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patient outcomes and cost-effectiveness are equivalent. However, when variability in adherence to the policy implementation guide is combined with inequity of access and funding concerns, a picture emerges where few teams are sufficiently resourced to provide a comprehensive service for the patient and the family.

Although the original brief for 50 services each covering 1 million population is translating into a larger number of teams covering smaller areas, any celebration of early intervention provision should be tempered by an awareness of the current inequity of access and the early, fragile nature of service development. On-going national programmes of research, including the First Episode Research Network and the Pan-London Research Network, will aid understanding of the impact of early intervention for patients and families, but key structural challenges remain. The main goal should be to build and consolidate services. This includes improving capacity and geographical coverage to ensure equitable access for all patients and families, particularly those under 16 years, improved measurement of the duration of untreated psychosis using standard methodology, effective engagement with child and adolescent mental health services, early detection strategies and capacity to undertake psychosis education and promotional work. Variation in adherence to the policy implementation guide *per se* does not indicate a poorer service model but innovative early intervention teams should document the impact of their practices on patient and family outcomes.

Declaration of interest

None.

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HELEN L. CAMPBELL AND NICOLE K. FUNG

How safe are patient interview rooms?

AIMS AND METHOD

A cross-sectional survey was conducted to investigate the safety of rooms used by medical staff to interview patients in out-patient and in-patient settings of a mental health trust. An assessment tool was designed, and examined the features of an interview room that were likely to promote safety.

RESULTS

The survey included 112 rooms and demonstrated shortcomings that compromised interview room safety. Rooms were frequently overcrowded with furniture ($n=30$), cluttered with loose objects ($n=101$, 90%) and used for multiple purposes ($n=82$, 73%). Room layout often compromised either access to alarm systems ($n=51$,

46%) or exit from rooms ($n=99$, 88%). Necessary facilities for summoning assistance were found to be lacking.

CLINICAL IMPLICATIONS

The safety of interview rooms has not been emphasised sufficiently within everyday working practice and should be revisited.

There are increasing concerns regarding violence directed towards National Health Service (NHS) staff (Department

of Health, 1999a). In 1996 the National Audit Office highlighted concerns about the burden of accidents on



the NHS, including violence and aggression (National Audit Office, 1996). Since then Secretaries of State for Health have made reducing levels of violence and aggression a priority for all health service managers. In 1998 the Secretary of State for Health launched the NHS Zero Tolerance Zone campaign (Department of Health, 1999b). It has been recognised that staff in acute mental health units are at a higher risk of exposure to violence and aggression. The Healthcare Commission is currently launching a national clinical audit in conjunction with the College Research and Training Unit of the Royal College of Psychiatrists on violence in mental health settings (see <http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/nationalauditofviolence.aspx>). The National Institute for Health and Clinical Excellence has recently published guidelines on the management of violent behaviour (National Institute for Clinical Excellence, 2005).

In 1998 the Department of Health set targets to reduce incidents of violence and aggression by 20% by 2001 and 30% by 2003 (Department of Health, 1998). However in 2000/2001 there was an increase of 30% over 1998/1999, with 84 214 incidents of violence and aggression against NHS staff reported (Department of Health, 1999a, 2001a). This increase continued with 95 501 reported incidents in 2001/2002. Recent figures for 2002/2003 reveal 116 000 reported incidents (11 incidents per month per 1000 staff), of which 51 000 (34 incidents per month per 1000 staff) were in mental health and community trusts, more than three times the average for all trusts together (Department of Health, 2003).

Measures to reduce violence include sound risk assessment and management, courses and training, security systems and provision of a safe workplace. A National Audit Office document (National Audit Office, 2003) states that NHS staff have a right to expect a safe workplace and NHS organisations have a legal and ethical duty to do their utmost to prevent staff from being assaulted or abused while at work. A number of national documents outline the importance of clinical environment in contributing to workplace safety and reducing the incidence of violence, however there are limited studies referring specifically to essential safety features of interview rooms (Davies, 1989; Osborn & Tang, 2001).

The safety of interview rooms is an important aspect of managing violence in a clinical setting and should not be overlooked. The Royal College of Psychiatrists (1999) has emphasised the relationship between clinical environment and violent incidents and has addressed the design features of interview rooms that promote safety. Environmental safety is also stressed by the National Institute for Mental Health in England in a document on mental health policy (Department of Health, 2004).

