

**Foundation Congress of HORATIO -
European Psychiatric Nurses**



***Mental Health in Europe:
the contribution of psychiatric
nursing practice and science***

***“Discover the field,
enjoy the scenery”***

***Congress 22-23 March 2007
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Edited by Ber Oomen

**Mental Health in Europe:
the contribution of psychiatric
nursing, practice and science.**

“Discover the field, enjoy the scenery”

This book is dedicate to Chantal Klimaszweski and Lucette Gariod, who have savagely been killed on Friday 17 December 2004 while performing their duty as psychiatric nurses in Pau –France during the night, as they were on call.

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1 - Introduction

Ladies and Gentlemen, Fellow Nurses, Colleagues,

It is a great privilege for me as President of Horatio to welcome you to Arnhem, Holland for this event, our inaugural International Conference. I am pleased to welcome our many colleagues from the North American Continent, Asia and Australia and of course our fellow Europeans representing fifteen European Countries.

In many parts of the World today young adults leaving second level education and contemplating a future career are less likely than in the past to nominate Nursing as a first choice career option. At the same time an estimated 500,000 Nurses are today in practice across Europe as Psychiatric Nurses. Our discipline is rarely highlighted for the wonderful work we do. The stigma associated with the illnesses afflicting those we care for is equally undermining of the reputation of our discipline. Yet our role is essential in fostering positive mental health, preventing illness, treating the acutely ill and caring for those with enduring mental illness. Mental Ill Health impacts on all aspects of Society , including :

- More than 27% of adult Europeans are estimated to experience at least one form of mental illness during any one year (Hans-Ulrich Witchen, Frank Jacobi 2005)
- By 2020 depression is expected to be the highest ranking cause of disease in the developed world (WHO 2001)
- 58,000 Europeans citizens commit suicide every year (extrapolated from the WHO mortality database)
- Mental illness costs the EU 3% to 4% GDP annually (Mental Health Economic European Network)

While the art of caring has long been associated with psychiatric nursing the science underpinning this care is of relevantly recent description. Indeed many would argue that the science of psychiatric nursing is still evolving ; that we are challenged when asked to describe what it is we do ; that it is Conferences such as this which allow us to examine the work of our Nursing philosophers and theoreticians. As we are increasingly challenged to justify our existence , to demonstrate the evidence upon which we base our interventions and to provide an economic justification for our continued employment we are more and more dependent on the work of people like yourselves who wrestle with the challenge, who seek the answers, who study and debate, travel and confer , who develop the body of knowledge on which our profession is founded.

Our discipline is relatively young. We still have so much to learn. All around Europe in hospitals , colleges, institutes, universities and indeed through independent research nurses are active at the highest levels of academic work and research in pursuit of new knowledge, new insights and new information which will empower us to respond with initiative, innovation and creativity to the needs of our clients. Psychiatric Nurses deploy the low visibility skills of

listening, befriending, encouraging, consoling, counselling as we use ourselves as instruments for growth and healing within the therapeutic process. We cannot bandage hallucinations, administer creams to delusions or wrap chains around unbearable anxieties. Very often it is the use of medication which 'opens the doors', which disposes the person to better benefit from our therapeutic interventions, which allows us to be the 'spirit of recovery'.

Today the challenges are all the greater as we seek to maximise care and recovery in community settings with hospitalisation a last resort. I know that all of us here today are coming from Countries at different stages of development. It is surely true to say however that we are all moving in the same direction with our practice moving more and more to where the patient lives and works and enjoys recreation. This presents very real challenges to which we are adapting and which we will conquer.

As we meet this challenge Psychiatric Nurses across Europe have come together to form an Organisation which will at once represent us, support us, inspire us; which will facilitate our development, enhance our reputation and celebrate our contribution; which will unite us so that we can share knowledge, learn from models of best practice, identify issues for political canvass and representation and use this age of information technology and unparalleled scientific investment and development to foster and advance the best interests of our nurses and those we serve. HORATIO was conceived here in Holland as a concept shared between Ber Oomen and Steven Demicoli. It was fertilized in some initial contacts with the current Board Members and further evolved during 2005 before being formally launched and registered here in Holland in 2006. It may be our 'baby' but it's character, it's structure and it's impact on the world of Mental Health Care will be influenced by all who have and who will become members of HORATIO. I look forward to watching it develop, to contributing what I can but most of all to working with our Board to facilitate the greatest possible involvement of psychiatric Nurses across all of Europe; and with the support of our friends in Australia, Asia and Canada. We have been privileged to have been present at the birth of what we believe is something special.

Within your Congress Package you will find this booklet which is a composite of all of the presentations. Sometimes Psychiatric Nursing is referred to as a Specialty within the family of nursing and within health care in general. However a brief perusal of the contents of this booklet eloquently demonstrates that Psychiatric Nursing is of course a field of care in which there are many Specialties and Sub-Specialties. What is not included in the booklet are the debates, the networking, the Poster Presentations, the sharing of grief and joy particular to our profession. With this booklet we aim to set a tradition of publication for our future Congresses which will contribute to the process of informing and developing this wonderful profession.

I am pleased to declare this Conference opened and invite your active participation.

Des Kavanagh,
President

2 - European perspective on mental health nursing; building an association.

Introduction

“Today people travel throughout Europe with greater ease than ever before. In much of the Continent, border checks are things of the past. Budget airlines made it possible to fly cheap, and some people have even decided that their quality of life is improved if they work in one country and spend the weekend in another. Other seek their luck or improvement of life in an other region. All of these developments have implications for health systems. The freedom of movement granted by the European Treaties to Europe’s citizens can only be a reality if those citizens know that they will receive high-quality and appropriate care. And those responsible for delivering health care may want to take advantage of the opportunities created by the European Union, sharing capacity in highly-specialized care. It’s not only that Europe is changing, but the whole society does. In fact it’s no a change but; development. Not very much items can be discussed without consideration about what’s going on abroad. It’s not only for the whole society that the international aspects have an effect on the daily life but also for the professionals”. These conclusions are drawn by officers in the EU and are recognisable. For a lot of colleagues; ‘Psychiatric nursing and Internationality’ do not easily relate. In this presentation I hope to clarify this and put this in an inspiring scene so that by the end you not only feel proud as a nurse in the mental health field but also as important part of a very large European and even maybe beyond.

What about the word ‘Internationality’.

We often use the word ‘international’ but in the very near future we need to be more specific. Regularly I receive e-mails from persons who questioning the selected words we use like ‘International’, ‘mental health’ and ‘psychiatry’. International can be; between European nations, nations from across the ocean or in a neighbouring network. For some this makes no difference, but being active in this field it’s practical being more specific. While being specific I learn regions better understand. International today is more than only: ‘abroad’. Communicating in Europe means; learning about the language and culture. For example, in our association we use the words Mental Health and Psychiatric. Horatio is an association for ‘psychiatric nursing’ active in the ‘mental Health field’. These words have been carefully selected, derived form a conversation between European representatives. In one nation, Psychiatric has a strong negative connotation because it is politically sensitive meaning or is stigmatised, in another nation it’s the exactly opposite. When we select words or meanings we need to avoid controversies as much as we can. So we use the word Mental Health as the broader

meaning, and Psychiatric related to diagnoses we use in the scientifically sense. Is just a choice but one of the very inspiring moments for me. What we agree on in any case is to use English and: “lets discover Europe”.

EU and Mental health Nursing

In the documents and presentations made by the EU and the WHO it is clear that there is a lot of work to do to tackle the problems in mental health. It's not only a health problem but also a financial one; the top ten of most costly health problems are mental health related. To face these problems a lot need to be done. Quotes we often hear are:

- We need to use better resources for patients such as rights and duties and for example to share technology,
- Care should be accessible and of good quality,
- People do not need to travel around Europe to find good help,
- National objectives need to be reconciled with European obligations,
- Funds should be used for reasons to provide areas to develop on the level they require complying with the EU standards.

On the other hand this gives huge challenges because the differences are expressed in tariff-setting for patients and professionals. In some nations a therapy is far cheaper than those from the neighbour nation. There is a lot of movement of professionals going on you may question if this is the right answer to tackle the European problems in sharing capacity. There is a movement from the east to the west while these nations are beautiful, rich of recourses, only, not in the stage we like them to be in. We spend our holiday's in these nations and admire the nature and resources, the good food and also their wine, so let us also agree to invest also in living conditions and make us wanting to be a patient because of the environment, high care and fantastic nurses.

While the EU has no section MHN, the questions arises, where do the nurses come in? It is not only about the call for action but we need to visualise the workforce in all it's diversity. In Europe we have at least 450.000 nurses working in the field of the mental health. It is a good sign that in the past years in a lot of nations psychiatric nurses have collectivised them selves in an independed organisation or proved them selves qualified enough to form a special section within the National Nursing Association. Their policies are tuned to international level. That is where the possibility occurs to create a European organisation for Psychiatric nursing association like other nursing specialist have done years and years ago like the diabetes, anaesthesia, oncology, and much more. They have reached the point of having an influential advisory position as non-governmental organisation, with sufficient budgets. Horatio is just starting as the section for Psychiatry towards the right level.

Psychiatric nurses; a special breed

The psychiatric nurse have however a double road to take in gaining a similar position. We do not easily tend to seek the platform and be at the spot where the applause is easily got. When you look at the media such the soap series where the beautiful nurses and doctors, psychiatry is some thing to be a shamed of. Psychiatry or mental health is some how still 'not-done'. Psychiatry is still to often related to 'one flew over the cuckoo's nest', even after 30 years, and this is not strange if you face the publications in the media about psychiatry. It is known by a survey in the Netherlands that patients still identify them self with the patients decades ago and see the bad nurse in Miss Rachel while the nurses do not recognised them self in such a role. We have to work on these gaps.

There are still to much negative publications for example.

1. 3 December 2006 at the BBC eight o'clock news headlines. Death caused by mental illness persons, one each week a victim, 29% of the patients who committed a crime has seen a health worker that same day. Question if the MH workers are enough aware of problems and can prevented.; 'medical staff misses crucial signs' and 'avoidable death'.
2. Very early example during the Second World War when psychiatric patients where introduced as the 'unnutzigen - unnötigen menschen' (the not usefully) and where systematically brought to gas chambers, situated on the psychiatric institutes with nurses (involuntary) involved.
3. More recently there have psychiatric institutes in the former communist regimes, strongly driven by political motivated 'health system'.
4. At the Second of December 2006 Dutch television. 'Seclusion as a ineffective and inhumane answer on persons with violent psychiatric behaviour and not follow national legislation on these points: not true but reached the media.
5. In the Journal of Psychiatric and mental Health nursing; august 2006. The Slow death of psychiatric nursing. Colin Holmes of the James Cook University of Townville in Australia about negative publications with an impressive list and an analysis.

