

A Vision for Psychiatric/Mental Health Nursing

A shared journey for mental health care in Ireland



Changing practice to support service delivery



Office of the
Nursing & Midwifery
Services Director



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Services Director, Health Services Executive

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A Vision for Psychiatric/Mental Health Nursing -
A shared journey for mental health care in Ireland

Office of the Nursing & Midwifery Services Director

Health Service Executive (HSE)

March 2012



Forewords



Office of the Nursing & Midwifery Services Director

Psychiatric nurses are the largest profession working within the Irish mental health services and they are central to the delivery of care. Mental health services are changing and evolving in a more recovery and user

focused way. Service users' needs and expectations are increasing, legal and policy reforms are altering how services are delivered and professional roles are changing. In this report nurses are responding to these changes and outline the profession's vision to meet the aspirations of a Vision for Change and beyond. This report aims to put collaboration with service users and families at the heart of nursing practice for every psychiatric/ mental health nurse regardless of their location of practice and to ensure that we respond in a truly holistic way. All mental health services and nurses need to consider the applicability of these recommendations in their practice - they are the building blocks for this professional strategy.

I would like to thank all those who contributed to this work and particularly the services users and families who gave up their valuable time to tell us their stories, share their views to inform a better future for all.

Michael Shannon
Assistant National Director
Office of the Nursing and Midwifery Services Director (ONMSD)



A consultation process which was held with members of the elected executive of the NSUE identified that the twin pillars of 'listening' and 'giving hope' were the two most important

factors in aiding recovery. This report fully incorporates the views of service users and family members. It supports the cultural shift to a values based system of care which promotes recovery, the necessity for positive risk taking and the recognition that service users are central to management and delivery of services that is intrinsic to the full implementation of A Vision for Change. Most importantly it adopts a 'can do' and positive approach which is so vital for health professionals and service users alike in the current economic climate.

John Redican
Chairperson
National Service User Executive





An Roinn Sláinte
DEPARTMENT OF HEALTH

I welcome the Report of the Vision for Mental Health Nursing. *The Programme for Government 2011* commits to a comprehensive range of mental health services as part of the standard insurance package offered under Universal Health Insurance. This includes development of community mental health teams and services to ensure early access to more appropriate services for adults and children and improved integration with primary care services. The Mental Health Act 2001 is being reviewed at present in consultation with stakeholders. The Nurses and Midwives Act 2011 provides for a modern nursing and midwifery workforce that can fully engage with the programme of healthcare reform.

The Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Care (DoHC 2011) outlines a framework for role expansion in line with service need and national policy direction. As psychiatric nurses make up the largest proportion of the mental health workforce it is essential that their skills and competencies are utilised in an effective manner. This Report identifies an enhanced role for psychiatric nurses which will improve the range and quality of services and support the further implementation of *A Vision for Change* and the achievement of the goals of the *Programme for Government 2011*.

Sheila O' Malley
Chief Nursing Officer
Department of Health



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Before embarking on any journey it is essential to first establish where your starting from. *A Vision for Psychiatric/ Mental Health Nursing* has provided us

with a detailed grid reference and demonstrates the strengths and limitations of our current position. Mental Health Nurses have made the transition from institutional care to dynamic acute inpatient, rehabilitation, community and Child and Adolescent Mental Health Services. This progression has been iterative and at times uncertain. The *Vision for Psychiatric/ Mental Health Nursing* research provides an evidence based grounding from which we can set clear goals. We now know the new skills required and the great strengths within mental health nursing in Ireland.

Martin Rogan
Assistant National Director (Mental Health)
Health Service Executive





An Bord Altranais

An Bord Altranais as the statutory regulatory body for psychiatric nursing welcomes and commends this major study which will inform the on-going development of mental health care provision in Ireland. The Board contends that this research provides significant evidence to support a congruent approach to addressing mental health needs, implementing national policy, and aligning professional education and training to the provision of competent, evidence based, high quality, client centred and recovery orientated care. The Board was delighted to collaborate with all stakeholders to support this important work. The findings and recommendations of this major study support the mandate of An Bord Altranais: public protection.

Anne Carrigy
President
An Bord Altranais



Implementation of many of the recommendations in Ireland's Mental Health Policy Vision for Change (Department of Health and Children: 2006) is contingent on the development of a sustainable, flexible, dynamic mental health workforce including the psychiatric nursing profession. The Vision for psychiatric/mental health nursing articulated in this report complements the standards for mental health services in Ireland (Quality Framework for Mental Health Services in Ireland, MHC: 2007). In particular, the emphasis placed on the adoption of a recovery approach, service user and carer outcomes, improvement of service quality and overall organisational effectiveness within a context of effective team working is welcome.

Patricia Gilheaney
Chief Executive
Mental Health Commission



Irish Society and those members of it who, from time to time, need to access the support of mental health professionals and services deserve focused, responsive and measured services which are the most effective, least intrusive and provide value for money. This report which is the result of high level collaboration from all stakeholders seeks to provide a psychiatric nursing professional who is qualified to respond appropriately with a range of treatment modalities to the needs of service users and to do so in collaboration with other multidisciplinary team members. Working from this comprehensive resource this report will inform educators, managers, advocates and the community of the potential of the Psychiatric/Mental Health Nurse across the entire panorama of care – Primary, Secondary and Tertiary. In an era of scarce resources, reducing numbers of nurses and growing demand for services this report is not just timely but absolutely essential to the future preparation of nurses and organisation of services. The PNA is delighted to have contributed to its development.

Des Kavanagh
General Secretary
Psychiatric Nurses Association





Irish Institute of Mental Health Nursing

This report, the result of a collaborative endeavor between a large number of stakeholders, not only maps the current strengths and capabilities of mental health nurses but it sets a clear and thoughtful road map for the years ahead. Central to the strategic vision articulated for mental health nursing within the report is the development of a compassionate, competent, reflective and recovery oriented practitioners who will engage with service users and family members from a value base of collaboration, equality, and respect for diversity, autonomy and rights. The Irish Institute of Mental Health Nursing welcomes this report, especially its emphasis on improving equitable access, quality of living and health outcomes, as well as its acknowledgment of the need for ongoing education, professional development, audit and research.

Prof Agnes Higgins
Chairperson
 The Irish Institute of Mental Health Nursing



Mental Health Nurse Managers Ireland (MHNMI) welcomes this timely comprehensive review of the current and evolving role of the psychiatric nurse in line with Vision for Change. MHNMI acknowledges that it is a difficult time for all services. We wish to thank the team for conducting this research and providing this evidenced based strategy for nursing. On behalf of the MHNMI, we look forward to working towards implementation of its findings.

Padraig O'Beirne
Chairperson
 Mental Health Nurse Managers Ireland



SIPTU welcomes the publication of this research report which shows the high level of expertise of psychiatric/ mental health nurses. Since the Commission on Nursing (1999) notable gains have been made in the profession. Professional development has empowered psychiatric/ mental health nurses to become full participants in multidisciplinary teams. They are making contributions in care, research, strategic planning and in the preventative arena of mental health care. Lower numbers of nurses is a concern for the future of the care that can be provided to service users and the development of the profession. It is hoped this report will influence health policy and inform the public about psychiatric nursing and provide a solid foundation for future progress of the profession.

Padraig Heverin
President
 Services Industrial Professional Trade Union (Nursing)





**National Council for the
Professional Development
of Nursing and Midwifery**

*An Chomhairle Náisiúnta d'Fhorbairt
Ghairmiúil an Altranais agus
an Chnáimhseachais*

The key component of planning services for citizens is robust health and social policy that expresses the interface between need and resources. This document takes Irish modern mental health policy, and through review and consultation identifies how Irish Psychiatric Nurses should develop their roles and skills to fully implement the type of services planned for in 'A Vision for Change'. Psychiatric nurses have always been at the forefront of innovation in the mental health services, expanding and creating new roles, developing new skills and moving into new care areas. As the largest group of mental health workers providing the most comprehensive service to people with mental health problems, their leadership and involvement in implementing Vision for Change is key. This project has comprehensively captured the views of psychiatric nurses and other key stake-holders together with contemporary evidence on what the psychiatric nursing response should be to implement the principles of Vision for Change. As the agency that has had responsibility for setting standards for and implementing clinical careers pathways in nursing, and supporting role development, the National Council for the Professional Development of Nursing and Midwifery has been involved in this project from its inception, as a co-funder and through membership of the steering committee and welcomes this report and its comprehensive recommendations.

Yvonne O'Shea
Chief Executive Officer
National Council for the Professional Development of Nursing and Midwifery (2011)



**Office of the
Nursing & Midwifery
Services Director**

'We must become the change we want to see'
Gandhi

Nursing is at the heart of modern mental health care services. Psychiatric nurses have always been at the forefront of leading change and innovations in mental health service delivery in Ireland. This report identifies the values, capabilities, practices and leadership that should underpin the role of every nurse working in mental health care. It will ensure that individuals who may need to access mental health care services will be able to receive nursing care that will respond to their individual strengths, wishes, needs and circumstances in an equitable and uniform way in all care locations nationally. This report is a result of a national study following extensive consultation and collaboration with all relevant stakeholders. It sets out an ambitious vision of a confident and responsive nursing profession and it provides a platform from which further nursing innovations and recovery orientated practice development can happen.

This report should be used by every psychiatric nurse to shape everyday practice wherever care is given to individuals who require it and their families.

Eithne Cusack
Director
Nursing and Midwifery Planning and Development



Table of Contents	6
Members of the steering group	9
List of abbreviations	10
Glossary of key terms	11
A note on terminology	13
Chapter 1:	
Introduction	15
1.1 Background	15
1.2 Project aims	16
1.3 Project objectives	16
1.4 Terms of reference	16
Chapter 2:	
Action Plan	18
2.1 Introduction	18
2.2 The consultation process	19
2.3 The publication format	19
2.4 Summary of key findings	20
2.5 Format of recommendations	24
2.6 Recommendations	25
2.7 Implementation and review	55
Chapter 3:	
Literature Review	56
3.1 Introduction	56
3.2 National Policy Context	56
3.3 Population mental health needs	57
3.4 Quality & Safety In Mental Health	61
3.5 Psychiatric/Mental Health Nursing & Professional Issues	62
3.6 Core Nursing Skills to Work in a Recovery Orientated Way	63
3.7 Improved service user outcomes as a result of psychiatric nursing interventions	66
3.8 Developments in Specialist and Advanced nursing practice roles in Ireland and improved outcomes for service users/careers	69
3.9 Conclusion	70



Chapter 4:

Project Methodology	71
4.1 Introduction	71
4.2 Project Design	71
4.3 Anonymous Survey	71
4.3.1 Eligibility to participate and designing the survey	71
4.3.2 Piloting the survey	72
4.3.3 Recruitment of the survey to maximise response rate	72
4.3.4 Data collection for survey	72
4.4 Focus groups and written submissions	72
4.4.1 Recruitment and designing the format for the focus groups and written submissions	72
4.4.2 Advertising for the focus groups and inviting written submissions	73
4.5 Data analysis	73
4.5.1 Quantitative data	73
4.5.2 Qualitative data	73
4.6 Ethical considerations	74
4.7 Limitations	74
4.8 Summary	74

Chapter 5:

Findings from the survey	75
5.1 Introduction	75
5.2 Response rate and profile of survey respondents	75
Current grade	75
Area of work	75
Professional registration	76
Years working as a nurse	76
Highest educational qualification	77
HSE area	77
5.3 Organising & planning care	77
5.4 Service user & carer/family involvement	81
5.5 Recovery oriented approach	82
5.6 Systems & processes	83
5.7 Service user & /carer family education	84
5.8 Professional development	85
5.9 Development of role	86
5.10 Qualitative aspect of survey	87
5.10.1 Understanding of recovery	87
5.10.2 Factors that facilitate adoption of a recovery approach	88
5.10.3 Factors that inhibit adoption of a recovery approach	90
5.10.4 Skills and competencies	90
5.10.5 Development of RPN role	91
5.11 Summary	92



Chapter 6:

Findings from the focus group and written submissions	93
6.1 Introduction	93
6.2 Respondents understanding of working in a recovery-oriented way	93
6.3 Facilitating RPNs to work in a recovery-oriented way	96
6.4 Values and principles that should underpin psychiatric nursing	99
6.5 Skills and competencies that require development to improve the experiences and outcomes as identified in A Vision for Change (DoHC, 2006)	100
6.6 What needs to be put in place to ensure that RPNs incorporate an evidence based approach into practice?	102
6.7 Development of the RPN role to improve services	105
6.8 How can RPNs best promote social inclusion	108
6.9 Developing and supporting effective leadership for psychiatric nurses	111
6.10 Summary	113
References	114
Appendices	120



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List of Abbreviations

ABA:	An Bord Altranais
ADoN:	Assistant Director of Nursing
AMP:	Advanced Midwife Practitioner
ANP:	Advanced Nurse Practitioner
CAMHS:	Child and Adolescent Mental Health Service
CBT:	Cognitive Behavioural Therapy
CMHN:	Community Mental Health Nurse
CMHT:	Community Mental Health Team
CMS:	Clinical Midwife Specialist
CNM:	Clinical Nurse Manager
CNS:	Clinical Nurse Specialist
CPC:	Clinical Placement Coordinator
CPD:	Continuing Professional Development
DoH:	Department of Health (Changed from DoHC 4/6/11)
DoN:	Director of Nursing
DSH:	Deliberate Self Harm
EBP:	Evidence Based Practice
ECD:	Executive Clinical Director
HEI:	Higher Education Institution
HIQA:	Health Information and Quality Authority
HSE:	Health Service Executive
ISA:	Integrated Service Area
KPI:	Key Performance Indicators
LGBT:	Acronym for 'lesbian, gay, bisexual and transgender
MDT:	Multidisciplinary team
MHC:	Mental Health Commission
NCNM:	National Council for the Professional Development of Nursing and Midwifery
NESF:	National Economic Social Forum
NMPDU:	Nursing and Midwifery Planning and Development Units
NOSP:	National Office for Suicide Prevention
NPDC:	Nurse Practice Development Co-ordinator
NPDU:	Nurse Practice Development Unit
NQAI:	National Qualifications Authority of Ireland
NSRF:	National Suicide Research Foundation
ONMSD:	Office of the Nursing and Midwifery Services Director
RDO:	Regional Director of Operations
RPN:	Registered Psychiatric/ mental health nurse
SCAPE:	Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland
WHO:	World Health Organisation



Glossary of Key Terms

A Competency	'Describes what is observed when a nurse or midwife combines knowledge, skills, attitudes and judgement to perform role-relevant tasks' (Higgins et al. 2010a: 5).
Advanced Nurse Practitioner	Advanced Nursing is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice. They are highly experienced in clinical practice and are educated to Masters Degree level (or higher). (NCNM, 2004:7).
Clinical Nurse Specialist	Specialist practice encompasses a major clinical focus, which comprises assessment, planning, delivery and evaluation of care. A nurse specialist in clinical practice has undertaken formal recognised post registration education relevant to his/ her area of specialist practice at Level 8 or above on the NQAI framework (NCNM, 2008a:5).
Clinical Supervision	'Clinical supervision is regular, protected time for facilitated, in-depth reflection of clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part s/he plays as an individual in the complexities of the events and the quality of her practice. This reflection is facilitated by one or more experienced colleagues who have expertise in facilitation and frequent, ongoing sessions are led by the supervisee's agenda. The process of clinical supervision should continue throughout the person's career, whether they remain in clinical practice or move into management, research or education' (Royal College of Nursing Institute, 1997 cited in NCNM (2008b:2)).
Culture	'A shared system of values, beliefs and behaviour' (Australian Government, 2010: 31).
Domains of Health	'The physical, psychological, emotional, cultural, social, practical, spiritual and informational aspects' of a person's health and wellbeing' (Fitch, 2000 cited in EdCaN' (2008:5)).
Early Interventions	'Interventions targeted at individuals who are displaying the early signs and symptoms of a mental health experience' (Australian Government, 2010: 32).
Effective	'Producing the intended result' (Australian Government, 2010: 32).
Efficiency	'Achieving the desired results with the most cost effective use of resources' (Australian Government, 2010: 32).



Equitable	'Minimising avoidable disparities in health and its determinants, including but not limited to health care, between groups of people who have different levels of underlying social attributes' (Australian Government, 2010: 33).
Intervention	'An activity or set of activities aimed at modifying a process, course of action or sequence of events, to change one or several of their characteristics such as performance or expected outcome' (Australian Government, 2010: 33).
Involvement	'A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change... '(HeBE, 2002: 3).
Mental Health Promotion	'Action to maximise mental health and well being among populations and individuals. Mental health promotion is concerned with promoting wellbeing across entire population groups for people who are currently well, for those at risk and for those experiencing illness' (Australian Government, 2010: 36).
Positive risk taking	'Positive risk taking is weighing up the potential benefits and harms of exercising one choice of action over another. This means identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve desired outcomes and to minimise potential harmful outcomes' (Morgan, 2004: 18).
Recovery	'...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose on one's life as one grows beyond the catastrophic effects of mental illness' (Anthony, 1993: 559-560).
Risk Management	'The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. (HSE, 2010a: AS/NZS 4360:2004).
Risk assessment	'The process of identification, analysis and evaluation of a risk' (Australian Government, 2010: 40).
Scope of Practice	'The range of roles, functions, responsibilities and activities which a registered nurse [midwife] is educated, competent, and has authority to perform' (An Bord Altranais, 2000: 3).
Strategic plan	'Plan that is organisation wide, that establishes an organisation's overall objectives' (Australian Government, 2010: 41).



A note on terminology

The term 'service user' was chosen as the most appropriate to use throughout this report and it includes people who are either current users or past users of services.

The term 'carer' in this report describes both people who are family members and also non-family members who have a supportive and caring role in relation to service users.

The term *mental health difficulties* has been used throughout this document to describe the full range of mental health problems that might be encountered, from the psychological distress experienced by many people, to what some people classify as 'serious mental disorders' and 'illnesses' that affect a smaller population.





CHAPTER 1

Introduction

This report is the first formal strategy for psychiatric/ mental health nursing in Ireland which outlines a vision for the profession for the next 10-20 years. In light of the adoption of a recovery approach to underpin mental health service and care provision as iterated in *A Vision for Change- The Report of the Expert Group on Mental Health Policy* (DoHC, 2006), nurses working with individuals with mental health difficulties are required to review their practice to reflect the embedding of this approach as central to their practice. In order to improve outcomes and experiences for service users, it is essential that the psychiatric/ mental health nursing profession strengthen and maximise the potential of nursing to ensure that it is fit for purpose in a dynamic and evolving health care context. Some services will have reviewed their practice to ensure its alignment with the philosophy and values of *A Vision for Change* (DoHC, 2006); others may have more work to do. The purpose of this report is to outline a strategic framework to facilitate all psychiatric nurses to respond to the varying health needs of service users who are at different stages on the mental health continuum of care and in all health care settings.

Mental health difficulties can have a profound impact on an individual, family members and community health and well being, including physical, social, emotional, psychological, informational and practical aspects. People with mental health difficulties will require varying health and support needs across the life span; these will change over time and require a range of health and support services from primary, secondary, tertiary, community and voluntary care agencies. Throughout their care journey, people's needs for specialist mental health services will also vary. This report has been developed to support nurses working with people experiencing mental health issues at all levels to achieve enhanced clinical effectiveness through improving service quality and outcomes for service users, family and society. This report provides a strategic direction for the future of psychiatric/ mental health nursing practice and aspires to progressing a standardised approach and to reduce variability in service delivery nationally.

1.1 Background

Psychiatric nurses play a pivotal role in mental health services, are the largest staff group involved in the provision of mental health care in Ireland (DoHC, 2006), and are responsible for a wide range of services in community and hospital environments

A Vision for Change- The Report of the Expert Group on Mental Health Policy (DoHC, 2006) proposes a comprehensive model of mental health service provision in Ireland and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health difficulties (DoHC, 2006). It describes a framework for building and fostering positive mental health across the Irish community and for ensuring accessible, community based, specialist services for people with mental health difficulties. It is therefore timely to review the role of the psychiatric nurse in Ireland with a view to making evident and further promoting the significant contribution of psychiatric nurses to existing and future mental health services to ensure the delivery of modern, quality and recovery oriented mental health care in Ireland.



Promoting a collaborative approach, the Office of the Nursing and Midwifery Services Director (ONMSD) and the Office of the Assistant National Director of Mental Health the Health Services Executive (HSE), in partnership with all stakeholders in mental health initiated this national psychiatric/ mental health nursing project with the aim to inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change - The Report of the Expert Group on Mental Health Policy* (DoHC, 2006). A national steering group was established and held its inaugural meeting in July 2010.

Co-funded by the National Council for the Professional Development of Nursing and Midwifery, the NMPDUs and the ONMSD, this project aims to identify nursing skills and competencies which may require development in order for psychiatric nurses to continue to provide accessible, community-based specialist services for people with mental health difficulties.

1.2 Project Aims

- To inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoHC, 2006) in Irish mental health services and beyond.
- To present a report which will identify an enhanced role which will improve the range and quality of services available to individuals and their families.

1.3 Project Objectives

- To review and establish the current role of the nurse working with people with mental health difficulties.
- To identify the factors that may inhibit role development for nurses working in the mental health services.
- To identify the knowledge, skills and competencies required by nurses working with people with mental health difficulties to respond to *A Vision for Change*
- To recommend a framework and action plan for implementation

This work was informed by the recovery approach with emphasis on advocacy, user involvement, psychosocial interventions, education and mental health promotion in order to maximise positive outcomes for service users, carers and the population as a whole.

1.4 Terms of Reference

1. Through a comprehensive literature review establish the core skills and competencies of the Registered Psychiatric nurse (RPN) and the context in which psychiatric/mental health nursing needs to be carried out within the Health Service Executive (HSE) services consistent with current policy.
2. Identify where psychiatric/mental health nursing services can contribute and require further development in the proposed new structures.
3. Review and establish the current role of the RPN
 - (a) Identify the future role required of the RPN to respond to *A Vision for Change*
 - (b) Identify the barriers that currently exist to inhibit role development for nurses working in the mental health services.



4. Identify the psychiatric/ mental health nursing skills and competencies that require development to meet existing and future service needs.
5. Identify areas where expanding the scope of nursing practice aligned with service need will result in improved outcomes for service users and improve the range and quality of services to individuals with acute and enduring mental health difficulties and their families/carers.
6. Identify the professional, regulatory, educational and organisational requirements to support role development for nurses working in mental health services.
7. Develop and agree an implementation framework and timeframe for the implementation of the recommendations of this report.



CHAPTER 2

Action Plan

2.1 Introduction

A number of Irish reports have been published over the last decade from the Mental Health Commission, Department of Health and Children, National Economic Social Forum, National Council for the Professional Development of Nursing and Midwifery, Health Research Board and others and have developed recommendations promoting recovery oriented working and supporting a recovery oriented mental health service in Ireland. These documents are referred to throughout this report and they emphasise the importance of individuals with mental health difficulties and their carers having access to a highly skilled, competent, recovery oriented workforce. The recommendations in this publication may overlap with recommendations in other documents however; these have been developed with a focus on psychiatric/ mental health nursing, the profession and improving service user and family outcomes resulting from nursing interventions.

In 2010, the HSE Clinical Strategy and Programmes Directorate (CSPD) introduced a clinical programme for Mental Health Services which seeks to create better access and improved quality of service delivery for all service users, and to achieve these objectives within a cost containment framework. Core to this overall plan are the principles of recovery and individualised care set within the context of a life cycle approach, and delivered in partnership with community and voluntary agencies, and based on early intervention and evidence based practice. The Mental Health Clinical Programme is a five year plan that will develop service models that implement *A Vision for Change* (DoHC, 2006).

The Clinical Programme aims are:

- The management of serious mental disorders within an updated context of service provision based on *A Vision for Change* (DoHC, 2006)
- The adoption of an early detection approach and increase in assertive and effective interventions/ prevention strategies
- The development of intervention partnerships with primary care and voluntary and community services
- The promotion of positive outcomes for those individuals with mental health difficulties, including reducing the impact of those mental health difficulties, improving social functioning, and the promotion of personal autonomy and well being.

In 2011, this programmes first year of operation, the clinical programme for Mental Health Services has prioritised the following:

- Early Intervention for First Episode Psychosis,
- Early Intervention in Eating Disorders and
- Management of Self Harm presentations to Emergency Departments



The Mental Health Commission (2011) provided an overview of the evidence on economic adversity and mental health and presented recommendations for actions in the Irish context. A number of the recommendations in this report, *A Vision for Psychiatric/ Mental Health Nursing* are cost neutral and could be implemented within existing resources. The recommendations outlined here are reliant on a change in work practices, service models and attitudes. These recommendations will have implications for HSE Corporate Mental Health and organisations in which nurse's work. It is envisaged that these recommendations will complement the key recommendations of *The Report of the Expert Group on Mental Health Policy- A Vision for Change* (DoHC, 2006) and the recommendations of the other publications that are referred to throughout. These recommendations relate to psychiatric nursing practice in all locations of care across the lifespan.

This document should be used in conjunction with *A Vision for Change* (DoHC, 2006), professional discipline specific documents and Department of Health/ Mental Health Commission/ An Bord Altranais documents and reports which apply to the profession.

2.2 The Consultation Process

An extensive consultation process was conducted between November 2010 and June 2011 using both quantitative and qualitative approaches to facilitate data collection*. The process sought to engage with the profession of psychiatric/ mental health nursing, service users and their carers; policy makers, service planner and managers. Written submissions were sought through advertisement in press and a survey and focus groups were utilised. An extensive and systematic review of literature, policy documents and reports was also undertaken and has informed this report.

2.3 The Publication Format

This report is published in two parts:

1. A Vision for Psychiatric/ Mental Health Nursing Action Plan which outlines the recommendations and implementation plan and
2. An overview of the literature and the findings of the consultation process along with the Vision for Psychiatric/ Mental Health Nursing Action Plan which outlines the recommendations and implementation plan.

2.4 Summary of Key Findings

Responses from the consultation process were critical in informing the recommendations produced in this report**. The following were some of the key findings which emerged throughout the consultation. These findings and the recommendations are organised under the following four themes for readability purposes and at times certain findings will inevitable overlap across themes.

1. Adopting a recovery approach

2. Improving outcomes and service quality

3. Developing clinical capacity

4. Enhancing organisational effectiveness

*The overview of the literature and the project methodology sections are available in chapters 3 & 4 of the report 'Vision for Psychiatric/ Mental Health Nursing'

** Presentations of all of the findings of the consultation are available in chapter 5 & 6 of the report 'Vision for Psychiatric/ Mental Health Nursing'



Adopting a recovery approach

- The large majority of respondents described positive attitudes, beliefs and values towards recovery and person-centred and outcome-focused care as the foundation of good nursing practice.
- A systemic approach in relation to the embedding and integration of the recovery values and principles needs to be adopted within mental health services, professional teams and organisations.
- While service users and carers are currently involved in many aspects of care ranging from decision making to evaluating care, there is however, a need to ensure increased involvement and participation of service users and carers in all aspects of care, including design, delivery and evaluation of services where they have meaningful and genuine influence.
- Supportive family relationships and community/ peer support services for service users were identified by the survey respondents as the top two factors facilitating the adoption of a recovery approach. The bio-medical format of documentation within the mental health service as well as the biomedical focus within care planning were identified by the survey respondents as the main barriers to adopting a recovery oriented approach.
- Psychiatric nurses currently facilitate social inclusion and integration in many areas and nurses must continue to provide support to service users who are 'doing well' to facilitate social inclusion. Respondents identified that social inclusion is interlinked to a recovery approach.
- Psychiatric nurses have developed their roles in promoting mental health in a number of areas for example in schools, nurses holding parenting groups in community centres etc. The further development of this aspect of the role is required according to many respondents.
- The requirement for nursing metrics or performance indicators to measure the effectiveness of nursing interventions and associated service user outcomes was highlighted.
- Respondents throughout the consultation indicated that there is a need for interdisciplinary training on recovery principles and values and working in a recovery oriented way



Improving outcomes and service quality

- Public health data should inform population-focused nursing practice in mental health for example suicide awareness.
- The evolving needs of service users and carers should be continuously identified through research
- The rights and responsibilities of individuals experiencing mental health difficulties should continue to be respected and upheld by mental health practitioners and promoted throughout the care journey.
- Professional and service user determined outcomes need to be identified which can then serve as the basis to measure intervention effectiveness.
- Psychiatric nurses in some areas have developed roles aligned to primary care services from within the mental health care teams. These roles entail prevention, early detection and early intervention. These RPNs provide specialist and advanced practice skills in assessment and therapeutic interventions to service users and their carers/ family members. They also provide specialist knowledge and advice to GPs and members of the primary care teams. Evaluation of these roles indicate improved access, improved quality of service, decrease in admission rate and increased service user satisfaction. There is a requirement for more specialist and advanced practice roles to reduce the burden on service users and carers/ family members and provide a more efficient and effective service
- The majority of survey respondents considered all aspects pertaining to medication management, from administering to prescribing as critical in the delivery of an efficient service to service users.
- Inequity and lack of standardisation in relation to the application of a recovery approach, care options and choices for service users and families including the model of service delivery was a constant throughout the consultation process. This needs to be addressed according to many respondents to ensure that service users can expect similar choices, outcomes and experiences, regardless of the service they attend or the location in which they live.
- People working in mental health services must respect cultural and social diversity according to many respondents.
- People working in the mental health services should support service users to exit the services and re- enter according to their needs.
- Psychiatric nurses work as key members of interdisciplinary teams and respect the contributions of other team members. Supportive interdisciplinary practice should be the established professional standard for people with mental health difficulties, with nurses considered equivalent participants in the professional team.
- Psychiatric nurses liaise with a vast range of organisations and individuals within and outside the mental health services on a daily basis and these partnerships must continue to be established, respected, supported and strengthened.
- Although psychiatric nurses utilise a large range of tools as part of the assessment process and incorporate a large number of areas when assessing and planning care with service users, further emphasis needs to be placed on a holistic assessment which incorporates physical assessment and the needs of carers and children of service users. Peer support, voluntary organisations and external agencies should continue to be considered and utilised when assessing and planning care with service users and carers/ family members.
- Respondents reported that the implementation of the moratorium on recruitment has had a negative impact on the continuity of care to service users. Workforce planning issues were referred to throughout the consultation such as the high numbers of staff retiring and reduction of experienced nurses in acute services.
- Mental health services must provide a safe and therapeutic environment for service users, carers and the community.



