

# Life in acute mental health settings: experiences and perceptions of service users and nurses

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**Background.** Acute psychiatric provision in the UK today as well as globally has many critics including service users and nurses.

**Method.** Four focus groups, each meeting twice, were held separately for service users and nurses. The analysis was not purely inductive but driven by concerns with the social position of marginalised groups – both patients and staff.

**Results.** The main themes were nurse/patient interaction and coercion. Service users and nurses conceptualised these differently. Service users found nurses inaccessible and uncaring, whereas nurses also felt powerless because their working life was dominated by administration. Nurses saw coercive situations as a reasonable response to factors 'internal' to the patient whereas for service users they were driven to extreme behaviour by the environment of the ward and coercive interventions were unnecessary and heavy handed.

**Conclusion.** This study sheds new light on living and working in acute mental health settings today by comparing the perceptions of service users and nurses and deploying service user and nurse researchers. The intention is to promote better practice by providing a window on the perceptions of both groups.

Received 3 September 2013; Revised 24 October 2013; Accepted 28 October 2013; First published online 16 December 2013

**Key words:** Acute care, mental health, nurse researchers, service user researchers.

## Background

What is it like to live and work in an acute mental health wards today? In reviewing the literature on this topic there is an imbalance. There are many peer-reviewed nursing journals, some dedicated solely to psychiatric nursing. But there is a paucity of user research so that in order to access the views of service users the grey literature often has to be relied upon. Naturally, research conducted by psychiatric nurse researchers often takes the patient experience as the focus. However, this entails a certain power relation because in doing empirical research the patient participant knows that the researcher belongs to a group in a position of power over them in other contexts. We tried to resolve this problem by having service user researchers investigate the experiences of patients and nurse researchers investigate the experiences of nurses. In this way, we hoped to level the power relations between researcher and researched (Rose *et al.* 2011).

## Aims

The aim of this study was to explore the perceptions and experiences of service users and nurses in an acute psychiatric ward setting. We conceptualised both groups as marginalised and the analysis was motivated by an attempt to understand their relative positions with particular reference to the balance of power.

## Acute psychiatric nursing today (and yesterday)

It is often stated that nurses want to give a good service to their patients. Indeed, as long ago as 1952, Peplau (1952) called this the essence of the nursing process and it is what is known as 'therapeutic relationship' (Higgins *et al.* 1999). At the same time, nurses know that this is not how their service is perceived and they themselves can find their situation to be one of powerlessness. In probably the first survey of patients' own views of acute care, it was found that ex-patients of an asylum were broadly happy with their care but thought that the nursing relationship could be improved (Gordon *et al.* 1979). Sharac *et al.* (2010) had similar results when examining nurse–patient interaction in the literature across four

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decades. This seemingly intractable problem appears to persist despite major service reconfigurations.

There are a number of issues that may hinder therapeutic interaction between staff and service users. The reconfiguration of services in most developed countries from hospital to community has led to bed reductions and has changed the in-patient population towards those with the most severe problems, especially in urban areas of high demand (Saxena & Barrett, 2007). In the UK, mental health hospitals are also facing nursing staff shortages, bed shortages and an increase in complex presentations especially in disadvantaged urban areas. Inadequate staffing has been cited as a major source of stress (Jenkins & Elliott, 2004). Cleary & Edwards (1999), writing in Australia, describe providing nursing care as a situation where 'something always comes up'. Emotional exhaustion, stress and burnout in acute wards have also been linked to high levels of violence (Sullivan, 1993). Authors also report disempowerment and moral dilemmas experienced by nurses particularly when they cannot deliver the care service users patently need (Austin *et al.* 2003). Our study is based in a single mental health provider in an inner London area but it is typical of the sorts of acute services currently under similar pressures. Nurses find themselves at the bottom of the medical hierarchy in such environments and as such are a marginalised group.

A further feature of the nursing literature is its focus on violence, which is a prominent theme in our data. Wards often go to great lengths to prevent any risk whatsoever including installing CCTV cameras in the grounds, security personnel and, at a more mundane level, the use of plastic cutlery. One quarter of the wards in one study were permanently locked and a further half sometimes locked despite the fact that many patients were voluntary (Bowers *et al.* 2002).

