**37019**	**36415**	**34149**	**31546**	**30014**	**30598**	**30419**	**30541**	**31265**
per 1000 pop.	10.6	10.4	10.3	9.8	9.1	8.6	8.9	8.8	8.9	9.2
Deaths	**41143**	**40757**	**40003**	**38919**	**40399**	**41072**	**40990**	**41340**	**43799**	**44813**
per 1000 pop.	11.5	11.5	11.3	11.1	11.6	11.8	11.9	12.0	12.8	13.2
Natural increase	**-0.9**	**-1.1**	**-1.0**	**-1.3**	**-2.5**	**-3.2**	**-3.0**	**-3.2**	**-3.9**	**-4.0**
Infant mortality per 1000 live birth	**10.29**	**9.24**	**8.62**	**8.52**	**7.82**	**7.86**	**6.8**	**7.9**	**6.9**	**6.8**
Number of physicians	**14757**	**14622**	**14578**	**14034**	**14031**	**13856**	**13682**	**13397**	**13650**	**13510**
per 10000 pop.	41.43	41.35	41.51	40.25	40.37	40.02	39.71	39.11	40.11	39.91
Number of dentists	**2153**	**2259**	**2306**	**2446**	**2490**	**2309**	**2372**	**2272**	**2453**	**2249**
per 10000 pop.	6.04	6.39	6.57	7.01	7.16	6.67	6.88	6.63	7.21	6.64
Number of specialists with high medical education	**38484**	**37968**	**38603**	**36917**	**36191**	**34945**	**34123**	**33201**	**32902**	**32626**

per 10000 pop.	108.03	107.36	109.91	105.87	104.13	100.9	99.0	96.92	96.68	96.39
Incidence of malignant neoplasms	**12849**	**13434**	**13888**	**14039**	**14060**	**14483**	**15103**	**15945**	**16124**	
per 100000 pop.	359.4	378.5	394.1	401.2	403.9	417.5	437.2	464.1	472.25	
Prevalence of malignant neoplasms	**51551**	**54102**	**57436**	**60351**	**62160**	**62880**	**63541**	**66309**	**68020**	
per 100000 pop.	1447.1	1529.9	1635.4	1730.7	1788.5	1816.0	1844.0	1935.9	1998.7	
Incidence of tuberculosis (excl.relapses)	**2789**	**2826**	**2558**	**2330**	**2225**	**2097**	**2247**	**2027**	**2107**	**2097**
per 100000 pop.	78.0	79.6	72.6	66.6	63.9	60.5	65.1	59.0	61.7	61.8
Incidence of mental disorders per 100000 pop.	**298.1**	**461.8**	**360.8**	**341.0**	**317.1**	**269.9**	**260.7**	**266.8**	**255.4**	**251.7**
of which alcohol and drug abuse	147.2	193.7	114.0	93.0	94.7	79.8	72.9	76.6	95.3	89.4
Prevalence of mental disorders per 100000 pop.	**4364.9**	**4372.9**	**4437.0**	**4545.6**	**4662.2**	**4722.3**	**4656.8**	**4715.2**	**4735.7**	**4793.2**
Incidence of syphilis	**3146**	**2326**	**1676**	**1171**	**905**	**539**	**456**	**341**	**294**	**336**
per 100000 pop.	88.0	65.5	47.6	33.5	26.0	15.5	13.2	9.9	8.6	9.9
Incidence of acute gonorrhoea	**2021**	**1487**	**1253**	**1004**	**740**	**641**	**503**	**482**	**433**	**437**
per 100000 pop.	56.5	41.9	35.6	28.7	21.3	18.5	14.6	14.0	12.7	12.9
HIV carriers (number of cases)	**83**	**135**	**201**	**266**	**338**	**688**	**785**	**895**	**1001**	**1087**
of which AIDS	15	23	29	36	45	30	34	45	50	68
Number of hospital beds	**36442**	**35615**	**34714**	**34145**	**32104**	**31031**	**29990**	**28972**	**27727**	**27114**
per 10000 pop.	102.3	100.7	98.8	97.9	92.4	89.6	87.0	84.58	81.47	80.11
Admissions	**808071**	**894866**	**905466**	**862919**	**836691**	**819312**	**811343**	**817825**	**812666**	**788526**
per 1000 pop.	226.0	252.1	256.9	246.6	240.3	236.2	234.9	238.0	238.0	232.3
Average length of stay	**12.9**	**11.8**	**11.3**	**11.2**	**10.9**	**10.7**	**10.3**	**10.2**	**10.19**	**10.03**
Bed turnover	**21.7**	**25.0**	**25.9**	**25.1**	**25.5**	**25.9**	**26.6**	**28.2**	**29.0**	**29.15**
Bed occupancy	**281.1**	**294.2**	**293.3**	**280.5**	**277.5**	**276.2**	**275.7**	**287.8**	**295.6**	**292.3**
Hospital deaths (%)	**1.72**	**1.67**	**1.68**	**1.73**	**1.85**	**1.97**	**2.00**	**2.09**	**2.28**	**2.47**

References: Lithuanian Health Information Centre 2007,www.lsic.lt

There are no reliable statistics on the population prevalence of mental and behavioral disorder in Lithuania, because no epidemiological surveys have been carried out. Data

collected by the State Mental Health Centre are only available on cases registered by state mental health institutions. The registered prevalence of mental illness was 4.2% in 1998 (WHO 2001).

Table 2. Incidence and Prevalence of Mental disorders in 2002 - 2006

	Incidence					Prevalence				
	2002	**2003**	**2004**	**2005**	**2006**	**2002**	**2003**	**2004**	**2005**	**2006**
Mental disorders-total	**9362**	**9004**	**9167**	**8721**	**8542**	**163512**	**160467**	**161511**	**161167**	**168843**
per 100000 pop	269.9	260.7	266.8	255.4	251.7	4722.3	4656.8	4715.2	4735.7	4793.2
Mental diseases	**6594**	**6487**	**6535**	**5466**	**5508**	**93368**	**91436**	**92858**	**92466**	**93292**
per 100000 pop	190.1	187.8	190.2	160.1	162.3	2696.5	2653.5	2710.9	2717.0	2756.1
of which schizophrenia	**370**	**355**	**369**	**427**	**376**	**16878**	**16268**	**16086**	**16050**	**16029**
per 100000 pop	10.7	10.3	10.7	12.5	11.1	487.4	472.1	469.6	471.6	473.6
Alcohol and drug abuse	**2768**	**2517**	**2632**	**3255**	**3034**	**70144**	**69031**	**68653**	**68701**	**68951**
per 100000 pop	79.8	72.9	76.6	95.3	89.4	2025.8	2003.3	2004.3	2018.7	2037.0
alcoholic psychosis	**831**	**778**	**927**	**1122**	**1292**	**2250**	**2412**	**2790**	**3077**	**3424**
per 100000 pop	24.0	22.5	27.0	32.9	38.1	65.0	70.0	81.5	90.4	101.2
drug abuse	**471**	**356**	**424**	**349**	**323**	**4405**	**4689**	**5011**	**5371**	**5573**
per 100000 pop	13.6	10.3	12.3	10.2	9.5	127.2	136.1	146.3	157.8	164.6

References: Lithuanian Health Information Centre 2007, www.lsic.lt

Official data on the prevalence of schizophrenia, Alzheimer's disease and intellectual disability are also relatively uninformative due to their lack of completeness, and the lack of specific epidemiological surveys. According to data from the State Mental Health Centre, however, the prevalence of schizophrenia has remained stable, the prevalence of Alzheimer's has risen significantly and the prevalence of intellectual disability has decreased since 1997 (National Health Council 2002).