Do these publications and negativism in the media ever stops and finds a way to mention the hard working and highly motivated persons? The answer of Horatio is to do the same. Speak out, be proud, seek the media and make your efforts and quality visible. React instantly on negative publications and do not defend. We have to show our pride and firmly expose our profession. We also should not be satisfied with small victory; we have to go for the jackpot, nothing less. Let the public decide on the real course of the problems and let them discover them self that they have elected for the current policy. The nurses are not the problem-owners; the problem-owner is the observer and the elected politicians who has the information.

Mental Health as 'container concept'.

Compared with other specialist, Psychiatric nursing or Mental Health nursing is a 'container concept'. We have all kind of experts. In our Horatio contacts we often ask them to identify their interest or speciality. Here you find the impressive selection.

General: Research, development, Prevention, Information Technology, Education, Staff, Leadership, History, Human Rights and Administration.

Specific: forensic, community, addiction, clinical, interdisciplinary, traumatic brain injury, army, rehabilitation, behavioural treatment, Assertive Community Treatment, Psychoses, Eating Disorders, Obsessive / Compulsory, Children, Elderly, Aggression management, Intercultural, Music, Drama, Post Traumatic Stress, Occupational.

Much of these areas have organisations and developed themselves on the international field and I have the impression this development is growing more rapidly than we can cope. The question occurs where do these come together? It can not be the case that there is no relation on a wider scale and they remain hard to find and only join forces for the occasion.

Horatio

When I speak of Horatio, I mean the recent formed association for Psychiatric nurses with the National Psychiatric Nursing Organisations as their members and with supporting organisations in the mental health field where the science is and the experience. This organisation has been formed based on a huge response on a questionnaire if it would be worth while to create a European network. When I was at the RCN meeting two years ago, we had about 10 contacts. After this meeting, a year further about 80 and today about 300. We started last year with 5 full members and this year we have started with nine. A lot of nations do struggle at this moment to get them self organised as a national organisation or as a national alliance with a policy and budget for international affairs. This due to a NHS, but it might give you comfort with the awareness that all European nations do struggle with this, and always have been although we forget this sometimes. Some nations have strong regions, counties or federations and some with different language to express their identity. This is one of the reasons why some can not join Horatio as a full member, but we know they work hard on this. Horatio sees her organisation as a platform to discuss this item and find way's to overcome obstacles and help each other in getting solutions and we should have the guts to proclaim that we as nurses are holders of an important key in solving national problems.

The current members have been working on objectives and an organisation. The objectives are:

-
- 1 To promote and facilitate information about psychiatric nursing within Europe
 - 2 To represent the special interests of psychiatric nurses in Europe and collaborate with stake holding nursing organisations
 - 3 To advance the art and science of psychiatric nursing within Europe
 - 4 To improve the recognition of psychiatric nursing within Europe, within all fields of health care
 - 5 To contribute to effective cooperation between health professionals, organisations, institutions, agencies, charities and groups who have an interest in the care of mentally ill patients
 - 6 To inform the development of standards for education and continuing competence
 - 7 To strengthen nursing leadership in mental health care
 - 8 To provide conferences, congresses and continuing education opportunities for psychiatric nurses
 - 9 To link the Horatio network with similar national/international organisations external to the European Community (i.e. USA, Australia, Africa and Asia)

Contacts and members

In our associations there is an abundance of persons and organisation who are interested in this ranging for wanting to stay informed towards full commitment with investing time and finances. These groups are divided in a membership structure. This structure is advised by Faculty Association Management of the University of Amsterdam and is also practices by the other nursing specialist organisations.

- 1 • The main body is formed by the full members and are identified by national organisation for mental health of psychiatric nursing or section mental health in the national nursing associations. They are in fact the foundation of the whole organisation from where policy is made and activities are initiated. When you want to make your voice heard in the EU, questions are raised in what way you reflect the European citizens and using this construction, it gives the only answer to this.

The present nine (9) members are: Finland, Sweden, Norway, Ireland, Netherlands, Czech-Republic, Malta, Croatia and Cyprus. It is in the interest to get as much nations as possible in our network as members, not only to reflect Europe but to get and give the best information from first hand.

- 2 • The second group is of great value because they hold experience, knowledge, science and great networks. I name for example, the hospitals, colleges, universities and interest groups such as research, student exchange organisations, the GIP and so on. As I say, this group is of great value because most of the key figures have positions and connection with several stakeholders and this makes it very practical and in some matters also in a strategic sense.

This second group is too large to mention in detail in this presentation but frequently e-mails come to us, still unknown group, but very interested for us all to get in contact with. As being active at the office, it's every day a surprise what's coming in but more surprisingly is the interest in this international alliance for mental health nursing.

- 3 • Thirdly we have a group of individuals who have chosen not to get allied with organisations and prefer to stay independent.

Beyond Europe

By getting this organisation in function, we as mental health nurses can become a strong non-governmental organisation and a very interesting group to focus on based on our numbers and quality within our reach.

A group which I have not mentioned is the group outside Europe. There is an interest from Canada, New Zealand, Australia and China in our organisation which also shows that this is a still expanding process. There is also an organisation in process about a Pan-American Network for Mental Health Nursing. Questions are raised if this organisation can contribute to a more global organisation like other specialist nursing organisations have. An example is the International Federation of Nurse Anesthetists, the IFNA. The IFNA has developed a global Standard of Education, Standard of Practice and a Code of Ethics.

It is in the very interest of every psychiatric nurse and national organisation for mental health nursing to promote further development towards that level. Figures of a future surveys would be very convincing.

The ESNO.

As have mentioned earlier, there are a lot more nursing specialist organisations and they are in close contact with each other. The ESNO is the organisation for European Specialist Nursing Organisation and Horatio plays a vital role in this as co-founder. The ESNO works closely with the EFN, the European Federation for National Nursing associations. While being in contact with the other nursing specialities, it is surprisingly how much we inspire and support each other. This not merely in the grounds of organisation but mutual interest, for example, nurses at the wards for dialyses, experience a lot of violence. Patients face a lot of difficulties with their diseases and limited way of living, the nurses are their first contacts and get the frustration as failing coping mechanism with their despair. So here comes our speciality and we agreed to stay in contact when we need to help each other.

Another example is the structure of the Bachelor - Master system. All specialities face these challenges and it is very important to tune these issues from the beginning. Some have already made some progress on international level and are very well informed, while others are working still on this on national level and are struggling with several national systems. Beside this there are more obvious connexions such as the Acendio,

the FINE and the Nursing Directors. That is where this cooperation is of great value. Horatio needs to be in Brussels as the collective voice of the nurses in Mental Health.

Conclusions

If we as nurses in Mental Health and psychiatry want to play a role in the international field, it is not essential that all are going to be focused on this field. It is also not essential to visit all congresses around Europe. Your contribution becomes of importance when you get active in your internal network, being a member of your national organisation, help your organisation to focus on international developments and encourage playing an active role on behalf of you.

- Embrace the local, regional and national resources to put mental health nursing high on the agenda where you can.
- Remain an ambassador of this very inspiring profession with all its diversity, complexity, be aware, you're a part of a huge international group, don't forget to enjoy it and,
- Europe is not a fact, it's a process and it is up to every European to decide how it's going to look like.

With my wish that from now on you are introduced in the International field for Mental Health Nursing and being a part of a great number of colleagues with ambition and sharing this on a wider scale. Thank you for your attention.

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Relevant websites;

www.horatio-web.eu
www.efnweb.org
www.esno.org

3 - European Forum for Primary Care

By Diederik van Aarendonk

Our vision

Strong Primary Care (PC) produces better health outcomes against lower costs. That is the briefest summary of available scientific evidence. By promoting strong PC the population's health can be improved. Strong PC does not emerge spontaneously. It requires appropriate conditions at the health care system level and in actual practice to make PC providers able and willing to take responsibility for the health of the population under their care. Everywhere in Europe the process of strengthening PC is ongoing, with a large diversity in the way PC is organised. Therefore, Europe is in a sense a laboratory landscape of experiments for organising primary care. There is a strong need to collect and share information about what structures and strategies matter. This is a support to practitioners but will also provide the evidence to convince policy makers at different levels that PC needs to be strengthened.

What we aim at and what we do

The European Forum for Primary Care is multidisciplinary and brings together interested parties from many European countries. The aim of the Forum is to connect three groups of stakeholders in the field of Primary Care:

- The health care field; this includes practitioners from the different professions: physicians, nurses, social workers, physiotherapists, pharmacists, dentists and several others.
- Health policy makers,
- The producers and evaluators of (health) care information: universities and other research groups.

These parties work at three levels: the local or district level, the national level and the supra-national level. By linking policy, practice and research the Forum intends to stimulate policy making based on vision and evidence as much as it intends to support PC practice oriented towards quality and equity. The Forum monitors policies in the European Union as far as they bear relevance to Primary Care, it informs its members and offers its reflections and opinions. However, the Forum is not limited to member states of the European Union but encompasses all European countries. The Forum seeks to expand its membership and thereby to become a leading force for Primary Care in Europe.

The Forum provides information and opportunities for debate to its members, using thematic discussion groups, facilitated by the website and the secretariat. It also

formulates Position Papers, based on contributions of its members and third parties. In 2006, Position Papers on Mental Health and Primary Care, Diabetes and Primary Care and Self Care and Primary Care have been initiated and in 2007 priority topics for further Position Papers are identified. The Forum advises its members, the relevant organisations in the European Union and its member states on policies that bear relevance to Primary Care.

Who we are

The European Forum for Primary Care was initiated in early 2005 by a group of interested parties from Belgium, The United Kingdom, the Netherlands, France, Estonia, Italy and Denmark. Its growing membership includes individual practitioners and local, regional and national organisations in many countries of Europe. Among them are practitioners and management, policymakers and researchers. The Forum works in close collaboration with several organisations like WHO, Wonca, EUPHA, EUSP and ENOTHE. Chairman of the Forum is Prof Dr Jan De Maeseneer (Belgium). The secretarial support to the Forum is carried out by the International Centre of the Netherlands Institute for Care and Welfare.