### *Service users' perspectives*

Here we will focus on the rather sparse literature written by service user researchers themselves because information given to academic or clinical researchers may be influenced by the differential status of the two parties. Both Walsh & Boyle (2009) and Rose (2001) found service users to experience low levels of involvement and a lack of information about their care and treatment. This mirrors the nursing literature. Rose's (2001) participants reported a lack of activities leading to crushing boredom and like MIND's 'Wardwatch' campaign (2004), patients reported feeling unsafe.

Alison Faulkner, a service user-researcher who spent time in acute wards, combines her systemic knowledge of mental health services with her own

experience and that she has witnessed of others (Faulkner, 2005). Drawing on the grey literature (Sainsbury Centre for Mental Health, 1996) she confirms the shabbiness of wards, the intense boredom and the petty rules and regulations. She further concludes that in the inpatient wards she has frequented she was treated as 'less than human' and witnessed other patients also being constructed as Other.

Studies where the researcher was a service user (Gilbert *et al.* 2008, 2010) found that what was most important was the quality of the therapeutic relationship. This is entirely in line with both UK policy and some of the nursing literature. Interestingly, good therapeutic relationships were prized whether the user was in a traditional acute ward or an alternative style of service such as a crisis house.

## **Method**

### *Setting*

The study was conducted in a South London provider Trust of mental health services. The region is characterised by high levels of social deprivation and poverty and has a diverse ethnic mix. There are however, pockets of affluence.

### *Sample – service users*

The inclusion criterion for the study was that the participant had been an in-patient in the previous 2 years. Participants were recruited through mental health teams. One group was convened especially for patients who had been detained in hospital and treated against their will – known as 'involuntary' patients in the UK – although in the event all groups contained patients who had been detained. Altogether 37 people participated in the focus groups, 16 men and 21 women. 18 participants were from a white background and 19 from black and ethnic minority (BME) communities. The most common diagnosis, allocated to half the group, was schizophrenia/psychosis. 20 had been detained, 12 had been voluntary and 5 did not disclose this status. The ethnic mix reflects the local inpatient population but we had a higher proportion of women than pertains locally. Only one person did not return for the second focus group, which suggests that they were engaged in the process.

### *Sample – nurses*

Forty-eight nurses employed in the same provider Trust took part. Qualified nurses and healthcare assistants were included; however team leaders were excluded as during an initial pilot study, the presence

of senior staff was observed to inhibit the responses of more junior staff. One group was therefore convened for healthcare assistants only, although the other groups were mixed and sampled purposively to mirror the team structure that operates on acute in-patients wards. Overall, 18 healthcare assistants and 32 qualified staff participated. There were 15 men and 33 women. Reflecting the inner London demographic, there were 13 white British participants and 35 from BME groups. Staff ages ranged from 21 to 58.

### Researchers

The study adopted a participatory approach (Cornwall & Jewkes, 1995). What this means in this context is that the service user focus groups were facilitated by people who, as well as being researchers, had used mental health services themselves. There is evidence (Gillard *et al.* 2010) that the use of user researchers leads to more relaxed and open discussions and to different findings. The nurse focus groups were facilitated by nurse researchers once again making use of 'insider knowledge'.

### Data collection

A topic guide was produced and piloted allowing for open-ended discussion of the experience of acute care from the perspectives of both nurses and service users. The pilot led to minimal amendments. Four focus groups of both service users and nurses each met twice, the second time for purposes of respondent validation (Pope & Mays, 2008). Data were digitally recorded and transcribed.

### Analysis

This was an in-depth secondary analysis of focus group data. The original task of the groups was to construct measures of patient and staff perceptions of acute wards (Evans *et al.* 2012; Laker *et al.* 2012). However, the groups were not structured so as to only construct measures and the data were also appropriate to independent analysis. This analysis involved recoding the data. We used Nvivo8 software to identify, prune and merge codes and finally construct the main themes of nurse/patient interaction and coercion. This type of analysis produces some numerical information on codes but this should not be seen as strict numerical or ordinal data. There were, however, vast discrepancies in the number of codes allocated to different chunks of text and so we have chosen the term 'reference density' to distinguish codes, which appeared very frequently to those that were rare.