Table 3. National Health statistics related to mental health

Most common mental health problems among population	Alcohol and Drug abuse, Schizophrenia, Mood and Affective disorders
Most common diagnosis in psychiatric hospitals	Schizophrenia and Schizophrenical delirium, Affective disorders
Number of psychiatric hospitals	**10** hospitals
Number of psychiatric hospital beds	**2726** (in 2006)
Number of staff in psychiatric hospitals	**1307** (1045 nurses)
Number of involuntary treatments	**267** (168 in general care facilities, 77 in medium and 22 in strict regime facilities)
Average hospital days and length of hospital stay	**29.4**

Reference: Data of State Mental Health Centre of Lithuania, 2006 http://www.vpsc.lt

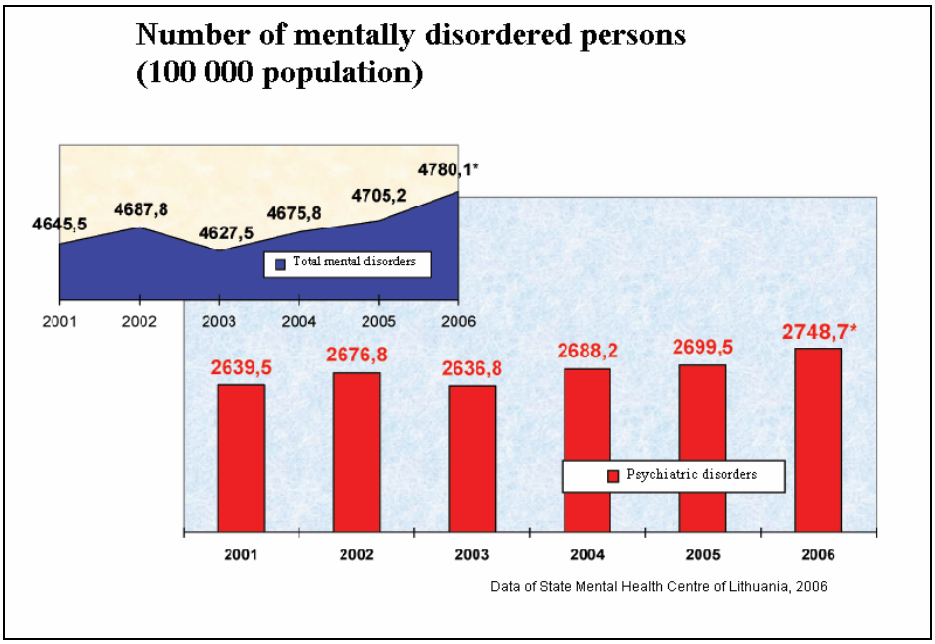


Figure 2. The number of persons suffering from mental health problems (100 000 population)

THE LITHUANIAN HEALTH CARE SYSTEM

General

After re-establishment of Lithuanian independence, health policy makers focused on structural and organizational changes, market mechanisms, development of the health insurance system and a new approach to public health. Aspects of implemented reforms of the Lithuanian health care sector are: development of primary health care, mother and child protection, restructuring of health care institutions, legalization and development of private medical practice, preparation of qualified specialists, disease prevention, modern methods of diagnostics and treatment.

The goal of the health care system is the physical and mental well being of each Lithuanian citizen. This is to be achieved by ensuring accessible, good quality effective health care. There should be equity of access opportunities for all residents of the country to receive necessary medical aid, as well as the right to choice their physician or a medical establishment.

The main strategic trend of the national health system development is health preservation and strengthening and prevention of diseases. The State shall ensure effective functioning of the system by involving all social and economic structures for implementation of this goal, by creating the necessary conditions for a healthy lifestyle and by achieving the good health of the community and each of its members.

The main trends of the health care system development are:

- Development and de-centralization of primary health care;
- Expansion of the rights of local authorities in the public health care sector;
- Restructuring and modernization of the public health care institution network;
- Improvement of service rendered by emergency medical treatment services;
- Integration of nursing services into general hospitals;
- Optimization of inpatient rehabilitation services and development of outpatient
- rehabilitation services (Health care in Lithuania 2006).

Institutions of the National Health Care System (NHCS) provide individual health care and public health care services and carry out pharmaceutical activities. They are based on public or private funding system. The levels of NHCS activity organization are as follows: municipal, county, and national level (Health care in Lithuania 2006).

Primary health care services are available to the entire population of Lithuania and are oriented towards the main health problems of patients. Primary, individual and public health care is organized by municipal executive institutions.

Municipal, county institutions and institutions subordinate to the Ministry of Health provide secondary and tertiary individual health care services that are divided into outpatient and inpatient services. In Lithuania primary, individual, health care services are provided by outpatient individual health care institutions that have a license to engage in primary health care activities (Health care in Lithuania 2006):

- medical stations;
- primary health care centers;
- outpatient facilities;
- polyclinics;
- family physicians offices;
- mental health centers;
- institutions providing statuary services of individual health care.

In Lithuania, there are 146 hospitals, out of which 64 are general hospitals, 55 nursing homes, 24 specialized hospitals, and 3 rehabilitation hospitals. County and university hospitals render specialized and particularly qualified individual health care services and treat patients with severe diseases.

In Lithuania there is no comprehensive document describing national mental health policy and its implementation, but there are several documents aimed at specific problems at different levels which, taken together, reflect the state's mental health policy. These include the:

- State Programme on the Prevention of Mental Disorders, 1999
- National Drug Control and Drug Addiction Prevention Programme, 1999
- National Alcohol Control Programme, 1999
- National Suicide Prevention Strategy (approved by the Ministry of Health in December 2001 and currently awaiting Government approval) (Puras et al. 2004).

Mental health services

The institution that governs overall mental health policy and activities in Lithuania is the State Mental Health Care Centre, established in 1999 under the Ministry of Health. The State Centre coordinates mental health and drug, tobacco and alcohol prevention programs, and their implementation nationwide. It is also empowered to make suggestions for the development of mental health care centers at the regional and municipality levels. A third role is to carry out epidemiological research on mental disorders and alcohol and drug addiction and other dependency diseases. A fourth is to improve the implementation of psychosocial rehabilitation. The centre is authorized to organize prevention on mental and dependency disorders and to provide Lithuanians with related information on healthy lifestyles and mental hygiene (Puras et al. 2004).

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN LITHUANIA

Nursing education in Lithuania executed at Universities and Colleges (Undergraduate studies, Bachelor (Professional)). Acts related to nursing education and practice are as follows:

- The Constitution of Lithuania (1992)
- The Law on Higher Education (2000)
- The Law on Nursing Practice (2001, No.IX-413)
- The Lithuanian Medical Norm MN:28:2004 General practice nurse. Rights, duties, competence and responsibility (2004)

Degree education

The structure of general practice nurse study program, duration and qualifications are being described in Table 3.

Table 3. Structure of general practice nurse study program

Study program	Duration, volume, structure of studies		Professional qualification
General practice nursing (together with specializations):	3.5 years 140 credits 210 ECTS		General practice nurse
- Community nursing,	General subjects of higher education	30 credits	Professional baccalaureate degree
- Mental health nursing, - Pediatric nursing, - Anesthesia and intensive nursing	Subjects to acquire qualification	40 credits	
	Professional activities practices	54 credits	
	Subjects of specialization	10 credits	
	Diploma thesis	6 credits	

According to General Practice Nursing programme 2006.

Vocational continuing education

The Mental health nursing specialization – 40 credits is included into the study program of General Practice Nurse. There is no educational strategy on continuing education for mental health nursing specialization. Vocational continuing education in Lithuania is executed in two ways:

- Nurses who graduated from College prior to the year 2002 acquire the specialization of mental health nursing at the Development and Specialization Center of Nursing Employees. Duration of courses consist of 12 national credits (480 hours).
- Nurses who graduated from College from the year 2002 onwards acquired the specialization of mental health nursing within a diploma program.

Nurses role in mental health services

The main role for mental health nursing is to take care for people of different ages with mental disorders. Nurses must be competent to analyze and identify the needs of people with mental health disorders. They must be able to organize and carry out mental health care. In the organization of the mental health care in the community, the mental health nurse must be able to 1) cooperate with individual health care, educational, social care and other institutions in order to ensure individual mental health; and 2) analyze and disseminate the experience of mental health care (General Practice Nursing Program 2006).

