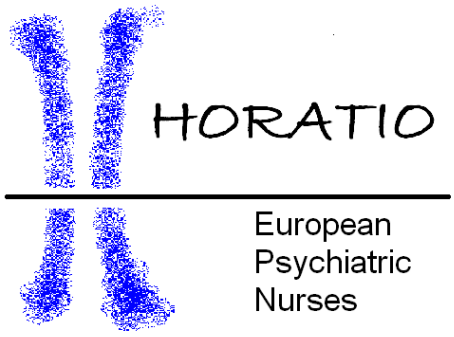

Educational Preparation for Nurses Working with the Mentally Ill: The case of Cyprus

Martin F. Ward

Chair, Horatio European Expert Panel of Psychiatric Nursing
Coordinator, Mental Health Nursing Programmes, University of Malta
Honorary Research Fellow, Univerity of Kingston
Independent Mental Health Nursing Consultant

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Executive Summary

Following a World Mental Health Day seminar in Cyprus 2009 Horatio: European Psychiatric Nurses (PMHN) was asked to prepare a consultation report on the future of psychiatric and mental health nursing preparation. This would be used for discussion purposes between service and educational providers to establish a strategy for the preparation of PMHNs in Cyprus. This current report is the product of the research and consultation undertaken to provide a comprehensive over view of the options available and the rationale for them. The report is divided into five sections. Section one looks at the current mental health situation worldwide and draws upon reports and data from a variety of sources to look at the educational directives guiding the development of mutually agreed courses in higher education institutions withi Europe, problems associated with nursing shortages and some of the potential considerations for PMHN recruitment and retention and the contribution of management and clinical leadership in manitaining care quality and negotiating academic programmes with educational providers.

Section two considers the demands placed upon mental health services in relation to care quality and describes their expectation of both new graduates and their existing PMH workforce. It also discusses the relationship between service menagers and their educational providers in determing the nature of PMHN preparation. Section three is a resume of the roles and responsibilitoes of PMHNs provided in this report to give a backdrop to their educational preparation needs. It describes the necessity for suitable mentorship and clinical supervision whilst also considering some of the ramifications for the discipline if their preparation is diminshed by negative educational decisions. Section four looks at the current educational preparation of PMHNs within Europe, offering four possible strategic alternatives upon which all other varients are based. The experiences of Australia, Malta and Ireland are described to provide a case study for comparison as much of their academic development since the mid 90's mirrors that being experienced at present in Cyprus. The complex roles and responsibilites of PMHN is discussed as is their role within the psychiatric multi-disciplinary team.

The final section, five, considers the educational options available to Cyprus and identifies a series of criteria that must be considered for whichever option, or combination of options, are chosen. Five educational options are described and discussed and recommendations made as to which this report considers is the most appropriate for Cyprus. Ultimately, it strongly recommends the combination approach, effectvely using a direct entry PMHn degree programmes, supplimented by post-graduate specialist diplomas, plus general nurses trained practitioners who carry their practical education forward by undrtaken post-graduet PMHN courses. The workforce flexibility issues and care quality agenda are the main reasons for ecommending this ption, although the strengths and eakeness of the other four options are described.

The report concludes by restateing the importance of an appropriately trained, prepared and supported PMHN workforce, able to address the complex changes in mental health care reform and development and meet the challenges associated with a growing world need for quality mental health care in an age when mental illness looks set to become the greatest health burden for all.

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Recommendations contained within the report do not necessarily reflect those of Horatio: European Psychiatric Nurses in other countries of the EU where other educational options would be more appropriate.

1. Introduction – the problem in context

Education and mutual recognition

The educational and academic preparation of those nurses who work in Europe with the mentally ill is far less regulated than its general (adult) nursing counterpart. Curricular, content, teaching styles and practice hours are dependent upon directives from national regulatory bodies rather than over-arching European Union (EU) standards. This situation is further complicated by issues of international qualification recognition, employment related mobiity for EU citizens between member and non-menber states of the EU and the general agreements between states concerning the harmonization of the architecture of higher education preparation for professionals. Under the terms of the *Bologna Process* (European Higher Education Area 1999) the 47 signatory countries agreed to syncronise higher educational systems through the use of a framework which defined both qualifications and credit transfer. By 2010 this had become the European Higher Education Area (EHEA) with Bachelor degrees, or Bologna first cycle awards, of which nursing is one, awarded on gaining between 180 – 240 ECTS **(**European Credit Transfer and Accumulation System). Unlike the general nursing agreement for the qualification of a Registered Nurse (RN), where there is general consensus of a split of 2,400 hours theory and 2,400 hours of practice constituting the award of the qualification and its associated university award, psychiatric/mental health nursing (PMHN) has neither an accepted curricula nor universal recognition of the award.

This situation has developed over time because each country has created its own professional pathway for PMHN education and there is no accepted commonality between these programmes. Indeed, the problem is far greater than simply an inability of countries to recognise the training of other countries, it reflects the status of PMHN in different states, with some having no training at all and others receiving preparation to function as a specialist on graduation. A report issued following the Lisbon Recognition Convention (2008) indicates that this situation is of growing concern to the European Commission, In addition, the European Centre for the Development of Vocational Training (CEDEFOP) recently released two reports (CEDEFOP 2011[a], CEDEFOP 2011[b]) which address some of the problems associated with this complex situation, building on those of the European Commission (2010) and the original CEDEFOP report (2010). However, revised recommendation 8 of the United Nations Educational Scientific and Cultural Organization (2010), which states that countries should use, "...alternative or partial recognition..." (p5) seems to be the only approach that has gained any usage within the EU.

The International Council of Nurses (ICN) published their own approach to the problem in their fact sheet, *Mutual Recognition Agreements* (ICN 2009) but to date little has happened as a consequence of this document. Finally, if one explores the EU website, some 322 documents of various types explore different aspects of this topic but there remains little, if any,concerted effort to come to a difinitive conclusion on the subject of PMHN.

Nursing Shortages

The situation is further compounded by the shortages within national labour markets of enough professionals to staff either existing services or potential new ones. The demand for the growth

of mental health services continues unabated within EU member states with all the evidence suggesting that mental ill health, and specifically depression, is expected to become the leading health problem by 2020 (WHO 2007). Financial implications, resource calibrations and the social impact upon communities all play a part in the demand for professional personnel to resource these initiatives. As theraprutic interventions become more and more sophisticated, and the necessity for mental health professionals to have adequate educational preparation before embarking on a career in their respective discplines has become apparent, so questions about the preparation of national mental health services personnel have become a priority for many EU states. In 2005 the World Health Organisation published its *Mental Health Atlas* (WHO 2005) in an attempt provide a data about the situation. They reported a median of 24.8 psychiatric nurses per 100,000 population in Europe, considerably higher than anywhere else in the world. Their definition of psychiatric nursing is worth repeating here:

> "*Psychiatric nurse: a graduate of a recognized, university-level nursing school with a specialization in mental health. Psychiatric nurses are registered with the local nursing board (or equivalent) and work in a mental health care setting".* p34