Having started as an informal network, the Forum will gain legal status early in 2007.

Why and how to become a member

Benefits of the membership are:

- opportunity to participate in the exchanges within the Forum through theme-group discussions, the publication of articles and documentation on the Forum's website
- full access to member website via the members area
- regular e-mail newsletters on Primary Care developments
- information on conferences, thematic meetings and other activities organized by the European Forum for Primary Care and its partners; reduced registration fees for some conferences
- a chance to network and meet colleagues who have similar interests and concerns

Membership fees

Per calendar year:

- Organizations: 300 Euro (includes three passwords)
- Individuals 120 Euro (includes one password)
- Lower rates will be applied for members from countries below the European average of GDP: 10 euro per year for individuals, 50 euro for organisations
- Student organisations pay 50 % of the regular fee. Members who register after July will be charged 50 % of the fee for the current year.

Registration:

Use the registration form on the website of the Forum or send an email to the secretariat

Contact:

European Forum for Primary Care
PO Box 19152
3501 DD Utrecht
The Netherlands
tel +31.30.2306552
fax +31.30.2306540
info@euprimarycare.org
www.euprimarycare.org

The Position Papers European Forum for Primary Care

Among the many activities of the Forum is the formulation of a series of Position Papers from 2006 onwards. Aim of the Position Papers is to provide policymakers in WHO, EU and in the individual European states with evidence and arguments which allow them to support and develop Primary Care. In addition, the Position Papers aim to facilitate the exchange of experience and know how between practitioners in different countries and to identify issues for further research. The Position Papers are the result of consultation and discussion among many relevant stakeholders in Europe, under leadership of one of the members of the Forum. The format and the process of development of the Position Papers gradually will be standardised, resulting in a series, demonstrating the added value of Primary Care.

Position Papers

2006

- Mental Health in Europe, the role and contribution of Primary Care.
- Encouraging the people of Europe to practice self care: the Primary Care perspective.
- The management of chronic care conditions in Europe with special reference to diabetes: the pivotal role of Primary Care.

2007

- Prevention and treatment of chronic heart failure in Primary Care
- Prevention and treatment of COPD/asthma in Primary Care
- Prevention treatment of chronic renal failure in Primary Care
- Prevention and treatment of depression, the role of Primary Care

Mental Health in Europe, role and contribution of Primary Care

Mental Health has been selected as one of the first topics on the list of Position Papers because of its increasing importance in Primary Care.

The burden of Mental Health disorders and illness increases in all countries of Europe and leads to a wide range of national and international initiatives aimed at its reduction. A number of the networks in Europe that work on Mental Health put emphasis on Primary Care. During the development of this Position Paper, representatives of those networks have contributed to this Paper, see Box 1.

Box 1 Contributing organisations to this Position Paper.

- EMIP “Implementation of Mental Health Promotion and Prevention Policies and Strategies in EU Member States and Applicant Countries” that has been running until July 2006 with the overall objective to build and support good practice in the development and effective implementation of mental health promotion and prevention policy and strategy in the Member States of the European Union and in applicant countries. (<http://www.emip.org>)
- The “European Alliance Against Depression (EAAD)” is an international network of experts with the aim to promote the care of depressed patients by initiating community-based intervention programmes in 18 European countries. (<http://www.eaad.net>)
- The Wonca Working Party on Mental Health was established in October 2006 and serves as a focus for the development of mental health issues for Wonca worldwide. It has a strong European representation. (<http://www.globalfamilydoctor.com/aboutWonca/sig/sig.asp>).
- Mental Health Europe (MHE) is a non governmental organisation committed to the promotion of positive mental health, the prevention of mental distress, the improvement of care and the protection of human rights of (ex-)users of mental health services, patients of psychiatric hospitals, their families, and carers. (<http://www.mhe-sme.org>)
- In several countries, national networks operate, like in the UK the PRIMHE (Primary Care Mental Health & Education) network. (<http://www.primhe.org>).

In paragraph one a brief overview of issues and current policy approaches is presented and discussed. In paragraph two, the currently prevailing views on how Primary Care can deal with the increasing burden are presented. Paragraph three offers a number of practices that work in some countries – and may serve as inspiration for other countries or contexts. In paragraph four, a number of outstanding issues for research and policy development is listed.

4 - A Survey of the Education of Nurses Working in Mental Health Settings in Twelve European Countries

Peter Nolan: PhD, RMN Professor of Mental Health Nursing, Staffordshire University and South Staffordshire Healthcare NHS Trust.

Neil Brimblecombe: PhD, RMN. Director of Mental Health Nursing. National Institute of Mental Health in England.

Abstract

Background:

Recent European policies emphasise that the training and education of health professionals are a major means of improving mental health services. Little comparative research has been undertaken to ascertain the degree of homogeneity in the training of nurses working in mental health settings across Europe.

Objective:

The aim of this study was to investigate the training of nurses working in mental health settings in a range of European countries. Specifically, information regarding criteria for entry into training, type of qualification awarded and further training opportunities was to be explored.

Methods and participants:

A specially designed questionnaire was devised to gather data from senior mental health nurses working in the mental health field in a sample of twelve countries from across Europe

Results:

Findings disclosed considerable disparity between countries in respect to nurse training, with only three countries requiring a specialist nursing qualification to practice in the mental health field. There appears to be little homogeneity in terms of educational provision pre and post-qualification, and in career prospects for mental health nurses in Europe.

Conclusions:

More research is needed into how European states deliver nurse training and education, how students are prepared for various practice settings and the effect on outcomes for service users of different models of training.

Introduction

Europe currently has a population of 700 million people living in 49 states in different stages of economic development, with different natural resources, and speaking a range of languages. Each country faces complex health, social and environmental problems, including pollution, decreasing the gap between rich and poor, a resurgence of diseases such as tuberculosis, cholera, typhoid and malaria, and especially in Eastern Europe, unacceptable levels of maternal and child morbidity and mortality (WHO, 2001a). Cancer, cardiovascular conditions, sexually transmitted diseases and mental health disorders are common. Unhealthy life-styles characterised by poor diet, lack of exercise, smoking, alcohol addiction and substance abuse, severely challenge existing health care systems (WHO, 2003). The European Union currently has twenty-five members, and affects the lives of more than 375 million people. More countries are eager to join, with Turkey being the closest to accession. Dedman (1996) notes that the advantages provided by membership of the EC cannot negate the many unresolved tensions in relation to the sovereignty of each member and the harmonisation of education, employment, social benefits and health care.

Despite steady economic growth, greater availability of health services, better living conditions, and increased life expectancy, the number of Europeans suffering from mental health problems continues to rise and this trend is likely to continue (WHO, 1998). Commitment to the improvement of mental health services in all European states was expressed by the European Ministerial Conference on Mental Health held in Helsinki in January 2005. The Conference acknowledged that mental health is fundamental to the quality of life and to the productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative citizens. The primary aim of mental health care was defined as to enhance well-being and functioning by focusing on people's strengths and resources, building up their resilience by strengthening protective external factors (WHO, 2005). For this to happen, mental health services require sufficient personnel, appropriately trained with the skills to work flexibly in integrated teams and having adequate resources.

The history of mental health care across Europe shows a common pattern with the establishment of large asylums in the 19th century followed by varying degrees of deinstitutionalisation during the second half of the 20th century (Priebe, 2004). However, there is and has been considerable variation in the culture and practices of mental health care systems (see for example Goldstein, 1987; Nolan, 1993; Goldberg, 1999; Boschma, 2003) and in current policies (Becker & Vazquez-Barquero, 2001). This is notably so with respect to the number of mental health nurses recruited, the training provided and the work they undertake.

To combat the morbidity, disability and mortality arising from mental illness, WHO (2003) has focused on the need for well-educated and skilled nursing staff. The Munich Declaration (WHO, 2000) states that nurses are both the most appropriate personnel

to tackle the public health challenges of our time and also the most cost-effective. If nurses are to realise their full potential to assist the health of the citizens of Europe, they need a well developed knowledge-base, specialist skills in caring and in the technological dimensions of treatment, and proficiency in making clinical judgements both autonomously and as members of multidisciplinary teams.

While concern has been expressed about the increasing number of people with mental health problems, very little consideration has been given to the unique contribution that mental health nurses might make to alleviating this problem. Most European Directives are aimed at medicine and nursing in general, and not at specific specialities within these professions (Mossialos et al, 2003) and it would appear that interest in mental health nursing is waning in Europe (Healy, 2002). This paper aims to establish how various European countries prepare nurses to work in mental health settings by:

- Establishing how nurse education is managed in each country
- Identifying if and how specialist training is provided for nurses working in mental health settings

Nurse Education and Mental Health Care in Europe

At the start of the 21st millennium, there are approximately six million nurses and midwives in the EU member states (WHO, 2003). In 2001, WHO estimated the numbers of psychiatric nurses and psychiatric beds per head of the population (WHO, 2001b). These figures are reported, where available, in Table 1 for the countries participating in the present study. It is important to note that WHO's definition of a psychiatric (mental health) nurse is 'a graduate of a recognized, university-level nursing school with a specialization in mental health. They are those registered with the local nursing board (or equivalent) and working in a mental health care setting'. The figures reported in Table 1, therefore, do not take into account the situation in countries where a significant proportion of nursing care in mental health settings is provided by nurses with a generic nursing qualification rather than by specialist mental health nurses. Table 1 also illustrates the wide variation in the extent of in-patient provision, with moves to deinstitutionalisation and reduction in numbers of beds varying markedly from country to country.

Table 1
Psychiatric Nurses and Beds in Europe (WHO 2001)

Countries	Population (millions)	Psychiatric beds per 10,000	Psychiatric nurses per 100,000
Belgium	10.2	25	-
Germany	82.2	7.6	52
Greece	10.6	8.7	3
Ireland	3.7	11.5	87
Italy	57.3	1.7	26
Malta	0.4	18.9	13
Netherlands	15.7	18.7	99
Norway	4.4	13	42
Romania	22.8	7.6	9
Sweden	8.9	6.7	32
Switzerland	7.3	13.2	-
United Kingdom	58.7	5.8	104

Specialist mental health nurses constitute a small proportion of the total number of nurses across Europe. For example, Table 1 indicates that the United Kingdom has a relatively high number of specialist mental health nurses, yet these constitute only 13.2% of qualified nursing posts in England (Department of Health, 2005).