LEGAL AND ETHICAL NORMS RELATED TO PATIENT RESTRICTIONS IN LITHUANIA

Legal norms related to patient restrictions

A number of acts exist in Lithuania related to patient restrictions. These laws are listed below as follows:

- The Constitution of Lithuania (1992)
- The Law on Mental Health Care Republic of Lithuania (1996)
- Medical Norm MN 22:2006. Mental Health Nurse. Rights, duties, competences and responsibilities.
- Law on Patient's Rights and Injury Compensation Republic of Lithuania (1996)
- Lithuanian National Mental Health Strategy for 2005-2010

Ethical norms related to patient restrictions

Ethical codes related to patient restrictions can be found as follows:

- The Constitution of Lithuania (1992)
- The ICN Code of Ethics for Nurses (2005)
- The Code of Professional Ethics for Nurses in Lithuania (2000)
- The Code of Ethics of Lithuanian Physicians Association (1993)

Professional codes related to patient restrictions

To date there are no professional codes related to patient restrictions in Lithuania. The Orders related to patient restrictions are generally developed and used at the level of the individual Psychiatric hospital.

PATIENTS RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN LITHUANIA

Health statistics and patient restrictions used

There are no official records regarding patients' restrictions available in Lithuania.

Management of distressed and disturbed patients

Every hospital has its own rules and recommendations with regard to the use of restraint techniques on patients. These are, based on the Law on Rights of Patients (1996) and the Law on Mental Health Care (1996).

Patients are only restrained when it becomes clear that the patient is either a danger to him /her self, or to other people. There is a respectful attitude to distressed and disturbed patients in order to respect their autonomy, uniqueness and rights.

CONCLUSIONS

We can conclude that mental health now is at the centre of Lithuania Health and Social Policy. The mental and spiritual health of every citizen and society is the most important aspect of the Lithuania economy and society. Participation in this Leonardo da Vinci project will help us to develop continuing education in mental health care for mental health nurses'. It will enable us to share innovative practice in caring for patients with mental disorders, and to use national and international networks in the field of mental care in Europe. The most important aspect of the project is to enable us to implement new knowledge, new international experiences and new research approach in mental health nursing practice.

Participation of Klaipeda psychiatric hospital and Klaipeda College (Faculty of Health) in this project ePsychNurse.Net is of great importance in realization of the following:

- Assurance of human rights
- Modern services corresponding to the patients' needs
- The balance in the spread of the bio-psycho-social model
- Encouragement of autonomy and participation
- Treatment of mild mental health disorders at non-special health care institutions
- Strengthening of mental health and prevention of mental disorders are inseparable and a priority part of implementation of health, education and social security strategies
- Strengthening of the role of patients' and the non-governmental sector

This project is very important to us since it enables us to co-operate closely with nurse training and health care institutions. Developing mental health care, Lithuania has to assure high quality mental health services and proper and effective nursing. In Lithuania the nurses will be given the possibility of developing their professional competence in light of the experience of other countries. In Lithuania there is an urgent need to continue nurses' education in order to obtain mental health specialization. At present continuing nursing education is being improved and new specialist mental health course syllabi are being designed. Therefore the results of the project will enable us to improve further mental health nurses' education, with reference to modern science-research-based knowledge and evidence-based nursing practice.

References

The Code of Professional Ethics for Nurses in Lithuania (2000). http://be.sam.lt (Accessed 18.9.2007)

The Code of Ethics of Lithuanian Physicians Association (1993). www.lgs.lt (Accessed 18.9.2007)

The Constitution of Lithuania (1992) http://www.servat.unibe.ch/law/icl/lh00000_.html (Accessed 18.9.2007)

Data of State Mental Health Centre of Lithuania, (2006) www.vpsc.lt (Accessed 18.9.2007)

Department of statistics (2006) Demographic tendencies 1990-2000. Department of Statistics, Vilnius.

Department of Statistics to the Government of the Republic of Lithuania (Statistics Lithuania), (2005). http://www.stat.gov.lt/en/ 15.5.2007

General Practice Nursing programme 2006. www.klk.lt (Accessed 18.9.2007)

Health care in Lithuania (2006). Sveikatos apsauga Lietuvoje. UAB, Petro ofsetas Vilnius. Lithuania.

The ICN Code of Ethics for Nurses (2005) www.icn.ch/icncode.pdf (Accessed 18.9.2007)

The Law on Higher Education Republic of Lithuania (2000), www.smm.lt (Accessed 18.9.2007)

The Law on Nursing Practice Republic of Lithuania (2001) No.IX-413, www.sam.lt (Accessed 18.9.2007)

Lithuanian Health Information Center (2007) Health statistic. The Main Health Statistics Indicators 1997-2006. http://www.lsic.lt/html/en/lhic.htm 15.5.2007

The Lithuanian Health Program 1997 – 2010. www.euro.who.int/document/e699920 (Accessed 18.9.2007)

The Lithuanian Medical Norm (2004) Rights, duties, competence and responsibility. General practice nurse. MN, 28.

Lithuanian state mental health strategy 2005-2010. www.lps.vu.lt (Accessed 18.9.2007)

The Law on Mental Health Care Republic of Lithuania (1996) www.3.lrs.lt (Accessed 18.9.2007)

The Law on Rights of Patients Republic of Lithuania (1996) www.sam.lt (Accessed 18.9.2007)

National Health Council. (2002). Annual report 2001. Problems of general health and mental health in Lithuanian residents and organizational problems of the health care system. National Health Council, Vilnius.

Lithuania State Mental Health Centre. National Health statistics related to mental health. 2006. www.vpsc.lt Accessed 18.9.2007)

Puras D, Germanavicius A, Povilaitis R, Veniute M. & Janilionis D. (2004) Lithuania mental health country profile. International Review of Psychiatry, vol. 16(1-2), 121-122.

WHO Regional Office for Europe and European Commission. (2001). Highlights on health in Lithuania. WHO, Copenhagen.

Baseline information from Portugal: Towards improved quality by developing nurses continuing vocational training in psychiatric hospitals and inpatient units in Portugal

Rebelo Botelho M. A, Costa e Silva I, Rocha Santos L.
Escola Superior de Enfermagem de Lisboa
Department of Mental Health and Psychiatric Nursing,
Centro Hospitalar Psiquiátrico de Lisboa, Potugal

INTRODUCTION

In the 1st International Meeting in Finland all the countries evolved in the ePshychNurse.Net - Project had the opportunity to present their national realities. This paper is the result of this work and has the purpose to present Portugal in terms of health and education systems The Mental health care system is in the centre of our attention, special the way how health professionals deal with patient's restrictions

Portugal is an independent country since 1143 and one of the oldest nations in Europe. Portugal is situated on the west side of Iberian Peninsula and Lisbon is its capital city. In 1986 Portugal became a member –state of the European Union.

In accordance with the Constitutional Law, "the Republic of Portugal is a democratic Legal State, based on the sovereignty of people, freedom of democratic expression and political organization, respect for and guaranteed enforcement of fundamental rights and liberties, and the separation and interdependence of powers, with a view to achieving an economic, social and cultural democracy and the development of participative democracy". The official language is Portuguese and is spoken throughout the country, including the Azores and Madeira Islands. The Portuguese is the eighth most spoken language in the world and the third most spoken western language.

The presentation will follow the editor guidelines: 1) introduction; 2) description of the country; 3) legal and ethical norms; 4) patients restrictions; 5) discussion and conclusions; 6) implications into the clinical practice and references.

DESCRIPTION OF PORTUGUESE POPULATION AND HEALTH STATISTICS

Population statistics

In 2005 Portugal has a resident population of 10 579 millions 5 516 is males and 5 454 is females (INE, 2006a). Sixty five percent of the population lives in urban areas. Tourism plays an important role in economy; in 2001 the country hosted 13 million tourists. In 2005 a total of 5.122,6 million people were employed: 57, 6% in commerce and services, 31,2%

in industry and 11,8% in agriculture (INE, 2006b). The unemployment rate in 2006 was 7. 2%. Life expectancy in 2005 was for males 74.9 years and females 81.39 years (INE, 2006b).

During the past decades, Portugal has seen a rise in the education level of their citizens (see Table 1).

Table 1. Education level in Portugal

Literacy (2003)	**92.5%**
• Men	95%
• Women	90%
Enrolment	**1,930,645**
• Primary	767,872
• Secondary	766,172
• Post-secondary	396,601
Attainment	
• Secondary diploma	15%
• Post-secondary diploma	9%

Reference: Portugal, Ministry of Education and Ministry of Science, Technology and Higher Education 2003

Enrolment in Post-secondary education, both university-level education and high-level vocational programmes, increased more than 20% between 1995 and 2002. However 47% of 20-to-24 years old have only secondary school qualifications (OECD 2004).