However, they recognised the limitations of their data because in many countries nurses working with the mentally ill did not comply with their definition, being personnel who had graduated as general nurses with limited and in some cases, no, psychiatric preparation at all. Their later study (WHO 2010) failed to differentiate between general and PMHN nurses and was therefore relatively unhelpful in the preparation of this report. Nonetheless, under objective 3 or their recommendations, Practice and Health System Improvement, the did identify the necessity for nurses... "To improve access to quality nursing and midwifery services as an integral part of health services aimed at individuals, families and communities – particularly among vulnerable populations." P99. Presumably, "*vulnerable populations*" includes those with mental illness, requiring nurses with specific skills, not those of generalists. One of the main academic problems facing many countries wishing to develop their PMHNs training is the provision by national registering bodies of registers for qualified nurses that are not flexible enough to meet the demands of either the profession or the health services. By restricting portals of entry to the profession services may be deprived of new recruits and some, such as mature students, do not have the opportunities for life long learning that so many of the EU states aspire to. Cyprus's response to the EU Green Paper on mental health stated "....Investment in these areas (effective deployment, training and recruitment) will lead to the achievement of productive Healthcare Workforce with high delivery rates in terms of qualitative healthcare services". (Ministry of Health, Cyprus 2009)

Human Resource Management

Different countries face different problems but all EU member states identify some form of "brain drain"; Hungary and Estonia report a loss medical doctors, midwives and nurses, for example. This raises the issue of higher university courses being designed for national, rather than international, consumption. When the ICN addressed this issue in 2006 they stipulated that curricula should be designed for local use, rather than for the purpose of exporting its graduates (ICN 2006 p25). Perhaps the shortages reported in this, and many other reports, could be

reduced if higher education institutes were to consider how this approach might be addressed. This is a global problem as the ICN state (2004) but nursing shortages, expecially in the field of mental health, have to be addressed by local, national initiatives. Cyprus's own report to CEDEFOP (ReferNet 2009) made the same point. "....The development of a NQF for promoting the recognition of academic and vocational qualifications that have been acquired in Cyprus is a priority of the government." (p16). What is clear from all these reports is that nurses working with mentally ill people need to have educational preparation for such work, whether it be at graduate or post-graduate level.

It would be incorrect, however, to suggest that it is only the higher education institutions that need to consider their approach to mental health nursing programmes. It is not just nursing shortages causing problems within mental health services but human resource management that need to be examined to establish if adequately trained and prepared staff are being used to their potential. This is also reflected in the National Research Report (NRR 2009) prepared by the Human Resource Development Authority of Cyprus. Polarisation of the global labour market, whereby increases are experienced in both the higher and lower income brackets, with a decline in the middle income spectrum – of which nursing is one, would suggest that this is a trend that will continue unless steps can be taken to balance the outcomes of technological advance and basic health care needs. Davison, Elliott & Daly (2006) highlighted the importance of leadership, rather than management, in clinical practice at local levels in Australia, and their comments have significance for Europe's PMHNs. The International Initiative for Mental Health Leadership (IIMHL) highlighted similar needs but suggests more collaboration as the key to success within specifically trained workforces (Beinecke, Daniels, Peters & Silvestri, 2009).

The above issues will be addressed in this report with specific attention being paid to those that impinge upon the ability of the mental health services to deliver high quality nursing interventions to those suffering mental ill health. However, as an illustration of the importance of this endeavour consider one aspect of the work of PMHNs that is both highly techincal and requires skill and sensitivity if it to be carried out effectvely – compulsory admission and/or involuntary treatment. The professional journals are littered with research and practice papers that emphasis the importance of these activities being undertaken by experienced and properly trained individuals. Nonetheless, Salize, Dreßing & Peitz (2002), in their research for the European Commission, were quite catagoric that such interventions, undertaken in one form or another throughout the EU, were the domain of qualified personnel only. Such advice needs to be taken into consideration when reading following pages of this report.

2. Service Needs

Clearly, the main function of a mental health service is the delivery of high quality, evidence-based mental health care. Contemporary services are a complex mix of in-patient and community facilities and over the last two decades these have grown to include a variety of different sub-specialities within the psychiatric arena. Child and adolescence, drug and alcohol, forensic, challenging behaviours, dual diagnosis, gender related services, elderly care, acute and long term institutional are just a few of the hospital-based ones, whilst the community includes far more than the traditional out-patient and community psychiatric nursing services. Assertive outreach, case management, walk-in centres, specialist therapy groups, first episode psychiatry, home treatment faciltities and a large proportion of follow-up activities are all the domain of the community teams, themselves an innovation of the 1990's. Keen (1999) in his treatise on the educational developments of mental health nurses during the late twentieth century argues that in many cases curricula initives to meet these changes have not kept pace with the introduction of the developments themselves. He points out that research and creativity have become the drivers for practice development but these have not necessarily filtered through into the educational preparation of those whose job it is to provide the services. He also highlights concerns about the ability of modern educational programmes, in striving to accommodate the more technical aspects of mental health care, to be able to engender quality caring relationships as the foundation for the work of practitioners. This will be addressed in more detail later in this report but such concerns are relevant to the outcomes associated with a care service because they directly affect their ability to deliver sustainable support programmes and, ultimately, meet the requirements of their patients.

Care Outcomes

Care outcomes can be measured against a series of variables and those which invariably occur within the literature are patient satisfaction with care provided, clinical audit, multi-disciplinary working and the effectiveness of skill mix (though financial considerations and cost effectiveness are increasingly becoming an important part of this equation). All of these are dependent upon a service being staffed by appropirately prepared personnel (ICN 2006). Mental health reforms in Europe have brought about a variety of changes within the requirements, roles and responsibilities of care staff from all the core disciplines of psychiatry. Initiatives have increasingly been in the area of post-graduate preparation as a form of educational top-up. The European Federation of Psychiatric Trainees (EFPT) highlight the need for their 31 member organisations across Europe to reconfigue training to respond to the realities of mental health service provision. They specifically focus on the need to increase skills in psychotherapy, a reflection in itself of the changing face of psychiatry as much as the nature of general mental health services within Europe (Nawke Kuzman Giacco & Malik, 2010). They also highlight difficulties associated with poor working conditions, low recruitment, insufficient training opportunities and the difficulties of attributing new curricula to the practicalities of working within modern mental health organisations. They also point to the wide variation of service provision across the region as one of the reasons for trainee migration from country to country, further adding to the problem of adequalty staffing these services. The question raised by their paper is whether or not such a situation has a detrimental effect upon the mental health service itself, and directly upon the care outcomes they aspires to?

Patient outcomes have long been recognised as a gauge to service effectiveness. In a study examining empirical literature between 1997 and 2007 Montgomery, Rose and Carter (2009) found that the inconsistency of the tools used to gather data about the impact mental health nursing had on patient outcomes made it difficult to draw any real conclusions about their effectiveness in this area of service provision. Over the years there have been any number of reports and published papers identifying PMHNs as the key to effective service provision and in particular patient outcomes (see particularly Brimblecombe, Tingle & Murrells 2007 for a detailed analysis in this area). More recently these have focused more on the interventions that PMHNs are able to offer and more specifically the preparation required for them to be able to do so (Curran & Brooker, 2007). Patient satisfaction, especially in a psychiatric setting is always difficult to establish because i many cases the service needs to undertake interventions that reduce the potential for harm and these may run counter to the needs and wishes of the individual. The work of Salize, Dreßing & Peitz (2002), already mentioned in relation to involuntary treatments and formal admissions is one example, but PMHNs also have to deal with other delicate and sometimes ethically difficult situations necessitated by safe service provision, not just for individual patients but other members as staff as well.