The last decade has seen great strides in mental health nursing research (Clancy et al, 2002) and an increasing number of national studies have been undertaken in different countries (Lauri et al, 1999; Kiikkala et al, 2001; Holst & Severinsson, 2003; Thurston et al, 2003; Magnusson et al, 2004; Campbell, 2004).

Such studies provide valuable insights into experiences of nurse training and systems of nurse education in different countries. In Sweden, Magnusson et al (2002) reported that students rated clinical supervision as their preferred way of learning. Good supervision made them feel secure in their decision making, and helped them to form effective relationships with patients based on better insight into their conditions and understanding of the most appropriate interventions. In Spain, Lopez and Alonso (2002) found that mental health nursing students saw keeping a reflective diary as the most important way of learning through practice, while in Portugal, Pedr et al (2002) concluded that students bring with them into training deeply ingrained stereotypes of mental illness which require considerable work to change.

Felton and Stickley (2004) argue that recent innovations in service provision require innovative ways of imparting ideas and meanings to students in training. Involving service users in the design and delivery of nurse training courses improves nurses' skills, maximises their effectiveness in practical settings and helps them to challenge outdated practices (Hanson & Mitchell, 2001). Magnusson et al (2004) show that the need for good quality education and training has never been more urgent in mental health nursing, due to radical and ongoing changes in the way that services are provided. Working in various community and interdisciplinary settings, and in people's homes means that the role of the mental health nurse today is very different from that of the nurses who worked in institutional settings (Gulliver et al, 2003). This role is likely to continue to evolve as people with severe and enduring mental health problems increasingly receive support from nurses in various social and cultural settings (Devane et al, 1998). This raises challenges for basic and ongoing training, especially in relation to caring for older people with depression (Mayall et al, 2004), providing appropriate care for people in acute mental health care settings (Jones & Lowe 2003) and meeting the needs of people with psychosis (Baguley & Baguley, 1999). Concerns, too, have been expressed about the ability of mental health nurse lecturers to prepare practitioners with the skills, knowledge and attitudes required to deliver best practice. They have been criticised for lacking clinical competence and credibility, and for being out of touch with developments in modern services (Owen et al, 2005).

Allen and Brimblecombe (2004) note that common challenges are being experienced by nurses working in mental health settings across Eastern Europe including limited community based resources and continuing dominance of the medical profession in healthcare settings. While the problems that European nurses are encountering may be similar, approaches to education, even in adjacent countries, may be very different. Grant's study (2002) of mental health nurses in England and Southern Ireland found substantial disparity in pre-registration mental health nurse training at that time, with England emphasising the specialist nature of mental health nursing, and the Irish taking a far broader approach based on a general health care curriculum. Smoyak (1996) has recommended that more comparative international studies should be undertaken with the aim of clarifying the role of mental health nurses and their contribution to health care services. Such studies would assist in the development of targeted and effective programmes of education for an increasingly mobile health professional workforce.

Methodology

A questionnaire was specially devised by the authors to explore differences and similarities in the pre and post registration training of nurses working in mental health settings across Europe. Most of the twelve participating countries (Belgium, Germany, Greece, Holland, Ireland, Italy, Malta, Norway, Romania, Sweden, Switzerland and England) were identified opportunistically, as links already existed between the researchers and educationalists in these countries. International networks were used to make contact with countries where there were no existing links.

Senior nurses specialising in mental health in each of the twelve countries were contacted and invited to distribute or complete the questionnaire. All those approached agreed to participate. No ethical approval was sought for this study, as it simply sought to gather information already in the public domain in the twelve countries. However, in order to ensure that the questionnaire was acceptable and relevant to the nurses in each country and comprehensible, its purpose and structure were discussed at length with each respondent. The questionnaires were sent out by email between October 2004 and January 2005 and all had been returned by the end of January 2005 without the need for any reminders. Ambiguous responses were clarified by direct communication with the respondent who had completed the questionnaire and the final analysis of each questionnaire was shared with the respondents to allow them to verify the authors' interpretation of their responses.

Results

In response to a question regarding recent or future plans to change mental health nurse training, ten of the countries represented in this study have either recently changed or are about to change both the form and content of nurse training. The exceptions were Sweden and Greece. Respondents were asked whether specific courses existed for the preparation of mental health nurses at pre-registration level, in which academic institutions, and about the qualifications required of teachers providing pre registration training courses. A summary of the responses is presented in Table 2.

Table 2:
Pre- Registration Nurse Training

Countries	Pre registration speciality training	University based	Level of Qualification	Requirements of education staff
Belgium	No	No	Dip and Degree	Bachelors degree, nursing qualification
Germany	No	No	Dip	Bachelors degree, teaching qualification and nursing qualification
Greece	No	Not all	Degree	Master's degree and nursing qualification
Holland	No	Yes	Degree and Dip	Master's degree and nursing qualification

Countries	Pre registration speciality training	University based	Level of Qualification	Requirements of education staff
Ireland	Yes	Yes	Degree	Master's degree and nursing qualification
Italy	No	Yes	Degree	Bachelors degree, nursing qualification
Malta	Yes	Yes	Degree	Bachelors degree, teaching qualification and nursing qualification
Norway	No	Yes	Degree	Master's degree, teaching qualification and nursing qualification
Romania	No	Not all	Diploma	Bachelors degree, nursing qualification
Sweden	No	Yes	Degree	Master's degree, teaching qualification and nursing qualification
Switzerland	No	Not all	Dip	Bachelors degree, teaching qualification and nursing qualification
England	Yes	Yes	Dip and Degree	Bachelors degree, teaching qualification and nursing qualification

Only three countries, Malta, Ireland and England, have specialist training for pre-registration students leading to registration on a dedicated register for mental health nurses. Parts of the English and Maltese pre-registration nursing courses are shared with students from other nursing areas, with specialisation in mental health occurring after one and two years respectively. The Maltese course lasts four years compared to three years in England. The other nine countries have generic registration, comprising nurses from various specialities, including mental health. Holland and Sweden have systems where a third year of training may be devoted to mental health for those interested in that speciality, but at the end of the course, students still receive a generic nursing qualification and are subsequently able to work in any speciality. Although all twelve countries require their nurse lecturers to hold a nursing qualification, only six (Germany, Malta, Norway, Sweden, Switzerland and the United Kingdom) stipulate that they should possess a teaching qualification. Five countries (Greece, Holland, Ireland, Norway and Sweden) require nursing lecturers to hold a Master's degree, although its content is not specified.

All countries reported that at least 50% of their pre-registration training courses were spent in practice situations. The academic part of pre-registration training is exclusively University-based in seven of the countries (Holland, Ireland, Italy, Malta, Norway, Sweden and England), with a range of educational institutions also providing training in the others. Belgium, Holland and England provide both Degree and Diploma level training, and Germany, Switzerland and Romania provide only Diploma-level training. The remaining countries (Greece, Ireland, Italy, Malta, Norway and Sweden) only provide a Degree level course.

Responses to questions regarding the registration of nurses and post-basic training in mental health nursing are recorded in Table 3. Respondents were asked whether there was a body that registered nursing qualifications, the availability of specialist mental health training after basic qualification, and entry requirements for such courses.

On completing basic training, nurses are registered with a registering agency in all countries except Germany. Only Norway and Sweden reported registration systems organised by their Health Ministries. All other agencies were, at least nominally, independent and possessed disciplinary powers (except in Switzerland) to regulate the provision of training and remove nurses from the Register for actions not in keeping with professional responsibilities.

All those countries with no specialist qualification at pre-registration level (Belgium, Germany, Greece, Holland, Italy, Norway, Romania, Sweden and Switzerland) provided some access to specialist training post qualification although such training was not a pre-requisite to practising in a mental health area. Some countries (Germany, Greece, Holland and Switzerland) required a minimum period of practice after registration before starting specialist training. Norway was unusual in that its post registration training course was not specifically for nurses, but open to all health and social care professionals. In England, some of the wide range of courses available were exclusively for nurses whilst others were not.

Table 3:
Registration and Post Registration Training

Countries	Registering body	Specialist mental health training available	Entry requirements
Belgium	Independent	Yes	Each School sets its own requirements
Germany	No	Yes	Dip. in Nursing and 2 years practice
Greece	Independent	Yes	Degree and 2 years practice
Holland	Independent	Yes	Nursing Diploma/Degree and 2 years practice
Ireland	Independent	Yes	Normal university requirements

Countries	Registering body	Specialist mental health training available	Entry requirements
Italy	Independent	Yes	Registered Nurse
Malta	Independent	Yes	General Matriculation University requirements, one subject must be science
Norway	Government	Yes	Nursing Degree
Romania	Independent	Yes	Registered Nurse
Sweden	Government	Yes	Registered Nurse
Switzerland	Independent	Yes	Diploma and 2 years practice
England	Independent	Yes	Nursing Diploma or Degree, experience requirements vary

From respondents' answers, it appears that only Holland and England expect recently qualified nurses to have a period of additional support. In Holland, provision is made for nurses to continue to be mentored by senior colleagues after basic training is completed and in England, there is a similar expectation that a period of 'preceptorship' should follow initial qualification.

The last section of the questionnaire concerned the qualifications of lecturing staff (see Table 2) and to what extent they were required to keep abreast of clinical practice. The only academic qualification required of lecturing staff in seven countries (Belgium, Germany, Italy, Malta, Romania, Switzerland and England) was a Bachelor's Degree, while five countries (Greece, Holland, Ireland, Norway and Sweden) require a Master's Degree. Three countries (Belgium, Greece and Italy) do not require lecturing personnel to have a teaching qualification, although all twelve require a nursing qualification. No country required lecturers to possess a Doctorate, nor were lecturers required to maintain contact with practice areas, although in four, (Greece, Norway, Sweden and England) respondents reported that it was left to the discretion of staff as to how much time they devoted to clinical work.