Health statistics

In Portugal the main cause of death are the diseases of the circulatory system, special the cerebro vascular diseases. The main causes of death in all ages are described in table 2

In 2001, according to the Psychiatric Census, among the population the prevalence of psychiatric disorders is round 30%. Depressive disorder: 20% of the population. The most common diagnosis in mental health was in psychiatric hospitals and inpatient units schizophrenia (36.2%), oligophrenia (28.1%), and alcohol abuse (7%). In ambulatory services, the most common diagnosis was depressive disorders (21.5%) and schizophrenia (12.4%). In 1970s there were 3,020 beds in psychiatric hospitals and 5,124 in social institutions (607 acute, 3,931 institutionalized patient and•586 others)

THE PORTUGESE HEALTH CARE SYSTEM

General

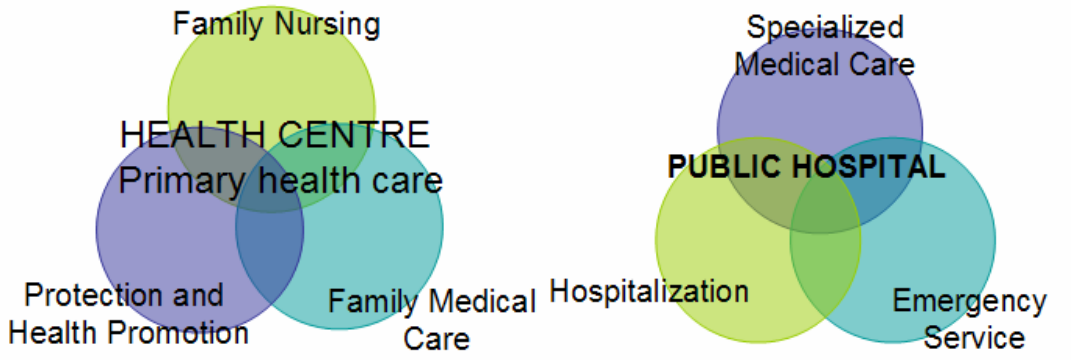
The Portuguese health care system was created in 1979 based on the classical National Health Service model. NHS is characterised by universal coverage (access and total care) and free or nearly free at the point of use. The NHS was almost entirely financed from

taxation via National Budget (over 90%) and co-payments (pay roll taxes, private insurance). In 2003 (OECD 2006) the total health expenditure was 9.6% of gross domestic product, the Public health expenditure was 25.5% of National budget and the Mixed Nature – Public expenditure on health – 69.7%

Table 2. The main causes of death in all ages in year 2004

Causes (CID 10 – European short list)	Deaths		
	Nº	%	Taxa ‰ooo
All Causes	102 371	100	660,3
Circulatory system diseases (33)	37 118	36,3	353,4
Cerebrovascular diseases (36)	16 795	16,4	159,9
Ischemic heart disease (34)	8 896	8,7	84,7
Neoplasic tumours (6)	22 837	22,3	217,5
Trachea, bronchus, lung cancers (15)	3 480	3,4	33,1
Stomach cancer (10)	2 404	2,3	22,9
Prostate cancer (21)	1 698	1,7	16,2
Female breast cancer (17)			
Respiratory system diseases (37)	8 675	8,5	82,6
Pneumonia (39)	3 415	3,3	32,5
External causes (58)	5 470	5,3	52,1
Accidents (59)	3 250	3,2	30,9
Traffic accidents (60)	1 760	1,7	16,8
Nutritional, metabolic and endocrine diseases (26)	5 065	4,9	48,2
Diabetes mellitus (27)	4 485	4,4	42,7
Digestive system diseases (42)	4 652	4,5	44,3
Liver chronically diseases (44)			
Infectious and parasite diseases (1)	2 045	2,0	19,5
HIV (4)	904	0,9	8,6

Reference: DGS (2006a) – Statistic Elements: General Information: Health/ 2004. Lisbon: Directorate-General of Health (DGS)



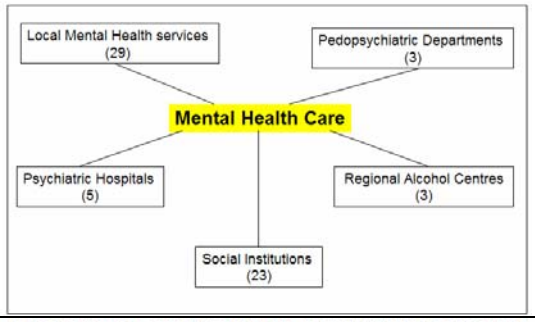
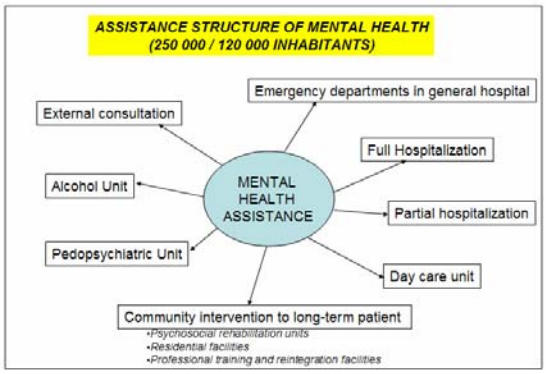
Reference: Constitutional Law n. º 48/90 of August 24; Law n. º 27/2002 of November 8; Decree-Law n. º 11/93 of January 15

The NHS is composed of both public and private institutions (Directorate-General of Health,2004). The public sector and the Private sector have 38.239 beds of which 74% belong to the public sector.

- Hospitals – 217: of which 83 are public hospitals, including psychiatric hospitals (83 public hospitals, 71 general hospitals and 12 specialized hospitals) total of beds 23.214
- Primary health care centres – 363 with inpatient units- 55 total beds 835)
- Administrative regions (ARS) – 5
- Pharmacies – 2.663 (3,761 inhabitants / pharmacy) (DGS 2004)

The number of nurses working at NHS is 48,296, of which 6,856 are specialists; 931 are psychiatric post-graduate nurses. (ORDEM dos ENFERMEIROS 2006)The density of nurses per 1000 population (2004) was 4.4. The number of physicians is 36,138 and density per 1000 population in year 2004) was 3.4 (OECD Health data 2006). Mental Health Expenditure is 4.5% of total health expenditure (Mental Health Economics European Network 2004)

Mental health services

<table>
<tr>
<td>Mental health care providers:
• Psychiatric hospitals – 5
• Local mental health services – 29
• Pedopsychiatric Departments – 3
• Regional alcohol centres – 3
• Social Institutions – 23</td>
<td>DESCRIPTION OF THE MENTAL HEALTH CARE SYSTEM
 
</td>
</tr>
<tr>
<td>Assistance Structure of Mental Health
• Emergency departments in general hospitals
• Full hospitalization
• Partial hospitalization
• Day care unit
• External consultation
• Alcohol unit
• Pedopsychiatric unit
• Community intervention to long-term patient (Psychosocial rehabilitation units; residential facilities, professional training and reintegration facilities)</td>
<td>DESCRIPTION OF THE MENTAL HEALTH CARE SYSTEM
 
</td>
</tr>
</table>

Reference: Mental Health Reference Network (2005)

A decisive shift occurred in Portugal in 1984 (Direcção geral da Saúde 1999) with the integration of mental health services, including mental hospitals, into the Ministry of Health. The emphasis was on gradual de-institutionalization and on the integration of mental heath care into community in a way that they can best meet the population needs. Nowadays, the number of beds in psychiatric public institutions is: 2,852 (1,451 acute situations, 1,192 for long stay patients and 209 beds in forensic psychiatric units). With regards to human resources, there are 1,911 professionals in public mental health institutions: 1,166 Nurse, 417 Psychiatrist, 139 Psychologist, 107 social Assistant, and 2,054 in social institutions: 514 nurse and 73 psychiatrist. The average hospital days are: 40.1 days (in acute units 20 days). Occupation rate 74.8%. In 2002 the involuntary treatment corresponded to 3% of all admission patients.