Developing clinical capacity

- Psychiatric nurses use a large range of interventions and strategies when working with service users and their carers/ family members for example goal setting and early intervention strategies. Areas identified that require further skill development include holistic recovery oriented assessment, assessment of risk to inform clinical judgement, psychosocial interventions and professional and clinical leadership.
- A key area for role development identified was working more closely with carers/ family members in employing a range of carer interventions.
- Psychiatric nurses engage in a wide range of professional development activities throughout their careers. They incorporate new practice areas as they evolve. Psychiatric nurses should continue to negotiate their scope of professional practice with other professionals involved in the mental health care team.
- The majority of respondents identified that the availability of and participation in clinical supervision as critical to facilitate and sustain recovery oriented practice in the mental health services.
- Robust undergraduate programmes are critical to preparing nurses with the appropriate knowledge, skills and competencies to practice effectively and manage risk within a recovery framework. The curriculum needs to reflect the competencies that are required to implement the recommendations in *A Vision for Change* (DoHC, 2006) while also educating individuals on how to respond to service users unique circumstances in a flexible manner while promoting positive risk taking.
- All current postgraduate and continuing professional development programmes to be evaluated to ensure they reflect the recovery principles and values.
- Interdisciplinary training on a recovery approach and recovery principles and values should be available, accessible and evaluated at undergraduate and postgraduate level.
- A culture of lifelong learning should be developed and promoted within mental health services.



Enhancing organisational effectiveness

- Many respondents reported that the culture of an organisation and the degree to which their systems and processes support recovery are critical in driving and/ or inhibiting a recovery philosophy and agenda within clinical services.
- Some respondents indicated that the dominant culture and paradigm for understanding mental health difficulties is through the biological/ medical model that prevails within some mental health services.
- The majority of survey respondents indicated that the two most powerful inhibiting factors to the development of the Registered Psychiatric Nurses role in their areas of practice were the 'medical model' and the 'organisational culture'.
- Within the majority of groups and, in particular the service users/ carers groups, it was stated that the dominance of the executive clinical decision making of the consultant psychiatrist determines the treatment modalities and choices available within the respective mental health services. It was felt that this restricted the care options provided by the clinical team.
- Psychiatric nurses have increased their clinical capacity through the development of a range of skills and therapeutic interventions, for example, cognitive behaviour therapy, counselling, psychotherapy, psycho-social interventions, solution focussed interventions, art therapy, and in new roles for example community, liaison, addiction and rehabilitation in response to emerging need.
- Positive therapeutic risk taking is central to the role of the psychiatric nurse and working in a recovery oriented way. All organisational structures, systems and processes need to be supportive of positive risk taking according to many respondents.
- Teamworking and a learning culture must prevail within services in order to facilitate critical incident analysis and evaluation.
- Psychiatric nurses and other professions identified the Clinical Nurse Specialist (CNS) and the Advanced Nurse Practitioner (ANP) roles as critical to providing clinical leadership in psychiatric/ mental health nursing.
- A number of survey respondents indicated that their line manager facilitates the development of the role of the psychiatric nurses. Others stated that effective and empowering managers are critical to ensuring supportive, recovery-oriented leadership for all nursing grades nationally.
- Concern was expressed throughout the consultation, in relation to the impact of the reduction of nursing structures and roles that provide governance and leadership within services.



2.5 Format of recommendations

The recommendations are presented comprehensively in 2.5.1. An introduction to each theme is provided and outlines the values and experiences articulated and the literature. Quotes are used throughout to support the responses received. Some of the publications supporting each theme are also presented. All recommendations are then presented as follows:

- The recommendation
- The actions that are necessary to implement each recommendation are presented
- For each action, suggestions are made as to who, or which organisation, is responsible for leading on the implementation and what other stakeholders might be involved in this process
- Service outcomes as a result of implementation of each recommendation have been provided.
- Supportive publications sections are included. These are not intended as reference lists, the complete reference list is included towards the end of the report.



2.6

Recommendations

Adopting a recovery approach

Introduction

'Belief that recovery is possible should underpin all our practice'

Each individual with a mental health difficulty faces the challenge of recovery, that being rebuilding a meaningful and valued life (Repper and Perkins, 2003). *The Report of The Expert Group in Mental Health Policy- A Vision for Change* (DoHC, 2006) has a firm emphasis on recovery while detailing a comprehensive model of mental health service provision for Ireland. The National Service Users Executive (2011) produced *'Involving service users in mental health services- Changing the balance of power'* which details the importance of service user involvement and practice pathways for involvement across all levels. They describe real and meaningful partnership/ involvement as outlined in **Figure 1**. Meaningful user involvement requires organisations to consider the practical aspects of the process such as financial and structural changes that need to happen (Tait and Lester, 2005).

'A core tenet of the recovery approach is that the person with a serious mental illness is the best source of information about what works and what does not' (WS 22).

The recovery approach grew from the desire to provide a more holistic, person centered approach in mental health. Psychiatric/ mental health nursing is a profession which is based on clearly defined values that informs every aspect of practice and service delivery. The values held and applied by people working in mental health services directly influence their practice and delivery of care. Higgins and McBennett (2007) suggested that the concept of recovery challenges mental health practitioners to think in a new and creative way about serving people who access the mental health services.

'Fundamentally, psychiatric/mental health nurses are required to practice from the core belief that recovery is possible and demonstrate this consistently in all of their interactions with service users and their carers.' (WS 4)

Values such as a non- judgemental approach, trust, dignity, respect, the provision of choice and promotion of rights are some of the values that are core to the profession of psychiatric nursing. Higgins (2008) captured the common themes underpinning the writings of people who have described their individual journey of recovery through the petals of mental health recovery (See **Figure 2**).

To fully adopt a recovery approach and translate the values and principles of a recovery philosophy into practice, commitment and sustained effort is required not only from every mental health professional in the clinical setting but also from those at policy, organisational and corporate levels.

'One way that might help to foster a recovery orientated service is a move away from the way that we describe ourselves as psychiatric/ mental health nurses. The psychiatric services have now become the mental health services and perhaps we should consider this change as a greater indicator of what we do. In addition, this change might reflect a move away from a medical/illness perspective.' (WS 6)



Figure 1: Involving service users in mental health services- Changing the balance of power NSUE (2011)

Real and Meaningful partnership/involvement

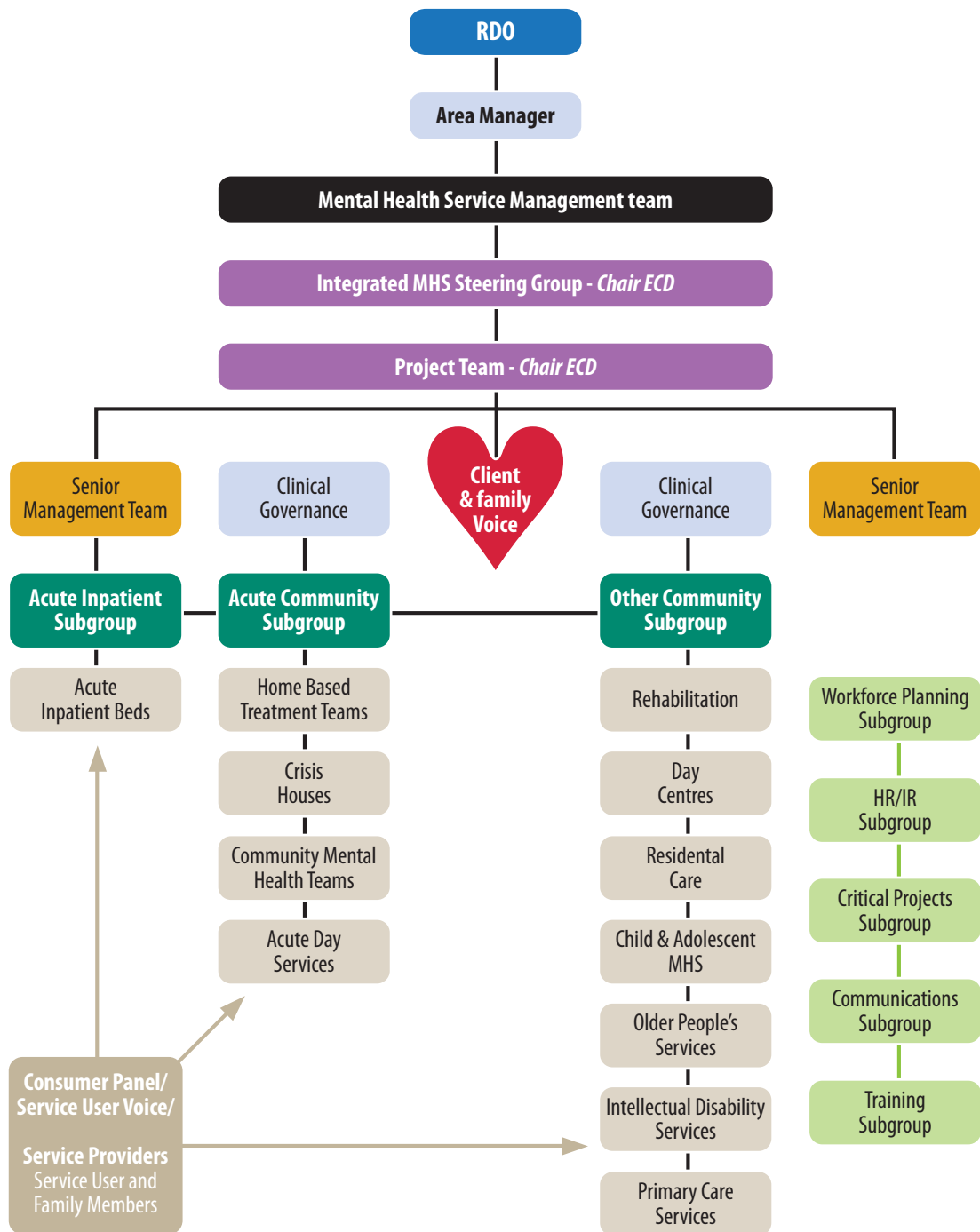


Figure 2: Petals of Mental Health Recovery

(Higgins, 2008)

'The core principle of a recovery approach is that the person is at the centre of the mental health system' (WS 7)

The following recommendations and associated actions support adopting a recovery approach across all levels and aim to improve the experiences and outcomes for service users.

Supportive publications

1. Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. The Stationary Office, Dublin.
2. Department of Health and Children (2008) *Building a culture of patient safety- Report of the Commission on patient safety and quality assurance*. The stationary office: Dublin
3. Higgins, A. and McBennett, P. (2007) The Petals of Recovery in a Mental Health Context. *British Journal of Nursing* 16(14), 852-856.
4. Higgins, A. (2008) *A Recovery Approach within the Irish Mental Health Services: A Framework for Development*. Mental Health Commission, Dublin.
5. Higgins, A., Creaner, M., Alexander, J., Maguire, G., Rani, S., McCann, E., O'Neill, O., Watts, M., Garland, M. (2010) *Current Education/ Training available for professionals working in mental health services in the Republic of Ireland- A Scoping Study*. Mental Health Commission, Dublin.
6. Mental Health Commission (2007) *Quality Framework- Mental Health Services in Ireland*. Mental Health Commission, Dublin.
7. Repper, J. and Perkins, R. (2003) *Social Inclusion and Recovery- A Model of Mental Health Practice*. Bailliere Tindall, London.
8. The National Service Users Executive (2011) *Involving service users in mental health services- Changing the balance of power*. National Service Users Executive, Dublin



Adopting a recovery approach

Recommendation 1

The principles and values of the recovery approach will inform psychiatric/ mental health nursing practice in all areas of care and service delivery

ACTIONS		RESPONSIBILITY OF
1	Evidence based interdisciplinary training in recovery principles and practices to be available to all staff working in the mental health services	Policy, Professional & Corporate HSE Corporate MH HSE ONMSD ABA Clinical Care Programme Service ECDs Nursing DoNS/ADoNs CNEs
2	Evidence based resources to be utilised to direct and inform decisions and practice at all levels and across all services for example <i>A recovery approach within the Irish mental health services- A framework for development*</i> (Higgins, 2008)	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme Service ECDs RDOs ISAs GMs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
3	Organisational, service, professional and operational policies & guidelines to be reviewed to ensure they reflect the principles and values of a recovery approach	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme Service ECDs RDOs ISAs GMs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
4	Mental health practitioners shall support service users to exit the services and re-enter according to their needs	Policy, Professional & Corporate HSE Corporate MH Service ECDs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
5	Clinical supervision** shall be made available internally to all nurses and to be availed of by all nurses to ensure recovery values and principles have been translated and maintained in clinical practice	Policy, Professional & Corporate HSE ONMSD ABA Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN



6	<p>The implementation of metrics to monitor organisational progress and professional performance in relation to recovery to be developed, utilised and evaluated nationally. PoRSAT* (Higgins, 2008) is recommended for application nationally</p>	<p>Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD HEIs Clinical Care Programme</p> <p>Service ECDs RDOs ISAs GMs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p> <p>Individual Each RPN</p>
<p>Service Outcomes</p> <ol style="list-style-type: none"> 1. Service users and their carers/ family members confirm that they receive support in their recovery journey and this to be measured. 2. RPNs report that they are directed and supported by the organisational systems, structures and processes to work in a recovery oriented way. 		

* Higgins (2008) presented a framework and audit tool for the development of a recovery approach within Irish mental health services. The audit tool, namely The Pillars of Recovery: Service Audit Tool (PoRSAT) was developed to allow the provider, the team and/ or the individual to monitor their progress in developing a recovery oriented service. This framework outlines 6 'pillars' of service development which are leadership, person centred and empowering care, hope inspiring relationships, access and inclusion, education and research and evaluation. Under each pillar, elements, rational and criteria have been identified.

** As described in glossary of key terms

Recommendation 2

National Practice Standards will be developed for all professionals working in Mental Health Services

	ACTIONS	RESPONSIBILITY OF
1	<p>An advisory/ working group comprising of a service user, a carer and a member of each profession that make up the majority of the mental health workforce in Ireland to be established. The priority of this group will be to develop National Practice Standards for all professionals working in Mental Health Services to improve health outcomes for service users and carers. These standards will complement each disciplines competencies and address the shared skills when working in interdisciplinary teams</p>	<p>Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs</p>
2	<p>Professional standards of practice for psychiatric nurses will be developed</p>	<p>Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD ABA</p>
<p>Service Outcomes</p> <ol style="list-style-type: none"> 1. These standards will provide a benchmark for all levels of mental health professionals working in mental health in Ireland. 		



Recommendation 3

An inclusive consultation process is required to review the title of 'Registered Psychiatric Nurse' to reflect the role related to the health component of the mental health spectrum of care

	ACTIONS	RESPONSIBILITY OF
1	Service users, carers and all other key stakeholders to be involved in a consultation to investigate how the health component of the mental health spectrum will best be reflected in the title of 'psychiatric nurse'	Policy, Professional & Corporate ABA

Service Outcomes

1. An inclusive discussion from an Irish perspective will be conducted regarding the title of the psychiatric nurse.



Improving outcomes and service quality

Introduction

'Medication is good as part of treatment but it should be used in conjunction with other treatments like psychotherapy, counselling, giving advice. There should be several aspects to treatment' (FG 21)

The domains of health incorporate the physical, psychological, emotional, cultural, social, practical, spiritual and informational aspects of a person's health and wellbeing (Fitch, 2000 cited in EdCan (2008: 5)). Dreenan et al. (2011) concluded following their study that extending a prescribing remit to nurses and midwives has been an effective addition to the delivery of health care and commented that providing individuals with the time to address their concerns impacts positively on service user outcomes. The common goal for health professionals across all disciplines is to improve outcomes for individuals using the service.

The HSE (2011) states that clinical governance assists to ensure people receive the care they need in a safe, open and just environment arising from corporate responsibility for clinical performance. Formalising governance arrangements ensure that individuals working in health and social services are aware of their responsibilities, authority and accountability towards achieving improved outcomes (HSE, 2011). The guiding principles for clinical governance as described by the HSE (2011) are outlined in **Figure 3** and the descriptor for these guiding principles is included in Appendix I.

Figure 3: Guiding Principles for Clinical Governance



'Over the years I had too much medication- more emphasis should be on prevention, earlier intervention, preventing relapse, stress management and relaxation' (FG21)

'Nurses who recognise the absolute centrality of service users (and carers) perspective and recognise the service users ability to be actively engaged in all decisions... [will improve outcomes for service users and carers].' (WS 4)

Health outcomes are used to evaluate the effectiveness of care, describe the effect care has on a persons life, identify the areas for improvement in care and establish a basis for clinical decision making (Davis et al. 1994 cited in NCM, 2010).

'Nurses who practice from the core belief that recovery is possible and demonstrates this consistently with service users and carers will improve outcomes for service users and carers.' (WS 4)

Key performance indicators (KPIs) are measures of performance which are based on standards determined through evidence-based literature or through the consensus of experts when evidence is unavailable (HIQA, 2010). Modern mental health service providers must demonstrate service-level clinical effectiveness to key stakeholders (Sugarman et al. 2009). KPIs are essential tools for both monitoring and improving the quality of health services (Australian Government, 2005). The literature on performance measurement for mental health services has grown extensively over the past decade and according to Australian Government (2005) the driving forces for indicator development are the need to improve monitoring and accountability of services for funding purposes and to improve quality of services for consumers and carers (Australian Government, 2005). According to Sugarman et al. (2009) the use of KPIs based on routinely collected outcome data promotes a transparent, open-book culture about outcomes and it allows providers to monitor performance at the same time as giving clinicians the freedom to develop therapeutic programmes that can best deliver real health improvement. **Figure 4** describes the different levels of KPIs that are required.

Figure 4: Key Performance Indicators



Psychiatric nurses are the largest profession working in the mental health services in Ireland therefore they have a major role in the provision of mental health services and they are in direct contact with service users and their carers/family members. They are well placed to measure outcomes and they must continue to strengthen their focus on measuring service user outcomes in practice. **Figure 5** identifies factors that enhance clinical outcomes (DoHC, 2008).

Figure 5: Factors that enhance clinical outcomes (DoHC, 2008)



'Nurses need ... to measure the interventions they provide and define outcomes' (FG 22)

Organisations and services must have clear concise service objectives and emphasis must be placed on using a range of methods to measure experiences of service users and the effectiveness of interventions in relation to service user outcomes.

'My CPN helped me out with a place to stay- It is great, my CPN handled the whole lot. I was unhappy in the group home- in independent living for 16 yrs and it is great- CPN is vitally important' (FG21)

The following recommendations and associated actions aim to improve the experiences and outcomes for service users as well as service quality across all levels of service provision.



Supportive Publications

1. Byrne, M and Onyett, S. (2010) *Teamwork within Mental Health Services in Ireland*. Mental Health Commission, Dublin.
2. Department of Health and Children (2001) *Primary care- A New Direction- Quality and Fairness- A Health System for you Health Strategy*. Stationary Office, Dublin.
3. Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Stationary Office, Dublin.
4. Drennan, J., Naughton, C., Allen, D., Hyde, A., O'Boyle, K., Felle, P., Treacy, M., Butler, M. (2011) Patients level of satisfaction and self reports of intention to comply following consultation with nurses and midwives with prescriptive authority: A cross sectional survey. *International Journal of Nursing Studies* doi: 10.1016/j.ijnurstu.2011.01.001.
5. Health Information Quality Authority (2010) *Guidance on Developing Key Performance Indicators and Minimum Data Sets to monitor Healthcare Quality*. Health Information Quality Authority, Dublin.
6. Health Service Executive (2010) *Guidance Document: Risk Management in Mental Health Services*. Health Service Executive, Dublin.
7. Health Services Executive (2011) *Clinical Governance Development- Quality and Patient Safety Directorate*. Health Services Executive, Dublin
8. Mental Health Commission (2007) *Quality Framework Mental Health Services in Ireland*. Mental Health Commission, Dublin.
9. National Economic and Social Forum (2007) *Mental Health and Social Inclusion: Report 36*. National Economic and Social Forum, Dublin.
10. World Health Organisation & Wonca (2008) *Integrating Mental Health into Primary Care- A Global Perspective*. World Health Organisation & Wonca, Singapore

Recommendation 4

Key Performance indicators/ measures will be developed, implemented and monitored to manage and facilitate the delivery of quality and co-ordinated services

ACTIONS		RESPONSIBILITY OF
1	Key Performance indicators relating to mental health service delivery to be developed, implemented and evaluated across all levels (corporate, organisational clinical, professional (See Figure 3))*	Policy, Professional & Corporate HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme Service ECDs RDOs ISAs GMs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs
2	Nursing specific key Performance indicators to be developed, implemented and evaluated	Policy, Professional & Corporate DoH HSE ONMSD Clinical Care Programme Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs

Service Outcomes

1. Agreed aspects of the system will be measured to ensure good quality information is available
2. Standardisation of care will be provided by mental health workforce nationally
3. The culture and processes where monitoring of implementation is the norm will address the variation and inconsistency in all professional practice within the mental health services

* HIQA (2010) published a document entitled 'Guidance on developing Key Performance Indicators and Minimum Data Sets to Monitor Healthcare Quality' which is based on an analysis of evidence from an extensive literature review. It is intended as a resource for all stakeholders.



Recommendation 5

Clearly developed quality, safety and risk management systems and processes will be developed and utilised to enhance clinical governance and to ensure that evaluation of all services is an integral part of future service delivery

ACTIONS	RESPONSIBILITY OF
<p>1 Guidelines to be produced on service user focused quality management systems for use in mental health nationally. These guidelines must be informed by a comprehensive review of existing systems internationally and dovetail with the Quality Framework (MHC, 2007)*</p>	<p>Policy, Professional & Corporate HSE Corporate MH HSE ONMSD Clinical Care Programme</p> <p>Service ECDs RDOs</p> <p>Nursing DoNS/ADoNs NPDCs</p>
<p>2 Organisational and nursing metrics to be developed and utilised to support evaluation of care and performance</p>	<p>Policy, Professional & Corporate HSE Corporate MH HSE ONMSD Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p> <p>Individual Each RPN</p>
<p>3 National guidelines for the management of clinical presentations to support the standardisation of care, consistency of approach and promote best clinical practice (for example DSH). These guidelines will also assist clinicians in the clinical decision making process and enhance clinical performance</p>	<p>Policy, Professional & Corporate DoH HSE Corporate MH ABA</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs</p>
<p>4 Team working practices of mental health teams to be audited using a recommended tool kit to ensure quality of care standards are being met e.g. Teamworking audit tool (Byrne and Onyett, 2010)</p>	<p>Service ECDs</p> <p>Nursing DoNS/ADoNs</p>
<p>Service Outcomes</p> <p>1. All practice will be informed by defined service user and carer focused quality management systems</p>	

* The Quality Framework for Mental Health Services in Ireland (MHC, 2007) aims to inform service users and their families as to what to expect when consulting mental health services in Ireland. It provides standards of continuous improvement in the quality and safety of mental health services. The framework consists of eight themes, 24 standards, and 163 criteria

- The commission on patient safety and quality assurance was established in 2007 with the overall objective being to develop clear and practical recommendations to ensure that quality and safety of care for patients is paramount within the healthcare system. In 2008, the Commission on Patient Safety and Quality Assurance made 134 recommendations, based around changing structures and practices within the health services to improve quality and safety.



Recommendation 6

Psychiatric nurses will continue to enhance the integration of social inclusion values into their clinical practice as members of the treating clinical team

ACTIONS		RESPONSIBILITY OF
1	Awareness/ training sessions to be made available to RPNs on the benefits of inclusion for individuals with mental health difficulties	Policy, Professional & Corporate HSE Corporate MH HSE ONMSD Clinical Care Programme Service ECDs Nursing DoNS/ADoNs CNEs
2	Mental health services shall develop arrangements to facilitate inclusion at local and at national level	Policy, Professional & Corporate HSE Corporate MH HSE ONMSD Clinical Care Programme Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
3	All policies used by RPNs and all service developments to be assessed for their impact on facilitating social inclusion and access to community resources and opportunities for participants	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme Service ECDs RDOs ISAs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs
4	RPNs to establish and be supported to establish collaborative partnerships with community and voluntary groups and these partnerships should be an integral part of the nurses role	Policy, Professional & Corporate HSE Corporate MH Service ECDs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
5	RPNs to enable and facilitate service users and carers to link with a broad range of health and social services within the community	Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
Service Outcomes		
1. Service users identify that they experience an improved sense of community integration 2. Effective partnerships exist with mental health services and community agencies		



Recommendation 7

Public Health data will inform population focused nursing practice

ACTIONS		RESPONSIBILITY OF
1	Social and health epidemiological data and population profiles shall be evaluated to inform nursing practice in mental health services*	Policy, Professional & Corporate ABA
<p>Service Outcomes</p> <p>1. Nursing services and developments in practice will be informed by up to date epidemiological data</p>		

* At the time of writing, the Department of Health is developing a new Public Health Policy Framework. The aim is to develop a high-level policy framework for public health in order to improve the health of the nation from 2012 to 2020.



Developing Clinical Capacity

Introduction

'Without a forward thinking ADoN, we would not be as proactive (FG 9)

Psychiatric nurses have developed their practice to ensure they have the appropriate skills and competencies to respond to the needs of service users and their carers/ family members. Following the publication of Planning for the Future (DoH, 1984) psychiatric nurses needed to change their traditional ways of working to take on new roles to provide a better service to people with mental health difficulties. Psychiatric nurses embraced and led this change in many areas nationally. They worked alongside service users in a variety of settings including working as valuable members of interdisciplinary teams and are recognised as being strong advocates for service users and their carers/ family members.

Nurse's advocacy role is vitally important- nurses advise the doctors, I have no relationship with the doctor, only see the registrar every 3 to 6 months (FG21)

The DoH (2011) provides a policy framework for the further expansion of the role of nurses and midwives to promote the delivery of safe, high quality care. The degree to which nursing roles have been developed to improve outcomes for service users has varied from area to area. **Figure 6** outlines an overview of professional psychiatric/mental health nursing roles.

'My mother would be in contact with the CPN, advising on my medication which was very helpful. When I get sick I cannot rely on myself. Nurses should have more say, give feedback, be a voice for us. Doctors don't know us like the nurses' (FG 21)

A Vision for Change (DoHC, 2006) provides opportunities for RPNs to further develop and expand their roles, to take on new roles in different areas e.g. liaison roles, home care, in reach, out reach etc and provide choice to service users in the provision of specific therapeutic interventions.

Health professionals, according to HSE (2010a) must balance individual risk, needs and autonomy with the demands of personal, professional and public safety and accountability. Morgan (2004) outlines ten steps in relation to taking positive risks and comments that shifting the predominant culture of an organisation towards a no- blame culture would be an example of positive risk taking.

From the experiences of mental health services, positive risk taking may be characterised by:

1. Real empowerment of people through collaborative working and establishing trusting working relationships
2. Supporting people to access opportunities for personal change and growth
3. Understanding the consequences of different courses of action, making decision based on the range of choices available and supporting by adequate and accurate information.

(Morgan, 2004)

'Recovery is all about creative risk taking all of the time- Nurses are taking on much more roles in risk taking- competency to manage risk to be developed' (FG22)



Psychiatric nurses maintain their professional development and engage in a wide range of CPD activities following initial registration to enhance their knowledge and develop their skills. Service users expressed the requirement for nurses to take an active role and expand and advance their practice in the management of their care.