The use of seclusion within mental health services is well documented and varies from country to country. However, it is always the responsibility of PMHNs to action this activity and patient satisfaction here becomes a very delicate outcome. Bowers, McCullough and Timmons (2003) reviewed the use of physical restraints and seclusion in inpatient acute care settings and their conclusions make intersting reading. Clearly, to carry out this work with the least negative impact upon the patient the staff involve need to have both the correct training but also be able to coordinate the actions using knowldge, skill and not a little sensitivity to be able to retain patient trust and cooperation. In another, less discussed area of PMHNs work, but one which nonetheless has a direct impact upon patient satisfaction, Newbold and Roberts (2007) discussed the use of therapeutic touch. This often neglected aspect of interpersonal care is relevant here because it identifies an area of srvice provision which is highly personal and often far more important to patienmts than procedures and organisational protocols. It lays at the heart of the relationship between PMHNs and patients and defines the quality of services generally. As Newbold and Roberts point out, knowing how to use this skill, when and for what purpose is a highly skilled process and only comes about as a consequence of appropriate training and supervision from more experienced practitioners.

Service delivery and educational support

Service delivery and the preparation of its practitioners is a subject that has long been discussed and the so-called, *theory-practice gap* continues to draw attention both in literature and practice. Evans (2009) argues that the division of responsibility between the educational and service providers, as it stands at present, does not allow for the gap to be reduced. Preparation for PMHNs needs to reflect what the service provider actually does in reality whilst teaching materials that are not used, or not using contemporary interventions that are taught, nor research that influences the provision of care, only adds to the confusion that becoming a PMHN generates. For this situation to be over come it means that service providers must have a say in the academic outcomes of the educational providers, but similarly, those same service providers

must consider the role that education plays in improving the service quality. The transistion between being a student to a practitioner (Romyn et al 2009), the role of PMHN lecturers within clinical practice (Owen, Ferguson & Baguley 2005) and the function of preceptorship for newly qualified staff (O'Hanlon, Reynolds & Gale 2005) all need to be considered if the gap is to be closed and mental health service provision is to attain the level of quality, audit and clincal governance, team working and patient satisfaction that it aspires to.

There are obvious country specific service priorities that will determine the progress of change and practice development. However, one thing is clear. If service provision is to continue to meet service user needs and/or expectations, education and practice have to come together to determine the nature of preparation required for its future PMHNs and both parties have to work together to utilize their respective experience and expertise.

3. Roles and Functions of Psychiatric and Mental Health Nursing

It is beyond the scope of this report to consider all aspects of PMHN roles and responsibilities. What is deemed important here is discuss those aspects of PMHN activity that relate specifically to the discipline or have relevance either to the aforementioned literature or service directives. Some examples of clinical responsibilities in relation to interventions will be described but in the main this section is designed to highlight the signifcant role played by PMHNs as a specialist nursing discipline.

The Turku Declaration

In early 2011 Horatio: European Psychiatric Nurses published the Turku Declaration (Horatio 2011) on their website (http://www.horatio-web.eu/) . This document was originally drafted in Finland in November 18th 2010 by the Executive Board of the Europoean association and has since undergone a series of redrafts in order to produce a document which describes those activities that are undertaken by PMHNs and no other nurse or member of the core psychiatric disciplines. It is the first part of a programme of work to explore the nature of PMHN activity whilst also scoping European national bodies to establis the exact nature of the preparation for the staff. The document currently describes three sets of agendas: 1. those dealing with inclusion, including the reduction of carer burden, psychiatric harm and mental health stigma reduction and applying social policy initiatives to nursing support and interventions., 2. those dealing with workforce activities such as preoviding 24/7 sufferer contact, sometimes having to work against the will of sufferers and having a legal responsibility for the safety of sufferers and the general society, and finally 3. the professioanl agenda which includes frontline activities during psychiatric emergencies, undertaking compliance and adherence activities and feeding back comprehensive assessment information for use by the other mental health disciplines.

The document is not intended to be a comprehensive list of roles and responsibilities that PMHNs may do, just those that are central to their work which they have to do. What is important about this declaration is that the activities it describes are in themselves specialist, complex and require skill and sensitivity to perform. They also beg the question, how, without specialist PMHNs, these activities can be accomplished and mental health services can deliver on the care described in the previous scetion. For, it is the PMHNs that form the rubric for mental health care. No other discipline has the necessary scope of practice to be able to tackle everything that has to be undertaken with, and on behalf of, those suffering from mental illnesses. No other discpline is organised to cover patient contact throughout the 24 hour period and no other discipline explores the therapeutic preparation in the same way that specialist PMHNs do to be able to deliver such a braod range of supportive and interventionist activities to such a variety of mental health problems, behaviours and situations. It is not just the interventions provided, or even the therapeutic relationshipos that have to be developed using specific models and theoretical approaches, but also the care coordination, assessment feedback and carer support that seperates these staff from others within the core psychiatric MDT.

PMHN recognition within the workplace – an Australian example

This can be taken a stage further because it is also not possible to undertake these sophisticated activities unless a suitable period of training, academic preparation and mentorship has been successfully completed and students have had the opportunity to practice under the careful

supervision of experienced PMHNs who are able to develop their potential and pass on their own skills. Holmes (2006), whilst describing what he considered to be the slow death of psychiatric nuring in Australia lay the blame for his observation squarely at the door of authorities responsible for the commissioning and funding of mental health services for failing to recognise the true potential and clinical significance of propeely trained PMHNs. He attributed the stigmatizing attitudes of both other health care professionals and academics against mental illness for the steady decline in recruitment and, along with other discipline representatives, such as Malhi et al (2003) and Malhi & Parker et al (2003) the eventual cripling shortages of care staff for those who were effectively already excluded from society. Indeed it was these authors and several other who will be discussed in the next section, who were ultimately responsible for the radical changes in PMHN preparation within the Australian care system. However, one further example from Australia is worth mentioning at this point. Clark, Parker & Gould (2005) reported that 70% of generalist nurses working in remote areas felt their lack of knowledge of mental health problems prevented them for being able to deal with such problems with any degree of effectiveness. The authors concluded that generalist training did not adequately prepare them for working with the mentally ill.

Expectations of PMHNs

Jackson and Stevenson (2000) conducted a study to explore what various groups, including PMHNs themselves, expected of nurses. A sample of 92 mental health professionals, carers and patients undertook a series of 13 focus groups. The results showed a remarkable confidence in the PMHNs ability to be able to do anything! The most significant outcome was that nurses were expected at any time to be one of three people; the patient's friend, a friendly professional or take a more distant professional stance. Being able to switch between these stances, and at a moments notice, would demand an extremely high level of self awareness and not just a little skill on the part of the PMHN. Knowing how to predict the right approach at the right time, with patients suffering any number of cognitive, behavioural, psychological and emotional problems suggests a level of knowledge about human relationshipos that would have to come through careful preparation in interpersonal skills as well as acute assessment routines.