NURSING EDUCATION AND NURSES' ROLE IN MENTAL HEALTH CARE IN PORTUGAL

- Pré-school education
- Basic education with the duration of 9 years
- Secondary education with the duration of 3 years
- Higher education divided into two main subsystems: university and polytechnic education.

In 2006 the National education Budget was 6.1million euros.

Degree Education

Nursing education is integrated since 1988 within the polytechnic education. The Nursing Colleges are under the supervision of Ministry of Science Technology and Higher Education. The requirements for the nursing course are twelve years schooling and a national examination as for the other courses within higher education.

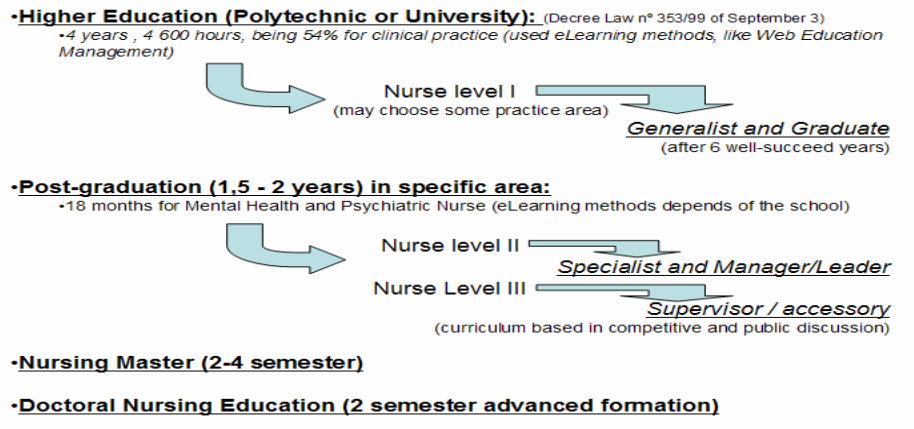
Since 1999 (law nº 353/ 99 OF SEPTEMBER 3) the length of the graduation nursing course is: 4 year: 4, 600 hours, with 54% for clinical practice (used eLearning methods, like Web Education Management*)* and the graduates have a licentiate degree.

After the graduation, nurses can do Post-graduations (specialised nursing courses) in different areas, such as mental health and psychiatric nursing, master and doctoral degrees in nursing or in other areas.

Vocational continuing education

The Bologna Process provides the opportunity for a new wave of reforms in vocational education. Nowadays continuing vocational education is provided according to the Education Programme of each Institution (Hospital / Department/ Service) and guide by

Nursing Education and Nurse Career structure



The Decree Law nº 437/91:

- The Education Department of an Institution must be sure than all nurses have continuing education;
- All nurses may use 42h/year for continuing vocational education, this period can extend, by Administration authorization, if it is deemed to bring benefits to the institution;
- Specialists and Chief Nurses may use up to 6 months (after 3 years in Level II) for scientific and technical actualization (investigation, practical training);

Continuing Education must be assured by the specialist nurse, in collaboration with Chief/Head Nurse, and should be responsive to the real service needs.

Nurses' Role in mental health services

In psychiatric care the nurse's role depends on the education level: Nurses on Level I (generalist or graduate nurse) and Nurses on Level II (specialist)

Nurses Level I (generalist or graduate) have the capacity and the authority to competently (with scientific, technical, human and cultural skills) practice primary, secondary and tertiary mental health care:

- Promote mental health, and prevent mental illness in individual, families and communities;
- Plan and manage the care of individuals, families and communities with mental illness, disabilities or rehabilitation needs (in community and institutional settings)
- Participate in the management services or health institutions
- Participate in nurse's education or health staff education
- Participate in the development of nursing research.

Nurses Level II (specialist) has the capacity to use more complex interventions. They are experts in mental illness care, mental health strategies, helping relations (individual and

group), therapeutic and interpersonal relationships, relation supervision, and in ethical decision-making.

LEGAL NORMS AND ETHICAL CODES IN PORTUGAL RELATED TO PATIENT RESTRICTIONS

Legal norms related to patient restrictions

Portuguese acts related to mental health care system are as follows:

- Decree Law nº 35/99 of February 5 (Organization of psychiatric and mental health care provision) Full hospitalization for acute diseases, preferably in general hospitals. Although psychiatric hospitals continue to provide care at local level in the population areas and to provide care for long-term institutionalized patients (developing rehabilitation programmes) and provide residential units to patients without any family or social support system.
- Decision nª 407/98 and Directive nº 348-a/98 of June 18 (Psychosocial rehabilitation Services)
- Minister Council Resolution nº 166/2000 of November 29 (Action Plan against Alcohol)
- Decree law nº 318/2000 (Create the National Alcohol Network)
- Decree law nº 281/2003 of November 8 (continuing care network)
- Decree law nº 15/93 of January 22 (Anti-drug legislation)
- National Health Plan: 2004-2010 (Priorities diseases: depression and addition) (DGS 2004)

Law nº 36/98 of July 24 : Mental Health Act

Chapter I - General provisions

> *Article1 "The present Act establishes the general principles of the mental health policy and governs the compulsory detention of persons suffering from mental disorders, namely persons with mental illness."*

The Mental Health Act describes that mental health care is undertaken primarily at the community level and provided in the least restrictive environment possible; the creation of a National Council of Mental Health (government's advisory body). The Law nº 36/98 protects the patients rights and duties making clear the conditions for compulsory detention:

Ethical codes related to patient restrictions

Chapter II – Compulsory detention

Article 8 – General Principles

1. Compulsory detention may only be determined in cases where it is deemed to be the only way of guaranteeing that the detained patient is submitted to treatment, and shall be suspended as soon as the reasons for its inception have ceased to exist.
2. Compulsory detention may only be determined in cases where it is deemed proportional to the danger and the legally protected value in question.
3. Whenever possible, detention should be substituted for out-patient treatment.
4. The restrictions imposed by compulsory detention on a patient's fundamental rights shall be those that are strictly necessary and suitable to the effectiveness of the treatment and the safety and normal functioning of the institution, in accordance with the respective internal regulations.

There are a number of other laws related to patients' status in health care:

- Decree Law nº 161/96 of September 4:

Regulation of Professional Practice of Nurses (REPE)

- Decree Law nº 104/98 of April 21:

Deontological Code of the Nurses (Nurses' Rights, Duties, Incompatibilities and Values)

- Law nº 1/2005 (seven revisions): Constitution of the Portuguese Republic

Article 1 - Dignity of the human person
Article 12 - Principle of universality
Article 13 - Principle of equality
Article 22 - Liability of public bodies
Article 25 - Right to personal integrity
Article 27 - Right to freedom and security

Professional codes related to patient restrictions

There are no rules directly concerned with patient restrictions. The Mental Health Act establishes only the principles related to compulsory detention and the patients rights in these situations. The ethical professional codes (Nurses and doctors ethical codes) make clear the professional duty to respect human dignity and the protection of patient integrity. Although, the absence of rules governing the use of physical restraint and seclusion is a big issue that affects the patient and professionals.

Other regulations in Portugal are, for example:

- Patients' Rights and Duties Letter, Health Ministry
- Description of Quality Nursing Professional Exercise
- Standards of Quality of Nursing Care

PATIENT RESTRICTIONS IN FIELD OF MENTAL HEALTH CARE IN PORTUGAL

Mental health statistics and patient restrictions used

The terms “seclusion” and “restraint” are not defined in Portuguese legislation. Although, patients’ restriction, may be allowed, when they are the only means available to prevent harm to the patient or others. Mechanical restraint is used for the shortest possible period of time and it must be authorized by the Psychiatrist. Staffs are very attentive to the need of physical examination of the restrained person and regular observation during the procedure.

The seclusion room is used in the different kinds of units, especially in forensic psychiatric units. Sometimes when nurses use the term seclusion they are talking about using a quiet room (open or locked). It is only since 2005 that the episodes of restraint and seclusion are recorded in a register; because some hospitals were involved in the International Quality Indicator Project (IQIP). Four psychiatric hospitals were integrated into this Project and are using the eight IQIP-Psychiatric Care Indicators. (http://www.epos-bg.de/cms/fileadmin/downloads/epos_iqip_engl_ruh.pdf). The data collected are not yet available.