'Nurses take much more time with you, doctors only see you for two minutes in out patients. Nurses should be able to manage my care, advise and prescribe medications. Nurses need to have a role in patients review and assessment... She would have all the information. Nurses do not have enough input into my medication' (FG 21)

Nurse prescribing was a role which was cited as one that can be of particular benefit to service users in mental health services throughout the consultation. Positive outcomes can be achieved through the development of specialist and advanced practice nursing roles in areas such as enhanced service provision, increased satisfaction, a positive contribution to the delivery of quality care and population health (OECD, 2004) along with providing advanced clinical skills and strengthening nursing leadership and research. An evaluation of CNS and ANP roles in Ireland (SCAPE) (Begley et al. 2010) found the following:

- Reduced morbidity
- Decreased waiting times
- Earlier access to care
- Decreased re-admission rates
- Increased continuity of care
- Increased satisfaction
- Increased communication
- Increased job satisfaction (ANP/AMP) and
- Overall no additional cost for CNS/ CMS and ANP/ AMP services (staff costs and activity levels for CNS/ CMS and non- CNS/ CMS services and ANP and non- ANP services were matched)

'Mental health structure requires more clinical posts at CNS and ANP level. Clinical leadership should come from that area' (FG 22)

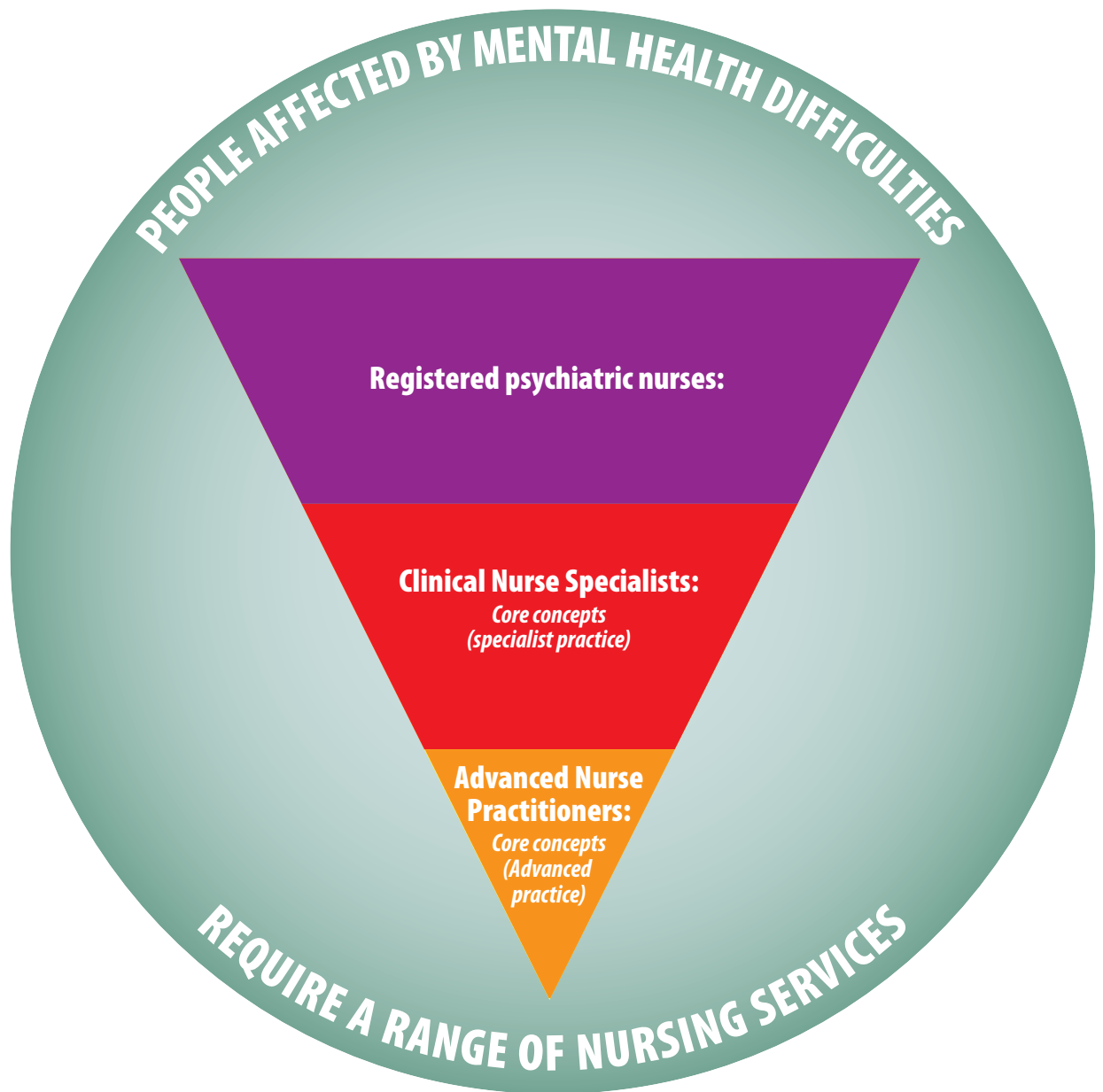
Supporting Publications

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2. Byrne, M. and Onyett, S. (2010) *Teamwork within Mental Health Services in Ireland*. Mental Health Commission, Dublin
3. Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Stationary Office, Dublin.
4. Department of Health (2011) *Strategic Framework for Role Expansion of Nurses and Midwives – Promoting Quality Patient Care*. Stationary Office, Dublin.
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8. Morgan, S. (2004) Positive risk taking: an idea whose time has come. *Health Care Risk Report* 10(10), 18-19.
9. National Council for the Professional Development of Nursing and Midwifery in Ireland (2005) *Service needs analysis for Clinical Nurse/ Midwife Specialist and Advanced Nurse/ Midwife Practitioner post document*. National Council for the Professional Development of Nursing and Midwifery in Ireland, Dublin
10. National Council for the Professional Development of Nursing and Midwifery (2010) *Clinical Outcomes- promoting patient safety and quality of care: implications for nurses and midwives. Discussion Paper 2*. National Council for the Professional Development of Nursing and Midwifery, Dublin.



Figure 6: Overview of professional psychiatric/mental health nursing roles

Professional Development for Psychiatric Nurses



<p>All psychiatric nurses:</p>	<ul style="list-style-type: none"> ● Assessing and evaluating care ● Planning care ● Nursing interventions ● Psychological interventions ● Educating ● Documenting information ● Co-ordinating services ● Communication 	<ul style="list-style-type: none"> ● Administration/organisation of clinical area (Cowman et al. 2001) ● Demonstrates core competencies ● Collaborative working ● Advocacy ● Family Psychoeducation ● Mental Health Promotion ● Social Inclusion
<p>Clinical Nurse Specialists: <i>Core concepts (specialist practice)</i></p>	<ul style="list-style-type: none"> ● Possesses specially focused knowledge, skills and competencies in psychiatric nursing at a higher specialist level than that of a staff nurse ● Clinical Focus (responsible for clinical management of care in specialist area of psychiatric nursing practice) ● Advocacy 	<ul style="list-style-type: none"> ● Education/ training ● Audit and research ● Consultancy ● Provides leadership in clinical practice and acts as a resource and role model for specialist practice ● May deliver specialist nurse led services as part of the treating multidisciplinary team (NCNM, 2004)
<p>Advanced Nurse Practitioners: <i>Core concepts (Advanced practice)</i></p>	<ul style="list-style-type: none"> ● Autonomous and advanced decision making (admission, discharge, comprehensive assessments, prescription, provision of treatment and care options and diagnostic procedures to achieve service user centred outcomes and evaluates their effectiveness. 	<ul style="list-style-type: none"> ● Initiates, refers and terminates care episodes as appropriate. ● Expert practice ● Professional and clinical leadership ● Research (NCNM, 2007)



Developing clinical capacity

Recommendation 8

Psychiatric nurses will continue to access, comprehend and utilise evidence based practice to inform their clinical practice and service delivery

ACTIONS	RESPONSIBILITY OF
1	Nurses will have access to relevant databases and IT facilities to support evidence based practice
2	RPNs, at all levels shall be able to articulate and document interventions in the care journey that they have engaged in to promote a recovery approach
3	HEIs, CNEs and service providers to continue to establish and develop collaborative partnerships to promote a learning culture in practice and projects to be designed to support developments in the clinical setting
4	Evaluation studies to be supported nationally which focus on outcome measurement (using agreed outcome measurement instruments) as a result of nursing interventions
Service Outcomes	
<ol style="list-style-type: none"> 1. Service users and carers will confirm that they have access to nursing staff at all levels who are equipped with the best available evidence and who have the ability to translate this into their practice and service delivery 2. RPNs will have access to facilities to promote evidence based practice 	



Recommendation 9

Psychiatric nurses will provide a more expanded scope of practice to increase clinical capacity and will continue to develop additional skills and competencies to provide a greater range of evidence based interventions and professional services for service users and their carers/ family members

ACTIONS	RESPONSIBILITY OF
<p>1 RPNs will have the appropriate skills, resources and competencies to respond to the needs of service users and carers including in the following areas:</p> <p><u>Therapeutic interventions</u></p> <ul style="list-style-type: none"> • Psychosocial interventions in practice • Counselling/ psychological therapies including CBT • Using interventions to work with people with dual diagnosis/ or presenting having engaged in DSH • Supporting physical health of individuals • Advocacy • Ethnic diversity <p><u>Assessment, care planning and risk</u></p> <ul style="list-style-type: none"> • Advanced assessment & advanced clinical decision making skills • Advanced risk assessment • Devising risk management plans in partnership with the service user and engaging in risk assessment and positive risk taking • Collaborative care planning <p><u>Working with families</u></p> <ul style="list-style-type: none"> • Enabling carers to work collaboratively within mental health teams • Working with carers and families and using supportive interventions 	<p>Policy, Professional & Corporate HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p> <p>Individual Each RPN</p>
<p>2 All nursing assessments to be reflected in interdisciplinary care plan</p>	<p>Policy, Professional & Corporate Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs</p> <p>Individual Each RPN</p>



3	<p>Risk management plans to be developed in partnership with service users and carers as appropriate and guidance documents to be used all at levels to embed risk management in all aspects of practice for example <i>'Guidance document on risk management in mental health services'</i> HSE (2010a)</p>	<p>Policy, Professional & Corporate HSE Corporate MH Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p> <p>Individual Each RPN</p>
4	<p>Positive risk taking to be promoted through guidelines, policies, processes and protocols and managed through local clinical governance structures. These administrative tools are required to support and promote clinical judgments</p>	<p>Policy, Professional & Corporate HSE Corporate MH Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p>
5	<p>Critical incidents and incident reports to be audited routinely and a culture of learning to be promoted as a result of these audits</p>	<p>Policy, Professional & Corporate HSE Corporate MH Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p>

Service Outcomes

1. Service users confirm that they have been involved in key aspects of the care, report that they feel consulted as partners in care and express satisfaction with the outcomes of the collaborative process.
2. Processes and protocols will be in place to guide nurses to positively manage risk and RPNs will report that they are supported in positive risk taking.
3. RPNs acknowledge that they feel supported to use a greater range of evidence based interventions in practice.



Recommendation 10

Psychiatric/ mental health nursing will improve care by developing new, expanded, specialist and advanced roles in response to local need

ACTIONS	RESPONSIBILITY OF
<p>1 The development of CNS/ANP roles must be in response to service need and in accordance with the criteria set out by the NCNM/ ABA</p> <p>Service Providers, DoNs and ECDs to evaluate the requirements for specialist and advanced nursing roles taking into account the following:</p> <ul style="list-style-type: none"> • Service user need • The need to develop new services and introduce new skills • The need for improved access and choice • The need for new ways of working and flexibility • The requirements of the working time directive • The level of experience and clinical decision making required • Shortages of a particular profession/skills • The need to create strong clinical and professional leadership 	<p>Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD ABA Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs</p>
<p>2 Services need to review the level of clinical decision making is required within the nursing team in relation to access, quality and responsiveness</p>	<p>Policy, Professional & Corporate DoH Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs</p>
<p>3 Therapeutic interventions to be reviewed within the nursing service to ensure equity and choice for service users</p>	<p>Policy, Professional & Corporate DoH Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs</p>
<p>4 Evaluation of nursing interventions to take place within the team to ensure access to services, equity, sustainability, quality, value for money and responsiveness</p>	<p>Policy, Professional & Corporate DoH</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs</p> <p>Individual Each RPN</p>
<p>Service Outcomes</p> <p>1. Service users will achieve positive outcomes through the development of new, expanded, specialist and advanced roles within psychiatric/ mental health nursing.</p>	



Recommendation 11

Psychiatric nurses at management and clinical grades must engage in professional and clinical leadership development both in the context of the organisation and the wider health care system

ACTIONS	RESPONSIBILITY OF
1	Leadership development should include strategies to assist all psychiatric nurses to articulate their distinct contribution to care in the practice setting*
	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
2	Different professional and clinical leadership strategies are required for clinical specialist and advanced roles and these to be developed, implemented and evaluated
	Policy, Professional & Corporate DoH HSE Corporate MH Nursing DoNS/ADoNs CNS/ANPs
3	Professional and clinical leadership development programmes should be part of ongoing professional and inter disciplinary team development
	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD HEIs Clinical Care Programme Service ECDs Nursing DoNS/ADoNs
4	Nurses in leadership positions in clinical care and management must work together and across professional boundaries to ensure that psychiatric nursing gets the recognition and influence they need to make a difference to services
	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD Service ECDs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs
5	Psychiatric nurses must have a dedicated representative and voice at national level to promote, inform and advise on psychiatric/ mental health nursing
	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD
Service Outcomes I. Strong professional and professionals and clinical leadership will promote and strengthen psychiatric/mental health nursing across all levels	

* National Nursing and Midwife Clinical Leadership Development needs analysis (HSE 2010b) described a clinical leadership development needs of a national sample of nurses and midwives in Ireland. Following consultation and on the basis of the evidence from the national needs analysis recommendations were presented and the above actions complement these recommendations.



Recommendation 12

The strengthening of all educational programmes is critical to preparing nurses with the appropriate knowledge, skills, attitudes and competencies to practice effectively and manage risk within a recovery framework

ACTIONS	RESPONSIBILITY OF
1	Service user and carers to be involved across all levels of programme design, delivery and evaluation
Policy, Professional & Corporate DoH HEIs ABA Nursing DoNS/ADoNs NPDCs	
2	All undergraduate education programmes for psychiatric nurses to be evaluated to <ol style="list-style-type: none"> Ensure they reflect the philosophy, principles and values of a recovery approach Ensure that they prepare nurses that are equipped with the competencies required to improve outcomes for service users and meet the recommendations outlined in A Vision for Change (DoHC, 2006) Ensure that they prepare nurses to work in a flexible and responsive manner while embracing positive risk taking, and promoting safety
Policy, Professional & Corporate DoH HEIs ABA Nursing DoNS/ADoNs NPDCs	
3	Service providers and HEIs nationally to continue to develop collaborative partnerships and devise strategies to enhance clinical skills, competencies and service user outcomes
Policy, Professional & Corporate HEIs Clinical Care Programme Service ECDs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN	
4	There is a requirement for ABA in conjunction with the ONMSD and mental health services to review which specified educational programmes are required (Category 2 approved) to ensure RPNs have the appropriate knowledge, skills and competencies to enhance the implementation of A Vision for Change (DoHC, 2006) (for example, some psychology based interdisciplinary programmes need to be considered for approved at Category 2 level e.g. Psychosocial interventions, CBT, etc)
Policy, Professional & Corporate HSE ONMSD ABA	
5	All post registration programmes to be developed in line with contemporary service requirements and aligned to service and policy needs
Policy, Professional & Corporate HSE ONMSD HEIs ABA Clinical Care Programme Nursing DoNS/ADoNs	



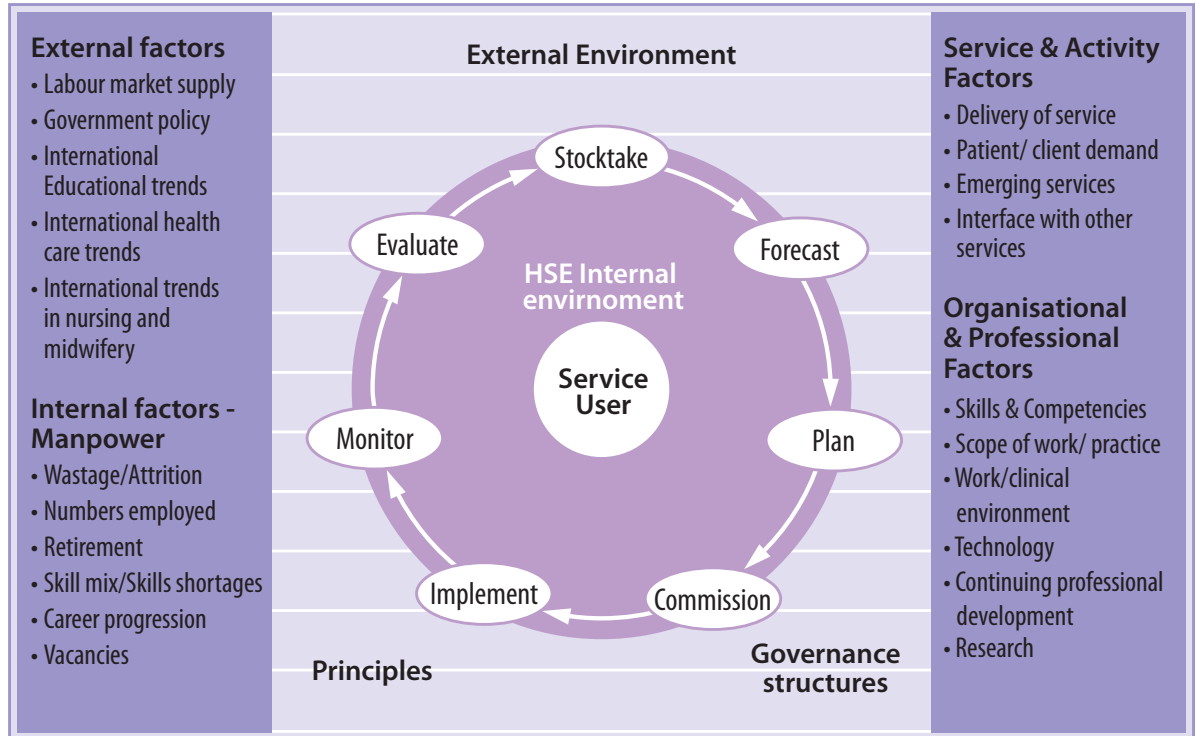
6	<p>A national approach to the development of standardised, regulated, accredited level 8 programmes to support RPNs skill and competency development is required. This will improve quality and provide a consistent approach nationally. The development of Level 9 programmes shall be in line with contemporary service requirements and aligned to service policy and needs to support specialisation and advanced clinical decision making and practice</p>	<p>Policy, Professional & Corporate HSE ONMSD HEIs ABA Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNEs</p>
7	<p>A national policy is required in relation to the re- introduction of post- registration programmes (conversion programmes) leading to additional registration on ABA register giving priority to Psychiatric, Intellectual Disability and General Nursing to meet service needs</p>	<p>Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD ABA Clinical Care Programme</p>
8	<p>Education and training for mental health professionals must be developed in a collaborative integrated manner throughout services**</p>	<p>Policy, Professional & Corporate HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme</p> <p>Service ECDs</p> <p>Nursing DoNS/ADoNs NPDCs CNMs CNEs</p>
<p>Service Outcomes</p> <ol style="list-style-type: none"> 1. All psychiatric nursing undergraduate and postgraduate curricula will reflect the recovery principles and values. 2. An enhanced interprofessional educational culture and commitment could be promoted following consultation with all relevant stakeholders. 		

** Higgins et al. (2010b) conducted a scoping study on current education/ training available for professionals working in mental health in the Republic of Ireland and presented a number of recommendations in relation to interprofessional education. These recommendations must be supported across all levels.

- At the time of writing, a review of the undergraduate nursing and midwifery degree programmes is underway by the Department of Health.



Figure 7: Strategic framework for the future development, delivery and evaluation of post registration nursing and midwifery education. (Adapted)



Source: Report of the Post registration Nursing and Midwifery Education Review group (HSE/ ONMSD, 2008).



Enhancing organisational effectiveness

Introduction

The key elements in the culture of an organisation include how the people in the organisation work, think and behave (Huggett, 1999). Custom and practice as drivers of behaviour can stifle innovation and change in workplace practice and design.

'I was attending a service for 7 years, I was never told my diagnosis. I moved flat and I was told I had schizophrenia. They did a wellness recovery action plan and I realised I had worked in the Civil Service in the past and that I could go back to work... I feel very lucky at [name of service] they focus on self help, nurses deliver preventative thinking, the Wellness Recovery Action Plan programme, learning about your triggers, what starts your illness off, keeping a diary, focusing on things to do, you set out your goals each week, review your progress and evaluate it- it's very helpful' (FG 21)

Over the past decade, major changes in Ireland's mental health delivery system and mental health policy has resulted in implications for the modern day psychiatric/mental health nursing practice. The interests of the service user must continue to be at the forefront of all organisational activities.

***'If I had had the facility of an RPN in primary care, I might not have needed to come and stay in mental health services so long as I would have had early intervention and wouldn't have waited so long...'* (FG 20)**

All individuals within the organisation must continue to work to translate the values and principles of a recovery approach into their practice in order for an organisation to be effective.

***'You need to have the skill of planting hope – Psychiatric/ mental health nurses have an essential role in this respect...'* (FG 20)**

As described by Byrne and Onyett (2010), the acceptability of the clinical primacy afforded to consultant psychiatrists requires discussion in mental health teams.

***'RPNs work in a healthcare system that has developed based on a biomedical approach to mental illness and that is part of a wider healthcare system that is heavily oriented towards a biomedical model. Therefore the structures and ways of working reflect this. In order for mental healthcare to be reformed to support recovery-oriented working there needs to be a formal, managed reflection and review of organisational culture in the context of 'recovery orientation' and structured planned frameworks developed to reform the whole organisation to facilitate working in this way. This would involve identification of barriers and facilitators to recovery-oriented work.'* (WS 23)**

In some areas the current structures and staffing levels present obstacles to reform in embracing a recovery approach. Structures and processes must allow psychiatric nurses to be accessible and continue to be responsive and consistent in responding to service users' individual needs in primary, secondary and tertiary health service locations.

***'From my experience working as Community Mental Health Nurse, many of the individuals that were treated in the Psychiatric Service could have been treated in Primary care if early detection/intervention services were available.'* (WS 9)**



***'Mental health nurses should be at the forefront of mental health service delivery in GP surgeries, A/E Departments, primary care, ancillary services and in an advisory capacity to families...'* (WS 7)**

The following recommendations and associated actions aim to enhance organisational effectiveness across all levels and aim to improve the experiences and outcomes for service users.

Supporting Publications

1. Byrne, M and Onyett, S. (2010) *Teamwork within Mental Health Services in Ireland*. Mental Health Commission, Dublin.
2. Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Stationary Office, Dublin.
3. HSE and DoHC (2009) *An Integrated Workforce Planning Strategy for the Health Services 2009- 2012*. Health Service Executive & Department of Health and Children, Dublin

Recommendation 13

Service users will have access to psychiatric nurses in primary care settings with specialist skills to engage in prevention, early detection and intervention activities while retaining the clinical and professional link with the mental health team

ACTIONS		RESPONSIBILITY OF
1	A formal written description of entry process shall be developed, implemented and evaluated to inform the public of how individuals can access RPNs with specialist skills in primary care settings	Policy, Professional & Corporate HSE Corporate MH HSE ONMSD ABA Clinical Care Programme Service ECDs Nursing DoNS/ADoNs CNS/ANPs
2	Mental health services shall have a developed documented system for prioritising referrals according to risk and urgency and this system to be implemented, monitored and evaluated	Service ECDs Nursing DoNS/ADoNs NPDCs CNMs CNS/ANPs Individual Each RPN
3	Clear operational protocols to be developed by each CMHT to support and provide this specialist mental health care nursing service	Policy, Professional & Corporate HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme Service ECDs RDOs ISAs GMs Nursing DoNS/ADoNs

Service Outcomes

1. Service users report that their mental health care needs are being met at primary care level by RPNs with specialist skills.
2. RPNs who work within the primary care structures confirm that they are supported professionally by the mental health team.



Recommendation 14

Service users will have access to psychiatric mental health nursing skills in prevention, early detection and intervention activities in acute hospital, maternity care, children’s services and services for older people while retaining the clinical and professional link with the mental health team

ACTIONS	RESPONSIBILITY OF
<p>1 Currently service users have access to RPNs with specialist skills that are involved in the delivery of care within particular locations and to specific care groups for example liaison roles in Emergency Departments, perinatal in maternity hospitals. A formal process needs to be developed, implemented and evaluated to ensure that all members of the public have equitable access to these specialist nursing skills in similar healthcare locations nationally</p>	<p>Policy, Professional & Corporate HSE Corporate MH HSE ONMSD HEIs ABA Clinical Care Programme</p> <p>Service ECDs RDOs ISAs GMs</p> <p>Nursing DoNS/ADoNs CNS/ANPs</p>
<p>Service Outcomes 1. Specific groups confirm that they have access to psychiatric/ mental health nursing care, information, early detection and prevention of mental ill health, when required.</p>	

Recommendation 15

Service users will have equitable access to psychiatric/mental health nursing skills that are consistent and responsive to each individuals needs in every mental health service

ACTIONS	RESPONSIBILITY OF
<p>1 Service users will have equitable access to psychiatric nursing skills and a quality mental health service regardless of geographical location*</p>	<p>Policy, Professional & Corporate HSE Corporate MH HSE ONMSD ABA Clinical Care Programme</p> <p>Service ECDs RDOs ISAs GMs</p> <p>Nursing DoNS/ADoNs CNS/ANPs</p>
<p>Service Outcomes 1. Service users and carers report that they are satisfied with the psychiatric/mental health nursing service that they receive to meet their individual needs and this to be confirmed by a consultation nationally.</p>	

* The Quality Framework for Mental Health Services in Ireland (MHC, 2007) aims to inform service users and their families as to what to expect when consulting mental health services in Ireland. It provides standards of continuous improvement in the quality and safety of mental health services. The framework consists of eight themes, 24 standards, and 163 criteria



Recommendation 16

The current mental health service delivery structures and legislation need to be re-aligned to enable the full implementation of A Vision for Change (DoH&C, 2006)

ACTIONS		RESPONSIBILITY OF
1	There is requirement to align legislation, policy and clinical accountability	Policy, Professional & Corporate DoH HSE Corporate MH
2	Nurses working in mental health services must continue to accept responsibility and accountability for their clinical decision making relating to nursing interventions and care	Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
3	There is a requirement for nursing professionals to inform consultant psychiatrists and management teams that nurses are clinically accountable and responsible for their own practice within an interdisciplinary framework	Service ECDs RDOs ISAs GMs Nursing DoNS/ADoNs NPDCs CNMs CNEs CNS/ANPs Individual Each RPN
Service Outcomes		
1. Psychiatric nurses across all levels will confirm that their professional judgement, autonomy and clinical accountability when working with service users is acknowledged and respected.		

Recommendation 17

A national psychiatric/ mental health nursing workforce group will be established to determine the range of skills, knowledge and experience required within mental health services to meet current and future identified need

ACTIONS		RESPONSIBILITY OF
1	A national psychiatric/ mental health nursing workforce group to be established with defined aims and objectives to meet the strategic goals and recommendations as identified in <i>An Integrated Workforce Planning Strategy for the Health Services 2009-2012</i> (HSE & DoHC, 2009)*	Policy, Professional & Corporate DoH HSE Corporate MH HSE ONMSD
Service Outcomes		
1. Service users and carers report that their needs are being met by having access to skilled staff nationally		

* The HSE & the DoHC (2009) published *An Integrated Workforce Planning Strategy for the Health Services 2009-2012* which states that workforce planning at all levels in the health services should be guided by four principles namely client focused, sustainable, available and flexible. According to the HSE & DoHC (2009) improved workforce planning enables and supports clinical and non clinical staff to achieve their full potential. The *Integrated Workforce Planning Strategy for the Health Services 2009-2012* will ensure workforce planning is a key activity in the Irish health and social care services (HSE & DoHC, 2009). This document identifies strategic goals and recommendation to meet the needs of a modern health service and provides the framework and a guide for future workforce planning decisions that will lead to better outcomes.



2.6.1 List of Recommendations

Adopting a recovery approach

1. The principles and values of the recovery approach will inform psychiatric/ mental health nursing practice in all areas of care and service delivery
2. National Practice Standards will be developed for all professionals working in Mental Health services.
3. An inclusive consultation process is required to review the title of the 'Registered Psychiatric Nurse' to reflect the role related to the health component of the mental health spectrum of care.

Improving outcomes and service quality

4. Key Performance indicators/ measures will be developed, implemented and monitored to manage and facilitate the delivery of quality and co-ordinated services.
5. Clearly developed quality, safety and risk management systems and processes will be developed and utilised to enhance clinical governance and to ensure that evaluation of all services is an integral part of future service delivery
6. Psychiatric nurses will continue to enhance the integration of social inclusion values into their clinical practice as members of the treating clinical team.
7. Public health data will inform population focused nursing practice

Developing Clinical Capacity

8. Psychiatric nurses will continue to access, comprehend and utilise best evidence to inform their clinical practice and service delivery.
9. Psychiatric nurses will provide a more expanded scope of practice to increase clinical capacity & will continue to develop additional skills and competencies to provide a greater range of evidence based interventions and professional services for service users and their carers/ family members
10. Psychiatric/ Mental Health Nursing will improve care by developing new, expanded, specialist and advanced roles in response to local need
11. Psychiatric nurses at management and clinical grades must engage in professional and clinical leadership development both in the context of the organisation and the wider health care system
12. The strengthening of all educational programmes is critical to preparing nurses with the appropriate knowledge, skills, attitudes and competencies to practice effectively and manage risk within a recovery framework.



Enhancing organisational effectiveness

13. Service users will have access to psychiatric nurses in primary care settings with specialist skills to engage in prevention, early detection and intervention activities while retaining the clinical and professional link with the mental health team.
14. Service users will have access to psychiatric nurses with specialist skills in prevention, early detection and intervention activities in acute hospital, maternity care, children's services and services for older people while retaining the clinical and professional link with the mental health team
15. Service users will have equitable access to psychiatric/ mental health nursing skills that are consistent and responsive to each individuals needs in every mental health service
16. The current mental health service delivery structures and legislation need to be re-aligned to enable the full implementation of A Vision for Change (DoHC, 2006)
17. A national psychiatric/ mental health nursing workforce group will be established to determine the range of skills, knowledge and experience required within mental health services to meet current and future identified need.