The depth of knowledge required to undertake PMHN in general psychiatric setting continues to grow. Elsom Happell and Maries (2009) talk of the informal role expansion on PMHNs in Australia, a fact reflected throughout the PMHN literature worldwide. (see also Happell 2008a, 2008b). There seems to be a variety of causes for such growth, not least new therapies, a growing evidence-base, a greater awareness of mental health issues and the need for care staff to management them (such as liaison and crisis work). Even legislation has a part to play. Hurley & Linsley (2006) identified the impact that the introduction of the new Mental Health Act in the UK would have upon the educational needs of PMHN, calling for more focus on the interplay between care and law, preparation for the development and management of complex care packages and the ability solve problems and remove potential obstacles to care effectiveness. Over the last few years we have seen changes in mental health legislations in several countries, Egypt, Bulgaria, the Republic of Ireland and the EU generally in response to the adoption of the Mental Health Pact for Europe, and all of these changes, if thought through carefully will have similar consequences for the preparation of its practitioners.

In countries such as the Netherlands, where PMHNs work in a wide variety of settings, there is a strict demarcation between hospital and community based services. However, a survey

undertaken by Koekkoeki van Meijela Shene & Hutschemaekers (2009) showed that the community psychiatric nurses (CPN) had lost contact with the other parts of the services and whilst making a valuable contribution to care process the lack of uptake of evidenced based practices was in danger of seeing them decline both in numbers and significance. This lack or contact with the research world to guide and develop practice is also evident with in-patient settings where van Doeselaar Sleegers & Hutschemaekers (2008) reported a significant reluctance on the part of PMHNs and other mental health professionals to reduce their dependence upon seclusion as a way of dealing with untoward incidents, violence and aggression, psychological disturbance and challenging behaviours. Many nurses in the Netherlands function within psychiatric settings without the requirement of psychiatric training. In countries where this training is a necessity the reliance upon any form of restraint is reduced because those nurses have the ability to handle the situation with interventions that are both less restrictive and intrusive for the patient. For many qualified PMHNs the use of seclusion is a very last resort, if used at all, and seen as a failure of all other attempts to resolve clinical problems in conjunction with the patient. This is evident in countries in the eastern part of Europe where the absence of specialist training of PMHNs is relative to the amount of seclusion that takes place.

At the other end of the practice spectrum some countries now have limited nurse prescribing within mental health and whilst this is not popular with all national authorities it would be impossible to develop this further unless the PMHNs involved had both a background in psychiatric nursing and specific in-service education to be able to be a safe and competent practitioner (see, Wells Bergin Gooney & Jones 2009 for an informative discussion on the merits of this advance in the Republic of Ireland)

Some of the basic nursing actions that PMHN take for granted in the daily working lives warrant closer attention. Dealing with psychiatric emergencies demands an understanding, not just of risk assessments, but also interventionists strategies, interpersonal skills, de-escilation techniques and a high level of knowledge about emergency situations such as self harming, aggression and violence and suicidal behaviours. Being able to use models such as A.I.R.S. (Assessment, Intervention, Resolution and Support) in such situation demands not just knowledge but self efficacy, which comes through practice, modelling and supervised experience (Ward 2005). The danger inherent in these situations demands effective practitioners, not caring onlookers.

Knowing how to start a conversation with a severely depressed patient: showing unconditional positive regard to a patient who tells the nurse he has been sexually abusing his daughter; being able to discuss a patients auditory hallucinations without promoting their authenticity, using counselling and basic cognitive behavioural therapy with a variety of patients or simply sitting quietly with someone whilst they contenplate the silence are all the domians of the PMHN. It is hardly surprising that the conclusions of Jackson and Stevenson's research suggested that in some way the PMH had to be the master of so many skills.

How, one might ask, does the nurse acquire such all round skill? Obviously their educational preparation plays a big part. The main difference between psychiatric and general nurses is the fact that for the duration of their training the psychiatric nurse has had placements with mentally ill people. As a consequence they are used to being with them, have a reduced threshold for their behaviours and an increased tolerance of those who demonstrate behviours outside the normal.

The effect of tis is to give them more confidence to work with these patients, to be able to utilize theoretical materials learnt in classrooms and labs and to feel comfortable, and therefore more relaxed in their company. This, as much as anything, demonstrates the difference between the two sets of graduates, not just the amount of knowledge they possess. There would seem to be a direct correlation between the time spent in educational preparation and mentored clinical practice, and the abilty to action concepts within the clinical areas.

Clinical supervision and mentorship

One also has to ask questions about the nature of both mentorship and clinical supervision (and preceptorship where it is offered). If there are limited 'experts' in the field who provides this service to new graduates? Indeed, if the quality of the supervision is poor, so too will be the practice based learning. Ultimately, the result of such a situation is that gradually knowledge and skills slowly diminish to the point where the skills associated with the PMHN are so limited as to be ineffective within the clinical teams. Functioning as a member of either a specialist community team working with psychosis, or an inptient step-down forensic unit, the PMHN will develop speicla skills and these will be precticed over time till they become 'expert' at them. But, they have to start from somewhere and the baseline has to be a good all around knowledge of psychiatry and psychaitric and mental health nursing. Freeburn & Sinclair (2009) highlight the stress and work load burden of PMHN students and highlight the need for the provision of 'proactive' guidance and professional support for them in clinical placements. This has to come from experienced practitioners who understand what the student is attempting achieve and not just benign support that has no direction or focus. Supervision, mentorship or preceptorship has to come from nurses who know the material that students are trying to learn, not seeking to learn it from the students themselves.

Rice, Cullen McKenna Kelly Keeney & Richey (2007) developed a project in Northern Ireland which strove to develop guidance and standards for student supervision within clinical placements with a view to implementing structures that would 'increase morale, decrease strain and burnout, and encourage self-awareness and self-expression'. Such supervisory approaches, the authors concluded, had to be provided by suitably qualified nursing practitioners. A similar situation was flagged up in Spain where dealing with primary care depression by nurses required considerable support and guidance (Aragonès López-Cortacans Badia Hernández Caballero Labad 2008). The same was alluded to in a similar, though much older, study from Finland that highlighted the need to reduce carer burnout (Nikkonen 1994) and in a Swedish study where nurses were taking the lead in dealing with post-partum depression (Engqvist Ferszt Ahlin & Nilsson 2009)

The PMHN and the psychiatric multidisciplinary team

Before concluding this chapter it is worth mentioning the PMHNs' role within the psychiatric multidisciplinary team (MDT). Their main role within this group is to provide accurate feedback to the team about such things as patient responses to psychopharmacolgy, mental health status, general health and response to treatments/therapies, as well as developing and managing individualised care packages. Taking just one aspect of this role, without an accurate knowledge of these issues it would be impossible to play an active part in the team and, if you take away the

eyes and ears of the team they are effectively trying to work blind. This is neither helpful for the service nor the patients and certainly creates a vacuum in the care team.

The UK Chief Nursing Officer review of mental health nursing (Department of Health 2006) asked how could PMHN contribute to the care of service users in the future. They identified that service users and carers want PMHNs to have positive human qualities, as well as a range of technical knowledge and skills, very much in line with the findings of the studies described above. The report made recommendations about including the Recovery Model and social inclusion as part of their approach to care, and providing more evidence-based psychological therapies. Perhaps most importantly of all the report noted that PMHNs need training, supervision and managerial support to be able to achieve, not just the recommendations of the report but the whole gammit of responsibilities and intervetions for which they are already responsible.