It is clear from the above that a safe environment is needed to conduct clinical interviews both in out-patient departments and on in-patient units. It is particularly important that the in-patient environment should be safe because of a greater potential for violence, as patients who are admitted are more likely to be severely disturbed. The aim of this study was to investigate the

safety of the clinical environment within a mental health trust.

Method

A cross-sectional survey was conducted to assess the safety of rooms used to conduct patient interviews. The survey included clinical sites covering a population of 670 000. All rooms regularly used by doctors to interview patients in out-patient and in-patient areas were included. Out-patient rooms included those based in traditional out-patient clinics and those in any other community settings. An assessment tool (available from the authors on request) was designed based on features of the clinical environment that are likely to promote safety (Royal College of Psychiatrists, 1998, 1999; Department of Health, 2001b, 2002). This tool was used to independently assess the following features for each room: location, furniture, phone and alarm systems and specific characteristics.

Results

Of the 112 rooms eligible for inclusion, 83 were out-patient interview rooms and 29 were in-patient rooms (Table 1). There were several differences between the out-patient and in-patient rooms; 71 of the out-patient rooms (86%) were specifically designated as interview rooms compared with 11 (38%) of the in-patient rooms. The median number of items of furniture present was 7 for the out-patient rooms (range 3–30) and 9 for the in-patient rooms (range 3–16). This difference was statistically significant ($P=0.005$). Use of the room for multiple purposes often accounted for the large number of items found in some rooms.

Significantly more out-patient rooms were greater than 15 m from a staff base than in-patient rooms ($P=0.002$). In most of the in-patient rooms ($n=27$, 93%) the doctor's chair could be positioned closest to the exit, but this meant that the alarm system was only accessible in 6 (21%) of these rooms. In contrast, the alarm system was accessible from the doctor's chair in 45 (54%) of the out-patient rooms ($P=0.002$), but only 40 (48%) of these rooms had a layout that allowed the doctor's chair to be closest to the exit ($P<0.001$).

The majority of in-patient rooms (26, 90%) had an unobscured viewing panel, whereas only 50 (60%) out-patient rooms had this feature ($P=0.003$). None of the in-patient rooms had a fixed alarm compared with 47 (57%) of the out-patient rooms ($P<0.001$), and only 6 (21%) had a telephone compared with 74 (89%) of the out-patient rooms ($P<0.001$).

Discussion

This survey demonstrated a number of shortcomings that compromised interview room safety. Davies (1989) suggested that rooms should be designated as interview rooms rather than have dual function. In this survey more than a quarter of the rooms (27%) were being used for

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Safety feature	Total, n (%) (n=112)	Out-patient, n (%) (n=83)	In-patient, n (%) (n=29)	P*
Location				
≤ 15 m from staff base	57 (51)	35 (42)	22 (76)	0.002
Furniture				
Doctor's chair closest to exit	67 (60)	40 (48)	27 (93)	<0.001
Alarm accessible from doctor's chair	51 (46)	45 (54)	6 (21)	0.002
≤ 3 chairs in room	30 (27)	22 (27)	8 (28)	1.000
No furniture can be lifted	12 (11)	7 (8)	5 (17)	0.292
No furniture blocking exit	99 (88)	72 (87)	27 (93)	0.509
No loose objects present	11 (10)	9 (11)	2 (7)	0.725
Telephones				
Present	80 (71)	74 (89)	6 (21)	<0.001
Working	79 (99)	73 (99)	6 (100)	0.166
Fixed to wall/desk	1 (0.9)	1 (1)	0 (0)	1.000
Alarm system				
Fixed alarm present	47 (42)	47 (57)	0 (0)	<0.001
Personal alarm available	23 (21)	17 (21)	6 (21)	1.000
Alarm tested regularly	59 (53)	48 (58)	11 (38)	0.084
Alarm light outside room	93 (83)	65 (78)	28 (97)	0.023
Room characteristics				
Door opens outwards	6 (5)	5 (6)	1 (3)	1.000
No key needed to exit room	112 (100)	83 (100)	29 (100)	1.000
Unobscured viewing panel	76 (68)	50 (60)	26 (90)	0.003

* χ^2 test.

multiple purposes, including art therapy, group activities and multidisciplinary team meetings. Davies also proposed a suitable layout for furniture to maximise safety. We found the layout of many rooms to be unsatisfactory, compromising either the positioning of the doctor's chair closest to the exit or the accessibility of the alarm system.