Management of distressed and disturbed patients

There are no guidelines for the management of aggressive patients and for this reason nurses support their interventions with experience and good sense. Older, more experienced staff is the main source of support. Only a few nurses have academic training concerning patients with aggressive behaviours and the management of these situations. Nonetheless the problem of aggression exists and for this reason some psychiatric hospitals, according their needs, offer vocational training to cover the topic.
Usually when there is an aggressive and disturbed patient, nurses, in the first instance, use anticipatory strategies (systematic observation of patient behaviour, preserve therapeutical environment, development of group activities, relaxation techniques, helping relation techniques), and only when these strategies are not effective, they use coercive procedures (chemical and mechanical restraint).

CONCLUSIONS

As the data show, the absence of rules governing the use of physical restraint and seclusion and the absence of systematic staff training is a serious problem that affects nurses’ and patients’ well-being. Nurses need guidelines for the management of aggressive and disturb patients, and training courses in aggression management. On a daily basis, nurses try to interrupt aggressive events before they get out of control, try to be attentive and recognise the sign of potential aggressively, and try to control environmental factors that can be associated with aggression, using non violent communication. Because there are no guidelines or staff training, nurses feel powerless and frustrated and sometimes they feel

that they are in danger. Usually when they use coercive procedures they feel uncomfortable because the ethical issues concerning coercion are not subject of discussion.

Where possible, there should be legislation that clearly defines the situations where seclusion and restraint are permitted. All episodes of physical restraint and seclusion must be recorded. Staff who deal with aggressive and disturbed patients need regular training on the relevant legal issues and must know how to assess patients (understanding patients history), the situation (understanding the causes of the aggressive episode) and carry out a full risk assessment (using risk assessment instruments) of the patient-in-context.

References

DGS – Direcção Geral de Saúde (2001) – Censo Psiquiátrico de 2001: síntese dos resultados preliminares. Lisbon: Directorate-General (DGS), 2001.

DGS – Direcção Geral de Saúde (2004) – National Health Plan: 2004-2010; vol. I – priorities. Lisbon: Direcção Geral de Saúde.

DGS – Direcção Geral de Saúde (2006) – Portugal Saúde: indicadores Básicos 2004. Lisboa: Direcção Geral de Saúde.

GIASE – Gabinete de Informação e Avaliação do Sistema Educativo (2006) – Estatística da Educação 04/05. Lisboa: Gabinete de Informação e Avaliação do Sistema Educativo / Direcção dos Serviços de Estatística.

INE - National Institute of Statistics (2006a) – Statistical Yearbook of Portugal 2005; Vol. I. Lisbon: National Institute of Statistics.

INE - National Institute of Statistics (2006b) –Social Indicators 2005. Lisbon: National Institute of Statistics.

International Quality Indicator Project (EPOS Health Consultants) http://www.epos-bg.de/cms/fileadmin/downloads/epos_iqip_engl_ruh.pdf (Accessed 21.9.2007)

Mental Health Economics European Network (2004) http://www.mhe-sme.org/en/european-projects/mental-health-economics-project.html (Accessed 21.9.2007)

OECD Health data 2004. Organisation for economic Co-operation and Development. 2004.

OECD Health data 2006. www.sourceoecd.org/database/16836243/healthdata (Accessed 21.9.2007)

Ordem dos Enfermeiros (2001) (Portuguese Nursing Order) – Padrões de qualidade dos cuidados de enfermagem. Lisboa: Ordem dos Enfermeiros.

PORTUGAL. Decision nº 407/98 and Directive nº 348-a/98 of June 18. Psychosocial rehabilitation Services. Lisbon: Official Journal, 1998. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 35/99 of February 5. Organization of psychiatric and mental health care provision. Lisbon: Official Journal, 1999. http://gddc.pt/legislacao-lingua-estrangeira/english/lei-da-saude-mental.html (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 437/91 of November 8. Nursing career. Lisbon: Official Journal, 1991. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree-Law nº 11/93 of January 15. National health service. National legislation. Lisbon: Official Journal, 1993. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 15/93 of January 22. Anti-drug legislation. National legislation. Lisbon: Official Journal, 1993. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 161/96 of September 4. Regulation of Nursing Professional Practice (REPE). Lisbon: Official Journal, 1996. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 104/98 of April 21. Deontological Code of the Nurses. Lisbon: Official Journal, 1998. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 353/99 of September 3. Nursing Education. Lisbon: Official Journal, 1999. http://www.dre.pt (Accessed 21.9.2007)

PORTUGAL. Decree Law nº 318/2000. Create the National Alcohol Network. Lisbon: Official Journal (National Legislation), 2000.

PORTUGAL. Decree law nº 281/2003 of November 8. Continuing care network. Lisbon: Official Journal, national legislation, 2003.

PORTUGAL. Law nº48/90 of August 24. Constitution of the Portuguese Republic. Lisbon: Official Journal, 1990. http://www.dre.pt

PORTUGAL. Law nº 36/98 of July 24. Mental Health Act. Lisbon: Official Journal, 1998. http://www.dre.pt

PORTUGAL. Law nº 1/2005 (seven revision). Constitution of the Portuguese Republic. Lisbon: Official Journal, 2005. http://www.dre.pt

PORTUGAL. Law nº 27/2002 of November 8. Hospital management law. Lisbon: Official Journal, 2002. http://www.dre.pt

PORTUGAL. Minister Council Resolution nº 166/2000 of November 29. Action Plan against Alcohol. Lisbon: Official Journal. 2000.

DISCUSSION

The overall goal of the ePsychNurse.Net project is to ensure high quality, ethically appropriate and therapeutically effective interventions to enable nurses to manage distressed and disturbed patients in European psychiatric hospitals and inpatient units. This publication is the first step in reaching the project objectives.

Before developing the e-learning education programme it was important to explore a number of key elements the outcomes of which would be used to inform the curriculum. These elements included nurses' attitudes to mental illness, the educational needs of nurses in the organisations affiliated to the project, and current approaches to how nurses manage and care for distressed and disturbed patients. Knowing the type of educational preparation required to become a nurse, as well as the continuing vocational training opportunities available to nurses was also necessary to ensure that the e-learning course could be fully integrated into the portfolio of courses offered in the participating universities and health care provider institutions.

As contextual material it was necessary to explore and describe the nature of the health care system in each country. Health care provision across the globe is highly political, not least because of the financial demands its places on governments. This demand is escalating as the expectations of citizens' increases together with advances in medical science and technology. To keep pace with such demands, health care systems need to be dynamic and consequently subject to change. The changing demography and increasing ethnic mix of some EU countries presents additional challenges for governments and health care providers and need to be taken into consideration when planning services. The type of health care provision offered influences the workforce strategy including the nature of the educational provision necessary to prepare practitioners, managers and administrators to deliver and manage an effective and efficient health care system.

The outcomes of the early empirical explorations associated with this project highlighted a number of similarities and differences across the six EU countries. These were in relation to the health care systems, the nature and type of educational preparation for nurses, statutory regulation and professional bodies for nurses, the management and care of distressed and disturbed patients, national guidelines and policies associated with clinical practice and how the division of labour and power dynamics were reflected in clinical teams.

Health care systems in general, including those offering mental health care are undergoing, or have recently undergone, change in many European countries. The focus of such changes and reforms is the delivery of high quality health care and high quality mental health care (Department of Health 1999, Lithuanian state mental health strategy 2005-2010, Sharp 2004, Vision for change 2006).

Each country and associated governments have a view on how best to improve the health of their citizens and the types of services best suited to do so. Decisions will be influenced by political orientation, demographic factors, economic considerations including health statistics and cultural and environmental factors. Not surprising, therefore, we found differences in the provision of mental health care in each participating country – Finland, Ireland, Italy, England, Lithuania and Portugal.

There are a number of reasons for these differences. For example, in Lithuania mental health care services are at an embryonic stage of development following the re-establishment of national independence. Largely, due to its short history, there is no comprehensive documentation describing national mental health policy (Health care in Lithuania 2006, Health Statistics in Lithuania 2005).