In light of the many recommendations made within this report it seems unlikely that within the UK a dilution of PMHN by under qualified generalists and/or minimally prepared auxillaries will take the place of the existing and future qualified PMHN work force. But, of course, there are 27 participating countries in the EU and many do not have the same traditions as the UK, whilst others have different but equally effective set ups, educational preparations and regulatory processes. What is crucial for every country and national body at this time is the recognition of what is required locally by its PMHN workforce and how, as a consequence, they can be prepared effectively to be able to deliver on these expectations.

4. Educational Preparation of PMHNs

The purpose of this section is to consider the educational options available for the preparation of PMHNs in Europe and to apply these to the Cypriot situation. Comparisons will also be drawn from the experience of both Australia and New Zealand where reforms have altered the nature of PMHN preparation due to service demands.

The current European situation

During the period from August till September 2010 Horatio asked members of its European Expert Panel to provide information about the nature of preparation for PMHNs in their country. The results showed that there are basically four approaches and to a degree geography, national history and European legislation appear to be the drivers behind which one is used. In some cases combinations of approaches are used but this is not common. The four approaches are:

1. Full time undergraduate programme (egree or diploma level) in PMHN
2. Post-graduate diplmas/degrees in PMHN
3. Continuing education programmes in aspects of PMHN
4. No preparation

In addition to this there are a variety of different Masters programmes that may, or may not, build upon the above but all requiring a degree level registration course from within a higher education institution. Post graduate training is either in core psychitric programmes or for specialist activities, such as drugs and alchol, child and adolescence, or nurse practitioner and/or advanced practice roles. PMHN nurses are not necessarily referred to in terms of psychiatric or mental health nurses, being called simply, nurses or in the case of Portugal, Technical Nurses (Zerbetto & Pereira 2009).

In 2006 Nolan & Brimblecombe published the results of their survey of educational and training of PMHN in12 European states. To date, this is the only piece of research to have attempted to gain a picture of the jig-saw puzzle associated with the preparation in Europe of nurses who work with the mentally ill in mental health care settings (estimated by Horatio to be in excess of 350,000 http://www.horatio-web.eu/index.html). They found a wide discrpency between the countries involved in terms of academic preparation (pre-registration education), roles and responsibilities of educational staff and their own preparation, registration requirements, licences to practice and post registration support and continuing professional education.

Thus we have a situation in Europe in countries such as Hungary, Russia and Bulgaria where nurses need only to have the equivalent of a Diploma qualificationin in general nursing, with no specific mental health training, to work in psychiatric settings; in Nordic countries different rules apply but psychiatric qualifications are gained following RN qualification, in the case of Sweden for example, a licensed mental nurse (LMN) qualification, especially in specialist areas such as Forensics; in central Europe, and particularly Germany and Austria a general nursing qualification (with the first BSc conversion course in Mental Health Nursing only opening in October 2010), countries such as Belgium (which till recently accepted direct registration to five seperate branches of nursing, including PMHN) and The Netherlands having quite sophisticated PMHN teams but with a general nursing background followed by post-graduate courses up to masters level and finally in the UK, Malta and the Republic of Ireland direct entry diplomas and degrees in psychiatric nursing being fully registered as such but not requiring general nurse training beforehand.

The post graduate and/or continuing education courses themselves range from a few days up to 18 months, some being part time, others full time but with placements included. Some receive a qualification, others merely a certificate. In some cases continuing education courses are delivered by staff from other countries because the expertise does not currently exist within the host country. Such course either have to be funded through the national or service provider budget or in some cases are part of bilateral EU agreements, or more informally between different institutions and are therefore provided at cost. Over the years Finland and the UK have provided much of the post graduate studies in mental health nursing for some Eastern European countries and specifically Russia (Bloor et al 2004).

In the last 12 months there have been questions asked in at least two EU member states about the nature, quality and effectiveness of their preparation for nurses working with the mentally ill. The Spanish Health Ministry disseminated a questionnaire to other EU states asking how they prepared their nurses and what were the issues associated with such a preparation. In Finland discussions have been on-going for the last year between the nursing association and the Health Minister about the same topic with a view to increasing the amount of time spent in post graduate programmes and re-visiting the content of the generic nursing programme to increase the mental health focus.

The Malta Experience

Indeed it is this last group, which also includes Cyprus (on statute but currently not operating) and Gibralter, that constitute the main diversion form the post-grad and continuing education options that exist throughout the rest of the wider European community. In the case of Malta the statute for registering as a psychiatric nurse, a different part of the nursing register, has been on statute with the maltese Nursing and Midwifery Council since its inception. In the late 1990's three cohorts of Diploma level nurses were recruited and qualfied as RMNs (Registered Psychiatric Nurses) very much on the lines of the UK system. Unfortunately these nurses were far to small in number to be able to make a difference in practice and were swamped by the considerably largher group of general trained nurses working within the mental health services. The result was that these nurses lost their mental health identity and psychiatry (and social work) continued to dominate the clinical environment, with nurses being instructed on the care activities by psychiatrists. These nurse were unable to operationaise ideas, theories and intervetions they had been expossed to during the three-year course and made little, if any, impact on the over all care offered to mental health patients, predominantly inpatient, despie a long running pilot programme in community care.

Historically, Malta had followed the UK system of nurse education but did not do so when in the early 1990's the UK began experimenting with its now much revised Project 2000, or common core system. With the exception of the few diploma prepared PMHN described above (and midwives) all nurses were generically prepared and on qualification took up post in which ever area they were needed in.

In early 2004 work began on the provision of a post-graduate part-time BSc in Mental Health Nursing that would convert those with general nursing qualifications working within the mental health services, to PMHNs. The programme would in effect convert diploma (and in some cases certificate) trained nurses to graduates, and from general to psychiatric nureses. They would also be able to register as psychiatric nurses with the governing body. This double conversion accounted for the length of the course, a three-year part time programme. The first cohort opened in in 2004 and to date 38 have graduated with a further 30 in their second or third year of study. The next cohort will

be recruited in October 2011. With a numerous clausis of 15, and with only two courses being able to run because of staff shortages within the mental health services, the demand is likely to be much greater than can be recruited – as has been the case for the last three intakes.

However, this is an expensive way to get specialist psychiatric nurses into the system. Indeed, there is no growth in terms of staffing levels because the only peope eligble for the course are those who work already in mental health but with generalist qualifications. Whilst the growth in service provision and the leadership offered by both the students and graduates has led to significant changes in care quality and the introduction of new interventions and services (all currently led by PMHN graduates from the programme) the issue of staffing, skill mix and, inevitably staff retirment, has not been resolved by this programme. As a consequence it was agreed in 2007 to try to reinstate the direct entry programme only this time to have it as a degree programme. Development of the new programme of studies began and was, in some cases linked to the new courses being developed in general nursing. The first small cohort was recruited in October 2009 and a second one in 2010. Currently 17 students are following the programme and all will eventually be eligable to work with in the mental health services or private sector mental health in Malta, having registered as first level nurses – mental health. With a work force of some 300 nurses in the Mental health services and and with considerable staff shortages, the injection of newly qualified, properly supervised and mentored graduates will be a lifeline to the hard pressed srvice. The third cohort will be recruited in October 2011

One of the ironic difficulties posed by the success and popularity of the PMHN developments was that nurses now holding a BSc had got back into the realms of study and many were keen to continue their studies. In the absence of an appropriate masters programme five of these went on to undertake a masters in Health Service Management. It was therefore agreed to develop an MSc Mental Health Nursing as a top up for BSc Mental Health Nursing holders. The programme of studies shares several study units, specically in the area of research, with its general nursing counterpart and in future will also share units with other disciplines within the Faculty of health Sciences. The first cohort of eight students were recruited in October 2010 (applications were 200% over the numerous clausis). The enxt cohort will be recruited in 2012 and already work is under way to redesign the course in line with new Bologna directives.