2.7 Implementation and Review

A number of mechanisms will be established to lead, drive and monitor the implementation of Vision for Psychiatric/ Mental Health Nursing nationally:

- The HSE, through the ONMSD will establish National and Regional Implementation Groups consistent with health service organisational structures. These groups will have clear terms of reference to implement the recommendations of this report.
- Regional implementation groups consistent with health service organisational structures will be established.
- These Regional Implementation groups will report four times yearly to the National Implementation Group.
- Every 2 years, a psychiatric/ mental health nursing conference, sponsored by ONMSD will take place to showcase and celebrate achievements in meeting the recommendations, and to consider overall progress, and any interim amendments to the recommendations, that may be necessary.
- At the end of the 5 year period, the ONMSD will formally review progress on the recommendations and consider the need for further developments.



CHAPTER 3

Literature review

3.1 Introduction

The relationship between mental health service users and practitioners has been at the heart of mental health practice since the emergence of the field. The nature of that relationship, however, has changed significantly over time. Over the past two decades, there has been a movement in the mental health world away from the traditional medical model towards a more holistic recovery-oriented approach. This shift is reflected in the academic literature, national and international policy, and in the daily provision of mental health services. The primary role of mental health professionals and services is to meet the health needs of the individuals they serve and their carers (Playle & Bee, 2009). Psychiatric nurses are the largest profession working in mental health services today (DoHC, 2006) and are core mental health professionals who deliver comprehensive care in a variety of settings, including the home, community and in hospital. The restructuring of mental health policy and services towards a recovery-oriented ethos demands a clarification of the key skills and competencies required for psychiatric nurses. The following chapter reviews the current national and international standards, policies, and trends in the mental health field to establish a set of core competencies and skills required by psychiatric nurses practicing in Ireland today.

3.2 National Policy Context

Planning for the future (DoH 1984) had been the main form of mental health policy in Ireland up to 2001 and was instrumental in driving the pace of deinstitutionalisation. In 2003, an Expert Group on Mental Health Policy was formed to prepare a national policy framework for mental health services. *The report of the expert group in Mental Health Policy- A Vision for Change* was published in 2006 by the Department of Health and Children (DoHC, 2006) following a comprehensive consultation process. During this consultation process, one of a number of consistent themes that permeated every part of the process was the need to adopt a recovery perspective at all levels of service delivery. *A Vision for Change* (DoHC, 2006) has a firm emphasis on recovery throughout and proposes a framework for promoting mental health at all levels and details a comprehensive model of mental health service provision for Ireland. While recovery does not necessarily imply a cure, it does suggest, according to the DoHC (2006), that the individual can live a productive and meaningful life despite vulnerabilities that may persist. Each individual who experiences a mental health difficulty faces the challenge of recovery that being to rebuild a meaningful and valued life (Repper and Perkins, 2003). *A Vision for Change* (DoHC, 2006) proposes a holistic view of mental health difficulties and recommends an integrated multidisciplinary approach which places special emphasis on the need to involve service users and their carers/family members at every level of service provision.



3.3 Population mental health needs

To holistically understand the concept of mental health, it is essential to determine the social and cultural context in which symptoms are recognised, as well as how public perceptions and stigma may influence the way mental health difficulties are addressed. According to the WHO, mental health is “a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (NESF, 2007; WHO, 2011). According to the WHO, poor mental health is often associated with rapid social change, unhealthy lifestyle, stressful life and/or work conditions, and exposure to marginalisation or discrimination. There are also key psychological, personal and biological factors that can adversely affect mental health (WHO, 2010).

According to the National Office for Suicide Prevention (NOSP), Ireland faces a high suicide and self-harm rate resulting from mental health difficulties, with over 500 deaths and 11,000 reported cases of self-injury occurring each year (HSE, 2007; NOSP, 2010). A study conducted by the National Economic Social Forum (NESF) (2007) found that six out of ten Irish adults expressed unwillingness to discuss personal mental health issues with those around them, despite widespread acknowledgement that mental health difficulties occur frequently throughout the population. Fear of how one’s condition may be perceived within the community also prevents many from seeking professional help for their mental health concerns (HSE, 2007). This suggests that attitudes around mental health concerns and their prevalence are negatively reinforced in the broader community. The fear of stigma and the unwillingness to openly discuss mental health concerns creates an unwelcoming environment for individuals struggling with mental health difficulties. This creates a cyclical effect in which individuals are hesitant to talk about their mental health concerns because of public stigma, while at the same time the public stigma exists for the very reason that people feel uncomfortable talking about their mental health concerns. The end result is individuals trying to deal with their mental health concerns on their own and in isolation. Keogh (2011) recommended that the possible impact of stigma for service users should be openly discussed by mental health professionals in partnership with service users and also recommended that decisions in relation to disclosure should be explored using problem solving approaches.

In addition to social stigma, there is also an issue of access when it comes to addressing overall mental health. According to Battel- Kirk and Purdy (2007) there is a strong link between social isolation and poor mental health. Those who live in poverty are susceptible to social exclusion and isolation at disproportionately high levels when compared with other socio-economic groups. There is a solid association between poor mental health and “indicators such as low income, poor education, unemployment and low social status” (Fryers et al. 2003 in NESF, 2007: p10). Socio-economic inequality increases the probability of mental health related issues within a person’s lifetime and the risk of mental health difficulties rises as the poverty rates increase. Amongst populations in economically deprived areas, there is double the reported suicide rate compared to those in more financially stable demographics (Battel- Kirk and Purdy, 2007). National and international initiatives have taken note of these trends and health care policy and practitioners are beginning to shift from practices aimed primarily at addressing symptoms of mental health difficulties to include more non-traditional approaches including prevention and recovery. Assessing factors that influence one’s quality of life such as environmental conditions, income and unemployment, gender, education and providing the tools and services necessary to facilitate a higher level of mental well-being is becoming more commonplace in the field of mental health. This approach acknowledges the significant role these factors play in the acceleration of mental health difficulties and the process of recovery (HSE, 2007).



Minority groups

Psychiatric nurses work across an extensive range of clinical services and with people with a wide spectrum of mental health difficulties and specific cultural and socio economic backgrounds. Inclusion is one of the core values of the *A Vision for Change* (DoHC, 2006) policy and states that the needs of people who require particular provisions within a mental health service (e.g. the provision of an interpreter) or who are from different cultural backgrounds need to be addressed (DoHC, 2006).

In Ireland, it is acknowledged that there are groups who have additional needs when they develop a mental health difficulty. These include: travellers, gay, lesbian, bisexual and transsexual individuals, individuals with sensory impairment, and people from other countries and cultures. In order to promote access to the mental health services, these groups require specific knowledge and understanding on the part of those delivering mental health services, in terms of their culture and other characteristics.

Service users from other countries

A Vision for Change (DoHC, 2006) proposes that mental health services should be provided in a culturally sensitive manner, that training should be made available for mental health professionals in this regard, and that mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters. Additionally, the literature has noted the importance of the availability of culturally-specific education materials in the relevant language and at the appropriate literacy level (Ailinger et al. 2010).

Lesbian, Gay, Bisexual and Transgender (LGBT)

In a recent report identifying the experiences and needs of older LGBT people in Ireland (Higgins et al. 2011), it is claimed that the effects of minority stress, or the chronic psychological stress due to their group's stigmatised and marginalised status (Meyer, 1995), can be detrimental to LGBT people's mental health.

Priorities identified by participants in Higgins et al. (2011) for health and social care services included the need for services to be more inclusive, particularly in relation to staff being aware and educated in relation to issues for older LGBT people. Therefore, one of the report's recommendations is that health and social care practitioners should be provided with training on sexual orientation and gender identity. A number of priority actions are outlined by Higgins et al. (2011) and recommendations are formulated around six central areas, namely policy development and implementation, increasing visibility, inclusion and participation, service and information development, education of service providers and future research.

Children

Responding to children's mental health needs can be conceptualised at different levels, ranging from early intervention and health promotion programmes to primary and community care services to specialist mental health services for the treatment of complex disorders (DoHC, 2006).

A Vision for Change, the report of the expert group on mental health policy (DoHC, 2006), policy describes the development of comprehensive Child and Adolescent Mental Health Services (CAMHS) for young people up to the age of 18 years in Ireland. According to the Second Annual Child and Adolescent Mental Health Service Report 2009-2010 (HSE, 2010c) in order to achieve the goals set out in *A Vision for Change* (DoHC, 2006) requires the allocation of significant additional resources to CAMHS. In addition, CAMHS face other challenges. These include: providing greater clarity about priority groups; developing relationships with primary care and other services by putting in place



clear care pathways and agreement about the nature of supports CAMHS provide for other services working with children and young people with mental health difficulties ; improving access for older adolescents who can find it difficult to engage with services; having a stronger focus on outcomes and measuring the quality and effectiveness of interventions through the increased involvement of service users and carers in service development and evaluation (HSE, 2010c).

The analysis of the data in the Second Annual CAMHS report (2009-2010) indicate that:

1. Adolescents from the 15 years of age group are most likely to be attending community CAMHS, followed by children aged 10 to 14 years.
2. ADHD/hyperkinetic category (33.1%) was the most frequently assigned primary presentation followed by the anxiety category which accounted for 16.1%.
3. Depressive disorders increased with age, accounting for 21.5% of the 15 to 17 year age group.
4. Deliberate self-harm, which increased with age, accounts for 6.2% of the primary presentations of the 15 to 17 year age group; however, deliberate self-harm/suicidal ideation was recorded as a reason for referral in 22% of the new cases seen.
5. Males constituted the majority of primary presentations apart from psychotic disorders (46.6%), depressive disorders (40.4%), deliberate self-harm (26.6%) and eating disorders (13.8%).
6. In 2009, the capacity of the HSE child and adolescent inpatient services increased from a total of 16 to 30.

A Vision for Change (DoHC, 2006) recommends that programmes addressing risk and protective factors early in life should be targeted at child populations at risk, e.g. being in a family with low income and education levels. In addition, it supports a health promotion approach in schools to mental health promotion which enrolls the whole school environment.

Deliberate Self Harm (DSH) & Suicide

Suicidal behaviour represents a global public health problem and its prevention continues to provide a major challenge to health and social services at all levels of Irish society (HSE, 2005). Suicide is the leading cause of death in men aged 15-34 years in Ireland, with suicide rates among young men aged 15-19 in Ireland the third highest in the European Union (Eurostat, 2009). Among older adults, an analysis of hospital-treated deliberate self-harm (DSH) and suicide showed that older adults (over 55) have high rates of hospital treated DSH but below average rates of suicide (Corcoran et al. 2010).

The highest rates of hospital-treated DSH are among 15- to 19-year-old girls (639 per 100 000) and 20- to 24-year-old men (433/100 000) (National Suicide Research Foundation, 2009). According to the National Parasuicide Registry (NSR7 2004), over 11,000 cases of deliberate self-harm are seen in the Emergency Departments of Irish hospitals annually and many more cases of DSH never come to the attention of the health services.

Suicide is never a simplistic event with one identifiable cause; instead, it usually results from a complex interplay of factors in an individual's life; it involves an inter-play of psychological, biological, social and environmental factors, which are sometimes aggravated by a recent personal difficulty (HSE, 2005).

The Irish government set up the National Task Force on Suicide in 1995 in response to the country's rising rates of suicide. Their findings and recommendations were published in the Report of the National Task Force on Suicide (1998). More recently, an Irish National Strategy for Action on Suicide Prevention was developed: *Reach Out* (2005-2014). This is a practical action plan, based on evidence and international best practice.



In line with key priorities of Reach Out (2005-2014) HSE (2005), in 2008 the HSE's National Office for Suicide Prevention commissioned the National Suicide Research Foundation (NSRF) to develop and pilot a Suicide Support and Information System (SSIS). The SSIS was developed to prevent suicide by facilitating access to support for the bereaved, while at the same time obtaining information about risk factors associated with suicide and deaths classified as open verdicts. Risk factors identified by the SSIS included: undiagnosed and untreated mental health difficulties, alcohol and drug abuse, history of deliberate self harm, impact of economic recession as a precipitating factor, recent separation of young men from partner/children and long-term consequences of sexual abuse in childhood and adolescence (between September 2008 and December 2009).

The extent of self-harm behaviour and its indication of a very high risk of later suicide, make it a key area for concern in any suicide prevention policy. A systematic review found that within one year of a self-harm presentation to A&E, on average, 16% repeat the behaviour and 1.8% die by suicide (Owens et al. 2002). Furthermore, it has also been found that many of those who take their own life do not come into regular contact with the health services (Departments of Public Health, 2001). In an Irish survey of almost 4,000 young people aged 15-17 years, 480 disclosed they had engaged in DSH, but only 11% of this group engaged services beforehand and 15% after an act (National Suicide Research Foundation, 2004).

Therefore, assessing the risk of repeated suicidal behaviour, as well as the broader psychosocial needs of DSH individuals attending A&E departments, is an important task. The need for all individuals who engage in DSH who attend Emergency departments to be given a comprehensive assessment by a suitably trained health professional followed by appropriate referral and follow-up has been recognised both nationally (DoHC, 1998) and internationally (NICE, 2004).

Although suicide prevention is a complex task, a review of the suicide prevention literature highlights one finding repeatedly, that the key to preventing suicide is personal engagement with the service user and the psychological and social circumstances of their particular predicament (Hawton and van Heeringen, 2000). All assessment instruments, protocols and positive practices fall short of their aims in the absence of genuine personal communication and listening between the individual at risk and the person who is engaged in assessing their pain. As acknowledged in the Reach Out (2005-2014) document (HSE, 2005), improving access to quality mental health services is an essential part of any suicide prevention strategy.

Physical health care

It has been shown that people with severe mental health difficulties have poorer physical health than the general population. For example, Equal Treatment: Closing the Gap (2006), commissioned by the Disability Rights Commission (DRC) in England and Wales, describes an analysis of 8 million health records in primary care in the UK. It confirms that for people with schizophrenia and bipolar disorder the rates of ischaemic heart disease, stroke, high blood pressure and diabetes are higher than in the general population, with diabetes 2 to 3 times more common than expected. In the person-centred new mental health service model it is proposed that specific attention be given to ensure that the service users' physical health is addressed in the same way as their mental health (DoHC, 2006).



3.4 Quality and Safety in Mental Health

In the field of mental health, service user safety and quality are two crucial and underlying facets. A number of reforms, including the establishment of an independent statutory body, namely the Mental Health Commission (MHC), which was established pursuant to Section 32 of the Mental Health Act 2001 and the Health Information and Quality Authority (HIQA), have influenced the landscape of health services. The Inspector of Mental Health Services conducts inspections in accordance with the 2001 Mental Health Act, which includes taking an active role in examining community-based services and assessing the quality and extent of service provision in six areas: community mental health and day hospital activity; day centre activity; rehabilitation, residential community placement and recovery services, along with acute inpatient services; primary care liaison activity; home care programmes; and specialist psychiatric services. The primary functions of the MHC are

“to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act [Mental Health Act 2001]” (MHC, 2007: 4)

According to the DoHC (2008), reviews of quality and safety in the Irish context revealed a number of shortcomings inherent in the system, including “weak governance structures, poor communication processes, failure to develop or implement clinical audit, poor working relations between clinicians and management, lack of senior clinical leadership within organisations and nationally, poor team working, lack of structured incident reporting systems, inconsistent analysis of adverse events, lack of clarity on reporting relationships and failure to participate in continuous professional development” (DoHC, 2008:2). The identification of these shortcomings and an increased awareness of the importance of quality and safety in health influenced the development of innovative, robust initiatives including the Report of the Commission on Patient Safety and Quality Assurance (DoHC, 2008) and the Quality Framework for Mental Health Services in Ireland (MHC, 2007).

The Quality Framework for Mental Health Services in Ireland (MHC, 2007) provides an empowering mechanism for the continuous improvement of all mental health services including public sector, voluntary sector, and independent sector. The framework aspires to inform service users and their families as to what to expect when consulting mental health services in Ireland. This framework assists in generating a culture of continuous quality improvement by encouraging services and staff to be pro-active (MHC, 2007). It also aims to provide standards of continuous improvement in the quality and safety of mental health services. The framework consists of eight themes, 24 standards and 163 criteria. The eight overarching themes of the framework are presented below. For a detailed description of the framework, please refer to the original document (MHC, 2007).

1. Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team
2. Respectful, empathetic relationships are required between people using the mental health service and those providing them
3. An empowering approach to service delivery is beneficial to both people using the service and those providing it
4. A quality physical environment that promotes good health and upholds the security and safety of service users
5. Access to services



6. Family/chosen advocate involvement and support
7. Staff skills, expertise, and morale are key influencers in the delivery of a quality mental health service
8. Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality service

In a similar vein, the Report of the Commission on Patient Safety and Quality Assurance (DoHC, 2008) examined the state of quality and safety services in Ireland and made recommendations for improvement of policy and practice in the area. The commission recommended that all health services in Ireland operate around a framework that characterised by “knowledgeable patients receiving effective care from skilled professionals in appropriate environments with assessed outcomes” (DoHC, 2008:3).

Within this framework there are several interwoven components of ensuring quality and safety including service user-centeredness, openness and communication, leadership, evidence based practice, accountability, effectiveness and efficiency.

These frameworks are broad and contain a number of standards of performance and measurable criteria that are required to establish these standards. However, it is important to note that the service user remains central in these frameworks of quality and safety. In working towards higher standards of quality and safety, the service user, the health practitioner, and the relationship between the two are all fundamental, inextricable components.

An understanding and acceptance of these holistic frameworks is central to the on-going improvement of mental services in Ireland.

3.5 Psychiatric/ Mental Health Nursing and Professional Issues

In adopting a holistic approach to mental health, there is a need for redefinition and restructuring of the roles of mental health practitioners. There is often difficulty in defining the role of the mental health practitioner. Studies have noted that practitioners themselves often struggle to define and articulate the skills needed to address the variety of conditions that individuals cope with (Cowman et al. 2001). In an effort to clarify the role of the psychiatric nurse under a holistic approach to mental health and well-being, it is important to review the current role of psychiatric nurses within mental health services.

Studies have attempted to classify the function and responsibilities of psychiatric nurses with varying degrees of accord, identifying key skills and characteristics of evidence-based practice within the mental health system, one being Cowman et al. 2001. The current nature of mental health require nurses to adapt to the changing needs and growing expectations of service users, providing risk management and stability during critical mental health emergencies, as well as offering a diversity of individualised holistic care.

Over the past decade, major changes in Ireland’s mental health delivery system and mental health policy have resulted in implications for the modern day psychiatric/ mental health nursing practice. Working within the scope of professional practice demands that Registered Nurses and Midwives are competent (ABA, 2000). Ironside (2008: 92) eloquently articulated that “nursing practice is evolving faster than decisions can be made on how best to meet these challenges.” Nurses, she argues, have many professional roles in varying settings with service users from varying cultures with varying needs. It is argued here that this is an apt descriptor for the role played by psychiatric nurses within the policy context that is *A Vision for Change* (DoHC, 2006).



Change is an omnipresent feature of modern health care policy and practice which takes place within a rapidly evolving knowledge and technological environment (Whittaker et al. 2000). Within such an environment the knowledge, skills and competencies required for competent mental health and psychiatric/ mental health nursing practice are changing also. The needs of service users and the evolving mental health services must inform the continued development of the psychiatric nurse as a practitioner. To navigate such change successfully, psychiatric nurses need to engage in analysing practice needs, on-going learning and practice development and expansion throughout their working lives. Ranson (1998) argues that only if learning is placed at the centre of our experience can individuals develop their skills and capacities to respond openly and imaginatively to change, and change is the imperative of policy and research. What is fundamental to modern psychiatric/ mental health nursing is a questioning and engaging approach to learning that will respond to and, more importantly, initiate change in practice to address service user need.

3.6 Core Nursing Skills to Work in a Recovery Oriented Way

For centuries, the dominant model of mental health treatment remained in line with the traditional medical model (Shanley and Jubb, 2007). Over the past decade, a shift occurred within the professional mental health community. Treatment pathways began to focus on the service user's experiences and understanding of their experiences, as well as on the contextual factors that are interrelated with the service users mental health and well-being. An alternative to the medical model, the recovery-oriented approach, grew from the desire to provide more service user-centred care in mental health. In the recovery model, the focus of moves away from the bio-medical emphasis on chronic mental illness towards a self-directed process of transformation, transcendence and acceptance (Lakeman, 2010). Much as being documented in relation to recovery internationally. *The Hearing Voices Movement* was established by Romme and Escher in 1987 in the Netherlands and Hearing Voices Networks have now being established globally. Romme et al. (2009) produced *Living with Voices: 50 Stories of Recovery* and outlines 50 stories of individuals who hear voices who claim to have recovered. These accounts aim to provide evidence for the effectiveness of the hearing voices approach outside of an illness orientation.

Recovery-oriented approaches are now at the forefront of policy agendas in Ireland, the United Kingdom, Australia, New Zealand, and Canada (Shanley and Jubb, 2007; Bonney and Stickley, 2008). The implication that this conceptual shift will have on the practical application of mental health services is heavily debated. Within the literature, dispute remains over the definition of 'recovery', its set of values, and its place in the everyday application of mental health services (Bonney and Stickley, 2008). Higgins (2008) captured the common themes underpinning the writings of people who described their individual recovery journey in *The Petals of recovery* (Figure 2). Higgins (2008) presented a framework and audit tool for the development of a recovery approach within Irish mental health services. The audit tool, namely The Pillars of Recovery: Service Audit Tool (PoRSAT) was developed to allow the provider, the team and/ or the individual to monitor their progress in developing a recovery oriented service. This framework outlines 6 'pillars' of service development which are leadership, person centred and empowering care, hope inspiring relationships, access and inclusion, education and research and evaluation. Under each pillar, elements, rational and criteria have been identified. Higgins and McBennett (2008) suggested that the concept of recovery challenges mental health practitioners to think in a new and creative way about serving people who access the mental health services. While there is no clear consensus as to what constitutes a recovery approach, a recent review of the national and international literature uncovered several underlying skills and competencies required for nurses to work in a recovery-oriented way (Bonney and Stickley, 2008). This list is not all-encompassing and items are not mutually exclusive. Rather, these skills and competencies are overlapping and interrelated components of good practice in recovery-oriented psychiatric/ mental health nursing.



Collaborative ethos

One of the underpinning values of the recovery-oriented approach to mental health is humanism and collaboration, the understanding that human beings are social animals and thrive in collective and collaborative environments. From this comes the belief that a person's mental health and well-being is inextricably linked with their various interpersonal relationships (Shanley and Jubb, 2007). With regards to mental health, the collaborative partnership and working alliance between the nurse and the service user is an integral component of the recovery process while being cognisant that the inclusion of peer support is also a core element of a recovery oriented service (Higgins and McBennett, 2008). 'Collaborative ethos' is a broad concept and involves many inter-working practices. One core element is a commitment to shared decision making between the service user and the practitioner (Cleary and Dowling 2009). Tait and Lester (2005) described why service user involvement is important and offered practical guidance on barriers to service user involvement and ways in which meaningful involvement is being implemented in practice. Having open discussions about the recovery process and decision making along the way builds trust between parties and allows service users to play an active role in their recovery (Shanley and Jubb, 2007). A recent study of mental health professionals in Ireland found collaborative skills to be the most important factor influencing a service user's recovery (Cleary and Dowling 2009). Key elements of a successful collaborative relationship between practitioner and service user include reciprocity, open communication, respect for each other's opinions and a sense of equality between the parties (Higgins, 2008).

Communication

Effective communication is a cornerstone of the recovery process. The ability to communicate comfortably, constructively and honestly is essential in establishing a collaborative working alliance between practitioners and service users (Shanley and Jubb, 2007). Successful communication is an essential component in empowering service users to take control of their recovery (Higgins, 2008). Psychiatric nurses can take certain steps towards facilitating open communication with service users. Perhaps most importantly, practitioners must respect the voice and the experience of the service user and believe that he/she has valuable insight and understanding with regards to his/her own mental health (Repper et al. 2003; Lakeman, 2010). Practitioners can disagree with a service user or negotiate with a service user but respect must always be underlying in all interactions. Practitioners can assist with the ease of communication by avoiding clinical jargon when conversing with service users. The use of everyday language minimises the power imbalance between practitioner and service user, creating a more reciprocal environment for both parties (Shanley and Jubb, 2007).

Reflexivity

As the recovery-oriented approach relies on collaboration between service users and practitioners, it follows that mental health professionals are a fundamental component of the recovery process. The subjective experiences and personalities of psychiatric nurses will play a defining role in the recovery process of service users and it is important that nurses reflect on their own experiences, strengths, weaknesses and challenges. By gaining a solid, reflexive, holistic and honest perspective on one's self, the nurse will be able to approach the collaboration with the service user in a constructive and sincere way. This will facilitate communication, mutual respect and trust in the relationship (Roberts et al. 2004).



Flexibility

A core component of the recovery approach is the recognition that recovery is an on-going, fluid process. Treating a mental health difficulty is not about “curing”; rather it is about accepting the difficulty and learning how to effectively cope with the issues to allow for a full and fruitful life. For most, this process is non-linear and on-going (Cleary and Dowling, 2009). It is important for psychiatric nurses to adopt a flexible attitude when working in a recovery-oriented way (Repper and Perkins, 2003). This includes an understanding that the process is not always steady and straightforward. It also involves an understanding that each service user has a unique and personal set of mental health concerns that is influenced by their own experiences and contextual factors. There is not a ‘one size fits all’ solution to mental health concerns (Higgins, 2008). Recovery is more than an end state but an individual journey that results in an internal change in attitudes and beliefs (Higgins and McBennett, 2008). This allows professionals to have realistic expectations about service users and the pathways of recovery (Cleary and Dowling, 2009).

Facilitating Support

In the recovery model, hope and optimism are fundamental components of recovery (Bonney and Stickley, 2008). According to Higgins (2008), mental health practitioners should have a commitment to engaging and developing relationships that acknowledge a common humanity between the service user, practitioner and family members. This can be done by promoting the belief that it is possible to have a fulfilling life with mental health difficulties, that mental health difficulties are not ‘chronic’, and in some cases, even reflecting about the potential positive aspects of certain mental health conditions (Repper and Perkins, 2003). However, in order to do so effectively, it is imperative for mental health practitioners themselves to believe that recovery is possible (Lakeman, 2010). This involves having realistic expectations for recovery, understanding that it is not about ‘curing symptoms’, but rather about learning to live comfortably and constructively.

Psychiatric nurses must also provide support with regards to identifying and restructuring coping mechanisms for service users. Many service users rely on their own personalised coping mechanisms. Often times these coping mechanisms can be unhealthy or detrimental to the service user. Other times, the user is unaware or in denial with regards to coping mechanisms (Shanley and Jubb, 2007). Recovery-oriented nurses aim to tap into the coping mechanism of service users, assisting them with identifying and then, potentially, restructuring how they cope with difficult situations. To do so effectively, psychiatric nurses may adopt the language and constructs employed by the service users to describe their mental health concerns. This minimises the power imbalance, eases communication between the two parties and places control in the hands of the service user (Shanley and Jubb, 2007).



3.7 Improved service user outcomes as a result of psychiatric nursing interventions

Enhancing the quality of care, health service provision and delivery is a central plank of the current national health strategy outlined in *Quality and Fairness – A Health System for You* (DoHC, 2001) and of the health service reform programme (DoHC, 2003). Hence, healthcare professionals are increasingly required to demonstrate the effectiveness of what they do and articulate how they are contributing to the quality of service user care (NCNM, 2006).

Psychiatric nurses fulfil a range of core functions across a variety of service settings to meet the needs of people with different mental health needs. They have a key contribution to make across all tiers of service provision, with the complexity of service users' needs determining the role focus at different tiers. The psychiatric nursing role in Ireland and the UK in recent years has undergone a period of great change. There is a new emphasis on health promotion, early intervention and community development, with nursing being provided closer to where people live and work, as well as making access to services easier for vulnerable groups of the population. Because of the continuous nature of nursing care and their constant presence in care settings, nurses have high levels of information about service users, thus, occupying a pivotal role in all mental health care settings (Cowman et al. 2001).

Rogers and Pilgrim (1994) reported that nurses were viewed more favourably than other mental health professionals by service users and the quality of nursing care regarded most highly was talking and listening. Building on psychiatric nurses' fundamental skills there are interventions that are safe and effective and could potentially be delivered by psychiatric nurses to improve service users' outcomes. Nursing interventions are treatments or actions that benefit a service user by presenting a problem, reducing or eliminating a problem, or promoting a healthier response (Carpenito-Moyet, 2004). By identifying their interventions and measuring the outcomes of these interventions, nurses can articulate and clarify their roles and functions in relation to both the settings in which they work and the individuals to whom they deliver services and care (NCNM, 2006).

In a systematic literature review of mental health nursing interventions efficacy, a set of ten core interventions was considered important to the role of the psychiatric nurse in day-to-day clinical practice (Gray et al. 2006). These included: cognitive behavioural therapy (CBT); family interventions; psychoeducation; management of violence; risk assessment and observation; engagement; assessment; counselling/psychotherapy (not CBT); case management; and assertive community treatment; medical management; and mental and physical health promotion. Similarly, in Ireland a descriptive qualitative research study aimed to examine the role and function of psychiatric nurses in clinical practice identified nine categories for the psychiatric nurses' role (Cowman et al. 2001). These included: assessing needs and evaluating care; planning care; caring interactions; pharmaceutical interventions; education (teaching and learning); documenting information; co-ordinating the services of nurses and other professionals for individuals; communication with other professionals and other grades of staff; and administration/organisation of the clinical area. The roles identified were both independent and interdependent roles. This is not an exhaustive list of all the interventions psychiatric nurses are involved in but a set of the main roles and functions consistently identified as key areas of intervention.