In England, the National Health Service (NHS) was established in 1948, and since its inception it has undergone numerous reforms influenced by different political parties and consultation exercises with citizens (NHS 2007). In an endeavour to promote better care for those with mental health difficulties, the National Services Framework (NSF) for Mental Health was introduced in 1999. The Irish health care system has recently undergone reform with the establishment of the Health Service Executive (HSE) and its four administrative areas that cover the country geographically with responsibility for all service management (Health Service Executive 2006). In Portugal, the current health care system was created in 1979 and is based on the British NHS model, covering both public and private institutions (DGS 2004). The Finnish health care system has gone through different developmental phases with perhaps the most powerful reform happening in the early 90s. The Italian National Health Service was established in 1978, replacing a health insurance system. Like all of the other health care systems it too has been subjected to reform. In terms of mental health care provision, Italy took a radical step in 1978 with the closure of all large mental hospitals. This decision has since influenced the pattern of closures of mental hospitals and the move to community based services in other European countries.

In terms of the human rights of those experiencing mental illness, each of the six countries has an Act in place to protect the rights and dignity of patients. Although each country has a somewhat different approach, the overarching philosophy is the same.

All six countries share a growing concern for the increase seen in mental health problems over the last decades. It has been estimated that approximately every second person in the EU will be affected by mental health problems at some point in their life. Mental health problems cause considerable disability, with the impact on the working age population having major implications for the economy and social service benefits through lost working days (Wittchen & Jacobi 2005). There is also major concern for the numbers of young men under the age of 35 who are committing suicide, especially in Finland and Ireland (Cocoran et al. 2006).

Given the predicted increase in psychiatric morbidity across Europe, together with the freedom of movement of individuals across the various countries, it is important to have a more homogenous approach to the care and treatment of those in mental distress. This joint approach needs to embrace the nature and quality of services as well as the education and necessary competency of those delivering the services. Across Europe, nurses are the largest professional group delivering care; consequently they are a powerful force in promoting health – including positive mental health – in addition to caring for those who are unwell. The professional competence of nurses is therefore a central factor affecting the quality of nursing care in general, including psychiatric nursing (ECCN, http://www.ec-cn.org/). However, the initial educational preparation and vocational education of psychiatric nurses varies widely across European countries and elsewhere.

In most European countries the education of nurses has undergone change in recent decades, moving from colleges of nursing to Higher Education Institutions (HEI). In terms

of academic qualifications this move enabled nurses to receive either a diploma or degree where previously the qualification was at certificate level. In Finland this move took place in the 1980s, followed by England and Ireland in the 1990s. In England it is possible to undertake either a diploma or degree programme whilst Ireland have degree entry only. Nurse education in Portugal and Italy also takes place in either a university or polytechnic, whilst in Lithuania it is university based. The academic qualifications achieved are accompanied by a nursing qualification leading to registration. With the exception of England and Ireland, none of the other countries offer a first level qualification for registration as a mental health nurse. Instead, there is a generic training with specialisation later on. There is also variation between the countries regarding the length of their nursing education programmes, the academic awarding bodies and the educational level (http://www.wap-leonardo.de/eng/index.html).

All countries have some form of continuing vocational education, though it differs in length and provider, with heterogeneous guidelines and recommendations in place. In Finland, for example, psychiatric nurses in some health care organisations have the opportunity to undertake 2.5 years continuing education in a polytechnic or a different continuing education programme in their workplace. All health care personnel in Finland are obligated to maintain and develop their professional knowledge and skills (Ministry of Education 2004, Ministry of Social Affairs and Health 2001). In England and Ireland there are well-established programmes for nurses in all areas and it is mandatory for English nurses to complete continuing vocational education in order to remain on the register of nurses and have a licence to practice. Lithuania has no standard for continuing vocational education or specialization (General Practise Nursing Programme 2006). Portuguese nurses can use up to 42 hours per year, which can be extended if deemed to bring benefit to the institution. However, the educational programme must be assured by the specialist nurse in collaboration with the Chief/Head Nurse and must be responsive to real service needs. Italian Nurses are required to attend some course/s every year to achieve obligatory credits (30 per year). Failure to do so may result in serious sanctions such as reduction in salary or removal from the nursing register (Ministry of Health 2007), However, whilst opportunities exist for continuing vocational training within each partner country it would appear that there are no set national standards. Neither does there appear to be specific education offered for psychiatric nurses in terms of how to manage distressed and disturbed patients as part of the vocational training. Any such training would seem to be provided at local level if at all. England has introduced a national curriculum for health care professionals on how best to manage violence and aggression across all health care sectors but with nothing specific for psychiatric/mental health nurses. It is therefore important to emphasise European nurses' continuing vocational education.

The focus of the ePsychNurse.Net project is to ensure high quality, ethically appropriate and therapeutically effective interventions to enable nurses to manage and care for distressed and disturbed patients. Emphasis will be placed on the use of caring and supportive approaches that are respectful of the personhood of individuals, their dignity and respect, humanity, and right to self-determination. The course will categorically promote a move away from coercive interventions with their accompanying ethical dilemmas to those with a stronger evidence base. The ambition is to enhance the skills, knowledge and confidence of nurses to enable them to question and critically appraise the nature and quality of care available to patients in their respective organisations. In addition, there is a need to recognise that whilst the most humane interventions should be used there may be occasions when the only safe option is to use a more invasive approach such as restraint or

seclusion, hence the need for ethically competent qualified nurses with the skills needed to conduct such interventions while respecting the patients' humanity and right to self-determination

Health care organisations have a responsibility to aid the systematic development and maintenance of a professionally skilled workforce, something that is not possible without high quality continuing vocational training. Health care organisations, such as psychiatric hospitals and inpatient units thus often carry the main responsibility for organising continuing vocational training for qualified nurses. The problem is however; that the content of such training is often overlapping and fragmented and does not satisfy qualified nurses' educational needs. There is therefore a clear need for programmes such as ePsychNurse.Net, which is based on the explicit requirements of nurses engaged in clinical practice. It is also important to develop new interventions to enable nurses to manage and support patients in ethically appropriate ways (e.g. The Lithuanian Health Program 1997 – 2010, Government of Ireland 2000, NIMHE 2004, NICE 2005). In association with the educational opportunities there needs to be appropriate ongoing supervision and good role models in the clinical environments to ensure that learning is consolidated and put into practice. This need emphasises the importance of educational institutions working in partnership with health care providers to ensure that such systems are in place as is reflected in the development of the e-PsychNurse.Net programme.

Psychiatric nurses have a variety of roles and functions in the care and support of patients. These roles and functions may differ depending on the country and the context of care. For example, in Italy, psychiatric nurses work in multidisciplinary teams (MDT) where medical doctors have an important role and are the key decision makers. In these multi-professional teams, the professional competence of the nurse is critical in order to help and support patients on their journey of recovery. Patients often have a more therapeutically effective relationship with a psychiatric nurse than a psychologist or other health care professional (Cantelmi et al. 2003). For the nurses to take a leading role in the MDT they must have the knowledge and confidence to do so, to ensure a more equal balance of power with respect to clinical decision-making.

Reference was made earlier to Europe's changing demography and ethnic mix and the implications this has for health care delivery. In England, for example, and London in particular, there are large ethnic populations. It is now well recognised that those from black and minor ethnic (BME) groupings do not always access mental health services through the conventional routes. It is also well documented that young black men are more likely to be admitted to hospital under a section of the Mental Health Act (1983) and are more likely to be subjected to coercive treatments such as seclusion. In addition, studies have shown that mental illness rates are higher for those from ethnic minority populations (Mental Health Act Commission et al. 2007). Caring for individuals from BME communities poses a variety of challenges, not least of all cultural and language barriers, for all health care professions, but perhaps especially nurses, Nurses have an important role in advocating on patients' behalf (with their consent) in situations where special care is needed. This reinforces the need for continuing vocational training that equips nurses with the necessary skills to confidently manage such situations. As the cultural landscape of Europe changes, such situations will be on the increase. It is therefore important to have a nursing workforce capable of making a difference.