Whilst the Mental Health programmes themselves appear to be making a marked difference within service provision pehaps the biggest contribution the academic input has made comes in the area of staff morale and identity. There would appear to be a genuine pride in both the work they do and their allegence with the wider international community of PMHN. Their association is a signatury to Horatio: European Psychiatric Nurses, and their president currenly sits on the Board of this European group. Despite being small in numbers their impact both locally, with educational events of their own as well as their input to new and existing services, but also internationally, has been considerable.

The case of Cyprus and the Republic of Ireland

As a contrast to this case study two of the other aforementioned direct entry countries have considered changing their programmes for generic ones, and indeed in one case have already done so. Cyprus no longer runs the direct entry programme at its higher education institution and service providers have to rely on their new staffing requirements from general trained nurses who will have had only limted exposure to mental health care. The onus for their development lies with the service providers, either in the form of in-house educational activities and short courses with a heavy burden resting on the qualified PMHN already in the service having to act as preceptors for a realitively

untrained new workforce. The issues discussed within the previous sections on care quality, clinical supervision and service effectiveness, have to be regarded as appropriate at this point. In addition this is not a cost effective way to progress, especially if no other system, agreed between the educational institute and servce managers, has been put in place to fill the gap.

The case of the Ireland is different in the sense that discussions about the nature of the preparation of PMHNs have been taking place between the Health Department, Universities and service providers for several years. Grant reported on the potential for change several years ago (Grant 2006) stating that new models might be better suited to preparing PMHNs for future psychiatric nursing practice. The approach considered, and later under modified version, adoptd in Ireland was to combine both the generalist and specialist training into one programme, almost mirroring where the UK had finally gone to. Interestingly, Grant argues that niether the traditional generalist nor the specific sprecialist education programmes serve the nursing profession well, because the lack of all around knowledge is not sufficient to be able to deal with all eventualities, the main thrust of the proposed changes in Ireland. This is an interesting arguement because the main rationale for the implementation of general nursing registration education in Europe tends to be that this form of training provided the nurse with the appropriate level of general health care necessary to function as a practitioner. The undertaking of post graduate PMHN education is seen as a way of preparing the individual to work in a specialist area of practice. However, if Grant is correct then the option of undertaking a three-year programme of study that only provides for general nursing skills is wholly innadequate given the conclusions of the WHO report (2007) about the huge growth in mental health problems and illnesses. To date the Nursing and Midwifery Board of Ireland accept registration from direct entry PMHN courses but with common components derived from the general courses.

The Australian experience

Much of the debate about nurse education and PMHN specifically has been influenced by reforms undertaken in Australia during the last decade. This section will provide only a brief over view of the changes taking place in the preparation of PMHNs.

Up until 1993 Australia had prepared its PMHNs using a simialr sytem to the UK, i.e. a direct entry programme of study. Nurses who worked in mental health settings had to have a quaification in the field. Happell (2009) reports that there several different types of courses running at the same time and in different states and territories of the country. Following the review of nurse preparation by the Australian Health Department in 1993 all direct entry PMHN programmes ceased. All nurses had to undrtake a generic programme and register as an RN, and were then eligable to work in any of the five clinical practice areas, with the exception of midwifery. In her review of the subject Happell describes four reasons put forward in support of this change.

1. The physical needs of patients were not met sufficiently under the specialist programme
2. All nurses had to deal with mental health issues and therefore it should be part of mainstream nurse education
3. A generic education provided nurses with flexibility of employment
4. There was no evidence that a direct entry programme could provide enough nurses to adequately staff the service needs

(Happell points out that whilst points 1-3 could easily be discussed either way, point 4 cannot be proven either way as no robust data was collected at the time upon which to base any conclusions).

In 2000 Clinton and Hazelton undertook a scoping exercise to establish the human resource factors associated with both the old and new courses and found considerable negative attitudes amongst generic student nurses towards mental health care. Questions were asked about the suitability of the programmes being offered and their abilty to prepare nurses to work in mental health settings (Wynaden Orb McGowan & Downie 2000). This led to changes in the basic approach and the provision of what is known as the 'comprehensive' curricular, essentially the same as that undertaken in the UK, with the exception that students can delay their choice of branch till the second year (in the UK they are still expected to choose the branch at outset of the course). Two further reviews of the preparation of nurses to undertake mental health care led to further changes in the curriculum (Nurses Board of Victoria 2002, Victorian Government Department of Human Services 2005). Yet still, questions are being asked about the suitability of nurses to work within the mental health arena and the ability to deliver effective PMHN interventions (Gough & Happell 2007).

To meet the demand three separate post-graduate programmes were, until recently, available in Victoria: a full-time postgraduate certificate (6 months duration), a full-time postgraduate diploma (six months duration and a full-time Masters in Mental Health Nursing (1-year duration) More recently in response to pressure from service providers a 36 week postgraduate programme has been introduced with a combination of both theory and practice components. Recently the main degree curriculum has been revised to increase the amount of mental health and service user involvement elements. Despite all these changes there still remain doubts about the preparedness of newly qualified generically trained staff to work within mental health service areas (Happell & Gough 2009) and the negative attitudes of students following the generic programme about both mental health and PMHN (Happell Robins & Gough 2008a, 2008b). To a degree the changes and reforms undertaken in Australia have been mirrored in New Zealand (Prebble 2001).

Lessons to be learnt

What conclusions can be drawn from the Australian experience? Firstly, historically the direct entry system used prior to 1993 followed the UK educational approach of preparing PMHNs, whilst the changes in the last decade reflect those made in the UK but with cultural and content variations to fit the needs of the Australian educational system and service provision. Such a case is similar to those found in other areas of the world that adopted a UK-style approach to nurse education (e.g. Malta, Cyprus, Gibraltar, Ireland, Canada, New Zealand, South Africa) though not all have opted for the current UK based approach. Secondly, as a response to concerns considered at the time to be about the suitability of the direct entry programme changes were brought into place which provided for all students to follow a generic programme. Subsequently, it can be seen that the concerns were at best misguided and at worst unfounded due to a lack of appropriate data. Thirdly, the problems associated with the preparation of PMHNs in Australia, including their recruitment and retention, do not appear to have been resolved by changing from a specialist to a generic programme. Indeed, it may well be that the original decision to do so was

not based upon clinical determinants but financial expediency. What is clear is that service managers have continued to request an increase in the mental health content of programmes and identify a lack of skills and knowledge in newly qualified nurses as one of the problems of staffing existing and potential new services. Finally, to accommodate the recognised deficiencies in the existing core programme post graduate programmes mental health 'top-up' getting longer and more complex, which raises the question of cost once again. It would appear that the cost of educating appropriately qualified and skilled PMHN has shifted from the universities to the service providers or the nurses themselves.