Psychoeducation

The aim of psychoeducation is to increase service users' knowledge of and insight into their condition to change behaviour (Pekkala and Merinder, 2002). In a systematic review of ten studies (Pekkala and Merinder, 2002) which focused on didactic interventions of psychoeducation or service user teaching involving individuals or groups compared to usual care, it was identified that compared to usual care, brief (up to 10 sessions) and standard (11 sessions or more) psychoeducation is effective at preventing relapse/readmission to hospital. It is estimated that approximately eight service users will need to receive psychoeducation to prevent one relapse over one year (Gray et al. 2006).

Cognitive behavioural therapy (CBT)/ Counselling/psychotherapy (not CBT)

Providing a range of treatment modalities has been identified as an important role for psychiatric nurse. For example, they can offer support through psychotherapy, counselling and bereavement counselling (Cowman et al. 2001; Gray et al. 2006). Gray et al.'s (2006) systematic review of studies and reviews (Jones et al. 2004; Bisson and Andrew, 2005; Price and Couper, 1998; Hawton et al. 1999; Bacaltchuk et al. 2001; Hayes and McGrath, 2000; Clare et al. 2003; McIntosh et al. 2004) on the efficacy of CBT on the treatment of different mental health difficulties concluded that there is strong evidence of the efficacy of CBT with some disorders (depression, PTSD, panic disorder, generalised anxiety disorder) and equivocal evidence for others (schizophrenia, deliberate self-harm).

Adopting a quasi- experimental control design, Bradshaw et al. (2007) assessed whether clinical supervision provided by workplace based supervisors can enhance outcomes for nurses attending a psychosocial intervention programmes and the service users whom they work with. They demonstrated that service users seen by the students in the experimental group showed significantly greater reductions in positive psychotic symptoms and total symptoms compared with those seen by people in the control group. There is increasing evidence that psychological therapy is a good investment compared to treatments that do not include a psychological therapy component, as significant savings are made through psychological therapy in reduced costs to the health service, shown in shorter hospital stays, lower use of prescriptions and better outcomes (Kuipers et al. 1998). For example, Baradell and Bordeau (2001), Saur and Ford (1995), Gournay et al. (2000) and Lovell et al. (2003) all report positive therapeutic outcomes with individuals who underwent psychotherapy with Clinical Nurses Specialists psychotherapists. Notwithstanding this, the consultation process that informed the policy of *A Vision for Change* (DoHC, 2006) revealed a concern on the part of many service users that they perceived a predominance of drug treatments and limited opportunities for discussion and resolution of their problems through counselling and psychotherapy. Similar results were reported in McCardle et al.'s (2007) national survey of community psychiatric nurses and their care activities in Ireland. From the observations, there was no evidence of CPNs practising cognitive, behavioural therapy or family therapies to any great extent, although there were instances when principles from these therapies were used by CPNs in their interactions with individuals. Therefore, one recommendation in *A Vision for Change* (DoHC, 2006) concerns the need to promote, fund and accredit psychotherapy courses that provide the required skills to respond to the needs of service users.

Management of violence, risk assessment and observation

The management of disturbed/violent behaviour is an important part of the work of the psychiatric nurse. The nursing role is perceived to be essential in times of crisis and psychiatric nurses frequently have to deal with very rapidly changing and sometimes dangerous environments (Cowman et al. 2001). Management of violence and risk assessment is a complex set of inter-relating biological, psychological and social interventions (Gray et al. 2006). According to *A Vision for Change* (DoHC, 2006) policy staff should be trained to manage violent behaviour with a variety of techniques, such as prediction and prevention of disturbed or violent behaviour, de-escalation, physical interventions, seclusion, rapid tranquillisation, resuscitation and defibrillation.



Assessment

Assessment is an ongoing process that nurses perform continually. Assessment may be a structured explicit activity, such as assessing a service user's symptoms using a validated outcome measure, or it may be an informal (intuitive) process, such as observation of a service user's level of arousal on the ward. Nurses take part in independent and interdependent assessments due to the nature of nursing care and through their constant presence in care settings, nurses have high levels of information about individuals, which was perceived to contribute significantly to multidisciplinary discussions and decisions about individuals (Cowman et al. 2001). Assessment, in and of itself, is not a therapeutic intervention, but it is essential for effective planning, implementing and evaluation of care (Gray et al. 2006). According to *A Vision for Change* (DoHC, 2006) policy, the development of clinical risk-management and risk-assessment approaches within mental health settings is essential. The recording and analysis of adverse events in clinical risk management must be seen in a wider context of service user safety, staff safety, quality service delivery and clinical governance.

Medication management

Stewart and Wheeler (2005) claim that the recovery journey is undertaken through empowerment. Therefore, medication management is a process of involving service users in decisions, exchanging information and monitoring, evaluating and providing feedback about treatment. In order to promote shared decision-making it is essential that health professionals have the communication skills needed to share the clinical knowledge about psychopharmacology involved in medication management (including risks and benefits) and gain concordance. Drennan et al. (2011) using a cross sectional descriptive survey measured the level of satisfaction and self reports of intention to comply following consultation with nurses and midwives with prescriptive authority. This study found that individuals surveyed were highly satisfied with the care they received from nurses and midwives with prescriptive authority indicating they had received comprehensive education. Overall levels of satisfaction with the process were high and the majority of respondents indicated that the nurses were comprehensive in the care they provided, listened to them and treated them like an individual.

Mental and physical health promotion

The Canadian Nurses Association (2009) stated that by being aware of and taking action to address the broad range of determinants of health, registered nurses can positively influence the health of individuals and their communities and assist them to realise improved health outcomes and to reduce health inequalities. Tagliareni and King (2006) assert that nurses play a critical role in health promotion programs and services and Cohen (2008) observed that health promotion has become the "primary goal of nursing practice" (p. 102). Consistent with this, Cowman et al. (2001) acknowledge that the education role with the public in aspects of health education is increasing. A report for the European Commission on the evidence for health promotion effectiveness, found ample evidence that mental health promotion programmes not only improve mental health and quality of life but also reduce the risk for mental disorder (Hosman and Jane-Lopis, 2002).

Given the consistent finding that people with mental health difficulties are at high risk of developing co-morbid physical health problems, Gray et al. (2006) highlighted the role of physical health-promotion interventions, defined as an intervention aimed at improving the knowledge of unhealthy lifestyle habits (e.g. smoking, weight gain, diet, exercise) and capable of influencing motivation towards healthier behaviours. Results of the review of studies on physical health promotion showed that there were positive outcomes from physical health promotion interventions with people with mental health difficulties for smoking cessation, interventions designed to manage weight and interventions to reduce HIV risk (Gray et al. 2006). Nash (2010) concluded that all mental health practitioners should continuously reflect on their attitudes, their approaches to physical health, their knowledge and skills and ensure that they have equitable access to physical healthcare services.



3.8 Developments in Specialist and Advanced nursing practice roles in Ireland and improved outcomes for service users/careers

The development of specialist and advanced practice roles in Ireland is part of the strategic development of the overall health service and is taking place in the context of contemporary health and social policy, the requirements of population health and the service planning process. National policy documents such as the Report of the Commission on Nursing (Government of Ireland, 1998), the national health strategy *Quality and Fairness: A Health System for You* (DoHC 2001) and Begley et al. (2010) recommend the development of specialist and advanced nursing practice posts. The National Council for the Professional Development of Nursing and Midwifery was formed in 1999 following a recommendation made by the Commission on Nursing (Government of Ireland, 1998) and the NCNM established the frameworks for clinical career pathway in nursing in 2000. As first signalled in the national health strategy (DoHC, 2001), the Irish health system has moved towards a population health approach to the provision of health services and healthcare. Changing models of care delivery in tandem with the changing demographic and epidemiological profile of the population will signal the service requirements for specialist and advanced practice nursing and midwifery posts into the future. The Clinical Nurse Specialist (CNS) and Advanced Nurse Practitioner (ANP) are distinct roles. Their levels on the clinical career pathway are defined by the scope of practice, levels of clinical decision-making, educational preparation, responsibility and subsequently the autonomy attached to the roles NCNM (2010). The core concepts of clinical practice, advocacy, education and training, research and audit, and consultation, are outlined by the National Council for the clinical nurse or midwife specialist in Ireland (NCNM, 2008a). Four core concepts of advanced nurse practitioners and advanced midwife practitioners are given: autonomy in clinical practice, expert practice, professional and clinical leadership, and research (NCNM, 2008c).

Research indicates that positive outcomes can be achieved through the development of specialist and advanced practice nursing roles, including enhanced service provision, improved staff retention, increased satisfaction and a positive contribution to the delivery of quality care and population health (OECD, 2004). Begley et al. (2010) adopted a three phase mixed method, explanatory sequential design and produced an evaluation of the clinical services provided by clinical nurse and midwife specialists and advanced nurse and midwife practitioners in Ireland and this study examined the clinical outcomes of clinical specialists and advanced practitioners practice. They concluded that care provided by clinical specialists and advanced practitioners improves outcomes, is safe, acceptable and cost-neutral (Begley et al. 2010). This evaluation demonstrated benefits for outcomes and service delivery as a result of having CNSs and ANPs as part of the overall nursing team. The formulated a number of recommendations in relation to service delivery and planning, role development, CPD and future research. Benefits in outputs from ANPs are considerable, including a higher level of care, increased leadership and greater research output. These outcomes are consistent with a recovery approach to mental health. The feasibility, therefore, of supporting the further development of CNS and ANP posts should be considered. This should be a key focus of the HSE for the future in line with its transformation plans for mental health care.



3.9 Conclusion

As the collective understanding of mental health issues grows more refined over time, so do the roles and responsibilities of mental health practitioners. The adoption of a recovery-oriented model of mental health care is now considered best practice in many countries around the world, including Ireland. Publications including the Framework for Development of a Recovery Oriented Approach in Irish Mental Health Services (Higgins 2008) and the Quality Framework for Mental Health Service in Ireland (MHC, 2007), provide frameworks and standards for the development of a recovery-oriented approach in the Irish context. In order to effectively implement these standards and work within these frameworks, it is necessary for mental health practitioners to be clear about their evolving roles and responsibilities.

The challenge to policy makers, managers and regulators is to promote the conditions in which a learning society can unfold with professionals, whose creative agency will be the key to social innovation, providing a high quality service. Government policy, organisational and professional regulation within the mental health services, along with the safety agenda emphasise the significance of a service user centred approach to professional practice. This is founded on the provision of continuously improving the quality of practice to deliver quality evidence based safe service user centred care.

Psychiatric/ mental health nursing practice must continue to strengthen its provision of a therapeutic contribution to the journey of the service user. Psychiatric mental health nursing practice must also articulate and document its therapeutic contribution to care. Beyond these essential skills is the capacity of the RPN to continue to maintain competence, to engage in practice audit and to strengthen their focus on measuring outcomes in practice.



CHAPTER 4

Project methodology

4.1 Introduction

Within this chapter an overview of the methodology used for this project is outlined. Information on data collection, recruiting participants, data analysis and ethics is also provided.

4.2 Project design

This project adopted an exploratory mixed method design using both quantitative and qualitative approaches to facilitate data collection. The data collection tools included:

- An anonymous survey that could be completed and submitted either online, or hardcopy and returned via email or post
- Structured focus groups
- Written submissions using an agreed framework

Due to time constraints, the different phases of data collection ran in parallel to each other.

4.3 Anonymous survey

4.3.1 Eligibility to participate and designing the survey

Registered nurses working in mental health and with individuals with mental health difficulties in the Republic of Ireland were eligible to complete the survey. The survey aimed to:

- ▶ review and establish the current role of the nurse working with people who experience mental health difficulties and
- ▶ identify the barriers which currently exist that inhibit role development for nurses working in mental health and with individuals with mental health difficulties.

A non- probability sampling technique was employed and was beneficial in maximising the response rate. The survey content was informed by the literature and in consultation with the project team. An information letter accompanied each survey (Appendix II). The complete survey (Appendix II) was comprised of 42 questions which focused on demographics, clinical role, factors that facilitate/ inhibit role development, and factors that facilitate/ inhibit adoption of a recovery approach. The survey was primarily comprised of closed questions and Likert scale questions that required participants to tick a box. It also included optional open response style questions where participants could write in responses. Text boxes were also included for participants to include further comments. The information letter communicated details about the study and informed potential participants that submitting/ returning the completed survey implied consent to participate.



4.3.2 Piloting the Survey

The survey was piloted amongst a group of nurses (n=10). The pilot study aimed:

1. to ensure that the questions were comprehensible and user friendly;
2. to ensure the aims of the survey were being met; and
3. to establish the length of time required to complete the survey.

The overall feedback from the pilot was positive and, as a result, only minor amendments were made to the wording of questions. Prior to dissemination, the final draft of the survey was reviewed by the project team to ensure it reflected its purpose.

4.3.3 Recruitment of the survey to maximise response rate

A variety of approaches were employed to maximise the number of people that were informed of the study; thus, providing increased opportunities for participation amongst the eligible population. In an attempt to reach as many people as possible, the survey was developed for on-line or hard copy completion. In order to facilitate on-line completion, a number of organisations (Appendix III) helped promote the survey by including project information and a hyperlink to the survey on their websites. All steering group members were encouraged to disseminate project information packs which consisted of a Microsoft Word copy of the survey, a flyer to advertise the survey for notice boards (Appendix IV) and invitation letters to complete the survey from the ONMSD and Office of the Assistant National Director of Mental Health (Appendix V). The survey, invitation letter to complete the survey, flyers and project information were disseminated widely by the steering group and the information packs were also disseminated at the NCMN Conference. To enable people who may not have internet access to participate, all advertising material included telephone details inviting people to request a postal version of the survey.

4.3.4 Data collection for survey

The survey data was collected during a three and a half month period from 10/11/10 to 25/2/11. In total, 1017 completed questionnaires were returned. Thirty seven surveys were excluded from the sample as they were incomplete.

4.4 Focus groups and written submissions

4.4.1 Recruitment and designing the format for the focus groups and written submissions

The focus groups and submissions aimed to:

- ▶ Identify the knowledge, skills and competencies that require development by nurses working with people with mental health difficulties to respond to *A Vision for Change* (2006).



4.4.2 Advertising for the focus groups and inviting written submissions

Focus groups were mainly organised through the NMPDUs nationally who were provided with information on the project and asked to nominate a 'link person'. This link person agreed the time and date for focus group with the project officer and organised a venue in the various regions. The link person then liaised with the organisations and mental health services in their region to advertise the focus group. Interested and eligible individuals were asked to come forward to participate. A number of additional key groups/organisations were also invited to participate. Each focus group participant was provided with an information letter (Appendix VI) explaining the rationale, procedures and the criteria for participation in the group and a consent form (Appendix VII). The focus group schedule is included in Appendix VIII. Each focus group took approximately two hours and questions (Appendix IX) to provide structure had been agreed upon by the project team. Minor adjustments to the schedule were made on occasions. Focus group interviews were recorded using flip charts and project officer's notes. Due to the time it would have taken to transcribe, the focus groups were not audio recorded. Probes to clarify answers and to request further information from participants were used. The project officer attempted to be reflexive throughout this process. Following each focus group, the data on the flip charts was collated with the project officer's notes. The project officer then sent the narrative to the facilitator or a nominated focus group attendee to ensure it was an accurate reflection of the group that took place. On receiving confirmation that the narrative was accurate, it was included in the analysis. All interested parties, organisations and individuals were invited to complete written submissions and those making a written submission were invited to do so using an agreed format (Appendix X). In total, 22 focus groups (Appendix XI) were conducted nationally and 28 written submissions were received (Appendix XII) from November 2010 to June 2011.

4.5 Data analysis

4.5.1 Quantitative data

The online survey software application 'surveymethods' was employed to assist with launching the survey, data collection and analysis. Hard copies of the survey that were returned were inputted into 'surveymethods'. Each survey variable was analysed to generate descriptive or frequency statistics. All percentages displayed in the findings were rounded to the nearest whole number for ease of interpretation and analysis.

4.5.2 Qualitative data

Burnard's (1991) method of data analysis was employed to analyse the qualitative data. This has been described as a method of 'thematic content analysis' (Burnard, 1991:461). This step-by-step approach was chosen as it was clear and concise. All focus group data and submissions were collated. Stage two entailed reading and re-reading the transcripts and the submissions thoroughly and making notes, so that the project officer was immersed in the data. Initially, the data were 'open coded'. These open codes were then sorted into higher order headings. Finally, the higher order headings were organised into final themes that incorporated all the data collected in the interviews and submissions. The project officer approached the project lead to verify whether the themes that were generated were authentic. The transcripts and submissions were re-read alongside the final themes to ensure that all major areas of the transcripts and the submissions were identified.



4.6 Ethical considerations

Nurse researchers have a professional responsibility to design research that upholds sound ethical principles and protects human rights (ABA, 2007). Informed consent, autonomy, beneficence and confidentiality were the main ethical considerations in the present study. Informed consent is a prerequisite for all research involving identifiable participants. To obtain consent, researchers must give as much information as possible to participants to enable them to make up their minds (Parahoo, 2006). Participants were given information about the purpose and scope of the study and how their anonymity and confidentiality was to be protected. The principle of beneficence, doing good and preventing harm, applies to providing confidentiality and anonymity for participants. Data were stored in a locked cabinet in a locked room and any data on electronic instruments had password restrictions in keeping with the Data Protection Act 2003. After five years, the data will be destroyed in accordance with the Department of Health Data Protection Act (2003). In the absence of an ethics committee, the project team sought and received ethical opinions from three experts in the area of ethics and mental health in relation to the survey instrument. This process was endorsed by the HSE Strategic Mental Health Management team (Appendix XIII)

4.7 Limitations

A first limitation of the study is that participants self-selected to complete the survey so it is difficult to answer how those who did not choose to participate would have responded. Secondly, due to time constraints, the written submissions and the data generated from focus groups were not analysed separately; thus, what is presented is an overview of the major themes and issues raised in both as not all of the individual messages or minor themes could be elaborated on fully.

4.8 Summary

This chapter provided an overview of the methodology used for the project. The design adopted for the project was an exploratory design using both qualitative and quantitative approaches to facilitate data collection. A combination of an anonymous survey that could be completed in a variety of ways, focus groups and written submissions were utilised. A variety of approaches towards recruitment were employed to maximise the number of people informed about the study. This approach included adding hyperlinks on websites, distributing information at conferences and promoting the project in their areas and organisations through the steering group. The following chapters will present the findings, both quantitative and qualitative, that emerged during the data analysis stage.



CHAPTER 5

Findings from the survey

5.1 Introduction

This chapter will provide an overview of the findings from the survey. The survey aimed to review and establish the current role of the RPN and to identify the challenges that exist to inhibit role development for nurses working in the mental health services. The survey also assisted in eliciting participants' views on the nursing skills and competencies that require development in order to meet existing and future service needs. The survey findings will be presented in this section and a discussion will follow in relation to the responses provided to the open response questions which were posed. All percentages have been rounded to the nearest whole number.

5.2 Response rate and profile of survey participants

In total, 1017 completed responses were received. According to a recent health service personnel census, there were 5460 nurses employed in the mental health services at the 31st December 2010. Given this survey was open to all nurses who work in mental health services, some respondents may not work directly in mental health services. Nonetheless, based on the above figure, it can be estimated that a response rate in excess of 17% was achieved.

Current grade

Nearly 60% of the sample indicated they were employed as staff nurses. An additional 23% (n= 237) were employed as DON, ADoN or CNM 1, 2 or 3 and 12% (n= 126) were CMHN, CNS, ANP or nurse therapists. Just 2% (n=15) of participants ticked the 'other' section, writing in that they were employed in positions comprising of acting positions, allocation liaison officer, operations manager or agency nurses and others. Table 1 provides a breakdown of all the current grades in which participants were employed.

Table 1: Breakdown of participants' current grade

Current grade (n=1017)	Number	%
Staff nurse	591	58
DoN/ ADoN/ CNM	237	23
CMHN/CNS/ANP/Nurse therapist/counsellor	126	12
Lecturer/CPC/NPDC/Clinical facilitator/ Other	63	6

Area of work

Table 2 below provides a breakdown of the participants' areas of work. The majority of participants worked in either CMHT (28%; n= 285), acute admissions (26%; n= 266) or rehabilitation settings (19%; n= 191). A further 14% (n= 141) of the survey sample worked in 'other' settings which included administration, education, management, CAMHS, nurse practice development, counselling services, psychiatric care units, homeless services, nursing agency work or no set area due to continuous rotation between settings.



Table 2: Breakdown of participants' area of work

Areas of work (n=1017)	Number	%
CMHT	285	28
Acute admissions	266	26
Rehabilitation	191	19
Other	141	14
MH services for older people	89	9
Special categories of service provision	38	4
MH service for people with ID	7	>1

Professional registration

Participants were asked to indicate what division of the ABA register they were registered under. They had the opportunity to choose multiple areas of registration. The vast majority of the sample (98%; n=999) indicated they were registered as psychiatric nurses. A further 13% (n=137) were registered RGNs or indicated through their responses that they had a dual qualification. Smaller percentages were on the intellectual disability registrar (2%; n=23) or registered as nurse tutors (2%; n=18), nurse prescribers (1%; n=13), midwives (> 1%; n=5), children's nurses (> 1%; n=3) or public health nurses (> 1%; n=3).

Years working as a nurse

Participants were asked to indicate how many years they have worked as a nurse (see Table 3). More than 60% of the sample had more than 10 years experience working as a nurse, indicating an experienced sample. Just 9% of the sample had worked less than 2 years as a nurse. The full results are presented in Table 3.

Table 3: Breakdown of the number of year's participants' work as a nurse

Years working as a nurse (n=1017)	Number	%
0-2 years	88	9
3-9 years	286	27
10-15 years	220	22
16-19 years	161	16
20 years or more	262	26



Highest educational qualification

Participants were asked to indicate their highest educational qualification (see Table 4). Nearly half of the sample (45%) had attained a degree. An additional 27% of participants had attained a postgraduate degree or higher, including a Masters or PhD indicating a highly qualified sample.

Table 4: Breakdown of the highest educational qualification of participants

Highest educational qualification (n=1017)	Number	%
Hospital/ college certificate	193	19
Diploma	104	10
Degree	458	45
Higher/ postgraduate Diploma	128	13
Masters	129	13
PhD	5	> 1

HSE area

Table 5 presents the HSE areas in which the participants work. One quarter of participants worked in the West, with between 20% and 22% employed in the DML, Dublin North East or South. Over 10% of participants worked in 'other' areas, with some indicating the specific service in which they worked or being employed in areas such as the private sector, agencies or educational institutions.

Table 5: Breakdown of the HSE area in which participants work

HSE area (n=1017)	Number	%
Dublin Mid Leinster	228	22
Dublin North East	199	20
South	206	20
West	254	25
Other	130	13

5.3 Organising and planning care

The most frequently used methods of organising care were primary nursing, service user allocation and team nursing. More than 40% of the sample indicated that primary nursing was the predominant method of organising care in their area and almost 25% indicated they used service user allocation. Team nursing accounted for nearly 20%. Even though participants were asked for the predominant method of organising care in their areas, some participants indicated through their responses that they use a combination of different methods in their areas, one of these combinations being service user allocation, team nursing and primary nursing.



Of the participants who indicated that using a nursing care plan was applicable to their role (n=935), more than nine out of ten (92%; n=864) reported using a care plan. Similarly, of those who responded that using an interdisciplinary care plan was applicable to their role (n=938), approximately eight out of ten (80%; n=753) reported using this type of care plan.

Respondents were also asked to rate how often they liaise with a variety of different organisations and individuals in their work with service users (see Table 6). The most commonly reported people participants reported liaising with were psychiatrists/registrars (92%; n=885) and other psychiatric nurses (86%; n=828). The fewest respondents reported liaising with pastoral care (9%; n=85), the Gardai (8%; n=76) and schools (5%; n=45). A further 18% (n=182) of participants indicated that they liaise with 'other' services or people including legal services, social welfare services, general hospital staff, community welfare officers, probation officers, household staff, maternity services, Traveller support groups, Alzheimer's association, and other specific community and voluntary organisations. It is clear from examination of this section that there are many other people and organisations that psychiatric nurses liaise with on a daily basis when working with service users. Percentages have been calculated out of applicable responses and do not include those who responded 'not applicable'.

Table 6: Organisations and individuals that participants' liaise with when working with service users

	Always / majority of time Number (%)	Occasionally/ never Number (%)
Psychiatrists/Registrars (n=960)	885 (92)	75 (8)
Other psychiatric nurses (n=961)	828 (86)	133 (14)
Carers/family members (n=955)	670 (70)	285 (30)
Social Workers (n=953)	559 (59)	394 (41)
Occupational therapists (n=944)	547 (58)	397 (42)
Psychologists (n=954)	506 (53)	448 (47)
GPs (n=942)	403 (43)	539 (57)
Community/voluntary organisations (n=952)	371 (39)	581 (61)
Counsellors/psychotherapists (n=947)	364 (38)	583 (62)
Pharmacists (n=938)	354 (38)	584 (62)
Dieticians (n=939)	198 (21)	741 (79)
Specialist services e.g. mental health service, mental health service for homeless people (n=928)	185 (20)	743 (80)
Advocacy services (n=943)	182 (19)	761 (81)
Public health nurses (n=919)	147 (16)	772 (84)
A&E staff (n=933)	132 (14)	801 (86)
Housing authorities (n=909)	102 (11)	807 (89)
Pastoral care (n=920)	85 (9)	835 (91)
Gardai (n=927)	76 (8)	851 (92)
Schools (n=919)	45 (5)	874 (95)



When asked what tools participants utilise as part of a service user assessment, the most common tools that participants responded they used from the list provided were the Mini Mental State Examination (44%; n=446) and the Beck Depression Inventory (30%; n= 120). Approximately one in ten participants (10%; n=104) indicated they used 'other' tools than those on the list provided. Examples of these included The Tidal Model, Clients Assessment Strengths, Interests and goals (CASIG), Sainsbury risk assessment, Hamilton Scale, Edinburgh Post Natal Depression Scale, as well as many others. Just over 8% (n= 87) indicated that this was not applicable to their current role.

Participants also reported on how frequently they included a variety of different areas in the assessment of service users. Participants reported least frequently including the needs of their carers (51%; n=469) and their children (48%; n = 424) in assessments of service users. However, as not all service users have children or relationships with their children or family members, care needs to be taken when interpreting this data.

Additional results are presented in Table 7. Percentages have been calculated out of applicable responses and do not include those who responded 'not applicable'.

Table 7. Frequency of including specific areas in assessment with the service user

	With all / most service users Number (%)	With few / no service users Number (%)
Medication management (n=943)	884 (94)	59 (6)
Risk assessment (n=942)	867 (92)	75 (8)
Hopes/ wishes for the future (n=938)	832 (89)	106 (11)
Fears/ anxieties (n=942)	828 (88)	114 (12)
Sources of income (n=928)	814 (88)	114 (12)
Employment history (n=919)	804 (87)	115 (13)
Support systems (n=941)	814 (87)	127 (13)
Coping styles (n=942)	811 (86)	131 (14)
Social relationships (friendships)(n=937)	803 (86)	134 (14)
Family relationships (n=941)	801 (85)	140 (15)
Education history (n=926)	772 (83)	154 (17)
History of abuse (n=933)	674 (72)	259 (28)
Physical assessment (n=917)	541 (59)	376 (41)
Sexual relationships (past/present) (n=925)	528 (58)	397 (42)
Needs of carers of service users (n=913)	469 (51)	444 (49)
Needs of children of service users (n=887)	424 (48)	463 (52)



In addition, participants were asked about how frequently they included a variety of different areas when planning care for service users. More than 80% of participants included medication management (90%), support systems (86%), coping mechanisms (85%), hopes and wishes for future (84%), fears/anxieties (83%), material resources (83%) and carer/family strengths (81%) in planning care with all or most service users. Participants reported least frequently including pastoral care (32%; n=296) in care planning for service users. Additional results are presented in Table 8.

Table 8. Frequency of including specific area in planning care with the service user

	With all / with most service users Number (%)	With few / with no service users Number (%)
Medication management (n=945)	851 (90)	94 (10)
Support systems (n=945)	809 (86)	136 (14)
Coping mechanisms (n=946)	803 (85)	143 (15)
Hopes and wishes for the future (n=945)	793 (84)	152 (16)
Fear / anxieties (n=945)	788 (83)	157 (17)
Material resources (money, food, housing, transport) (n=931)	777 (83)	154 (17)
Carer / family strengths (n=940)	758 (81)	182 (19)
Service user strengths (n=943)	696 (74)	247 (26)
Peer support (n=936)	577 (62)	359 (38)
Community/ Voluntary organisations (n=939)	565 (60)	374 (40)
Pastoral care (n=925)	296 (32)	629 (68)

The most common interventions that participants reported using were goal setting (80%; n=814), conversing (75%; n=765) and early intervention strategies (45%; n=459). Between 23% and 40% of the sample used the other interventions listed. Notably, only 4% reported using Dialectical Behavioural Therapy. These and the prevalence of other interventions used are presented in Table 9.