Discussion

Some caution needs to be exercised in interpreting the results of this small scale study. More affluent, Western European countries were over-represented and it is possible that the twelve countries which participated have far more in common with each other than with their Eastern European neighbours. The former Soviet Block countries may, in turn, be more similar to each other than to countries in Western Europe. Again, there is scope for future research in this area.

Whilst the differences between the countries in how they train nurses to work in mental health settings are notable, all twelve do expect that nurses will work in such settings. This suggests that there is a general common model of mental health care stretching across Europe, but that there is considerable variation in the detail of how that model is expressed at national levels.

The most significant variation in educational practice across the twelve countries is whether a specialist mental health nurse qualification is offered at pre-registration level. In reality, the existence or not of such a qualification may be relatively unimportant in terms of specialist skills on qualification. In the Netherlands and Sweden, students can choose to specialise in mental health in the later stages of their training, although having done so is not a requirement for practice in mental health areas. Ironically, nurses who have qualified in one of the minority of countries which provide a specialist pre registration training course in mental health may find it hard to work in mental health services in other European Community countries. This is because their specialist qualification may not meet employment requirements when a general nursing qualification is needed to work in any health settings including mental health.

The cross-Europe availability of specialist training post registration was notable, but in none of the countries was it a requirement for practice. The dominant model in mental health nursing would therefore seem to be derived from general nursing, with an assumption being made that the skills of the general nurse are transferable into the mental health arena. As mental health becomes the major public health issue of the twenty-first century in the Western world, it may be questioned whether this assumption is appropriate and whether nurses without specialist training will be able to meet the needs of clients presenting with complex combined physical and mental health problems.

The status of nursing across the twelve countries is apparent from the fact that all have some form of pre-registration training and register their qualified nurses centrally (except in Germany). The majority of registers are independent of Government, suggesting that in much of Europe, nursing is free to determine its own standards of practice and future development. All the pre-registration courses surveyed require students to spend at least 50% of their training in clinical placement. However, the universal lack of a requirement for lecturing staff to maintain contact with the clinical areas suggests that the theory-practice gulf may not be being vigorously addressed. Students from all the countries surveyed receive both an academic and nursing qualification at the end of training, demonstrating the increasing weight given to theory-based nursing practice.

The content of pre-registration and specialist post-registration courses was not explored; nor were methods and standards of assessment compared between the twelve countries. These are areas which certainly warrant further detailed research. Lecturers in all twelve countries are required to be both registered nurses and graduates. Studies such as those by Magnusson et al (2002) and Lopex and Alonso (2002) have suggested that

students do not necessarily benefit from being taught by lecturers whose base is firmly in institutes of higher education rather than in the clinical areas. These researchers found that formal teaching by academic lecturers was much less highly rated by students than clinical supervision and reflective diary-keeping. Coupled with the findings from the present study, there is certainly scope for reassessing the involvement of nurse lecturers in the clinical arena and the extent to which they are able to relate theory to practice in assisting students to bridge the gulf between the lecture hall and the ward or community. Education should both influence practice and challenge it.

The present study confirms the preliminary work of Clancy et al. (2002) who found that approaches to pre and post registration education for nurses working in mental health settings are evident across Europe. Seeking to adopt a European approach, they argued, is fraught with problems due to different countries having different health care systems, different nursing traditions, and different definitions of what nurses are and what they do. As the EC enlarges and perhaps becomes more centrally dominated, these differences may start to be suppressed in favour of a more homogenous and pan-European approach to the training of medical and nursing personnel. In the twelve countries surveyed, this may bring advantages in terms of sharing understanding of mental health nursing and experiences of training with a view to strengthening services to clients in an age when mental health issues will move to the top of the health agenda. Before this can happen, the differences in philosophy of training, approaches, assessment methods and post-registration support need to be made far more explicit (Smoyak 1996). And prior even to this, there is a need to investigate whether there is any homogeneity in mental health services across Europe and how differences explain differences in training or are explained by them.

Given that so many countries provide only general nurse training for mental health nurses, it is evident why there is not a critical mass of nurses in Europe able to analyse the role of nursing in mental health services. Although changes to the delivery of mental health services in Europe are planned (WHO, 2003; WHO, 2005), these do not seem to include harmonisation of mental health nursing, nor do they include a review of the training of nurses and their continuing educational support. There is currently no data to show whether the education and training that nurses receive across Europe is effective in improving standards of care, clinical outcomes, cost effectiveness, level of job satisfaction and satisfaction of mental health service users. Such studies as these are long overdue.

Conclusion

Despite WHO declarations on health, there is little homogeneity in terms of the educational provision, post-qualifying opportunities and career pathways for mental health nurses in Europe. More needs to be known about how nurse training is delivered and the impact on outcomes for service users of different educational models. More

generally, comparative European studies are required of the contexts in which nurses work, the configuration of the teams of which they are part, the types of interventions they employ and the range of clients for whom they care. Such information will enable rational and effective planning of services for mental health clients across Europe in the 21st century.

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5 - Continuing Competence Program for Registered Psychiatric Nurses: A Canadian Approach to Promoting Positive Practice.

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Canada

Canada is a federation of 10 provinces and three territories. Some of the processes in one jurisdiction may be different than in another. There are some basic principles that apply to all jurisdictions with few exceptions. One of the principles that applies to all jurisdictions is the Canada Health Act which states that Canadian health care will be publicly administered and universally accessible. In Canada, there are three regulated nursing professions: Licensed Practical Nurses, Registered Nurses and Registered Psychiatric Nurses.

RPNs in Canada

In four Canadian jurisdictions, there are distinct education programs and regulatory processes for Registered Psychiatric Nurses. In each of those jurisdictions there are education programs leading to eligibility to write a registration examination that in turn leads to registration with one of the four regulatory bodies.

The legislation in each of these jurisdictions is established to ensure safe, effective and accountable psychiatric nursing practice. Each has provision for a continuing competence program. There are four regulatory bodies in Canada: The College of Registered Psychiatric Nurses of British Columbia; the College of Registered Psychiatric Nurses of Alberta; the Registered Psychiatric Nurses Association of Saskatchewan and the College of Registered Psychiatric Nurses of Manitoba. There are a total of about 5,000 Registered Psychiatric Nurses in Canada. Several of them, especially in British Columbia, have been educated in England, Ireland, and other European countries.

RPNs in Manitoba

In the Province of Manitoba, there have been education programs for Psychiatric Nurses since 1920. These were diploma programs initially based on the apprenticeship model and in the late 60's this changed to diploma programs based on an educational model. Since 1995, the psychiatric nursing education program in Manitoba is a four year baccalaureate degree leading to the academic designation of Bachelor of Science

in Psychiatric Nursing. There is also a two-year post-diploma degree program for Registered Psychiatric Nurses that has been in place since 1986.

The mandate

The Registered Psychiatric Nurses Act of Manitoba states that the College of Registered Psychiatric Nurses of Manitoba (the regulatory body) must conduct its affairs and govern its members in a manner that serves and protects the public interest. To that end, the College has a Code of Ethics, Standards of Psychiatric Nursing Practice; expected competencies of the beginning practitioner; and various other documents that guide the practice of the profession.

The College also receives, reviews and processes complaints against Registered Psychiatric Nurses. This includes the administration of full disciplinary hearings or inquiries when necessary.

To ensure that RPNs continue to meet basic requirements, we have mostly depended on their need to practice about 1400 hours in any five year period before they receive practising status and the requirement for employers to report suspensions to terminations due to professional issues.

In 2001, the legislation changed and it included a requirement for a continuing competence program. From now on, unless expressly stated otherwise, I will address the Continuing Competence Program in the Province of Manitoba.

The Program

The significance of the Continuing Competence Program includes the fact that it is pro-active; it promotes positive practice; it requires that practice is documented; and, the adherence to the process is subject to an audit.

If there was time I would talk about the process that we used to develop the program; the preparation for change that we did with the members; the transitional implementation of the program; the inter-professional collaboration that continues to take place; and the resources that we make available to members. However, I do want to focus on the program itself.

The desirable characteristics of the program were identified as the program being flexible enough to meet the needs of Registered Psychiatric Nurses in the four domains of practice (clinical, education, leadership & research) and can be adapted for varied competencies; the program being based on the Standards of Psychiatric Nursing Practice; and the program requiring critical self-reflection on practice and the impact of continuing competence activities on that practice

Principles

A principle that was applied to the program was that each RPN has a professional responsibility for career-long maintenance and enhancement of competence. We also believe that each RPN is a responsible professional who shares the values of safe, competent practice. We do not expect each RPN to be competent in each and every aspect of psychiatric nursing practice. We do however expect each RPN to be competent at what she or he currently does.

The chronology

Prior to the proclamation of the new legislation (August 2001), a dedicated staff person was hired on a half-time basis in March 2000 to work on the development of the program. A committee composed of RPNs from various areas of practice and some public representatives worked with the staff person until the program was implemented and partially evaluated in May 2006.

For the 2004 registration year (before December 31, 2003) applicants had to sign a declaration of having completed the continuing competence requirements to renew their registration. This meant that they had to do a self-assessment; develop and implement a learning plan and maintain a professional portfolio.

Components

The components of the program include the requirement of a minimum of 1400 practice hours in any immediately preceding five-year period; a self-assessment of one's competencies in the area of practice; the development and implementation of a learning plan based on the self-assessment; and the maintenance of a professional portfolio.

A Continuing Competence Package was sent to each member and is now sent to each new graduate. It includes instructions; self-assessment tool worksheets; competency examples; a learning plan template; and a portfolio example and instructions.

The Self-Assessment Tool

It is possible to use any tool/process for the self-assessment as long as it is congruent with the Standards of Psychiatric Nursing Practice or other formal document of the profession. It may also be based on evidence-informed documents related to, and consistent with the Standards. RPNs may also use the CRPNM Self-Assessment Tool which includes the Standards of Psychiatric Nursing Practice; the Components of Psychiatric Nursing Practice; the Psychiatric Nursing Competencies; and the Competency Profile for the Profession in Canada.