Rare reference density is also important as it shows what is missing or absent. We also paid attention to the language used. The second round of focus groups largely endorsed our interpretation of what had been said, amplifying rather than changing it and furnishing more detail.

However, the analysis was theoretically driven and not purely inductive. We conceptualised our groups as participants reflecting on their everyday knowledge, experience and feelings about ward life, in other words expressing their situated knowledge. We drew here on Harding's (1991) focus on subjectivity and marginalisation where she first focused on the situated knowledge of women scientists and then extended this to the knowledge of other marginalised groups. Standpoint epistemologists have never studied those with mental health problems but we regarded users as a marginalised group and nurses as at the bottom of the medical hierarchy thus inserting a concept of power into the analyses of both datasets. In this way, the secondary analysis was not purely inductive but driven by a concern with how these disempowered groups situate themselves in the specific context of acute wards and how their experiences intersect.

### Results

Results will be presented as a narrative, focusing on dominant themes. Illustrative quotations may be found in the Appendix [see Supplementary Material]. Quotes are named but not demographics in order to preserve anonymity.

The results presented pertain to the twin themes of interaction between service users and nurses and how power manifests itself between and across them on acute wards. These were the commonest themes in our data, with the highest reference density. The themes are not new but we think the reader will find some more illuminations here, as this study considers service users and nurses together positioning both as marginalised groups.

#### *Staff and Service Users' Interactions on Acute Wards*

##### *Service users*

In terms of 'reference density' the overwhelming perception of service users was that the ward was 'untherapeutic'. A crucial contributor was the lack of available staff and helpful staff. For patients, it appears that staff are 'stuck in the office' and cannot help even when the situation is urgent, escalating and the service user is in crisis. This lack of availability was compounded by the use of 'bank' or 'agency' staff who were brought onto the ward in times of staff shortage but were usually

unfamiliar with the ward and did not know the patients. They were described as 'sitting and staring' and not prepared to have a conversation with users or even ask them how they were feeling. (Q1)

In the UK, every service user should have a care plan and documented notes on that care plan being met. In fact, this is the main form of 'structured interaction' that is meant to take place on wards. But even care planning was low in reference density in the data. One of our participants had been given his discharge summary, which included this documentation. It implied that he had had one-to-one conversations with a named nurse every day throughout his stay. However, this was not his memory of events (Q2).

Many of the service users understood that work pressures such as under-staffing, paperwork and work-related stress impacted on staff's lack of interaction. Nevertheless, this resulted in an untherapeutic climate where emotional distress was suppressed.

It is evident in the accounts that routine and therapeutic interaction was rare in ward life. Participants were more positive about talking therapies although they gave instances of them being unhelpful, especially groups where everyone, including the facilitator, sat mute for an hour. Although talking therapies were described as being helpful very few people had actual experience of such therapy whilst on the ward. They reported *in prospect* that talking therapies would be a good way to deal with distress. One participant had observed a suicidal fellow patient and thought that if there had been group therapy available she might have got better (Q3). Another favourably contrasted talking therapies with the ever-present use of medication (Q4).

Nevertheless, there were instances where the service user recognised that the ward had done them some good or at least were ambivalent about it (Q5).

### **Staff and Service Users' Interactions on Acute Wards**

#### *Nurses*

The nurse participants were aware that the care they were providing was less than perfect and that they did not spend enough time with patients. They perceived both administrative tasks and bed management as a barrier to interaction and the 'pressure' of these daily tasks was very frequently referenced. Instability both as a result of the distress of individual service users and the overall ward milieu were of concern.

Bed management, which involved early discharge, making space and moving clients around provoked a strong emotional response amongst nurse participants as they knew it led to poor interactions with patients. The practice of 'sleeping out' where a patient spent

the day on the ward and then was sent to another ward or even Bed and Breakfast to sleep evoked angry responses. Using periods of leave to free up beds also provoked feelings of guilt and anxiety alongside the view that senior management did not care (Q6 and 7).