Table 9: Types of interventions used

Types of Interventions used	Number	%
Goal setting	814	80
Conversing	765	75
Early intervention strategies	459	45
Anxiety management	422	41
Solutions for wellness	411	40
Cognitive Behavioural Therapy	346	34
Wellness Recovery Action Planning	328	32
Facilitating group work	319	31
Solution focused brief therapy	258	25
Motivational interviewing	234	23
Not applicable to my current role	65	6
Dialectical Behavioural Therapy	43	4
Other	34	3
None of the above	6	>1

Participants had option of ticking multiple responses

5.4 Service user and carer/ family involvement

Participants were asked to rate the level of service user and family involvement in six areas, namely planning care, decision making, goal setting, reviewing care received with the nurse, reviewing care received with the team and evaluating the care journey. Across all six areas, 62% to 92% of participants felt that service users were at least moderately involved. Participants indicated that service users were most frequently involved with goal setting (62%; n=589), decision-making (59%; n=555) and planning care (58%; n=552). They were least frequently involved in reviewing care received with the multi-disciplinary team and evaluating the care journey, with approximately three out of ten participants indicating that service users had little to no involvement in this aspect of their care. Table 10 more fully details these results. Again, percentages have been calculated out of applicable responses and do not include those who responded 'not applicable'.



Table 10. Level of involvement of service users

	Extremely / very involved Number (%)	Moderately involved Number (%)	Little / no involvement Number (%)
Goal setting (n=947)	589 (62)	287 (30)	71 (8)
Decision making (n= 940)	555 (59)	304 (33)	81 (8)
Planning care (n=947)	552 (58)	311 (33)	84 (9)
Reviewing care received- with the nurse (n=943)	494 (53)	264 (28)	185 (19)
Evaluating care journey (n=936)	408 (44)	232 (25)	296 (31)
Reviewing care received- with the multidisciplinary team (n=936)	401 (43)	256 (27)	279 (30)

Participants indicated that carers were less involved than service users; across all six areas, just 44% to 62% of participants felt that carers were at least moderately compared to the above figures for service users. Figures across all areas were relatively similar with the level of carer involvement rated between 22% and 29% as being extremely or very involved (see Table 11). Percentages have been calculated out of applicable responses and do not include those who responded 'not applicable'

Table 11. Level of involvement of carers

	Extremely / very involved Number (%)	Moderately involved Number (%)	Little / no involvement Number (%)
Decision making (n=906)	225 (29)	296 (33)	385 (38)
Planning care (n=915)	243 (27)	284 (31)	388 (42)
Reviewing care received- with the nurse (n=914)	216 (24)	218 (24)	480 (53)
Reviewing care received- with the multidisciplinary team (n=908)	198 (22)	204 (22)	506 (56)
Evaluating care journey (n=907)	197 (22)	200 (23)	510 (55)
Goal setting (n=916)	197 (22)	279 (30)	440 (48)

5.5 Recovery oriented approach

When asked, "Has your service adopted a recovery approach?" more than half of the sample reported that their service had, while 20% reported it had not and 25% were unsure (see Table 12).

Table 12: Participants' views on whether their service has adopted a recovery approach

"Has your service adopted a recovery approach?" (n=1017)	Number	%
Yes	522	51
No	193	19
Don't know	254	25
Not applicable to my current role	48	5



Two lists were provided for participants pertaining to factors that may facilitate or inhibit adoption of a recovery approach in their current area of practice. The most common factors that facilitate adoption of a recovery approach in their areas of practice according to the respondents were supportive family relationships (92%; n=847), community/ peer support services (88%; n=773) and the environment where care is delivered, including specifically the community setting (84%; n=721) and the service user's home (84%; n=721) (See Table 13). Percentages for both tables 13 and 14 have been calculated out of applicable responses and do not include those who responded 'not applicable' or 'don't know'.

Table 13: Factors which facilitate adoption of recovery model

	Facilitates adoption of recovery approach Number (%)
Supportive family relationships (n=925)	847 (92)
Community/peer support services (n=874)	773 (88)
Environment where care is delivered – community setting – day hospital/clinic (n=859)	721 (84)
Environment where care is delivered – service user's home (n=859)	721 (84)
Mental health professionals' attitudes (n=916)	564 (62)

The most common factors that were identified as inhibiting adoption of a recovery approach according to the respondents were medicalised format of documentation within the mental health service (83%; n=712) the biomedical focus of care planning (77%; n=638) and the side effects of medication (76%; n=676) (See Table 15).

Table 14 Factors which inhibit adoption of recovery model

	Inhibits adoption of recovery approach Number (%)
Medicalised format of documentation within mental health service (n=857)	712 (83)
Biomedical focus of care planning (n=830)	638 (77)
Side effects of medication (n=889)	676 (76)
Attitudes from the public (n=889)	581 (65)
Environment where care is delivered – hospital (n=885)	571 (65)

5.6 Systems and processes

Likert scales were used to measure how important the sample perceived a number of items pertaining to medication to be in the efficient delivery of care to service users by nurses working with individuals with mental health difficulties (see Table 15). These items included prescribing, supplying medication, making dosage adjustments, advising discontinuation of medications, withholding medications and administering medications. As across all six items between 63% and 88% of the sample agreed that the item was extremely or very important, it is evident that participants perceived all of the items listed as very important for the efficient delivery of care to service users by RPNs. Percentages have been calculated out of applicable responses and do not include those who responded 'not applicable'.



Further information is presented in Table 15

Table 15: Importance of factors related to medication in the efficient delivery of care

	Extremely / very important Number (%)	Neutral Number (%)	Not at all / not important Number (%)
Administering medications (n=942)	826 (88)	103 (11)	13 (1)
Withholding medications (n=926)	735 (79)	167 (18)	24 (3)
Advising discontinuation of medications (n=927)	719 (78)	186 (20)	22 (2)
Supplying medications (n=929)	717 (77)	180 (20)	32 (3)
Making dosage adjustments (n=909)	700 (77)	188 (21)	21 (2)
Prescribing (n=907)	574 (63)	274 (30)	59 (7)

For the participants who it was applicable (n=901), approximately 70% (n=632) indicated that they do not have the authority to accept referrals from others, excluding the consultant. In addition, for the participants who it was applicable (n=899), approximately 80% (n=740) indicated that they do not have not the authority to discharge service users from their case loads.

5.7 Service user and carer/ family education

In relation to service user education, participants were asked to identify from a given list the areas of service user education with which they were involved. They had the option of choosing multiple responses. The most common areas reported were education surrounding medication (79%; n=808), education on relapse prevention (63%; n=642), and education on the benefits of goal setting (52%; n=527). Responses in the 'other' response category included areas already addressed and education in relation to advocacy, social inclusion, effects of substance misuse, individual anxiety management and education on personal triggers. Further information is presented in Table 16.

Table 16: Areas of service user education in which participants are involved

Areas of service user education	Number	%
Education around medication	808	79
Education on relapse prevention	642	63
Education on benefits of goal setting	527	52
Education regarding community services	483	47
Education on benefits of being physical healthy	478	47
Education on coping with family distress	372	37
Education on peer support available	361	36
Education on managing stigma	283	28
Not applicable to my current role	77	8
None of the above	59	6
Other	25	2

Participants had option of ticking multiple responses



Participants were also asked to identify areas of family education with which they were involved. The most common areas identified were education surrounding medication (56% n=573), education surrounding early warning signs (43%; n=440) and education on carer supports available (35%; n=356). Examples of 'other' areas of family education that respondents referred to included caring for carer's programmes, educating families on cognitive impairment and dementia and facilitating evidence based family skills programme. This information is presented in greater detail in Table 17.

Table 17: Areas of family education in which participants are involved

Areas of family education	Number	%
Education surrounding medication (side effects etc)	573	56
Education surrounding early warning signs	440	43
Education on carer supports available	356	35
Education on coping with family distress	294	29
Education on stress management	261	26
None of the above	242	24
Education on managing stigma	191	19
Not applicable to my current role	124	12
Other	15	1

Participants had option of ticking multiple responses

5.8 Professional development

The most frequently used methods of professional development utilised by participants were reading health-related newsletters (68%; n=691), undertaking further courses organised with the service (47%; n=479), and reading peer review journals (43%; n=438). About one in three participants also reported that they undertook further courses through third level institutions (36%) and nursing centres (30%). One in four engaged in reflective practice sessions to develop their role both in nursing (26%) and in the multi-disciplinary team (25%). Approximately one in five participants (19%) developed their role through undertaking clinical supervision. The least used means of professional development reported was maintaining a portfolio (11%; n=114). Table 18 describes responses in greater detail. 'Other' responses (2%) included expanding the areas provided and engaging in web-learning, peer education/ support sessions, developing a professional development plan, attending conferences and seminars, and through team presentations.



Table 18: Methods of professional development used

Development of Role	Number	%
Reading health related newsletters	691	68
Undertaking further course organised within the service	479	47
Reading peer review journals	438	43
Undertaking further course organised by 3rd level institution	366	36
Undertaking further course organised by CNE Education	306	30
Engaging in reflective practice sessions (Nursing)	262	26
Engaging in reflective practice sessions (MDT)	255	25
Undertaking clinical supervision	194	19
None of the above	114	11
Maintaining a portfolio	113	11
Other	26	2

Participants has option of ticking multiple responses

5.9 Development of role

Respondents were asked to identify from a list of factors those which facilitate and inhibit the development of the RPN role in their current area of practice. The three most commonly identified factors that facilitate the development of the RPN role were knowledge (83%; n=823), personal motivation (83%; n=817) and skills (72%; n=689). Further results are presented in Table 19. Percentages have been calculated out of applicable responses and do not include those who responded 'don't know'

Table 19: Factors which facilitate the development of the RPN role

	Facilitates development Number (%)
Knowledge (n=992)	823 (83)
Personal motivation (n=985)	817 (83)
Skills (communication, clinical, etc.) (n=954)	689 (72)
Other nursing colleagues (n=919)	658 (72)
Line manager (n=961)	628 (65)

The two factors which respondents most frequently identified as inhibiting the development of the RPN role were organisational culture (68%; n=644) and the medical model (78%; n=706). Further results are presented in Table 20.



Table 20: Factors which inhibit the development of the RPN role

	Inhibits development Number (%)
Medical model (n=902)	706 (78)
Organisational culture (n=952)	644 (68)
Remuneration for engaging in new clinical practice/developments (n=811)	487 (60)
Employment profile of staff (Agency, Bank) (n=876)	515 (59)
Availability of protected time (n=943)	576 (61)

5.10 Qualitative aspect of survey

The qualitative portion of the survey was comprised of optional open-ended questions. Responses to each question were coded thematically and an overview of the major findings is presented below.

5.10.1 Understanding of recovery

One-third of participants (n=341) responded to the question asking about their understanding of recovery as an approach. A small number of respondents commented that they were not clear what recovery meant and that they haven't received education on recovery. However, three major themes arose from the majority of responses. The first approached recovery in terms of individual empowerment, focusing on the importance of a collaborative MDT that promotes service user-centred care and enables service users to focus on their individual strengths. Some respondents approached recovery as an attitude or belief, a life-long process of being well. Finally, reference was made on many occasions to the importance of a positive therapeutic relationship between the service user and the care giver in recovery.

Individual empowerment

The first theme identified in the responses indicated that recovery was a process that involved an empowering MDT, a collaborative supportive approach that was service user-centred, involving service users and carers on a journey unique to each individual. Respondents described the way in which a service and the nurse should act in empowering and enabling the individual to become a key decision maker in their recovery journey. One written comment included:

'Recovery to me encompasses service user involvement in their own care in aiding a person to get back to a functional state of being where they have support from family and carers with ongoing support from voluntary agencies. Recovery also means helping services users take responsibility of their own journey. Recovery is a very individual thing.'

Some participants specifically understood recovery to be strengths-focused and involving assisting service users to identify their strengths to facilitate them to return to the highest level of functioning for them. Their comments highlighted the importance of focusing on the individual's strengths and opportunities to empower them through their recovery journey. Examples of written comments included:

'The person experiencing the mental health disturbance is facilitated to examine their strengths and work towards a goal they have identified at their own pace.'



Recovery is a belief/ an attitude

Some of the written comments referred to recovery as the service user being 'symptom free' or indicated that recovery is 'a journey to meaningful symptom free life'. One respondent believed it meant 'getting better'. In contrast, many respondents understood recovery to be a belief or an attitude, a non-medical process which involves instilling hope and holding and instilling the belief that recovery is possible. Some written comments included:

'Recovery to me is a belief, i.e. you will get better from your illness, which is used to instil hope and empowerment to the service user on their journey to full health. Our service is structured in a way which facilitates this.'

'I believe it [recovery] is an attitude that a nurse has to incorporate into her practice with a service user – a mutual respect in a collaborative relationship in the assessment and setting of goals for their future, underpinned by social inclusion and hope, where realistic goals are complied and documented by the service user.'

Therapeutic relationship

Some written responses referred to the therapeutic relationship between the service user and the care provider or nurse being central and fundamental to recovery. One of the written comments included:

'It [recovery] is about the therapeutic relationship that develops between the care giver and the receiver and the care giver's views and attitudes on mental health.'

Other responses indicated that working in a recovery-oriented way involves supporting service users to live a high functioning life in the community: 'Facilitating the client to live in the community and live a high functioning life.'

5.10.2 Factors that facilitate adoption of a recovery approach

Approximately 20% (n=202) of participants provided further written information on factors that they thought facilitate adoption of a recovery approach in their area of practice. Some of the factors they described further elucidated findings from the quantitative aspect of the survey. The main theme to emerge from these written findings was the importance of a supportive environment, characterised by a cultural ethos underpinned by service user need and recovery. The second major factor described to facilitate recovery was the availability of care within the community that could support service users and their carers/ family members. Several participants outlined the importance of service user involvement in facilitating recovery and the way in which service users must have a voice throughout the process. Finally, interdisciplinary education and training was outlined as a factor in facilitating the adoption of a recovery approach in many written responses.

Supportive environment

The main theme to emerge from these written responses was the importance of a supportive environment. One participant summarised succinctly: 'The culture of an organisation needs to adopt this [recovery] approach.' Specifically, participants commented that flexible working practices, interdisciplinary cooperation, a cohesive committed team and good communication between team members were all necessary to facilitate adoption of a recovery approach. One comment included:

'A strong cohesive team dedicated to working with individuals in the early stages of illness, who communicate readily and place the service user and their families at the centre of the identification of needs and care delivery'



The importance of supportive management structures and organisational systems including recovery-oriented policies, protocols and guidelines, as well as consistent staffing to facilitate adoption of a recovery approach, were all referred to by participants. Specifically, one participant noted how, *'clinical supervision would facilitate adoption of the recovery approach.'* Others made reference to nurses being strong advocates to help facilitate a recovery approach. Some other comments included:

'If the focus is on recovery, the staff must feel competent and confident in their practice. They must support service users to make clear decisions about care and treatment. Organisational systems must change to support the shift of decision making to the service user.'

'Consistent staffing levels with staff who have built up a relationship with the patients. This also applies to having consistent consultants, not ones who change every six months.'

Community

The availability of psychiatric nurses and care outside the hospital setting was outlined as a factor in facilitating a recovery approach throughout the responses. Nurses being knowledgeable about, liaising with, and facilitating service users and carers to use community and voluntary groups were referred to by a large number of participants as factors necessary to facilitate adoption of a recovery approach. One comment included:

'If more psychiatric nurses were available to work in the community then the recovery approach would be better able to be implemented.'

Service user involvement

Other participants included written comments pertaining to the importance of service user involvement in the care journey and on all committees and groups locally and nationally to facilitate adoption of a recovery approach. The provision of choice to facilitate adoption of a recovery approach was also referred to. One respondent described his/her belief in the importance of service user involvement in recovery:

'Patients need to be involved in the support they want, decide what change they want to make to facilitate their recovery and the pace at which change is made and work collaboratively with the most appropriate professionals to meet their needs.'

Interdisciplinary education

Interdisciplinary education regarding the recovery model and training on how to work in a recovery-oriented way were both viewed as necessary components to the adoption of a recovery approach. Staff knowledge of a recovery approach was referred to on many occasions.

One comment included:

'Staff need more education on the recovery concept and this needs to be multidisciplinary wide. An approach that does not encompass on disciplines will fail as nursing staff will be working within a very medicalised, symptom-focused system.'



5.10.3 Factors that inhibit adoption of a recovery approach

A further question asked participants to expand on or provide information on factors that they think inhibit adoption of a recovery approach in their area of practice. One-fifth of the participants (22%; n= 224) provided additional information in response to this question. Their responses comprised four major themes. The first major theme dealt with the practical issue of a lack of resources, particularly staff shortages and time. The over-reliance on the medical model was also viewed by many as inhibiting a holistic recovery approach. Thirdly, a lack of interdisciplinary communication was viewed as an inhibiting factor, as was a lack of support from managerial staff. Finally, participants described how the stigma associated with mental health difficulties could impede in the adoption of a recovery approach.

Resources

A large number of participants who responded to this question referred to the lack of available resources, including staff and time available, as inhibiting factors to the adoption of a recovery approach. Many responses indicated current staffing levels and the current recruitment embargo were inhibiting factors and one typical comment included:

'Lack of psychiatric nursing personnel to meet the ever expanding demands by the public'

Medical model

The dominance of the medical model was referred to by an overwhelming majority of participants: *'over-dependence on the medical model'*. The medical model was described as focusing too much on the medical dimension of the service user, whilst not taking into account other holistic aspects of care. One participant described how, *'power for decision making remains with consultant psychiatrist who maintains a medical approach to care.'*

Interdisciplinary co-operation and support

Lack of interdisciplinary co-operation and poor communication structures were referred to by some participants as factors that inhibit adoption of a recovery approach: *'lack of communication up and down the MDT'*. Some participants commented that the lack of training provided on how to implement recovery was an inhibiting factor. Lack of managerial support and effective leadership was also referred to by some participants: *'Lack of leadership results in nurses feeling unsupported in their day to day work.'*

Stigma

Some comments referred to how *'stigma'* and *'negative attitudes'* towards mental health difficulties from staff and the public could interfere with the adoption of a recovery approach. One typical comment included:

'Stigma in the community inhibits recovery... some clients also keep their diagnosis a secret because of stigma in the media.'

5.10.4 Skills and competencies

Almost half of the participants (46%; n=469) identified particular skills and competencies they felt they needed to develop in order to enhance their practice. The main responses were centred around the following categories:

- education and training required (interdisciplinary) on recovery model and how to work in a recovery-oriented way;
- development in psychosocial interventions skills including motivational interviewing/ Family interventions/ early interventions strategies;



- assessment skills (including documentation, risk assessment and physical assessment skills);
- clinical supervision skills;
- management / leadership skills;
- psychotherapy skills (for example, Cognitive Behavioural Therapy);
- interpersonal skills (including the abilities to communicate hope, articulate their role within the MDT, present information, and to work alongside service user and carers);
- research & auditing skills/ IT skills/ accessing databases and;
- preceptorship and teaching skills.

The survey asked another open response question about whether respondents have developed particular skills and / or competencies which they are not using in their current area of nursing practice. Thirteen percent (n=136) answered 'yes' to this question. Some responses to this question included psychotherapy and counselling skills, management and leadership skills, clinical skills, venepuncture, and research skills.

5.10.5 Development of RPN role

Just over 10% (n=116) of the survey sample described other factors that they felt facilitate development of the RPN role. The main theme to emerge from their responses was the importance of a supportive organisation that fostered their development. This included an overall cultural ethos of supporting the RPN role through sound management and leadership, as well as the opportunity for learning and growth.

Facilitating the development of the RPN Role: The need for a supportive organisational culture

Organisational issues and culture were referred to by a large number of respondents. These included roster structuring, described by some as 'inflexible'. Participants suggested a re-structuring of organisational culture to develop their skills: *'culture and space for learning and development'*.

Management and leadership structures

Specifically, some respondents felt that better managerial structures, availability of good role models and effective leadership was needed to develop their roles. Examples of respondents' suggestions to improve the role of the included:

'Psychiatric nursing is changing and what is needed is strong leaders to support staff who wish to change practice and move from task-orientated approach to person-centred approach.'

Support opportunities for development

Supportive organisational structures and introduction of initiatives were called for in some of the written comments. Other comments described the need for their services to adopt a more service-user centred ethos: *'culture of service user/ carer involvement'* and *'culture of looking at service users needs'*. Some of the supportive initiatives called for included:

'Development of clinical supervision is an essential element required in the ongoing development of mental health nursing in Ireland.'

Inhibiting the development of the RPN Role

Another optional open response section was provided to give participants the opportunity to describe any other factors that inhibit development of the RPN role. About 15% (n=156) of participants responded to this question. The main factors viewed as inhibiting the development of the RPN role included: dominance of the medical model, lack of managerial support and leadership structures, as well as limited resources.



Dominance of medical model

The dominance of the medical model was perceived to be inhibiting the RPN role according to some comments, leading to the RPN's role being devalued as described by this participant:

'It is not uncommon to feel powerless as a member of the MDT because I am a nurse. Although nurses make up the majority of our team, our voice seems to be the least heard.'

Management support, leadership structures and resources

Some participants viewed lack of managerial support and leadership structures as inhibiting the development of their role. An example of a typical comment is:

'Lack of support from management – when new practices are introduced, management must start to encourage engagement and support staff with learning- support structures must be in place for staff to learn.'

In addition, a lack of adequate resources including nursing staffing levels, the recruitment embargo and increased workloads were seen as major inhibiting factor in developing the role of the RPN. In a characteristic response, one respondent described how reduced staffing impacts on a centre: *'Staff reduced by 50% over the past year, very little time to do individual work as this centre has average of 50 clients per day.'*

Five percent (n= 54) of survey participants took the opportunity to add further comments. These additional comments mainly referred to issues surrounding the dominance of the medical model, management structures, importance of having access of effective leaders, lack of resources, organisational culture and other areas that have already been addressed. Some respondents indicated that those working in HEIs must work closely with clinical staff. One comment included: *'Third level staff need to have links with practice, as students seem to find it difficult to link what they have learnt in college with what is happening in clinical areas.'* Other comments related to respondents experiences of participating in the project and their hopes for the role of the RPN following completion of the project. One comment included:

'I look forward to the development of the services and hope I will be in a position to further utilise my skills.'

5.11 Summary

This chapter has provided an overview of the findings from the survey which will assist in informing the recommendations for the report. The findings from the survey suggest that nurses are liaising with people from a number of areas and disciplines when working with service users. It is clear that participants are using a wide range of evidence-based tools as part of the service user assessment and are using a number of interventions when they are working with service users. Organisational systems and processes appear to be dominated by the medical model. Participants have provided their views on factors that facilitate and inhibit adoption of the recovery approach in their area of practice, as well as factors that facilitate and inhibit the role of the RPN. Participants have also identified skills and competencies that require development to enhance their practice. In the next chapter the findings from the focus groups and the written submissions will be presented.



CHAPTER 6

Findings from the focus group and written submissions

6.1 Introduction

The aim of conducting the focus groups and inviting written submissions was to gain an insight of individual views in relation to the knowledge, skills and competencies that may require development for nurses to work with people with mental health difficulties to continue to respond to *A Vision for Change* (DoHC, 2006). This consultation process also explored individuals' understanding of working in a recovery-oriented way and the structures that are needed to be in place for nurses to work in this way. It investigated participants' views on the values and principles that should underpin psychiatric/mental health nursing, as well as participants' vision in relation to development of the RPN role to improve the range and quality of services available to service users and families. Participants were also invited to outline what structures they perceived necessary to ensure that RPNs incorporate an evidence-based approach into their practice and service delivery and to describe how effective leadership could be developed and supported for psychiatric nursing.

This section provides an overview of the major themes that emerged from the responses. As it is not possible to include all quotes and statements relating to each area, samples were selected to offer the reader an insight into the discussions and submissions.

6.2 Respondents understanding of working in a recovery-oriented way

Higgins (2007) captured the common themes underpinning the writings of people who have described their own individual recovery journey. These included: positive self image and identity, hope, voice, self determination, relationships, personal resourcefulness, confidence and control, trust in self and spiritual connection. The first question posed in this phase of the consultation aimed to explore respondents' understanding of working in a recovery-oriented way. The first major theme to arise described a recovery-oriented approach as individual-centred, focused on the individual's strengths, needs, beliefs and individual expertise. In this understanding, respondents described the ways in which they incorporate a variety of therapeutic skills and interventions, beyond the traditional medical model, that would assist in the service users recovery. For some, moving beyond the traditional medical model meant that recovery and care should be community rather than hospital or institution based. While many respondents described this more holistic approach, some respondents did view recovery in terms of the traditional medical model, or being 'symptom free'. A large number of responses indicated that working in a recovery-oriented way involves working as a member of a MDT with a focus on establishing collaborative partnerships with key community and peer support agencies. The third major theme highlighted the view that a key characteristic of a recovery-orientated approach is instilling hope. In this view, it is the role of the RPN to be positive that recovery is possible and to transfer and inspire this hope in service users.



Individual empowerment

Under this theme, respondents described a recovery orientation approach as a process that respects service users as unique individuals, recognising their individual expertise, as well as their unique beliefs and strengths. The large majority of respondents indicated that working in a recovery-oriented way involves recognising that recovery is a journey that is individual to each person and involves looking beyond the individuals mental health difficulties. Some respondents understood that exploring how the person defines recovery for them was fundamental to working in a recovery-oriented way as was the availability of meaningful therapeutic activity. Some responses indicated that it is imperative that the care giver empowers the individual with the mental health difficulty to create a meaningful life plan for them and recognises the service user as an expert in the relationship. One participant described:

'Individualised care will contribute to empowering service users to take control of their situation and to view mental health professionals as resources rather than experts. This return of power to the service user will enhance their recovery as it promotes a sense of mastery and self-confidence in their abilities to resolve their problems.' (WS 4)

Individual care planning and collaboration

A number of respondents referred to engaging in individual care planning which is service user-centred and some respondents commented that working in this way involves working with and building on people's strengths rather than focusing on their deficits. Promotion of the individual's choice through information provision was also referred to on many occasions. A typical comment included:

'Working in a recovery-oriented way involves looking at patient's strengths. Identifying problems only achieves so much. It's a strengths-based approach, rather than a needs-based approach.' (FG 7)

Most respondents agreed that working in a recovery-oriented way means working in partnership with the service user and their carers and family members. *'Doing "with" rather than "for"'* was often referred to during this phase of the consultation. The large number of responses referred to decisions about care being made in partnership with the service user. A collaborative approach rather than a prescriptive approach was referred to on many occasions in relation to working in a recovery-oriented way. A large number of responses indicated that working in a recovery-oriented way involves working as an equal member of a fully resourced multidisciplinary team and liaising with and establishing collaborative relationships with peer support and community services. One typical comment included:

'It is my belief that community/ society needs to be involved.' (FG 7)

Community-based approach

Some respondents to the consultation understood that working in a recovery oriented way was best served and essentially based in the community outside of the hospital environment: *'providing approach within community environment'* (FG 10). In contrast, other responses indicated that working in a recovery-oriented way involves placing the service user at the centre of the service, irrespective of where the service is located. One typical comment included:

'Ideally working in a recovery-oriented way means delivering care in the community rather than hospital and preferably in the persons own home.' (FG 12).



Recovery as being 'symptom free'

Other respondents were of the opinion that working in a recovery-oriented way involves engaging in discharge planning and referred to the concept of the service user being 'symptom free' indicating a more traditional 'approach': *'The cornerstone of recovery is discharge planning'* (FG 1). Some respondents commented that recovery is nothing necessarily new and that it is perhaps just a change in the language we use: *'New language in recovery, not new approach'* (FG 11). This suggests perhaps that more clarity may be required in relation to the values and principles of working in a recovery-oriented way and translating the values and principles of this approach into practice. Others viewed working in a recovery oriented way as a new way of working and involves a paradigm shift in thinking and involve reviewing organisations structures. One comment included:

'Working in a recovery oriented way means that there is a requirement for a significant shift in thinking, service orientation and utilisation of multidisciplinary resources. This means that mental health services need to change their focus from treating/ managing symptoms of mental illness to engaging in a process, a path of tackling inclusion, access to roles, activities and facilities that support the uniqueness of the service user in living well in the context of having a mental illness' (WS 7)

A holistic approach: Moving away from the domination of the medical to incorporating a range of therapeutic skills and interventions

An overwhelming majority of respondents referred to working in a recovery-oriented way as a process involving 'moving away from the medical model', 'getting rid of the sick role' and 'moving away from illness orientation'. A number of respondents indicated that using a range of holistic therapeutic skills and interventions with service users and carers was a prerequisite to working in a recovery-oriented way. Some of these included empowering interventions through service user and carer education, psychosocial interventions, normalising the experience for service users and carers and promoting inclusion. It was perceived that applying a range of skills, interventions and techniques would assist RPNs to work in partnership with the service user and encompass a wider life perspective. One comment included:

'Nurses will need to articulate a comprehensive model of practice that enables the service user make sense of their illness and life experiences; they will need to be able to use a range of evidence-based psychosocial interventions that support the service users' sense of efficacy and personal control over their lives. Nurses will also need to coordinate service user access to the multidisciplinary team members and other voluntary and statutory groups as required.' (WS 7)

Inspiring hope

Holding and inspiring hope for individuals to live a meaningful life for them, despite the severity of their mental health difficulty, was another factor that a large number of respondents made reference to: *'Inspiring hope that individuals can recover from their illness and return to life in fuller lifestyle'* (FG 1). A change of mindset was called for on a number of occasions throughout the consultation. Some responses indicated that mental health professionals must believe that recovery is possible to work in this way. A number of responses indicated that nurse's beliefs and attitudes towards recovery were central to working in a recovery-oriented way, as was nurses challenging their own negative self-perceptions, when appropriate. One comment was: *'Recovery is more about we think rather than what we do'* (FG 9). Other typical comments included:

'Fundamentally, psychiatric/mental health nurses are required to practice from the core belief that recovery is possible and demonstrate this consistently in all of their interactions with service users and their carers.' (WS 4)



'Recovery orientated services means that mental health professionals' attitudes and beliefs about people who use the psychiatric services are positive. These attitudes and beliefs are demonstrated and role modeled through an active belief in the service user's ability to recover.' (WS 6)

6.3 Facilitating RPNs to work in a recovery-oriented way

The next question explored respondents' views on how nurses can be supported to work in a recovery-oriented way. Similar to the qualitative comments from the survey, respondents in the focus groups and written submissions described two major factors they perceived would assist them in working in a recovery-oriented way. The first dealt with the need to increase opportunities for recovery education and training. They described the need for student curricula to be reviewed, as well as the need for recovery-oriented training and reflection opportunities for those already working in services to be increased. The second major theme dealt with the need for an organisational culture and structures that would support a recovery-orientated approach. Respondents described how the ethos of recovery should permeate all levels of the organisation, including the interdisciplinary team, service managers and leaders.