What is clear from the Australian experience is that curriculum cannot stagnate and must move and be revised as a response to the needs of society. The Australian experience shows that if institutions are flexible enough it is possible to design programmes that mirror the growth in psychiatric technology and offer PMHNs the opportunity to develop their knowledge and skills in a contemporary fashion. In the case of Victoria, Melbourne, the universities worked with the service providers and educational commissioners, in this case, the Health department, to establish the best way forward. Certainly this type of collaborative approach would seem to be very positive.

The recent Australian developments in their core curriculum would suggest that as psychiatry develops a more recovery oriented approach to care and treatment, and the move from compliance shifts to aspirations of concordance, the user of services has to be more involved in not only their care activities but the educational preparation of mental health practitioners. (Three papers which are worth exploring on this issue are: Barnes Carpenter & Bailey 2000, Frisky 2001, Happell & Roger 2005)

Finally, the Australian experience would suggest that placing all your eggs in one basket is neither cost effective nor professionally sound, hence the need for a variety of post graduate programmes. However, their recruitment problems, or their ability to attract students to undertake the mental health branch of studies, are not an isolated case. Despite the number of nurses who work with the mentally ill in Europe it is still a stigmatized occupation, even by other health professionals. Positive attitudes towards either the conditions or the staff who care for them is a major health education agenda. Nursing itself must continue to examine the ways that new nurses are introduced into the mental health nursing work culture.

5. Educational Options

This final section of the report will exaimine some of the academic and professional issues so far raised and attempt to offer options to both resolve the local situation as it currently stands in Cyprus also to explore support and developmental activities that may be encorporated into any chosen option.

In some ways Cyprus has more options than most other countries. It has a tradition of PMHN and has for many years developed its services around the skills of these practitioners. In recent years it has succesfully reformed much of the service provision from an essentially in-patient one to a responsive and proactive community based one. Many of the chosen facilities and resources are led by qualified PMHNs and the system already has in place a support network of experienced and skillful practitioners. Its abilty to supervise and mentor its student population is therefore well established.

Issues for consideration

It would appear from the previous sections of this report that certain factors have to be considered before identifying potential developmental options for the provision of PMHN education in Cyprus. Any option eventually chosen must factor in these considerations.

Education

1. There are any number of registration based direct entry, post-basic and post graduation programmes for PMHN in the EU with no one approach fully adopted by every nation

2. The European Credit Transfer system allows for the accreditation of different forms of courses accross the EU

3. PMHN education is not restrictd to discipline specific activities – interprofessional education is one option open to both under and post graduate programmes

4. Educationalists have to have clinical contact to be able to attempt to bridge the theory/ptactice gap

5. Those teaching PMHN have to have experience or qualifications in the field

6. Even counties that have specific ways of educating PMHNs are still revising their courses to reflect the changing pattern of service requirements, including staffing, skill mix and intervention types

7. Courses have to take account of on-going mental health reforms

Practice

1. Evidence-based data is becoming more readily available leading to an increase in therapy and intervention options within clinical practice

2. PMHNs are expected to have a much larger tool box of interventions and skills than ever before

3. Practice development has to be resourced by effective practitioners with knowledge of the academic, as well as practice skills

4. If PMHNs are not prepared well service developments stagnate

5. The changing roles and responsibilities of PMHN are becoming more complex and cannot be learnt in either short periods of time or without theoroetical underpinning

6. Exposure to psychiatric patients is a vital part of the culturalisation of experienced PMHNs

7. Mapping skills, competencies and standards of the existing mental health nursing workforce may be one approach to determing the curriclar content of revised programmes of preparation for PMHNs

Professional

1. Mental illnesses and ill health are on the increase worldwide with depression specifically identified as a major health burden for the future. They are a concern for all health care providers but specialist care for them have to be provided by specialist staff

2. Users and carers have to be involved in every stage of the care process, including education of all mental health care professionals

3. Advanced practitioner roles, such as MDT working, case management, therapists, clinical team leadership and autonomous practitioners, require appropriate academic preparation

4. There are 350,000 nurses working with mentally ill patients in Europe and th quality of the care they offer has a direct correlation with the quality of their academic preparation

5. To function as genuine multi-disciplinary team members PMHN must have a thorough knowledge of their own theory, research and sills base

6. Service managers look to education to provide them with the appropriately skilled graduates. Any other approach is neither service driven nor cost effective

7. PMHNs are not generalists working in a psychiatric environment

Course Options

Any course option has to be based on four discreet criteria: the requirements of services, the ability of the education establishment to deliver the selected content, the research underpinning the discipline and the costs of academic provision. Based on these criteria the following five options have been identified as possible approaches for Cyprus.

Option 1 – No academic preparation
Under this option no specific time is spent addressing mental health and its care but the generic (or comprehensive) nursing course integrates PMHN skills into the over all programme. Hence, interpersonal skills, therapeutic relationship building, counselling, active listening and patient involvement are taught as elements of all nursing but not specifically mental health. Students receive no placements in mental health.

On graduation students are able to work in any clinical speciality but have little or no understanding of the culture of psychiatry, working with psychiatric patients or the roles skills and responsibilities of PMHNs. Service managers are responsible for developong all of the above within clinical practice as a form of apprenticeship. If only the known skills of the service are taught to the new PMHNs gradual their will be a dilution of both knowledge and skills and PMHNs will eventually not make a contribution to the MDT, care or mental health reform and propsed practice and/or service developments will be far more difficult to implement.

Option 2 – Generic preparation
This requires that all nursing students undertake a period of study in both theory and practice within mental health care. The basic theory of psychiatry and rudimentary interpersonal skills are taught but only limited mental health care. A certain amount of psychiatric culturalisation takes place.

Such an approach means that all nurses have been exposed to mental illnesses and their care but this does not prepare them on graduation to function as PMHNs. Post-graduate provision will be required to bring them up to the standard required by service managers. Absence of such provision for this option is likely to result in unsafe cinical areas, a stagnation of mental health reform and a gradual reduction of care quality.

Option 3 – Post graduate preparation
A recognised programme of studies is identified for all newly graduated staff who are deployed into mental health. This can take the shape of in-service induction programmes as a form of practice top up before staff enter the clinical areas and a higher education institute post-graduate certificate, diploma or degree undertaken within a specific time frame and as a requirement to practice within the mental health care field. This option requires that academic staff have qualifications in PMHN.

Whilst little or no culturalisation may have taken place prior to taking up post the newly graduated staff will have a period of preceptorship which will act as a preparation for working with mentalily ill people. The provision of specific post graduate training, devised jointly

between the service and educational providers, would counter academic and sklls deficits from the generic programmes. This is a costly option because there is a requirement for new staff to be released from work both on joining the service and ultimately for long periods of time during their initial practice. Service demands are therefore quite considerable but the pay-off is that all staff eventualy have specific mental health nursing qualifications. Further specialist training in areas such as child and adolescence, drug counselling, community and assertive outreach activities would take place after the post graduate training and enable he service to maintain reasonable levels of skill mix and care quality. Service developments could be resourced by PMHNs but woud take longer to bed in.