We identified seven main areas of psychiatric nursing competence upon which a self-assessment could be done:

- Communication and therapeutic relationships
- Planning & Interventions
- Leadership & Collaboration
- Mental Health Promotion & Community Development
- Assessment
- Evaluation
- Legal Issues & Professional Practice

The Learning Plan

- Assessment (learning objective)
- Planning (what actions could you take)
- Intervention (what actions did you take)
- Evaluation (impact of actions on practice & need for further learning)

What might go in a Portfolio

- Annual self-assessments
- Certificates, diplomas, courses taken
- Committee work
- Names of books read with impact on practice
- Ongoing learning plans
- Special accomplishments
- Writings, presentations
- Curriculum Vitae

The Audit

In June 2006, the first group of RPNs received a questionnaire asking them about their own Continuing Competence Program . Twenty percent of the practising RPNs were randomly chosen to participate in the audit. The goal of the questionnaire was two-fold:

1. Was the person engaged in the program?
2. Were the tools provided in the Continuing Competence Package useful?

The audit asks whether the RPN engaged in a process of self-assessment and whether that process was documented. The question that asks what tools were used for the self-assessment provides us with information about what tools RPNs find useful. This will help us to determine which ones of our current tools are being used; which are not; which other resources are available; and, possibly, what resources still need to be developed or refined. We ask a questions about where the documentation is maintained. This provides information that can be shared with other RPNs as well as reinforcing the need for the maintenance of a formal record.

Part B of the questionnaire addresses the Learning Plan requirement. RPNs don't have to use the tool that the College has developed. We do, however, want them to use a format that will serve their needs. We ask them how many learning objectives on which they worked during the past year. Some people work on more than one. Question 8 asks which of the seven main areas of psychiatric nursing practice relate to their learning objective. We find that some RPNs in administrative or education positions specify other areas than those that are identified.

We then ask if they implemented a learning plan and what types of activities they engaged in. We also want to know if they evaluated the plan and whether they did or not is best reflected in Question 12. Question 12 has been the most problematic and the most rewarding. Question 12 asks the RPN to reflect on the continuing competence activities in terms of how those activities have impacted their practice. The question has been problematic for about 25% of respondents. They had no problem identifying what they had done but they had difficulty documenting how it had impacted their practice. We have not yet had a chance to analyze the respondents and so therefore can only guess at some possible reasons that include :

- have never had to document their practice or have not done it for a long time
- have missed a step in the process
- do not understand the concepts inherent in the program
- are trying to bluff their way

We want to know about barriers they have encountered. If they have to identify the barriers, they will be more ready to address them if they arise again. It is part of the evaluation that goes back to self-assessment and to the learning plan. We then ask about the portfolio – whether one is maintained and what is kept in it.

We added two questions at the end to see how helpful the Continuing Competence Package was for them. Each response will add to the information needed to evaluate the actual package that is sent out to new registrants and to make any necessary adjustments.

The renewal of registration is done annually and there were persons who had not submitted their response to the audit prior to the renewal of registration deadline. Their registration was therefore delayed and some lost some work time because of that. We will be auditing 20% of the members each year.

What we have learned

The auditors are mostly persons who were members of the Continuing Competence Committee and we provide them with a small honorarium for their work as auditors. They work in pairs and their joint recommendation is made to the Practice Consultant

of the College. There have been many referrals to the Practice Consultant which means that we have to increase the knowledge base of the RPNs or maybe of the auditors.

However, this has increased the staff time required for the whole process and therefore has organizational implications.

There are some exciting things happening. In one workplace (where we had previously done a pilot project on competencies) the assessment is done individually, at the unit level and even at the organizational level. The learning plan is then developed accordingly.

The richness of the documentation of psychiatric nursing practice is especially rewarding. RPNs are documenting their practice and the impact their participation in the continuing competence program has had on that practice. They are also providing examples of situations that could be used for clinical psychiatric nursing research.

There is the beginning of a change in culture in areas that seemed to be entrenched in “old ways” of doing things. These RPNs are becoming curious about the potential for their practice again. There is a sense of renewal.

6 - Health & Safety – Safety Management & Training'

By Gernot Walter & Nico Oud (on behalf of ENTMA, European Network for Trainers in the Management of Aggression)

Germany & the Netherlands

Background

“Workplace violence – be it physical or psychological – has become a global problem crossing borders, work settings and occupational groups. For long a forgotten issue, violence at work has dramatically gained momentum in recent years and is now a priority concern in both industrialised and developing countries” (ILO, ICN, WHO, PSI, 2002). Whereby assaults represent a serious safety and health hazard for healthcare institutions, and violence against their employees continues to increase.

Altogether it may affect more than half of health care workers, and the negative consequences of such widespread aggression and violence impact heavily on the delivery of health care services. Evidence clearly indicates that workplace violence is far too high and interventions are urgently needed (ILO, ICN, WHO, PSI, 2002). Unfortunately especially for nurses aggression and violence is an all too familiar syndrome, as professionally nurses have not only to deal with the terrible outcomes of violence in caring for victims of violence, they are also threatened with aggression and violence themselves in the workplace. In fact nurses are three times more likely to experience aggression and violence than other health care professionals (ICN, 1999)

The recently published papers “Framework guidelines for addressing workplace violence in the health sector (ILO, ICN, WHO, PSI, 2002), the “Mental health policy implementation guide regarding developing positive practice to support the safe and therapeutic management of aggression and violence in mental health in-patient settings” (NIMHE, 2004), and the “Clinical guidelines for the short-term management of disturbed / violent behaviour in in-patient psychiatric and emergency settings” (NICE, 2005) provide some very important guidance to tackle this phenomenon.

Reaching a safe and secure working environment

A safe and secure working environment for all health care workers should be a basic right. It is an essential element for not only the provision of quality and safe patient care, but also for safe and therapeutic management of aggression, violence and sexual

harassment in health care settings, and of course also for the health care workers' well-being, as well as for the patients' well-being within the health care system. This is even supported by a recommendation of the Council of Europe (2004) which is binding for the member states.

Current thinking on workplace aggression and violence stresses therefore the need to address this problem more and more in terms of the total organisational dimensions of workplace aggression and violence. The assertion is that a total organisational response to this phenomenon must reflect the ideas of a learning organisation. An organisation that is able to reflect from top to down and down to top, and continually learn from its current experiences can meet existing and future demands more readily (Senge, 1999). Such learning however requires according to Paterson and Leadbetter (2004) detailed attention to the nature of the problem of aggression and violence in terms of both individual and organisational dimensions. It requires managers to move beyond the management of individual instances and prevalent cultures of victim blaming and embrace approaches such as root cause analysis which seek to identify causal factors at all levels (Paterson et al 2004). Responding in this way to and managing aggression and violence is therefore one of the major missions of health care services. The problem of workplace aggression, violence and sexual harassment in the health care system must therefore be addressed at a variety of levels, and should lead to a total consistent, coordinated organizational response.

The development of an incident of aggression, violence and sexual harassment can never be attributed to one singular factor or cause. It's always a result of various factors, like biological, genetic, sociological, psychological factors, as well as the personalities of involved actors (health care workers, patients, and relatives), staff patient interaction and environmental and organisational factors like ward / hospital structure and atmosphere. The problem of aggression, violence and sexual harassment is not a problem of the patient only or a mono-disciplinary problem of for example the nursing profession alone. It is an interdisciplinary and total organisational problem of the health care system. The solution to this joint problem needs therefore a comprehensive integrated approach, directed to all the influencing factors and stakeholders mutually and not only to one of them (Oud, 1997). For that matter a number of themes and factors reoccur in the literature, and from the perspective of organizational development, these themes and factors are interactive. Colton (2004) identified with regard to reducing the use of restraint and seclusion specific actions / factors that should occur or be addressed in order to achieve a reduction of the use of restraint and seclusion: leadership, orientation and training, staffing, environmental factors, programmatic structure, timely and responsive treatment planning, processing after the incident, communication, consumer involvement, systems evaluation and quality improvement. He states that although no theme is paramount, that a number of studies suggest that without effective leadership, efforts for that matter will be unfocused, unsupported, and ultimately less effective. This is also the case if the focus is only on one factor, for example training only nursing staff.

Staff training should be comprehensive and Colton's study (Colton, 2004) states clearly that those programs (trainings) that appear to be most effective tend to cover a range of topics, rather than focusing primarily on behavioural interventions such as the proper technique for implementing a physical hold. Comprehensive (interdisciplinary) educational training of all the staff members should orient them to the goal, structure and content of a comprehensive safety and health program for recognition, prevention and management of workplace aggression, violence and sexual harassment, in order to be effective. It should provide staff with the knowledge, skills and competencies to implement such programs consistently across shifts, and Colton states clearly that only in that way progress addressing one factor may result in progress in achieving another factor as well.

It is however also a matter of common knowledge that the actual number of incidents with regard to workplace aggression, violence and sexual harassment is often not known, as incidents of this kind are likely to be underreported, or not being reported at all (National Audit Office, 2003). According to the Occupational Safety and Health Administration (OSHA, 2004) this might in part be due to the persistent perception within the health care industry that assaults are a part of the job. And they state that underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them or employee fears that employers may deem assaults the result of employee negligence or poor job performance. In a study into the content of management of violence policy documents in United Kingdom acute inpatient mental health services (Noak, et.al., 2001) it was found that policies vary widely in their content, and serious shortcomings were noted in the extent to which policies included information regarding their status and review, advice on the prevention of violence, the management of violent incidents, and post-incident action.

General guidelines regarding training

According to the OSHA guidelines for preventing workplace violence for health care workers an effective safety and health program for recognition, prevention and management of workplace aggression, violence and sexual harassment should contain four main components: (1) management commitment and employee involvement, (2) worksite analysis, (3) an overall safety and health program for the total organisation, and (4) safety and health training / education to ensure that all staff are aware of potential risk factors and how to protect patients, themselves, and their co-workers through established policies and procedures (OSHA, 2004). The primary focus when dealing with aggression, violence and sexual harassment should be that of recognition, prevention and de-escalation in a culture that seeks to minimise the risk of its occurrence through effective systems of organisational, environmental and clinical risk assessment. This approach should also promote therapeutic engagement, collaboration with service users (patients / clients) and the use of advanced directives (NIMHE, 2004). A collaborative approach and engagement by staff and patients in planning care in order to minimise

aggression, violence and sexual harassment, and consequently compulsion and coercion should be the main first safety and health standard in health care institutions. All stakeholders have the right to work or to be treated in the safest and least restrictive health care setting, and a possible solution to the problem of aggression, violence and sexual harassment can never be found without taking the service user seriously into account and have him/her actively involved. It is becoming clear that the problem of aggression and violence needs to be managed with a multifaceted approach, but also it is clear that simply training staff to manage aggressive and violent behaviour only will not resolve the overall problem (Beech and Bowyer, 2004).