Increase opportunities for education and training

An overwhelming majority of respondents throughout the consultation indicated that appropriate education and training opportunities on recovery practices, competencies, principles and values must be available and accessible to all psychiatric nurses and all other disciplines working in mental health services nationally. The availability of training for referrers was also seen as important by some respondents in supporting nurses to work in a recovery-oriented way. An example of a typical comment is:

'Training /education around the recovery process is an absolute perquisite if nurses are to engage with the process, particularly when recovery is being promoted from top down. Ultimately service users can only benefit from this enhanced knowledge.' (WS 5)

Some responses throughout the consultation indicated that this training should involve service users and carers: *'A core tenet of the recovery approach is that the person with a serious mental illness is the best source of information about what works and what does not'* (WS 22). Many respondents called for interdisciplinary or multidisciplinary approach to training on how to work in a recovery-oriented way in practice and some respondents indicated that a discussion across all disciplines and teams on recovery is necessary to ensure a shared understanding exists. One comment included:

'Recovery is not only a nursing issue- there is a need for facilitation of open discussion in relation to what is meant by 'recovery' and the adoption of an inclusive approach to care planning in specific teams- not occurring in all teams or services.' (WS 24)

The majority of respondents agreed that nurses must have access to recovery-focused continuing professional development activities and information sharing forums to learn about recovery practices occurring across regions nationally and internationally. Responses included:

'There is lots of good practice out there involving service users we need to know what good practice is happening in different areas rather than re- inventing the wheel.' (FG 7)

'Opportunities for engagement in continuous professional development that reflects the recovery-oriented model needs to be provided.' (WS 23)



Review curricula and Continuing Professional Development activities

Many responses indicated that the recovery principles and values must be reflected throughout all undergraduate and postgraduate programmes nationally. These respondents recommended that undergraduate and postgraduate curricula be reviewed as well as reviewing all current training programmes offered to nurses to ensure the recovery philosophy is reflected throughout to facilitate them to work in a recovery oriented way.

One respondent described this issue:

'In relation to education for mental health, nursing curricula (under and post graduate) need to be reviewed to assess them in the context of recovery oriented working.' (WS 23)

Some respondents commented that the nursing curricula must include skills which enable nurses to become effective activists: *'Emphasis in nursing curricula on skills needed to be effective social and political activists'* (WS 20). Other responses indicated that nurses must enhance their knowledge about recovery and working within a recovery framework. This respondent explained:

'At the personal level each psychiatric/ mental health nurse has an obligation to strive to enhance and extend their knowledge about recovery and recovery oriented approaches and to extend their personal professional competencies for practice.' (WS 4)

Opportunities to reflect

A clear majority of respondents indicated that there is a need for nurses to have access to opportunities to engage in critical reflection. Support from organisational structures to engage in reflection was also called for in order to facilitate nurses to work in a recovery-oriented way.

'Registered Psychiatric nurses need to be able to critically reflect on their practice and possibly the biggest support for this is the underlying philosophy of the health service providers where they work.' (WS 6)

Supportive organisational culture, systems and structures

A large majority of responses referred to the importance of having organisational processes, systems and structures in place which are recovery-oriented to facilitate nurses to work in recovery-oriented way and allow them the flexibility and scope to work in this way. A large number of responses referred to the medical model as inhibiting recovery oriented working and called for a more service user-centred approach. Recovery-oriented audits, standards and clinical governance activities were all seen as vital structures to have in place. Some responses indicated that national standards and key recovery competencies need to be developed to facilitate mental health professionals to work in a recovery oriented way. The majority of respondents indicated that all organisational procedures, policies, protocols and guidelines should be embedded in the recovery philosophy, reflecting recovery principles and values. Some respondents expressed that protected engagement time for nurses to develop relationships with service users and carers is necessary and, at times, other tasks and lack of resources, including insufficient staff, impinge on this. Comments included:

'RPNs work in a healthcare system that has developed based on a biomedical approach to mental illness and that is part of a wider healthcare system that is heavily oriented towards a biomedical model. Therefore the structures and ways of working reflect this. In order for mental healthcare to be reformed to support recovery-oriented working there needs to be a formal, managed reflection and review of organisational culture in the context of 'recovery orientation' and structured planned frameworks developed to reform the whole organisation to facilitate working in this way. This would involve identification of barriers and facilitators to recovery-oriented work.' (WS 23)



Recovery-oriented leadership and management structures

A large majority of respondents indicated that support and recovery-oriented leadership and management structures, both locally and nationally, are vital to have in place to work in a recovery-oriented way. Some respondents emphasised that nurses who are embracing the recovery philosophy should be supported: *'Support RPNs who are willing to make a stand to move towards a recovery-oriented practice'* (WS 20).

Many responses indicated that strong nursing leadership and role models are required to facilitate nurses to work in a recovery-oriented way. Others called for support from their regulatory body and suggested recovery guidelines should be put in place. Some respondents called for a commitment at national level to support nurses to work in a recovery-oriented way and one submission called for a psychiatric nursing leader at senior management level to advocate support for recovery-focused nursing services. One comment included:

'A key requirement to supporting RPNs to work in a recovery-oriented way is the commitment of policy makers, service funders and planners to embedding a recovery-oriented approach at a societal, cultural and organizational level. Central to this will be the re-organization of how funding for mental health services is determined.' (WS 4)

Introduce supportive recovery-oriented initiatives

Some respondents called for initiatives to support ongoing recovery-oriented working. These included introduction of 'recovery champions' in organisations nationally to promote recovery practices. A process of formal ongoing evaluation of the application of recovery in psychiatric nursing through service user outcome measurement was also suggested in some responses.

'Create 'recovery champions' across the services, who can facilitate and support RPNs in developing a recovery-oriented approach to their work and the to the overall setting.' (WS 20)

'To remain mindful of recovery, a system of ongoing evaluation of the application of recovery in nursing should be undertaken as part of an ongoing process. This will keep the recovery ethos alive in nursing service provision.' (WS 7)

Supportive culture

The majority of respondents agreed that it is necessary for all members of the MDT to embrace the recovery model. Role clarity and interdisciplinary cooperation were viewed as necessary to be in place to work in this way. Many responses indicated that psychiatric nurses have a varied role and defining the nurse's role within the MDT and their role in recovery is paramount. It was referred to on many occasions that all members of the MDT must share a common goal and be in consensus about what recovery means. This written submission explained the issue:

'Recovery working is not only a nursing issue – there is a need for facilitation of open discussion in relation to what is meant by recovery and the adoption of an inclusive approach to care planning in specific teams – not occurring in all teams or services.' (WS 24)

An amount of responses referred to therapeutic risk taking and the fact that the level of risk may increase when working in a recovery-oriented way: *'Recovery is all about creative risk taking all of the time'* (FG 22). A number of respondents added that support from managers, peers and all members of the MDT is a prerequisite when working in this way. Some comments included:

'Mental health care management need to consider and provide support for mental health nurses (and indeed other staff) in relation to risk assessment/management and the implications in relation to recovery-oriented working.' (WS 23)



'The support of the MDT is important as there are risks involved in working in a recovery-oriented way.' (FG 8)

6.4 Values and principles that should underpin psychiatric nursing

Respondents were asked to comment on what values and principles they felt should underpin psychiatric / mental health nursing practice. Responses to this question covered a wide range of values and principles and the majority of respondents did not differentiate between the two concepts of values and principles in their responses. The underlying theme covered in most of the responses was the need for psychiatric nursing to be grounded in the values and principles of respect for individual human rights, equality, confidentiality, hope, empathy, advocacy, the reduction of stigma, safety, honesty, dignity for the service user, informed consent and the values and principles underpinning a recovery approach.

A recovery-oriented approach

Some respondents indicated that to facilitate recovery-focused care, the principles and values predating the recovery approach need to be incorporated into all aspects of care and service delivery. The majority of responses were formulated with a focus on the recovery approach and the values and principles that are required to work in a recovery-oriented way. This respondent described how *'working in a recovery-oriented way is about adopting a real and continued commitment to the principles of recovery'* (WS 4). Many respondents indicated a service culture of positive mental health, optimism and inclusiveness must exist and within this all recovery values and principles should co-exist.

Respect and dignity for the service user

Respondents indicated that a genuine interest in supporting people through emotional distress should underpin psychiatric nursing, as well as, a tolerance of differences and the upholding and respecting of the rights of individuals: *'Having tolerance for diversity and shared multidisciplinary philosophy, in cooperating responsiveness and flexibility'* (WS 21). Some values that were referred to by respondents were respect, dignity, empathy, honesty, a non-judgemental approach, a positive attitude towards people with mental health difficulties and a belief that recovery is possible.

Providing service-user centred care

Respondents also described the ways in which these key values and principles would be translated into care. Primarily, many described the way in which the service-user should be at the centre of their care and recovery: *'The core principle of a recovery approach is that the person is at the centre of the mental health system'* (WS 7). In practical terms, respondents described how the provision of choice for individuals, open communication, a collaborative approach and sustainable partnerships should be developed.

A focus on ongoing development

A large number of the respondents indicated that psychiatric nursing practice should be grounded in EBP, and a culture of CPD and lifelong learning must exist: *'Ongoing CPD underpinned by EBP'* (FG 1). The nurse being accountable for practice, being professional and working within scope of practice and promoting wellness were also referred to in response to this question.



6.5 Skills and competencies that require development to improve the experiences and outcomes as identified in *A Vision for Change* (DoHC, 2006)

The next area that respondents were asked to comment on was what nursing skills and competencies require development in order to improve the experiences and outcomes for service users, for family members and for nurses as identified in *A Vision for Change* (DoHC, 2006). A number of respondents in the focus groups cautioned that in the development of their skills and competencies, it is important not to lose the caring aspect of psychiatric nursing practice. They stressed the importance of retaining and building on the current skills and competencies that nurses have demonstrated in the development of services and improving service user outcomes. The first major category respondents stressed was recovery-focused assessment skills, particularly risk assessment and skill development in relation to psychosocial interventions. The second major competency respondents felt needed to be developed were interpersonal and recovery-oriented communication skills. These were described at all levels ranging from individual recovery-oriented communication to team work to leadership roles.

Assessment skills

A large majority of respondents indicated that recovery-focused assessment skills that capture the individual's unique history and experience require development, as do the skills to facilitate collaborative care planning and evaluation of the services user's experience of the service he/she received. Respondents indicated that RPNs must be competent in co-ordinating a holistic assessment of service users' needs. One submission indicated that there is a need for uniform guidelines for the assessment and aftercare of self-harm presentations to emergency departments. Skill development in relation to undertaking a carer's assessment also requires development according to a number of respondents. Some comments from the narratives and the focus groups included:

'Nurses should have expertise in undertaking a comprehensive assessment; have competence in eliciting the service users life experiences; engagement skills and able to comprehend the contribution of the a person's vulnerabilities and coping mechanisms in terms of biological, psychological, social and interpersonal functioning...' (WS 7)

Risk assessment skills

According to one focus group respondent, *'managing risk is one of the biggest challenges for psychiatric/mental health nurses'* (FG 4). A large number of respondents expressed that nursing skills need to be developed in the area of risk assessment / management and a number of respondents referred to skill development to enable therapeutic risk taking and positive risk taking as a requirement: *'Competence to manage risk needs to be developed'* (FG 22). A number of respondents recommended training in relation to assessing and managing risk as a requirement through risk assessment tools: *'Risk management training- using a universal tool'* (FG 6). Others called for guidance and support when making decisions surrounding therapeutic risk, promoting a learning culture throughout organisations following critical incident analysis, and the development and implementation of policies and procedures on risk management and assessment strategies.

Psychosocial interventions

There was agreement amongst a large number of respondents that nurses working with people with mental health difficulties should be confident using psychosocial interventions and that these skills should be developed through education and skill training: *'We submit that expertise in evidence-based psychosocial interventions is critical to enabling the recovery process'* (WS 7). Identifying and maximising service user and carer strengths were also viewed as imperative to improving outcomes. A typical comment included:

'Skills and competencies need to focus on the role of the RPN in helping service users and their families to manage the psychosocial consequences of having a mental health problem...' (WS 6)



Some respondents indicated that training in specific interventions to respond to individuals who engage in DSH and suicide prevention training must be available to all RPNs. One respondent to the written submission described:

'Specific training in Brief and focused Psychosocial/ Psycho educational interventions for people with recurrent suicide attempts looking at harm reduction and suicide preventions. These interventions would look at emotional awareness, problem solving and interpersonal communication' (WS 26)

Interpersonal and communication skills

Many respondents referred to the importance of having excellent recovery-oriented interpersonal skills. They stressed the need for nurses to recognise the uniqueness of each individual and embrace the language of recovery whilst working in partnership and communicating hope to service users and carers to strengthen partnerships and reduce clinical distance.

'You need to have the skill of planting hope – Psychiatric/ mental health nurse have an essential role in this respect...' (FG 20)

'Nurses who practice from the core belief that recovery is possible and demonstrates this consistently with service users and carers will improve outcomes for service users and carers.' (WS 4)

Many respondents emphasised the importance of the nurses demonstrating interest, placing the service user at the centre of care planning and having the ability to listen:

'The most important skill [for nurses] is the skill of listening, another skill to be nurtured and developed is that of giving or cultivating hope.' (FG 20)

Many respondents indicated that interpersonal skills must entail having purposeful conversations with service users and carers and all communication must be embedded in a recovery philosophy.

'Nurses need to be confident in their own professional practice in supporting the service user to tell their 'story' and then be skilled in communicating hope for recovery of the self and building this experience of mental distress into the service user's life plan.' (WS 11)

'Nurses who recognise the absolute centrality of service users (and carers) perspective and recognises the service users ability to be actively engaged in all decisions about...care [will improve outcomes for service users and carers].' (WS 4)

Some respondents indicated that development of skills in relation to forming and sustaining collaborative partnerships is a requirement and expressed that nurses must have the ability to step back and work alongside the service user and assist the service user to work towards their goals. Some respondents referred to the importance of nurses having the ability to work at the service users pace, promoting autonomy and choice. Typical comments included:

'...RPNs need to become competent in assisting and helping service users to make their own decisions and to problem solve. This requires a move away from the notion of service users as 'ill' and a move towards more collaborative partnerships.' (WS 6)

'Taking a step back from the paternalistic role, thereby allowing and encouraging patients taking responsibility for their action.' (WS 20)



Teamwork skills

Fostering skills and competencies to participate in interdisciplinary team working, lead reviews and communicating effectively and assertively with the MDT were also referred to in a number of responses. Many respondents acknowledged that mutual respect and appreciation of the skills within the team is imperative to effective interdisciplinary working. A number of respondents, particularly focus group respondents, indicated that there is a tremendous requirement for nurses to be clear about their role and, in turn, to have the ability to articulate their role and their specific expertise and interventions concisely within the interdisciplinary team:

'Knowing what we are doing, why we are doing it and we need to have the ability to communicate this.' (FG 7)

'Nurses are often unsure of their role in the MDT and lack a structured 'skill set' that can be demonstrated by other disciplines.' (WS 3)

Many respondents indicated that engaging in structured critical reflection through activities, such as clinical supervision, will assist nurses in articulating their role. It was believed that this, in turn, will improve outcomes for service users:

'Nurses who are reflective and actively challenge their personal practice and of the practices of other mental health personnel [will improve outcomes for service users].' (WS 4)

Some respondents indicated that psychiatric/ mental health nursing leadership skills would benefit from development, including the need for the *'development of skills in the area of advocacy and leadership so as to represent mental health issues at national and international level'* (WS 23).

Some respondents felt it was necessary for nurses to have the skills to promote the valuable work that they do in practice through formally evaluating and communicating the outcomes of their interventions. It was perceived that supportive structures and leaders would facilitate this happening.

Other responses to this question covered a vast range of skills and competencies including physical health, presentation and preceptorship skills. A number of respondents expressed that there is a need for the development of health promotion skills, as well as, skills in relation to involving service users and carers in all aspects of care. Others indicated that skills for nurses on how to fulfil their role with regard to social inclusion require development. A number of respondents indicated that there is a need for nurses to develop their IT, auditing and research skills to capture knowledge from practice.

6.6 What needs to be put in place to ensure that RPNs incorporate an evidence-based approach into practice?

Respondents were invited to comment on what they think needs to be put in place to ensure that RPNs incorporate an evidence-based approach into their clinical practice and service delivery. In many of the responses, it was indicated that all nursing practice is underpinned by best available evidence and some responses referred to the debate in the literature in relation to what constitutes 'evidence'. A major theme underpinning many of the responses was the requirement for developing a supportive learning culture across organisations. Ideally, they described how this culture would be characterised by the value placed on training and education, using evidence in practice, a welcome for innovation, and fostering support for service user outcome measurement and research.



Training, skills development and knowledge sharing

Some respondents referred to training and skill development to access evidence and apply findings into clinical practice. A large number of responses emphasised the importance of nurses having access to and engaging in information sharing initiatives. Some of the common initiatives cited were journal clubs, dissemination of knowledge and information sharing forums between regions nationally, regular education days and access to open dialogue seminars and conferences focusing on developments in nursing and nursing-led initiatives. This was especially prevalent in findings from the focus groups where different regions were invited together to participate: *'We don't share good practice, which we should'* (FG 5). The need for stronger collaborative partnerships between HEIs and mental health services was cited in some responses to support RPNs incorporating an evidence-based approach into their practice and service delivery: *'The universities need to be linked with practice'* (FG 5).

Supportive leadership and management

Supportive and motivational leaders, initiatives and management structures were viewed as necessary to ensure that RPNs incorporate evidence-based approaches into their clinical practice and service delivery. Many respondents indicated that supportive and proactive managers must be in place in psychiatric nursing today to lead the profession and promote recovery-oriented working. Some responses indicated that managers need to welcome innovation and promote the good practice that is occurring in the different regions nationally. Some responses indicated that these types of leaders are already in place in their service: *'Without a forward thinking ADON, we would not be as proactive'* (FG 9). However, other responses indicated that this is an area that must be addressed and those that are working using a recovery approach need to be supported and encouraged by managers locally and nationally.

'Service providers / managers need to seek the good work that's being done and broadcast this nationally at forums.' (FG 9)

In some responses, the provision of time and support were outlined as necessary for those in specialist posts to lead audits and research in the clinical setting and some responses indicated that leadership must come from those nurses in specialist posts, such as CNSs and ANPs. Development of performance indicators, recovery-oriented standards and clinical guidelines to support recovery-oriented working were all identified as necessary structures to have in place to support RPNs working in a recovery-oriented way and to support the continued implementation of best available evidence into clinical practice. Another supportive initiatives cited on a number of occasions was the suggestion of nominating a person within the nursing team to champion a recovery approach in practice, to promote information sharing initiatives and to disseminate research findings and best available evidence in the clinical setting: *'Identify champions within practice where their approach is informed by contemporary evidence and not just evidence that support biological psychiatry'* (WS 20).

Critical reflection

A large number of respondents indicated that a supportive organisational culture must exist for nurses to critically reflect on their practice. The most frequently cited mechanism for this was the opportunity for nurses to engage in clinical supervision. Many respondents expressed that protected time is required and value must be placed on critical reflection activities by management structures to facilitate and support nurses to participate and engage effectively. This respondent described the supports needed for clinical supervision:

'Use of clinical supervision in an organised and systematic manner – this will require time and appropriate skilled personnel to support this process.' (WS 24)



Practice-based research and outcome measurement

Many respondents outlined the necessity for service user outcome measurements and research into the effectiveness of interventions in the clinical area. Respondents also referred to the benefits of using this information to inform service planning and delivery. Some respondents indicated that nurses are in key positions and have the ability to lead in measuring outcomes due to the nature of the interventions they provide. Many responses indicated that nurses must have the support and the mechanisms including appropriate tools in place to measure the outcomes and the effectiveness of the interventions they provide. One comment included:

'It is the view of this organisation [name of organisation] that RPNs are central to this process [outcome measurement] as they provide meaningful individual programmes to those using the services measuring outcomes is an obvious method of objectivity assessing the worth of those treatment interventions for service users.' (WS 26)

Another comment included:

'Nurses need the ability to measure they interventions they provide and define outcomes' (FG 22)

The requirement for the development of guidelines for assessment and aftercare for individuals who self-harm and the availability of self-harm awareness programmes based on best available evidence was referred to on occasions throughout the consultation. Provision of funding for service user focused research was referred to at various times throughout this phase of the consultation. An amount of responses called for practice-based research involving service users and carers in a meaningful way; hence, acknowledging them as being the experts. One typical comment included:

'People who are in recovery can help others in the process of recovery. Therefore, qualitative research could be enhanced as this would enable people's understanding of the process of their recovery from their perspective. Mixed methods (including a quantitative aspect) would be beneficial...' (WS 14)

Other respondents referred to importance of carrying out clinical audits and communicating action plans to all mental health professionals that are developed as a result of these audits in order to facilitate and promote a learning culture throughout organisations. Some responses outlined the requirement of the development and implementation of a recovery-focused audit tool to measure progress in working within a recovery philosophy.

'Development of clinical audit based on standards and outcomes that reflect the recovery-oriented model' (WS 23)

'We started auditing in our service and it's being really good. It identifies standards and it links to reflective practice- it makes us challenge the way things are.' (FG 16)

Resources

The large majority of respondents referred to the need for resources to assist in accessing and keeping abreast of evidence-based practice. Primarily, they discussed this in terms of protected time and adequate staffing. In addition, on site access to IT facilities, internet, libraries and electronic databases to facilitate nurses reviewing publications were all cited on a large number of occasions throughout this phase of the consultation. These were all seen as fundamental to allow nurses to continue to incorporate best available evidence into their practice and service delivery.



6.7 Development of the RPN role to improve services

Respondents were asked how the role of the RPN should be developed to improve the range and quality of services available to service users and carers. First, many respondents felt that service user needs should be identified through research. Specific areas respondents felt could be developed were the RPN role in prevention and early intervention, providing specialist services, psychosocial interventions and health promotion. Respondents also discussed the need for RPN role development in relation to social inclusion and working with carers and family members. Finally, respondents viewed support and effective leadership as critical in developing the RPN role to improving the range and quality of services available.

Identify service user needs and impact of interventions through research

Respondents were in agreement that the role of the RPN should be developed towards meeting the needs of service users and carers and that these needs must be identified nationally: *'Nurses are there to meet our needs'* (FG 20). Some respondents indicated that mental health services and interventions should be evaluated regularly to ensure service user needs are being met: *'Proactive services rather than reactive'* (FG 10). Suggestions included service user outcome-focused research and nurses becoming involved in research to help in identifying service user and carer needs. One comment included:

'Improving range and quality of services requires nurses to have a full appreciation of the changing health needs of the populations they serve as well as access to expertise to support research and service evaluation. As front line staff, nurses are best placed to be able to identify existing and emerging needs. Engaging in scientifically robust research to further establish population needs and support the identification of services requires specific cohorts of nurses, including practice development, advanced practitioner and clinical specialist nurses to have the required competencies.' (WS 4)

Prevention and early intervention

Some respondents indicated that a large number of people with mental health difficulties present to primary care services nationally. Some respondents commented on the prevalence of suicide and DSH nationally and referred to Mental Health Policy in relation to Liaison Mental Health services as follows:

'Vision for Change outlines a requirement for Liaison Mental Health services- one multidisciplinary team per regional hospital, which equates to roughly one per catchment area or 13 teams nationally. This has yet to be implemented fully.' (WS 26)

A large number of respondents were in agreement that RPNs with specialist skills in areas, such as prevention, detection and early intervention, should be accessible and take a prominent role through the structures of primary care to improve the range and quality of services available to service users and carers. One submission outlined the range of services a CNS in primary care provides which included *'promotion of well-being and positive life choices'* and *'giving advice, support, and short-term counselling'* (WS 26).

Some respondents indicated that the role of the RPN should be further expanded to enhance services in the area of crisis intervention. Typical comments included:

'Mental health nurses should be at the forefront of mental health service delivery in GP surgeries, A/E Departments, primary care, ancillary services and in an advisory capacity to families...' (WS 7)



Some respondents actually indicated that contact with the mental health service could be avoided altogether if an RPN with specialist skills was accessible through the primary care facility. Comments included:

'If I had had the facility of an RPN in primary care, I might not have needed to come and stay in mental health services so long as I would have had early intervention and wouldn't have waited so long...' (FG 20)

'From my experience working as Community Mental Health Nurse, many of the individuals that were treated in the Psychiatric Service could have been treated in Primary care if early detection/intervention services were available.' (WS 9)

Promoting a consistent, responsive and timely service

Some responses outlined areas, such as community clinics, where nurses could lead and commented that the development of a more autonomous RPN role nationally was required to improve outcomes:

'Nurses take much more time with you, doctors only see you for two minutes in out patients. Nurses should be able to manage my care, advise and prescribe medications. Nurses need to have a role in patients review and assessment. My nurses loses all power when I meet the doctor. She would have all the information. Nurses do not have enough input into my medication' (FG 21).

Some respondents felt that nurses should take a more prominent role in assessing and reviewing service users, as this would facilitate a better quality and more timely service for service users. Responses considered that *'fair and equal access'* and *'uniformity'* across regions was also vital. One participant described her experience of moving service as follows:

'I was attending a service for 7 years, I was never told my diagnosis. I moved flat and I was told I had schizophrenia. They did a wellness recovery action plan and I realised I had worked in the Civil Service in the past and I could go back to work. I feel very lucky at [name of service] they focus on self help, nurses deliver preventative thinking, the WRAP programme, learning about your triggers, what starts your illness off, keeping a diary, focusing on things to do, you set out your goals each week, review your progress and evaluate it- it's very helpful' (FG 21)

One submission indicated that the development of uniform guidelines for the assessment and aftercare of individuals who self-harm are required and RPNs must have access to and partake in evidence based self harm awareness training programmes. One comment included:

'In order to optimise the care for self harm patients, the role of the RPN should be improved by offering training to implement uniform guidelines for assessment and aftercare of self harm patients and to participate in the self harm awareness training programmes' (WS 8)



Family/ carer education

Many respondents felt that RPNs have a vital role in working with and supporting carers and family members of service users, without compromising service user autonomy. Some responses indicated that these relationships should be recognised, valued, respected and supported by all members of the MDT and by management structures. Respondents suggested that nurses become increasingly involved in educating carers and assist them to facilitate supportive networks in the community. One comment included:

'The role of carers as a primary source of support for service users should be recognised by RPNs. Again, assisting carers to build supportive networks is essential to ensure that their needs are met. In addition, the role of the RPN should be developed to provide practical help to carers without compromising the autonomy of the primary service user.' (WS 6)

Specialist and advanced practice roles

The large majority of respondents indicated that the development of specialist posts, such as CNSs and in particular ANPs, would improve the range and quality of services available to service users and carers. A particular example described by some was the need for the development of ANP posts in areas, such as mental health services for older people and in the special categories of service provision. One submission outlined an essential component of the development of these roles as follows:

'An essential part of the development of these roles [CNS & ANP] is that they are developed in accordance with the criteria set out by the National Council for the development of CNS and ANP roles and a key component of these criteria is that posts are developed in line with patient/ client need health service policy. As movement towards a recovery oriented model of care is at the core of Vision for Change, posts have and will have to be developed with this in mind.' (WS 23)

Some respondents considered that the development of a more autonomous role for nurses, including CNSs and ANPs, was a requirement for improving the range and quality of services available to service users and carers: 'Development of a more autonomous role for RPNs including CNS and ANP levels to incorporate full mental health assessment and case management' (WS 23). Other referred to clinical leadership in relation to these posts. One comment included:

'Mental health structure requires more clinical posts at CNS and ANP level. Clinical leadership should come from that area' (FG 22)

Psychosocial interventions

Many respondents indicated that the role of the RPN should be developed further towards providing psychosocial interventions to assist service users to recognise their strengths and to develop strategies to facilitate them to avail of community supports and resources that may already be available to them.

'Further developments of skills and competencies for nurses working in liaison psychiatry or indeed all tiers of the services which would be beneficial to the individual in crisis, nurse or carer would include... specific training in brief and focused psychosocial/psycho educational interventions for people with recurrent suicide attempts looking at harm reduction and suicide prevention. These interventions would look at emotional awareness, problem solving and interpersonal communication.' (WS 26)



Health promotion and social inclusion

Some respondents indicated that the RPN role should be further developed towards health promotion outside of the mental health services in areas, such as schools and community groups, promoting mental health awareness and prevention.