We also found that in-patient facilities were inadequate. A substantial proportion of in-patient rooms had a dual function and consequently were overcrowded with furniture and cluttered with loose objects that could be used as weapons. In the in-patient setting, where the potential for emergency situations is greater, none of the interview rooms had a fixed alarm and only six had a telephone. Ensuring that assistance can be effectively summoned in the event of an emergency is vital. Active symptoms of mental illness have been identified as risk factors for violence and are prominent in patients admitted to hospital.

There are many strategies that when used together can promote safety in the workplace. Interview room safety should be incorporated in these measures and could be one of the simplest ways to reduce violent incidents in mental health trusts. There are cost implications to providing safe interview rooms, but conversely there are significant costs associated with violence in the workplace. The direct cost of work-related incidents (excluding staff replacement costs, treatment costs and compensation claims) is £173 million per annum, with violence and aggression accounting for 40% of incidents reported. Indirect costs are more difficult to calculate, but clear links have been demonstrated between violence and aggression and staff absence as a result of sickness,

staff turnover and lost productivity (National Audit Office, 2003). A number of features of interview room safety can be addressed without major financial implications. These include room layout, number of pieces of furniture, removal of loose objects and provision of alarms. Other features may be more difficult to change either because of financial constraints or structural design, for example location of rooms, design of doors and number of rooms available. Nevertheless the Department of Health has recommended that these features should be taken into account when commissioning new or refurbishing existing mental health facilities (Department of Health, 2004).

The study reveals that in everyday working practice the issue of interview room safety has not been emphasised sufficiently and should be revisited. Whether rooms that do not have adequate safety features are also those in which violent incidents are more likely to take place has not been investigated. Future research should address the relationship between the characteristics of interview rooms and the frequency of violent incidents.

Employees of the NHS have a right to expect a safe and secure workplace. Tackling this growing problem of violence against clinical staff involves collaboration between staff, who need to be aware of the risks that their clinical environment poses, and trusts, who have a responsibility to provide a safer place to work.

Declaration of interest

None.

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SARAH SAMUELS, IAN HALL, CHARLES PARKES AND ANGELA HASSIOTIS

Professional staff and carers' views of an integrated mental health service for adults with learning disabilities

AIMS AND METHOD

A study was undertaken to investigate the views of professional staff and paid and informal carers' views of a new integrated mental health service for people with learning disabilities.

RESULTS

Twenty semi-structured interviews were conducted and transcribed.

Most staff and carers were generally satisfied with the in-patient facility. However, information exchange, ward rounds and the ward environment were identified as areas requiring improvement.

CLINICAL IMPLICATIONS

Many of the participants had no previous experience of supporting a

person with learning disabilities and mental health problems in an in-patient setting. However, over time they became supportive of the mental health service and provided valuable input in improving the service provision for people with learning disabilities.

British government policy encourages the involvement of stakeholders in service initiatives (Department of Health, 2001). In addition, the role of the carers in supporting people with mental health problems has become the focus of further government guidance, through the National Health Service Reform and Health Care Professions Act 2002. A local study of carers in London showed that when visiting in-patient mental health units carers felt ignored, not given information and not included in after-care planning (Hervey & Ramsay, 2004).

In services for people with learning disabilities there has been little research on the experiences of healthcare staff and of paid and informal carers who support adults with learning disabilities and mental illness (Allen, 1999),

despite these individuals' greater reliance on social and professional networks compared with other service users. In our experience carers are often instrumental in enabling individuals to understand mental health legislation and treatment decisions. Carers also have a significant role within the psychiatric assessment process, as assessments of mental state of people with learning disabilities are often carer-led (Moss *et al*, 1993).

The authors have developed a new mental health service for adults with learning disabilities and mental illness (Hall *et al*, 2006). As part of this service we have four dedicated in-patient beds within a generic mental health service. Funding was approved at the outset for increased ward staffing levels, and learning disabilities mental health training is provided to nursing staff twice a