Option 4 – Direct entry preparation
Because Cyprus already has registration provisio for this option it is an alternative to the previous three options that is not necessarily available to other countries. Physical health skills would be taught in the initial perisod of the programme in conjuntion with general nusring students. A specific mental health branch would compliment a commoin core or multi-professional programme with graduates undertaking a minimum of 2,400 hours practice within mental health clinical areas during their training. Mentorship by qualified practitioners trained by the higher education institute ensures the application of theory to practice and service competencies and contemporary evidence would form the basis of the curriculum. Academic staff must have preparation and/or qualifications in PMHN.

Students would have received significant psychiatric culturalisation prior to joining the service and financial costs to both the serve and education providers would be reduced. Graduates would be able to make a contribution to service delivery relatively quickly with preceptorshp concerned more with honing skills rather than teaching them.Post basic qualifications could be gained as the PMHN progesses into specialist areas. Service development would be well resourced and care quality could be maintained and/or improved.

Option 5 – Combination of approaches
Having more than one portal of entry into the service is perhaps the ultimate approach to service resourcing. This option would see general trained nurses being deployed within mental health settings along with branch prepared direct entry PMHNs. General nurses who choose to remain in mental health could opt for post-graduate training and PMHN prepared nurses could more quickly move to the specialist courses. The nature and style of the combinations would be based upon service needs, servce user requirements and educational resources.

Skills mix and staffing levels would be better serviced because there would be a more consistet supply of new staff and all staff would be at graduate level. As long as student from the general stream had received at least option two level preparation prior to joing the mental health srvice there would be certain levels of aqcuired culturalisation, supplimented by the better levels of the PMHN prepared graduates. The bonus for the service is a steady stream of replacements for retirees, and to resource new initiatives, better skill mix and a more flexible workforce. The downside for the academic provider is the cost of providing a mental health specific branch as well as the comprehensive programme. This could be partly off set by developing practice based support staff, such as practice clinical specialists, funded by the service providers, who would take some of the responsibility for the educational programmes for the branch. They would also

remove the necessity for large numbers of PMHN qualified staff to be employed by the educational instution.

Recommendations

Ultimately it is not the responsibilty of this report to recommend any specific option for adoption within the Cypriot services. Information has been identified for the production of the report that informs the debate on this issue and this should be utilised into any decions made for the furture prepratation of PMHNs. However, some comment is required concerning the five identified options as a conclusion to the report.

Option 1, is patently a very poor one and would not be considered as suitable for a country that already has a history of sophisted mental health care provision and a track record of quailty seevice development, expecially in the area sof community health and PMHN contribution to specific therapies and interventions.
Not recommended

Option 2, also has its limitations but cannot be ignored because of the financial and human resource limitation imposed on higher education establishments. However, there are extreme costs and care care implications for service providrs expecially given the history of mental health care in the country and the requirments that PMHN play a leading part in current service provision. Such an approach would be seen to devalue both a discipline that already has to deal with the stigmatization and patients who tend to survive on the margins of society generally. Such an approach could have detrimental effects on the integrity of long term provision of quality mental care if they were the only option chosen and would be considered as a backward step fr the field. The experience of Australia must be considerd as extremely pertinent agaist the backdrop of this option only.
Only recommended if no other option is available

Option 3, post-graduate qualifactions are a good way of securing the furture of PMHN and mental health service provision but only if they are made mandatory. Failure to do so would allow those working within the speciality to opt-out of the process thus negating the development of the discipline and detracting for future service quality. The nature of the courses themselves would need to be carefully considered because they would in effect be a top-up fr generically trained staff and once again the experneice of Australia and New Zealand has shown that there is serios concerne sabout the quailty, knowldeg and skills of nurses before they attend the post-graduate courses.The courses themselves would need to be at least 12 months in length to be able to suppliment the deficits in the generic programme sufficiently.
Recommended in the absence pre-qualifying PMHN courses but seen as a poor option nless mandaory postgraduate training was implemented

Option 4, as stated, this option is only available because of historical developments in Cyprus. To an extent it is a question of whether or not there is a serious committment to the provision of experienced and and skilled nursing practitioners and whether or not there is a genuine concern for the care of the mentally ill within the country. Over the next decade the human and financial costs of mental illnesses will increase considerably if all the statistics available prove to be

accurate. What is clear is that if this option is chosen careful consideration will need to be paid to the content of the core programme prior to PMHN progressing onto the branch programme. Experiences from the UK would suggest that unless this is tackled properly mental health losses focus within the core programme and thse who have chosen the branch become frustrated with having to nderake what is essentially a genral nursing programme instead. Nursing lecturers with a mental health background tend to want to teach on the branch and not the core thus further diluting the input of vital mental health information for all students.
Recommended if such courses could be part of an over all package for the preparation of PMHN

Option 5, would appear to be a very good option in the sense that it appears to provides a broad range of options for both graduates and service managers. Educational providers may consider this to be an expensive option though because it entails both the provisoon of a PMHn specific branch and post graduate courses. However, if mental health services are really considered to be important to the country specialist courses must be considerd an essential element of this development. Sustainable service provision can only be achieved if their is stability in the preparation of those whose who will be responsible for resourcing them. The main gain for such an option has got to be the considerable flexibility offered to service managers and the resultant care quality for service users.
Recommended as the preferred option because incorporates all the experiences from around the world and offers the best chance for service and care quality and development.

Conclusion

There is no clear cut choice to be made here. The five options are a synthesis of the material availbale for the preparation on PMHN from around the world and there may be other varients availbale that have not been speficially addressed in this report. However, they are likely to be different forms of those described above.

What is clear is that if a country has a history of service delivery and workforce preparation that enables it to have choices not availble to other countries these should not be thrown away simply because it is more expidient to do so. Whether there is agreement that direct entry PMHN courses are good or bad (and even within Horatio: European Psychiatric Nurses there is no general agreement on this issue) developing all possibilities for the preparation of PMHN is a luxury that many new and developing countries would be envious of. It has to be rememberd that EU states continue to refine their PMHN courses and some are even questionning their current provision and opting for more intensive and advanced programmes to counter the growing need for quality care provision. This is a problem that will not go away and whether we have gcommon preparation throughout Europe or not is hardly the issue for this report. It is about what is right for a particular country and its culture, as demonsrated by the recent succeses in Malta.

The recommendations in this report are based on the available evidence within the literature and the experiences of senior members of the psychiatric nursing fraternity worldwide. But, one final comment must be made to put this all into perspective. Psychiatric and mental health services are becoming increasingly complex and sophisticated. In 2015 the American

Psychological Association (APA) will publish the fifth edition of the classification of psychiatric and mental health diagnosis (DSM) and this will show an expodential increase in conditions. The WHO has shown that mental health will continue to be a major health burden, their growth showing no signs of slowing down despite the introduction ofa barrage of new evidence based interventions. In the meantime mental health services are already struggling to extracate themselves from financial and human resources constraints in an attempt to meet these challenges. Key to all the intended developments and service strategies designed to deal with this almost constant explosion of mental health issues is the ability of countries to mobilize sufficient numbers of suitably qualified mental health pratitioners. Central to this core team of professionals is the PMHN for there can be no doubt that there are no mental health services without the discipline that manages care for the total 24 hour period and acts as both the care interventionists and rapporters for the other members of the psychiatrc MDT. In effect, there is no service without PMHNs. Whilst all other countries in the EU are attempting to improve the quality of these practitioners it would be sheer folly for Cyprus to impleent changes that would reduce it.

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