Nurses had complex emotional responses to the fact that they could not spend enough time with service users. They expressed frustration and concern that they were becoming deskilled (Q8). Anxiety, arising from the lack of interaction was a common response. Explicitly, staff remained committed to the need for interaction despite the daily pressures of working in an acute setting. But at the same time, there was an underling theme of avoidance, or interaction anxiety which suggested that many staff had withdrawn from interaction with the service users. The main cause of this 'burnout' appeared to arise from limited internal coping skills and from the need for staff to protect themselves emotionally from the complexities of individual service users in their care (Q9 and 10).

#### *Coercion and control*

As a barrier to therapeutic interaction and within the wider theme of violence, we will illustrate how service users and staff perceive their mutual powerlessness to be manifested on the ward. The two groups have differing perspectives: users feel coerced, whereas staff feel that they are delivering a legitimate response to violence.

#### *Service users*

For service users, coercion is a complex concept. Here we focus on control, restraint and forced medication (rapid tranquilisation), which had high reference density in the data and our patient participants devoted much time to this theme. Medication was the main (or sole) treatment but here we are concerned with medication that is given by force. Other countries use mechanical restraint but this is not deployed in the UK.

One of the main reasons given by patient participants for behaviour that might elicit restraint or forced medication was that users were cooped up in the ward and not allowed to go outside and get fresh air. Even those granted time off the ward would often find themselves without a suitable escort. Others put it more strongly, likening the environment to a prison or a cage for an animal. This they said provoked extreme frustration and anger which was responded to by nurses in a way they thought aggressive and unnecessary. Our participants conceptualised forced medication as violence and had a whole vernacular

to describe it: 'jump on you with the needle' or 'pound on you with the needle'. They, however, did not see their own behaviour as unnatural. For these participants, forced medication was not medical treatment but control (Q11 and 12).

Coercion can be experienced in more subtle ways and examples were common in the data. So, medication does not always have to be given forcibly. There can be pressure to take medication under the threat that if the patient does not then it will be given by force (Q13).

There is a dichotomy in our data. Inpatient wards were routinely described as unsafe, fearful places where users felt unprotected by staff. Perceptions of coercion regarding control, restraint and medication resulted mainly from 'being done to'. However, within the context of an often chaotic ward, coercion was sometimes perceived as an appropriate staff response to other violent service users (Q14).

### Nurses

Both service users and nurses reported a sense of 'them and us' on the ward. In the management of violence, nurses used interventions that were perceived as coercive by service users. However, nurses expressed some awareness and sympathy towards service users around this issue and referred to the therapeutic relationship as a protective factor in the management of violence (Q15).

At the same time, it was clear that control was not absolutely one sided in favour of nurses. They reported that violence as well as intimidation was a tool that service users could use to express their resentment at their situation on the ward. The lack of support felt by nurses in the face of violence was strongly expressed in the data. This is despite the provider Trust having a 'zero tolerance' policy with respect to abuse which would imply that police intervention was sometimes warranted. Nonetheless, many felt that they had to cope alone (Q16).

There is no doubt that some nurse participants had experienced very serious incidents. As well as physical assault, two nurses had been taken hostage and locked in the nursing office for many hours. Attempts to have the police intervene were of no avail as the police saw it as a 'mental health issue'.

Official documents from the Royal College of Psychiatrists and the Royal College of Nursing in the UK emphasise that the initial response to an imminent incident should be one of de-escalation where the staff member tries to 'talk down' the patient (Wing *et al.* 1998). The reference density of de-escalation in our data was tiny with only two chunks of text coded. One tried to explain why de-escalation was impossible

due to lack of staff. However, there was one instance where de-escalation, consequent on trust, was highlighted as best practice (Q17).