While, even where such a program exist, and best practice in the recognition, prevention and management of workplace aggression, violence and sexual harassment is implemented it is unlikely that all kind of this behaviour will be eliminated. Especially where physical violence or other dangerous behaviour is foreseeable, training in reactive behavioural management strategies including theoretical models of aggression, violence, sexual harassment, de-escalation, and physical interventions strategies and procedures is necessary. But, as stated earlier, training in the recognition, prevention, post-incident care and management of workplace aggression, violence and sexual harassment should indeed always form one component of a total strategy by the health care organization in achieving a safe, healthy and therapeutic environment for all the involved stakeholders of such an environment.

There remains however considerable debate about what the content and duration of such trainings should be and especially with regard to how the part of training in physical interventions as part of such wider trainings should look like in respect of procedures, overall course content and duration (Paterson and Leadbetter, 2004). Because with the emphasis on for example only physical restraints and interventions as an instrument for controlling patients, health care workers (nurses) are only being armed with those physical techniques as a possible solution when faced with violence, and not with alternative solutions (Tucker, 2004). Instead it should be compulsory that preventive strategies like verbal de-escalation, influencing work place setting, post-incident care, debriefing etc. are being trained as well. Regulation of physical restraint training and training in the recognition, prevention, post-incident care and management of workplace aggression, violence and sexual harassment and effective accreditation schemes should be priority one on the agenda for national health care workers (nurses) organisations, national health care employers organisations, national service users organisations, and national health care political policies.

Recommended content of training

According to Paterson and Leadbetter (2004) there is some agreement of the potential core constituents of such a training, and according also to the ENTMA (2005) and in accordance with the proposed curriculum for aggression management by the American

Psychiatric Association (APA), and the NMC (formerly the UKCC, UKCC,2002) the training should address at least the following elements:

- The recommended essential components of training the recognition, prevention and therapeutic management of violence: theoretical aspects, de-escalation strategies, breakaway techniques, and restraint techniques (UKCC, 2002 – Appendix Five);
- Promotion of an explicit core values base that is compatible with the ethos of caring services and relevant professional ethics e.g. service user involvement and collaboration with service users in order to achieve the safest and least restrictive and oppressive health care setting possible, and showing the willingness and ability to enhance / improve staff and service user safety;
- Integration of primary, secondary and tertiary prevention strategies, and not just crisis management skills;
- Provision of tailored solutions to local problems based on risk assessment (Doyle, et.al, 2002), detailed incident analysis and environmental assessment rather than a standard one size fits all program, and teaching only procedures on what on basis of this assessment is actually foreseeable in the workplace rather than worst-case scenarios;
- Demonstration of a hierarchical approach to the problem of aggression, violence and sexual harassment allowing graduated responses to the level of risk in any given situation compatible with the principle of least restrictive intervention, the relevant practice setting and the legal context;
- Provision of interventions capable of mastery and use by the majority of staff with the majority of service users, and only physical interventions / techniques that are described fully in writing and have been subjected to independent biomechanical evaluation, and in accordance with the recommendations regarding physical interventions described in the “Clinical Practice Guidelines for the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (NICE, 2005);
- Physical contact skills / interventions in relation to life support techniques, and the application of safe and therapeutic breakaway techniques and restraint / seclusion techniques;
- Identification of the risks involved in physical interventions during training and be actively working towards the reduction and / or elimination of procedures associated with higher risks of adverse consequences. These include prone and supine restraint, basket holds and procedures which involves pressure across a joint and / or deliberate application of pain. With regard to the latter, every effort must be made to use techniques that do not rely upon the deliberate application of pain, as application of pain distorts the therapeutic relationship and may lead to a worsening of an already highly charged situation and should therefore be avoided unless absolutely necessary (NICE, 2005);

- Content that is based upon regular evaluation of, and grounded in systematic collection of evidence and regular audit, and in accordance with the NICE guidelines for this matter;
- Demonstrating commitment to service user involvement in the development, implementation and evaluation of the training;
- The use of assessment instruments e.g. the Brøset Violence Checklist (Abderhalden, et al., 2004), the Staff Observation Aggression Scale – Revised (SOAS-R) (Nijman, 1999), and the Perception of Prevalence Of Aggression Scale (POPAS) (Nijman, et al., 2005).
- Definitions and theoretical models of aggression, violence and sexual harassment, whereby from the theoretical perspective of the interaction model the classical role allocation of perpetrator and victim is rejected, and participants engaged in aggressive / violent behaviour are perceived as actors in social interaction. Both parties (staff and service users) are actively encouraged to reflect their own contribution to the genesis, the prevention, the management and the aftermath of aggression / violence (course description in Needham, 2004). Aggression and violence is recognised as multifactory with a number of potential contributory sources / actors, and therefore the problem has also no single solution, such as only training staff in restraint procedures (Beech and Bowyer, 2004).
- Information regarding a safe working environment or systems of work in relation to design and layout, use of alarms, security procedures, reporting procedures, setting conditions and triggers, etc.;
- Information in relation to particular service user groups: children, elderly people, people experiencing mental illness, learning disabilities, acquired brain injury, etc., and taking into account minority ethnic groups, gender, pregnancy, racial, cultural, social, religious / spiritual and other special concerns;
- De-escalation techniques, effective interpersonal communication skills, theoretical models (aggression, violence and conflict) and practice strategies and training / applying specific communication skills, in order to prevent, de-escalate, apply post-incident care and / or manage safely and therapeutically incidents of aggression, violence, and sexual harassment. The main task of the health care worker should be to develop and maintain a therapeutic professional contact with the service user, or to restore this kind of relationship as soon as possible during and after an incident, whereby if necessary only the 'behaviour' of the service user could be condemned, but never the person him- or herself.
- Legal and ethical issues;
- Identification of the dimensions and practice of staff and service user support before and after incidents of aggression, violence or sexual harassment;
- Use of a variety of teaching approaches, such as classical lessons, but also role playing, reflection, live demonstrations, and practice sessions, and it is strongly recommended that this is coupled with mentoring and coaching on the job (Colton,2004);

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- Orientation to organization's as well as regional, national and international policies, procedures and programs, such as for example organization's values and norms, clinical treatment pathways, instructions with regard to the use of seclusion and restraint, pre and post incident care, and instructions with regard to documentation and assessment requirements;
 - All health care workers or staff directly working with service users should take part in such basic courses, and should be looked at as an interdisciplinary task, as also the American Psychiatric Association (APA) is recommending that psychiatrists should receive training so as to assist in emergency situations in which their assistance is crucial, and with regard to seclusion and restraint clinicians should be familiar with the standards for seclusion and restraint, including the indications, contraindications, and alternatives to seclusion and restraint and the criteria for release from seclusion and restraint;
 - All health care workers should regularly take part in refresher courses.

Focus, duration and effects of training

Up to date there is a lack of comprehensive research into the effects of such training due to varying training contents as well as limited and differing research design. Nonetheless, Richter & Needham (2006) conclude that due to increasing knowledge and self-assurance within training participants at least two common effects are obvious. Therefore, and because of other perceived effects which are not yet proofed by evidence training is recommended but still more research needed Richter & Needham 2006).

Taking into account the necessary comprehensiveness of the training and the broad range of topics it is therefore according the ENTMA (2005) clear that such training programs should be at least 4 – 6 days (or more if necessary) in length with a minimum of 4 days (24 hours). And according to ENTMA (2005), supported by Tucker (2004) and Colton (2004) it is also clear that if the training is less than 4 days, physical restraints techniques should not be taught at all, and also never restricted to only breakaway techniques. It is clear that programs (trainings) can only be effective if they cover a range of topics, rather than focusing primarily or only on behavioural interventions such as proper techniques for physical holds or restraints.

Next to this basic training for direct service staff working in the field, there is also need to focus on the training of at least two other major staff groups (Paterson and Leadbetter, 2004):

- “Management: Managers’ requirements tend to differ from direct service workers and the more senior they are the less likely they may be to experience violence. Their primary needs therefore are to understand their legal obligations for employee and service user safety and to develop an awareness of effective organizational approaches to managing of aggression, violence and sexual harassment. However, this does not mean that they may not require basic personal safety training.

- Support and administration staff: Support and administrative staff’s role may vary in terms of the degree of contact they have with service users. They may have no contact, limited direct service user contact or substantial contact. Their need for training will therefore vary”.

Training trainers

According to the Mental Health Policy Implementation Guide regarding the development of positive practice to support the safe and therapeutic management of aggression and violence in mental health inpatient settings of the National Institute for Mental Health in England (NIMHE, 2004) it is essential that education and training in the safe and therapeutic management of aggression and violence is developed and delivered by trainers who have expertise and practice credibility. The trainers within the ENTMA (2005) do recommend that such training courses for trainers should be preferably an integral part of the educational system for health care professionals, and also preferably linked with an university. In all of the European countries however there are no formal regulations or systematic evidence regarding the background, qualifications, status and practice credibility of trainers of trainers. And therefore the NIMHE (2004) have stated some positive practice standards in the absence of a mandatory accreditation and regulation scheme, and will be developing proposals for a national accreditation scheme for both trainers as well for education and training. It is recommended by the ENTMA (2005) that such developments should be set up in all European countries, and that the preparation of trainers should comprise an absolute minimum of 300 – 500 study hours, of which about 1/3 would be for face to face contact, 1/3 for (supervised) practice and 1/3 for self-study and carrying out some work towards a thesis as an written end product of the study.

Therefore, it is recommended (ENTMA 2005) to take initiative to set up such training programs for trainers in the recognition, prevention, post-incident care and therapeutic management of aggression, violent behaviour and sexual harassment in health care, and to develop mandatory accreditation and regulation schemes for those programs. According to the NIMHE guidelines (2004) appropriate programs should thereby develop standards for training and practice, assess competencies of trainers, and demonstrate regular review and evaluation. It is further stating that all trainers:

- “must attend an annual update / refresher course which incorporates a reassessment of the trainer’s competencies to practice;
- must have extensive knowledge and understanding of the challenges and implications for clinical practice in health service provision, which can be demonstrated via a portfolio of evidence or a relevant professional qualification (health / social care / teaching);
- must have a recognised teaching or assessment qualification;

- remain professionally accountable for what they teach and its influence on practice, and must promote the highest standards of professionalism to those whom they teach;
- need to remain clinically up-to-date and clinically credible;
- must maintain a portfolio of evidence to support continuous professional development and life long learning, and
- Internal trainer's portfolios should be reviewed annually by their employing organisation.