To be able to make a difference within mental health care, it is important that psychiatric nurses have clear guidelines and rules to support them as they care for distressed and disturbed patients. Currently however, there is great variation across the European countries with respect to the availability of guidelines and the role of professional bodies and organisations. Psychiatric nursing of a high ethical standard is a basic requirement. All countries have a Mental Health Act to legislate and control the care of those admitted involuntary for treatment, though these ethical codes differ. Most of the six countries involved in this project reported that nursing practice was guided by the ICN code of ethics for nurses (2000). Through the empirical work conducted as part of this project it has been made clear that some nurses feel there is a need to improve on the nature of the guidance available to them in this area. Nurses reported that they would like more specific standards and guidelines regarding the management of disturbed patients. Whilst some countries have none, such guidelines are already in place in others – for example in England where there are guidelines in the form of NICE and NIHME. In both Ireland and England there is also strong influence from the Irish Nursing Board (An Bord Altranais) and in England by the Nursing and Midwifery Council (NMC) respectively with regard to professional codes of conduct, standard setting and the monitoring of education and training. However, guidelines and rules of themselves will not enhance the care of patients. Nurses need the skills to be able to deliver care and support according to the guidelines and this can only be achieved by well-organised and high quality continuing vocational education.

The use of coercive forms of treatments and varying patient restrictions also differs across the six partner countries. For example, in Portuguese legislation there are no specific terms for seclusion and restraint, whereas in Lithuania there is no official record-keeping regarding patient restrictions. Every hospital has its own rules and recommendations with regard to the use of restraining techniques on patients (Law on Rights of Patients 1996, Law of Mental Health Care 1996). Italy also has no specific ethical code relating to patient restrictions. In England, as already mentioned, there are different local policies and guidelines as well as official external monitoring by the Mental Health Act Commission with a similar approach in operation in Ireland. Whilst there may not be national policies in all countries, most mental health care organisations have their own guidelines. These vary in their degree of detail, some requiring explicit information to be in place regarding decisions on the need for patient restrictions, including the staff involved, the reasons for implementing the restriction, its duration, the number of times the patient is seen by medical doctor, and so on.

The education and training of nurses in the use of coercive methods also varies across countries, with countries such as England having a national curriculum for the management of violence and aggression to help guide health care providers in the development of their training curriculum. In other nations, providers have developed their own organisational-based training. In some organisations it is compulsory to have completed such training before undertaking work in particular environments, such as acute and intensive care wards. In Finland, for example, there is education and training for psychiatric nurses related to these topics but the content and duration varies depending on the organisation. The lack of standardisation and guidelines is further evidence of the need for well-organised, high quality continuing vocational education supported by good role models and supervision in the work place.

The patient restrictions implemented and psychiatric nurses' education related to patient restrictions clearly differs across European countries. In Europe, nursing education should

follow the directives of the European Commission as it gives a basis for the homogenisation of nursing education. In order to increase transparency in psychiatric nursing education throughout Europe, however, it is important to understand the similarities as well as the differences between countries. Thus, empirical research is needed to establish nurses' educational needs in the different countries and be able to develop educational initiatives to meet those needs.

We can conclude that this publication has given a very clear indication of the need to develop and provide new ways of educating psychiatric nurses and improving the quality of psychiatric nurses' continuing vocational education for the benefit of patients and the advancement of the profession. We have found that there are differences in the mental health care systems, the laws and ethical codes that govern mental health care and the types of patient restrictions in use in European countries, as well as the differences in availability and organisation of psychiatric nurses' continuing vocational education.

There is a need to create systematic psychiatric nurses' continuing vocational education opportunities that are culturally sensitive, demonstrate patient involvement, adapts the recovery approach to care and shifts the balance of power, giving patients a greater say in decisions about their care. But for in the UK, there are no clear guidelines related to the management of distressed, disturbed and aggressive patients. All the countries involved in this project have recognised the urgent need to clarify and/or develop mental health care policies, guidelines and ethical codes in relation to the care of distressed and disturbed patients. This is not only important because the nature of psychiatric nursing is changing, but also to be able to offer guidance and support for nursing staff in how to manage challenging situations. Therefore, developing a multinational educational portal may be the first step to support the homogenising process in caring for distressed and disturbed patients in Europe.

References

Cantelmi T, Ciambrello C, Stendardo V. & Marra F. (2003) Il lavoro d'équipe Into: Infermieristica Clinica in salute Mentale. Cea, Milano. Italy.

Cocoran P, Arensen E, O'Mahony D. (2006) Suicide and the other external cause mortality statistics in Ireland. Crisis 27(3), 130-134

DGS – Direcção Geral de Saúde (2004) – National Health Plan: 2004-2010; vol. I – priorities. Lisbon: Direcção Geral de Saúde.

Department of Health (1999) National Service Framework for mental health: modern standards and service models. Department of Health, London.

Department of Health & Children (2006) A vision for change: report of the expert group on mental health policy. Stationary Office. Dublin. ISBN 0755773764

ECCN. European Competence in Care and Nursing. Leonardo da Vinci Project. http://www.ec-cn.org/ (Accessed 19.11.2007)

General Practice Nursing programme 2006. www.klk.lt (Accessed 18.9.2007)

Government of Ireland (2000) A Strategy for a Pre-Registration Nursing Education Degree Programme Report of the Nursing Education Forum. Stationery Office, Dublin

Health care in Lithuania (2006). Sveikatos apsauga Lietuvoje. UAB, Petro ofsetas Vilnius. Lithuania

Health Service Executive (2006) Transformation Programme 2007-2010. Health Service Executive, Dublin. http://www.hse.ie/en/Publications/HSEPublications/FiletoUpload,2602,en.pdf. (Accessed on 22.1.2007)

Health Statistics in Lithuania 2005 Health Statistics of Lithuania .2005. Lithuan Ministry of Health. Lithuanian Health Information Centre. http://www.lsic.lt/data/la2005.pdf (Accessed 22.10.2007)

The Law on Mental Health Care Republic of Lithuania (1996) www.3.lrs.lt (Accessed 18.9.2007)

The Law on Rights of Patients Republic of Lithuania (1996) www.sam.lt (Accessed 18.9.2007)

The Lithuanian Health Program 1997 – 2010. www.euro.who.int/document/e699920 (Accessed 18.9.2007)

Lithuanian state mental health strategy 2005-2010. www.lps.vu.lt (Accessed 18.9.2007)

Mental Health Act Commission, Care Services Improvement Partnership, National Institute for Mental Health in England, and the Healthcare Commission. (2007) Count me in: results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales. Commission for Healthcare Audit and Inspection, London.

Ministery of Education. (2004) Education and Research 2003-2008. Publication 8. Ministery of Education, Helsinki.

Ministery of Health (2007) Elenco codici ICD9CM per le Diagnosi. http://www.ministerosalute.it/programmazione/sdo/ric_codice/homepage_capitoli.jsp (Accessed 20.5.2007)

Ministry of Social Affairs and Health (2001) Nurses', public health nurses' and midwifes' competence requirements in health care. Essential elements in practising health care. [Sairaanhoitajan, terveydenhoitajan ja kätilön osaamisvaatimukset terveydenhuollossa. Terveydenhuollon ammatinharjoittamisen kannalta keskeisiä näkökohtia.] Brochures 2000:15. Ministry of Social Affairs and Health, Helsinki.

National Institue for Clinical Excellence (2005) Violence: The short-term management of disturbed/violent behaviour in in-patient setting and emergency departments. Clinical Guideline 25, February 2005. developed by the National Collaborating Centre for Nursing and Supportive Care. NICE London.

National Institute for Mental Health in England (2004) Developing positive practice to sujport the safe and therapeutic management of violence and aggression.in mental health in-patient settings; Mental helath policy implementation guide. NIME, Londoon.

NHS (2007) NHS in England. Strategic Health Authorities. http://www.nhs.uk/England/AuthoritiesTrusts/Sha/Default.aspx (Accessed 18.9.2007)

Sharp D. (2004) Return to asylum: the search for clients with enduring mental health problems in Italy. http://www.blackwell-synergy.com/toc/jpm/11/5 (Accessed 14.08.2007)

http://www.wap-leonardo.de/eng/index.html

Wittchen H-U & Jacobi F. (2005) Size and burden of mental disorders in Europe – a critical review and appraisal of 27 studies. European Neuropsychopharmacology 15, 357-367.