### Discussion

This paper interrogated the situated knowledge of two marginalised groups in the acute psychiatric care context – patients and nurses. The experiences of the two groups are characterised by different interpretations of the same themes. Patients want a decent quality of care and to be treated as human beings and their situated knowledge tells them that this is sometimes wanting. They want to get better and they want to get out. Their accounts of 'incidents' try to give some rationale for why sometimes they are pushed over the edge. Their narratives are hardly consistent with the work of Peplau (1952) and Higgins *et al.* (1999) highlighting positive therapeutic relationships as central to nursing. In fact, through poor levels of interaction, nurses can miss the right times for intervention, and early use of de-escalation techniques. We found this too in the user literature summarised earlier. So, these are not new findings, but our data are replete with references to poor care in a way that is unusual. We have called nurses a 'marginalised' group and this is because they are at the bottom of the medical hierarchy. At the same time they shoulder responsibility for patient care – there are very few references to doctors in our data. Day-to-day life is what supervenes.

But there is a conundrum. The accounts of our patient participants were replete with highly negative incidents and the staff rationale for lack of interaction was the amount of administration they were called upon to do. But the literature shows that this has always been the case. Quirk & Lelliot (2001) argue that reconfiguration of services brought about by de-institutionalisation accounts for the parlous state of acute wards today. But this cannot account for the fact that a similar situation pertained 40 years ago (Gordon *et al.* 1979) Further analysis might be able to solve this problem but perhaps there is a social psychological element hinging on an 'us and them' dichotomy described by both sets of participants. Further research could take a more social psychological approach and interrogate group identities in the inpatient ward setting.

The imbalance of power in our data was not one-way between staff and service users. Staff saw themselves working in the frontline under intolerable conditions and with little support from senior management. Their situated knowledge was of themselves as powerless. In these circumstances, it is hardly surprising that they experienced demands from patients as extreme and the ward atmosphere as volatile. For the patients, the nurses' actions were unnecessary,



inappropriate and heavy handed or even meant that they just did not do enough. Policy has it that patients should be treated with dignity and respect (Kendall *et al.* 2012). But what happens when dignity and respect are lost? Arguably, a group of nurses cannot restrain a patient and forcibly inject him or her with 'dignity and respect'. Moreover, there was virtually no evidence of other techniques of de-escalation in our data. It is, however, the case that we may have missed 'early' de-escalation on the part of service users as they may not notice when interventions are made when behaviour is just beginning to become difficult.

Having service user researchers and nurse researchers facilitate and analyse the focus groups has, we argue, elicited new insights into how patients and staff situate themselves in the acute ward context as well as how they do this differently. We followed an expanded participatory model (Cornwall & Jewkes, 1995; Rose *et al.* 2011) by not just taking our questions from service user and nurse discourse but by inserting our 'double knowledge' as both researchers and participants into the study. However, levelling the power relation between researcher and researched is not easy (Mason & Boutilier, 1996) and has even been ironically called a 'spiritual duty' (Henkel & Stirrat, 2001).

### Limitations

The main limitation to this study is the setting in which it took place. It was a highly deprived area of London with much poverty and a very diverse ethnic mix. This might make the results less generalisable. On the other hand, our findings do not contradict previous works as much as paint a more intense picture of them. In addition, our setting was consistent with those in the survey of Trusts in the London area carried out by Bowers *et al.* (2002).

### Conclusion

This is the first study to systematically examine and compare the perceptions of service users and nurses in the acute care setting. Using a participatory methodology, participants spoke freely of their concerns in a way we think might have been inhibited had the researchers been conventional academics or clinicians (Gillard *et al.* 2010). We are aware that some of our findings are shocking, while at the same time many are not new. Issues such as communication between nurses and patients, treating people with respect and de-escalation techniques need to be addressed urgently. This should not require repeating but our analysis shows that it cannot be said often enough.

### Financial Support

This paper presents independent research commissioned by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research scheme (RP-PG-0606-1050). The views expressed in this publication are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. DR and TW are supported by the Biomedical Research Centre for Mental Health at the South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry, King's College London.

### Conflict of Interests

None.

### Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. Ethical approval (07/H0809/49) was given for the study to be carried out in four boroughs within an inner city London NHS trust. This approval included the work reported here.

### Supplementary materials and methods

The supplementary materials referred to in this article can be found at <http://dx.doi.org/10.1017/S2045796013000693>.

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