'...The role should be developed to include mental health promotion at voluntary, schools and community groups.' (WS 7)

Many responses indicated that RPNs need to continue to broaden their scope in relation to working with structures in the community outside of the mental health services and they must have the necessary supports in place to do this in order to facilitate recovery-oriented working. 'Engagement with community services' was referred to on many occasions. Another comment included:

'Linkages- supporting nurses developing a range of community linkages, not just those with a mental health focus, but from a broader inclusive perspective' (WS 24)

Support

Support from relevant structures to develop the RPN role in practice, to develop and apply new skills, and the availability of and support to participate in clinical supervision were seen as fundamental by a large number of respondents. A number of respondents referred to the need for more autonomy and responsibility in decision making to assist in developing the role of the RPN. Some respondents indicated that nurses are in key positions and have the knowledge skills and competencies to be team coordinators and to act as advisors on planning and development committees locally and nationally. Some respondents commented that not all nursing activities are primarily linked to recovery and strong leadership and role models were considered fundamental by some respondents in supporting the development of their role. Respondents emphasised that organisational systems and structures must be recovery-focused, supportive and flexible to accommodate nurses to work in partnership with service users and carers, to provide flexible individualised care and to facilitate working within a recovery framework. An example of a typical comment included:

'By supporting nurses to develop their skills of working from a recovery perspective will be the first step in the provision of a quality service to our consumers.' (WS 5)

6.8 How can RPNs best promote social inclusion

During this phase of the consultation, respondents were also asked to describe how RPNs can best promote social inclusion. The first major theme to arise dealt with the importance of understanding the concept of 'social inclusion'. Respondents stressed that training and education was needed for nurses to understand the nature of social inclusion for individuals with mental health difficulties. The second major theme dealt with the importance of RPNs in using their role to reduce stigma in order to promote social inclusion. Respondents highlighted various mental health promotion activities that RPNs could support and engage, with some specifically highlighting an activist role that RPNs could play. Underpinning this theme, respondents felt that psychiatric nurses needed to challenge some of their own beliefs about mental health difficulties. The third theme of responses focused on how adopting a holistic and collaborative approach could enhance social inclusion. This approach was seen as taking into account each individual's needs and skills to build and maintain relationships and social inclusion. The final category of responses suggested the importance of developing and fostering links to the community setting in order to promote social inclusion for people with mental health difficulties.



Provide training and education

In a small number of focus groups, some respondents openly expressed that they did not completely understand what was meant by the term 'social inclusion'. A large number of the written submission also indicated this and suggested that all mental health professionals require awareness / training sessions on the principles of social inclusion and the factors that promote and inhibit social inclusion as well as the potential benefits, for individuals with mental health difficulties: *'In relation to social inclusion, we must understand the principles'* (WS 25).

Reduce stigma and mental health promotion

Many of the responses referred to reducing stigma and respondents generally were in agreement that psychiatric nurses have an important role in destigmatising mental health difficulties in communities nationally. This indicates that many respondents viewed being free from stigma as central to the concept of social inclusion. The majority of respondents agreed that to promote social inclusion, RPNs must promote mental health through activities, such as education, to increase public awareness. RPN involvement in mental health promotion in areas, such as schools and across communities, to dispel stereotypical images was also referred to in a number of the narratives and the submissions. Some respondents were of the opinion that this would assist in increasing public awareness to promote a wellness rather than an illness-orientation. Some focus groups respondents offered examples of work that they and other RPNs are involved in throughout communities nationally to promote social inclusion through initiatives. Examples included mental health promotion days in communities, parents groups held in community settings and facilitating information stands in third level institutions during freshers' week in colleges and universities.

'RPNs should promote and facilitate education programmes in schools and within community groups. These should be delivered by service users along with the nurse.' (WS 15)

Other respondents felt that RPNs should be accessible through primary care structures to enhance integration and reduce stigma. An example offered during the consultation of work being done to enhance integration was inviting community groups in to mental health centres to use rooms on occasions in order to break down barriers and promote social inclusion. Some responses indicated that RPNs are a valuable resource, and as such, should be accessible to individuals in the community. One comment described this:

'It is our view [name of organisation] that psychiatric nurses can offer crucial support to members of the community outside of the health sector who are providing assistance to individual's with mental health difficulties such as An Gardaí, Clergy, paramedics... which could be mutually enhancing and complementary to the mental health services.' (WS 26)

Psychiatric nurses as mental health activists

Throughout the responses, references were made in relation to the importance of nurse's being proactive, politically aware, and assertive, as well as becoming involved as social activists and advocates in relation to mental health both locally and nationally. Comments included in a number of the written submissions focused on the importance of nurses placing emphasis on the rights of individuals with mental health difficulties and their families: *'RPNs must use their voice to become active members of committees where decisions are made'* (WS 9). There was a call by some respondents for nurses to actively contribute to awareness campaigns and called for a national spokesperson for mental health to dispel stereotypical images and contribute to media items and awareness campaigns nationally: *'I would like to see an ambassador for mental health nationally'* (FG 5).



Challenging negative beliefs

An area that was addressed in some responses was the nurse's role in facilitating service users to challenge negative beliefs about their ability to live a meaningful life.

'RPNs also need to help service users to challenge negative beliefs to integrate about their ability to integrate or their ability to live a meaningful life.' (WS 6)

A small number of responses called for nurses to challenge their own negative beliefs about individual's abilities. Comments included:

'...to promote social inclusion and integration and to be effective, psychiatric mental health nurses must themselves develop competencies which support service users to develop and exercise competency... capabilities approach, psychiatric mental health nurses should develop practices which support the social engagement, connectedness and active citizenship of mental health service users.' (WS 4)

Adopt a holistic and collaborative approach

A large number of respondents felt that facilitating service user and carer involvement in a meaningful way and acknowledging their contributions in all aspects and areas of mental health including recruitment and decision making would aid in promoting social inclusion: 'The need for service user involvement is crucial to promote social inclusion' (FG 1). Many responses suggested that adopting a holistic approach to care as oppose to a biological illness-orientated approach was fundamental in promoting social inclusion. Collaborative working and facilitating service users to develop and utilise their skills in building and maintaining relationships was referred to by a large number of respondents. One comment included:

'RPNs need to assist service users in developing skills that assist in building extensive networks through encouraging the maintenance of existing relationships and the development of new ones...' (WS 6)

Promoting active engagement within services in the community

Fostering and maintaining links, as well as promoting active engagement, rather than just attending and participating in services within the community, were all seen as vital mechanisms to promoting social inclusion by a large number of respondents. RPNs and mental health professionals and stakeholders across all levels, must commit to establishing and maintaining these partnerships. A vast number of responses indicated that managers throughout organisations must value this work and support staff to foster and maintain these links.

Examples of typical comments included:

'We have to deprogram ourselves in our thinking- in that we have to think outside the mental health services.' (FG 4)

'By being aware of and linking with a range of community services and personnel and having the skills to link service users with these... This requires nurses actively sourcing and linking with such services and developing an inclusive network – requires time, effort and energy.' (WS 24)



6.9 Developing and supporting effective leadership for psychiatric nurses

The final question posed in this phase of the consultation asked respondents to comment on how effective leadership might be developed and supported for psychiatric nursing. Some respondents commented that there needs to be a distinction made between leading and managing and there was some that felt that there is an element of leadership in every nurse's role. However, others did not refer to this and indicated through their responses that leaders are managers within services. Four major categories of responses were identified. The first indicated the need for supportive initiatives to help nurses develop their leadership skills. The next theme suggested that those in specialist posts should be supported in leadership positions. Thirdly, respondents suggested how a national leader might be useful in order to promote, develop and support psychiatric nursing practice. Finally, a number of respondents described how some leadership qualities are innate to certain individuals and that while they can be developed in some, the completion of an education or training programme does not guarantee an effective leader.

Supportive initiatives

Some respondents indicated that those in acting positions should be appointed and a large number of responses called for the current recruitment embargo to be lifted to promote effective leadership for those working with people with mental health difficulties and their carers/ families. Others called for the recruitment policy and the promotional process within nursing to be reviewed. Some respondents expressed that having supportive initiatives and education in place to promote effective leadership and produce effective leaders is vital. Examples of cited supportive initiatives included the need for constructive formal appraisal and performance review mechanisms to be in place at all levels, mentorship programmes, shadowing, leadership workshops and ensuring leadership is built into the curricula for psychiatric nurses. One comment was:

'Undergraduate and Postgraduate Nursing Programmes need to include modules relevant to leadership in nursing. Leadership qualities can be seen in the most junior to the most senior nurses and should be developed rather than suppressed.' (WS 1)

Cultural and organisational support for nurse leaders and managers to attend forums where decisions are made was also referred to in some responses, as was the requirement for individuals to be encouraged and supported to be effective leaders. Management support for initiatives and guidelines was also referred to in this section. One response described the need for supportive leaders:

'Uniform guidelines for assessment and aftercare of deliberate self harm patients can only become a reality if agreed and supported by senior management for implementation across the system.' (WS 8)

An overwhelming majority of responses called for the availability of and support to engage in clinical supervision. One typical comment included:

'There is an opportunity for nurses at clinical level to become real leaders in nursing and role models within MDT teams. Access to support and supervision from nursing management and the wider organization is a prerequisite to this happening.' (WS 14)



Specialist posts

Some respondents indicated that those in specialist clinical posts have a fundamental role in acting as role models and displaying effective leadership. Some respondents expressed that CNS and, in particular, ANP posts needs to be developed urgently to promote improved outcomes for service users in all areas for example the addiction services. The majority of respondents expressed that clinical leadership should come from those in specialists posts where clinical credibility exists: *'Clinical leadership should come form that area [clinical posts at CNS and ANP level] (FG 22).*

Introduction of national leader for psychiatric nursing

A number of respondents felt that nurses who demonstrate leadership ability and have vision and ability to articulate this vision, as well as those with proven track records in change and effective leadership, should be representing mental health nursing at all levels. A large number of respondents called for an effective leader for the profession at a national level to promote, develop and support psychiatric nursing practice. Comments included:

'There is a need for national psychiatric nursing representation at a number of levels, including: Political, Senior nursing, Senior management – for example, where decisions pertaining to psychiatric nursing and services are being made, a senior psychiatric/ mental health nurse should be involved.' (WS 24)

'We must have a clear psychiatric nursing voice.' (FG 12)

Leadership qualities

Even though a number of respondents called for education and training, others indicated that just because an individual had completed an education or training programme, effective leadership was not guaranteed as a result. The majority of responses indicated that there are specific qualities a leader should possess to be effective. Respondents indicated that the right people need to be made leaders and some of the common attributes cited included being *'motivating', 'forward thinking', 'inspirational', 'approachable', 'a good listener, 'leading by example', 'engaging in open honest communication', 'having a positive attitude' and 'having a strong voice.'*

One respondent described what they felt constitutes effective leadership:

'Effective leadership can be developed through the appointment of practitioners who demonstrate excellent leadership qualities into key positions within the mental health service. These leaders should be individuals who have demonstrated a proven track record in achieving objectives and encouraging cohesiveness among teams and an ability to respond to different people and situations proactively and with sensitivity...' (WS 6)

Respondents were provided with the opportunity to add further comments. Many of the comments related to areas that have been previously addressed. Some respondents referred to the availability of adequate staff and resources. One comment included which was highlighted throughout the consultation was the need for the *'immediate lifting of the recruitment moratorium for psychiatric/ mental health nurses'* (WS 18). Others expressed how psychiatric nursing must be valued and the work that psychiatric nurses have done in the development of the mental health services should be recognised across all levels.



Other responses indicated that there is a need for the title of psychiatric nursing to be reviewed. One typical comment included:

'One way that might help to foster a recovery orientated service is a move away from the way that we describe ourselves as psychiatric/ mental health nurses. The psychiatric services have now become the mental health services and perhaps we should consider this change as a greater indicator of what we do. In addition, this change might reflect a move away from a medical/illness perspective.' (WS 6)

One submission emphasised in this section that it is important to recognise that not all good psychiatric care is primarily concerned with recovery. For example, in crisis or emergency situations the primary concern may not be recovery; however, similar values should inform the application of interventions. This submission concluded about the need for strength and perseverance in psychiatric nurses:

'If it is accepted that human experience is indeed complex then it must also be accepted that people are at times ambivalent about being helped or receiving help. Good psychiatric care therefore also involves having the tenacity to remain with people even when they are ambivalent about the need for help.' (WS 20)

6.11 Summary

This chapter has presented an overview of the major findings from this phase of the consultation process. The findings provided an insight into respondent's views in relation to the knowledge, skills and competencies that need development in order for nurses to work with people with mental health difficulties to more effectively respond to *A Vision for Change* (DoHC, 2006). This consultation also explored respondents' understanding of working in a recovery-oriented way and the structures that are needed to be in place to work in this way. Their views on the values and principles that should underpin psychiatric nursing, as well as their vision in relation to development of the RPN role to improve the range and quality of services available to service users and families, were also investigated. Respondents also outlined the structures that they felt are necessary to ensure that RPNs incorporate an evidence-based approach into their practice and service delivery. Finally, they described how effective leadership could be developed and supported for psychiatric nursing practice.



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Appendix I

Guiding Principles Descriptor (HSE, 2011)

Clinical Governance Development . . . an assurance check for health service providers

PRINCIPLE	DESCRIPTOR
Patient first	Based on a partnership of care between patients, families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
Safety	Identification and control of risks to achieve effective efficient and positive outcomes for patients and staff.
Personal responsibility	Where individuals, whether members of healthcare teams, patients or members of the public, take personal responsibility for their own and others health needs. Where each employee has a current job description setting out the purpose, responsibilities, accountabilities and standards required in their role.
Defined authority	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manger.
Clear accountability	A system whereby individuals, functions or committees agree accountability to a single individual.
Leadership	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
Inter-disciplinary working	Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Inter-disciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
Supporting performance	In a continuous process, managing performance in a supportive way, taking account of clinical professionalism and autonomy in the organisational setting. Supporting a director/manager in managing the service and employees thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the patients and staff experience being central in performance measurement (as set out in the National Charter, 2010).
Open culture	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to patients. Staff willingly report adverse events and errors, so there can be a focus on learning, research, improvement, and appropriate action taken where there have been failings in the delivery of care.
Continuous quality improvement	A learning environment and system that seeks to improve the provision of services with an emphasis on maintaining quality in the future and not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing.



Appendix II

Information letter & Survey

Please contact NMPDU, HSE, Dublin North for a copy of the survey information letter and survey

Appendix III

Organisations websites which promoted this project information

- Mental Health Commission
- Irish Institute of Mental Health Nursing
- Psychiatric nurses Association
- Health Service Executive and Office of the Nursing and Midwifery Services Director
- An Bord Altranais
- National Council for the Professional Development of Nursing and Midwifery



Appendix IV

Flyer to advertise study



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



**Office of the
Nursing & Midwifery
Services Director**



INSTITUTE OF MENTAL
HEALTH NURSING



An Roinn Sláinte
agus Leanaí
Department of Health and Children



pna



NSUE



SIPTU



National Council for the
Professional Development
of Nursing and Midwifery
to Develop Nurses of the
Future in Ireland
an tArdteicneolaíocht



Mental Health Nurse Managers' Society

A VISION FOR MENTAL HEALTH NURSING

RPN'S INFORM YOUR FUTURE - PUT VISION INTO ACTION



Change

The Office of the Nursing and Midwifery Services Director (ONMSD) and Corporate Mental Health at the HSE, in partnership with all stakeholders in mental health has initiated a national project which aims to inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoH&C), 2006. This project will identify the nursing skills and competencies which may need development in order for nurses to provide accessible, community-based specialist services for people with mental illness.

IF YOU ARE A REGISTERED PSYCHIATRIC NURSE AND YOU WORK IN MENTAL HEALTH IN THE REPUBLIC OF IRELAND YOU ARE INVITED TO COMPLETE AN ANONYMOUS QUESTIONNAIRE.

For more information and to access the questionnaire - log on to one of the websites below or you can opt to have further information and the questionnaire sent to you directly, electronically or by post.

www.hse.ie/go/onmsd- Follow link for capacity building- National Mental Health Project

www.irishnursingboard.ie www.ncnm.ie www.pna.ie www.limhn.org www.mhcirl.ie

Further information and to receive a copy of this questionnaire contact Fionnuala Killoury on (01) 8908792, fionnuala.killoury@hse.ie

YOUR PARTICIPATION IN THIS PROJECT IS GREATLY APPRECIATED

THIS PROJECT IS ALSO SUPPORTED BY AN BORD ALTRANAIS



Appendix V

Invitation letter to complete Survey from ONMSD and Office of the Assistant National Director of Mental Health



Vision for Mental Health Nursing: Inform your Future

Dear Colleague,

The Office of the Nursing and Midwifery Services Director (ONMSD) and Corporate Mental Health at the Health Services Executive (HSE), in partnership with all stakeholders in mental health has initiated a national project which aims to inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoH&C) 2006. *A Vision for Change* proposes a comprehensive model of mental health service provision in Ireland and recommends an integrated, multidisciplinary, recovery approach to addressing the biological, psychological and social factors that contribute to mental health difficulties.

This project aims to identify nursing skills and competencies which may need development in order for nurses to provide accessible, community-based specialist services for people with mental health difficulty. This work will be informed by the recovery model of mental health with emphasis on advocacy, user involvement, psychosocial interventions, education and mental health promotion in order to maximise positive outcomes for service users, carers and the population as a whole.

We wish to invite all registered psychiatric nurses working in mental health services to inform the future of psychiatric nursing in Ireland by participating in this project and completing a questionnaire. Focus groups will also be held over the coming months in your area.

To access the questionnaire please log on to one of the following websites:
www.hse.ie/go/onmsd- follow link for Capacity Building- National Mental Health Project-

www.nursingboard.ie

www.iimhn.org/

www.ncnm.ie

www.pna.ie

www.mhcirl.ie/

www.ncnm.ie/mhnmi



Appendix V

Invitation letter to complete Survey from ONMSD and Office of the Assistant National Director of Mental Health (continued)



Further information and to receive a copy of this questionnaire electronically or by post contact your local NMPDU or Fionnuala Killoury on (01) 8908792, fionnuala.killoury@hse.ie.



**Mr. Martin Rogan Assistant National Director
(Mental Health)**

Yours sincerely,



**Dr. Siobhan O' Halloran
Director Nursing & Midwifery Services**



Appendix VI

Focus group information letter*



Project: A mental health project which aims to inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoH&C, 2006) in Irish mental health services.

Lead Investigator: Eithne Cusack

Project Officer: Fionnuala Killoury

Introduction: The Office of the Nursing and Midwifery Services Director and Corporate Mental Health at the HSE, in partnership with all stakeholders in mental health has initiated a national project which aims to inform and strengthen the capacity within psychiatric nursing to support the implementation of *A Vision for Change* (DoH&C, 2006) in Irish mental health services. A national steering group of key stakeholders has been established.

Procedures: You may participate in this study if you are a registered nurse currently working in mental health in the Republic of Ireland.

Contribution required from participants: *A Vision for Change* (DoH&C, 2006) proposes a comprehensive model of mental health service provision in Ireland. This project invites registered nurses who are currently working in mental health to participate in a focus group to help in identifying the future role of the RPN to respond to *A Vision for Change* (DoH&C, 2006). This focus group should take approx 2 hours.

Risks: There has been no risks identified to you in taking part in this study.

Confidentiality: No participant will be identifiable during this study and all data collected will be treated and stored with the strictest of confidence complying with the Data protection Act (2003). Data collected for this study will not be used in future unrelated studies without further specific permission being obtained.

Consent to participate: Completing and submitting the consent form implies consent to participate in the study. The consent form will be provided on the day of the focus group.

Voluntary participation: There is no obligation to take part in this study and if you decide to participate in this study, you may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study.

Further Information: Fionnuala Killoury Project officer on (01) 890 8792, fionnuala.killoury@hse.ie

* Amendments were made to this letter on occasions to make applicable



Appendix VII

Consent form - Focus groups



Project: A national mental health project which aims to inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoH&C, 2006) in Irish mental health services.

Lead Investigator: Eithne Cusack

Project Officer: Fionnuala Killoury

Declaration:

I have read, or had read to me, the information letter and I understand the contents. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this study, through without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time.

Participant name: _____

Email Address: _____

Participant's signature: _____

Date: _____



Appendix VIII

Schedule for Focus Groups*



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Office of the
Nursing & Midwifery
Services Director

Preamble to the focus group: (5 mins)

- Welcome and review the project aims and objectives (Poster)
- Introductions
- Review key recommendations of *A Vision for Change* (Poster)
- Discuss structure and review information letter- answer any participant questions.
- Complete participant consent form
- Form subgroups of 4/5 (cross section of grades in each subgroup)

Focus group questions

Present questions to the subgroups and ask them to nominate a scribe, timekeeper and spokesperson. Ask them to present their answers in bullet point format on a flipchart. Facilitator will note key points and take note of emerging themes.

1. (a) What is your understanding of working **in a recovery orientated** way and (b) how can RPNs be supported to work in a recovery orientated way? (15 mins)
2. What are the **values and principles** that should underpin psychiatric/ mental health nursing practice? (10 mins)
3. What nursing skills and competencies require development **to improve the experiences and outcomes** as identified in *A Vision for Change*
 - (i) For service users?
 - (ii) For carers?
 - (iii) For you as a nurse

(15 mins)
4. What needs to be put in place to ensure that RPNs incorporate an **evidence based approach** into their clinical practice and service delivery? (10 mins)



Appendix VIII

Schedule for Focus Groups* (continued)



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Office of the
Nursing & Midwifery
Services Director

5. How should the role of the RPN be developed to improve the **range and quality of services available** to
 - (i) service users?
 - (ii) carers? (10 mins)

6. How can RPNs best **promote social inclusion** (common to all settings)? (10 mins)

7. How can **effective leadership** be developed and supported for psychiatric/ mental health nursing? (5 mins)

Group feedback on questions – Note key themes that emerged (25 mins)

Conclusion to the focus group: (10 mins)

- Collect all data from groups
- Answer any questions
- Thank participants for their involvement

* Amendments to schedule took place on occasions



Appendix IX

Focus Group Questions



1. (a) What is your understanding of working in a recovery orientated way and
(b) How can RPNs be supported to work in a recovery orientated way?
2. What are the values and principles that should underpin psychiatric/ mental health nursing practice?
3. What nursing skills and competencies require development to improve the experiences and outcomes as identified in *A Vision for Change*
4. How should the role of the RPN be developed to improve the range and quality of services available to
 - a. service users?
 - b. carers?
5. How can RPNs best promote social inclusion (common to all settings)?
6. How can effective leadership be developed and supported for psychiatric/ mental health nursing?



Appendix X

Invitation to make a written submission



Nursing & Midwifery Planning & Development
Quality & Clinical Care Directorate
Health Service Executive, Dublin North
Swords Business Campus
Balheary Road
Swords
Co. Dublin

Tel: (01) 8131802
20/10/10

Invitation to make a written submission

Dear Sir/ Madam,

The Office of the Nursing and Midwifery Services Director (ONMSD) and Corporate Mental Health at the Health Services Executive (HSE), in partnership with all stakeholders in mental health has initiated a national project which aims to inform and strengthen the role of the psychiatric nurse to support the implementation of *A Vision for Change* (DoH&C) 2006. *A Vision for Change* proposes a comprehensive model of mental health service provision in Ireland and recommends an integrated, multidisciplinary, recovery approach to addressing the biological, psychological and social factors that contribute to mental health difficulties. It describes a framework for building and fostering positive mental health across the Irish community and for ensuring accessible, community based, specialist services for people with mental health difficulties.

Supported by the National Council and the Nursing and Midwifery Planning and Development units, this project aims to identify nursing skills and competencies which may need development in order for nurses to provide accessible, community-based specialist services for people with mental health difficulty. This work will be informed by the recovery model of mental health with emphasis on advocacy, user involvement, psychosocial interventions, education and mental health promotion in order to maximise positive outcomes for service users, carers and the population as a whole. A framework and action plan will be developed to direct the implementation of this report on an ongoing basis.

A national steering group of key stakeholders has been established and held its inaugural meeting in July 2010. This group wish to invite all interested parties, organisations, individuals and professionals to make a written submission in relation to strengthening and developing the role of the psychiatric nurse in an integrated mental health service which is consistent with "*A Vision for Change*" (DoH&C, 2006) to maximise positive outcomes for service users and carers.



Appendix X

Invitation to make a written submission (continued)

Submission Format:

Written submissions using the following format will only be considered:

8. What is your understanding of working **in a recovery orientated** way?
9. What are the **values and principles** that should underpin psychiatric/mental health nursing practice?
10. What nursing skills and competencies require development **to improve experiences and outcomes** as identified in *A Vision for Change*
 - (i) For service users?
 - (ii) For carers?
 - (iii) For you as a nurse?
11. How can RPNs be supported to work in a **recovery orientated** way?
12. What needs to be put in place to ensure that RPNs incorporate an **evidence based approach** into practice and service delivery?
13. How should the role of the RPN be developed to improve the **range and quality of services available** to
 - (i) service users?
 - (ii) carers?
14. How can RPNs best **promote social inclusion** (common to all settings)?
15. How can **effective leadership** be developed and supported for psychiatric/mental health nursing?
16. Additional comments

Word limit: 1200 max

Receipt of Submissions

**Written submissions should be received no later than:
5 pm Friday 26th November 2010**



Appendix X

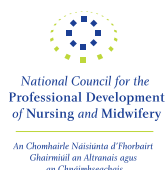
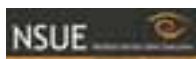
Invitation to make a written submission (continued)

Submissions should be addressed to:

Fionnuala Killoury
 Project Officer
 Nursing and Midwifery Planning and Development Unit, HSE Dublin North
 Quality and Clinical Care Directorate
 Swords Business Campus
 Balheary Road
 Swords
 Co. Dublin

Enquiries should be made to:

Fionnuala Killoury,
 Project Officer,
 Phone: 01- 8908792
 Email: fionnuala.killoury@hse.ie



This project is also supported by An Bord Altranais



Appendix XI

Completed focus groups*

- South City & South West Dublin
- Kerry
- National Service User Executive
- West Cork
- Donegal
- Dublin North, North West, North Central,
- Cork North & North Lee
- Carlow, Kilkenny & South Tipperary
- Waterford & Wexford
- North Tipperary, Clare & Limerick
- Sligo/ Leitrim
- SHINE
- South Dublin & East Wicklow (HSE Areas 1, 2 & 10)
- Mayo, Roscommon, Galway
- Louth, Meath, Monaghan & Cavan
- Dual Diagnosis: Mental Health & Intellectual Disability
- Dual Diagnosis: Mental Health & Addictions
- Mental health Services for Older People
- Directors of Nursing
- Child and Adolescent Mental Health Services
- Liaison Mental Health Services
- Executive Clinical Directors
- Longford, Westmeath, Laois, Offaly, & Kildare & West Wicklow**

* Staff from voluntary and private sectors took part from these areas as well as HSE staff.

** Cancelled



Appendix XII

Received Written Submissions

- Stephen Bradley, Anne Cleary, Maura Dowling, Fionnuala Jordan, Siobhan Smyth, Agnes Tully and Alison Van Laar, School of Nursing and Midwifery, NUI Galway
- An Bord Altranais
- Psychiatric Nurses Association
- Agnes Tully and Siobhan Smyth, School of Nursing and Midwifery, National University of Ireland, Galway
- Breege Scanlon, Staff nurse
- Bernie Joyce CPC, Catherine Cunniffe CPC, Mary McHale NPDC
- Mental Health Commission
- Professor Agnes Higgins, Irish Institute of Mental Health Nursing
- Ann Brennan, Dublin North central Mental Health service/ St. Vincent's Hospital Fairview
- Dr. Ciaran Crummey, National Service Users Executive
- National Council for the Professional Development of Nursing and Midwifery
- Rita Bourke, CPC, Merlin Park Hospital, HSE West
- Services Industrial Professional Trade Union
- National Forensic Mental Health service- Prepared by David Timmons, Training and Development Dept, Central Mental Hospital and working group comprised of Paul Braham, Alice Malone, Andrea Nulty, Joe Scales, Paul McKenna, Johnny Thompson and Jass Singh
- Dr. Ann J Sheridan with contribution from Ms Anne Grant, UCD School of Nursing, Midwifery and Health Systems
- Anne Cleary, ANP Recovery and Rehab in psychosis, East Galway
- Psychiatric Nursing Forum, School of Nursing and Midwifery, TCD
- Mary Begley, ADON Limerick and Mary P Butler Lecturer, University of Limerick
- Irish Association of Suicidology
- Geraldine Freeman, CPC East Galway, Galway Mental Health Services
- Mental Health Ireland
- Elsie Donoghue, Clinical Nurse Specialist, Acute Care, Day Hospital, Health Centre, Ballinasloe,
- Breege Conlon.
- Conor Quinlan, HDip University College Cork
- 2010 intake of PGDip Mental Health nursing students, University College Cork
- Catherine O'Rourke and Malachy Feely, on behalf of nurse managers Louth/ Meath MH service
- Anthony Fitzpatrick, A/DON, Regional NPDC, Liaison officer for implementation of the Mental Health Act (2001) Merlin Park, Galway
- Nurse Managers Association for Intellectual Disability



Appendix XIII

Ethics



1st November 2010

Ms. Eithne Cusack
Director of Nursing & Midwifery Planning & Development
HSE Dublin North
Quality & Clinical Care Directorate
Swords Business Campus
Balheary Road
Swords
Co. Dublin

Re: Vision for Mental Health Nursing- Survey

Dear Eithne,

In response to the request from the Office of the Nursing & Midwifery Services Director for approval by the National Strategic Mental Health group to conduct a survey, the group are satisfied that the process employed i.e. the receipt of three external opinions from three ethical experts in academia is appropriate to conduct this survey.

Yours Sincerely



Martin Rogan,
Assistant National Director Mental Health











A Vision for Psychiatric/ Mental Health Nursing
ISBN 978-1-906218-47-8

March 2012

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