Conclusion

In relation to the actual situation in all European countries a proactive attitude towards an integrated approach in the management of aggression, violent behaviour and sexual harassment in health care is needed. This should involve all stakeholders and reflect in public policies. Also, such an approach should cover all preventive levels. One component of such an approach should be compulsory staff training based on acknowledged standards regarding contents, duration and methods, tailored to the needs of the participants and their working situation and delivered by trainers who are trained themselves according to agreed and transparent standards.

It is one task to be tackled with the coming years to bring forward such a process within European health care and (psychiatric) nurses should be one driving force within this process.

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7 - Nurse responsibilities in a multidisciplinary context

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The Dutch situation

In the Netherlands topics on responsibilities in a multidisciplinary context play a major role due to developments in patient care, nursing associations, legislation, education and nurse positions.

When patient care shifted in the 90's from clinic centered care to community centred care nurses accompanied patients from inward care to more outcentered care. Almost 40 to 50 % of the nurses who worked on wards received extensive education to become accustomed to the situation where nurses stay in the frontline alone, not being backed up by a team nearby. Responsibility became in the first place something you have to bear alone and decisions had to be made on the spot for example how to handle in a crisis or what to do when a patient doesn't hold onto the drugs treatment program. Another important question was how to organize the other caretakers and psychiatrists and ask them for information or help when needed.

Also the discussion on early interventions started to play a more prominent role especially with research on the care of schizophrenic patients. The development of this illness showed a predictable line of events which could be written down in an early intervention plan customised for a patient. It enabled nurses to see signs of exacerbation early and act upon those signs instantly to prevent the patient for further damage. It made it also easier to work on the patients rehabilitation plan.

Care has become more outcome-centered and goals and effects must be formulated in advance as to work more efficiently and effectively towards recovery from illness or to become more capable to handle your problems as a patient. In this respect clinical pathways, guidelines based on evidence are developed and implemented in daily nursing care. But because of daily working floor concerns and prioritizing in daily care there seemed to occur problems in implementing those guidelines. Working evidence based should become more of one's own repertoire in caring for patients.

One aspect of the level of organized nurses on a national scale is the fragmentation of nurse associations which made it difficult to stand together as one in negotiation with politics, influencing education programs and also communicate with other associations of health care professionals on topics as working together as a multidisciplinary team and sharing responsibilities or sharpen the depiction of responsibilities characteristic of a health care domain. For example fragmentation consisted of five different nursing

associations on psychiatric nursing such as the national association on psychiatric nursing, one on sociotherapeutic nursing, one on consultation, one on staff and one on social psychiatric nurses. The same situation existed for the other nurses in general health care. Just from 1996 the AVVV started to end this fragmentation. Also in 2000 the fragmentation in psychiatry ended when the Federation of nurses in mental health care started and just in 2006 the V&VN was born: Nurses and caregivers Netherlands. It was the first time in history that nurses could become an individual member to one central association by paying their contribution directly to the V&VN and have influence directly on health care issues.

Legislation: An advisory board of Ministry of Health called CONO which stands for an organisation to coordinate post graduate education programs in mental health care, thus for all professionals in this field, advises the ministry on these matters. CONO distinguishes three major domains:

- Psychiatric nursing
- Psychiatry
- Psychology

Also three levels between each profession are distinguished and recognized in nurse positions; a basic level, a level of specialists and in between a level of differentiation. In the near future the basic and specialist level are formally existing levels as they are both formally regulated by law. The level in between can be more flexible organized in order to meet specific demands of regional needs from patients and employers.

In those three domains education programs are organized the same way and with a shared vision on becoming a specialist in a health care profession. They last a minimum of three years fulltime education where tasks and responsibilities are learned mostly in a hospital under guidance of a master in a specific domain and of course coming from your own profession.

Also because of developments in patients needs and shortage of psychiatrist or specialist in medicine on a national level, discussions started to shift tasks from one domain, i.e. of psychiatry, to the other, psychiatric nursing. For patients it mostly means a normal and understandable way of thinking because most of the care is already provided by nurses and they are satisfied with it. So the theme of changing borders should not be such a hot issue.

The domain of the psychiatric nurse:

One important issues remains is what is still considered as psychiatric nursing. For psychiatric nurses it is necessary to remain to their basics and these are; to treat, to guide the patient on disabilities and handicaps in a exceptional context, to let them live as normal as possible and to overcome hindrance of disabilities and handicaps by creating the necessary conditions. A nurse helps a patient to see himself as a person in the community and not as a patient in community. Every new task should be seen from this perspective.

Also from that perspective it is possible for nurse specialist to take full responsibility for treatment, prescribing drugs and use techniques to influence behaviour, as many practicing nurses already do. When the nurse specialist is able and licensed to be responsible by law there is no formal objection to act as such. In the early days you could only formally act in these issues under responsibility of a psychiatrist.

Nurse diagnoses:

What then should be added to the domain of psychiatric nursing? Nurse should use the international standards of DSM and ICF and formulate diagnoses according to these classification. In Holland it is also the way to finance care. The nurse specialist then delivers a treatment plan, executes the treatment or orders others to do certain tasks or ask for consultation on certain matters, ends treatment, sends through patients to other professions or consultates other professionals.

Prescribing drugs:

The nurse specialist now is licensed by law to prescribe. It should concern drugs which influence the way nurse work with patients to overcome disabilities and handicaps or to let disabilities and handicaps have a less prominent role in daily living. But the expectation is that it should concern protocolized drugs programs, stabilized situation without the need of rapid changes in drugs treatment etc. Mostly it concerns situations where psychiatric diagnoses don't change anymore and treatment choices are few according to standard drug protocols.

Techniques to influence behaviour

More in line of standard protocols is the use of techniques to influence behaviour often lend from psychotherapists. It concerns the use of techniques to modify behaviour (CBT, DGT, motivational interaction therapy), and for example techniques concerning prevention of automutilation and enforcement of normal behaviour.

Ready to take full responsibility:

You could say that nurses are ready to take over most of care and probably cure, but that is of course not evidence based but practice based. We will always need each other but from the patients perspective there is better patient care because nursing care is better adjusted to their needs and therefore leads to better care (and cure?).

As shall be recognized this is a short summary of the workshop and in the workshop discussion following the presentation the discussion will take place on matters mentioned above and other related issues. The input and perspective of other countries will enrich the discussion.

8 - The History of psychiatric nursing – a vivid speciality within the mental health setting.

By Gunel Svedberg and Cecile aan de Stegge

The history of psychiatric nurses and psychiatric nursing in the diverse European countries varies, although of course there are also some major similarities. What does this diversity on the national level mean for the future of HORATIO? How much tolerance is there within the collective of psychiatric nurses for awareness and appreciation of the national differences in training systems, caregiving ideologies and professional identity? Does HORATIO see itself as a European meeting point for psychiatric nurses; a platform where the pro's and con's of the different traditions can be discussed, with the effect that these can serve as a source of inspiration, reflection and knowledge exchange? This we consider an important question.

International comparative history

The existence of different lines of development in the history of psychiatric healthcare has been brought to light through the rapidly growing body of research around the history of psychiatric nursing and the resulting opportunity to conduct comparative international studies. With the publication of historical research it has become increasingly clear that major areas have yet to be explored and, not least, that many perspectives remain to be elucidated.

The older historical literature is frequently written in a style that glorifies the (female) nurse. Since the 1980's, however, this glorification is replaced by a more critical historical analysis of the rise, the function and the position of nursing. However, a lot of this recent national research is written in a language that can be understood by few outside the national language area, which makes successful international comparisons more difficult. Yet, the history of psychiatric nursing increasingly emerges as a speciality within psychiatric nursing training and research. There is a growing demand for historiography with a critical understanding of the shifting and complicated contexts within which nursing was practiced and developed. As with society in general, we see a growing interest in good historical literature of a popular scientific nature.

A range of unexplored issues

Can we explore more of the history of psychiatric nursing by looking at critical and under-examined areas in its past, such as:

- The borders, boundaries and political context of psychiatric nursing and healthcare history
- Speciality areas and regions of practice within and between countries

- Power struggles and competition between different categories of staff in the psychiatric context
- Relations between psychiatric nurses and nurses from other branches of nursing
- Professionalisation and professional strategies of psychiatric nurses
- Influence of local, regional and global contexts on the practice of psychiatric nursing
- Impact of political regimes on psychiatric healthcare practice and administration
- Influence and participation of nurses in mental health politics and practice
- Tensions relating to claims of knowledge and skills
- Professional identity of psychiatric nurses
- Professional image of psychiatric nurses
- Professional organisations created by psychiatric nurses
- Relations between psychiatric nurses and the labour movement
- Relations between psychiatric nurses and the early women's rights movement
- Religious influences on psychiatric nursing
- Gender perspective in psychiatric nursing
- Crossroads in the evolution of psychiatric nursing
- Psychiatric education at the academic level
- Early literature on psychiatric nursing
- The first books written by psychiatric nurses
- Evidence based psychiatric nursing practice
- Critical examination of the extent and focus of scientific dissertations written by psychiatric nurses.

Networks and Organisations

There are various more or less formalised networks as well as institutionalised organisations working for the development of historical knowledge and dissemination of information related to the history of psychiatric nursing.

The EUROPEAN PSYCHIATRIC NURSING HISTORY GROUP is a network of researchers in the area of the history of psychiatric care. The network was founded on the initiative of Cecile aan de Stegge and its first meeting was held in 2003 at the National Museum for the History of Nursing in Zetten, Holland. The following year Cecile invited us again, but this second meeting was funded by the Brothers of Charity from Belgium and held at Vormingscentrum Guislain in Gent. Last year the meeting was organized by Gunnel Svedberg and Lilian Pohlkamp Turac and took place at the Department of Nursing, Karolinska Institute, Stockholm, Sweden. For June 2007 Ann Sheridan invited us to come together in Dublin, Ireland.

At present the network has members in 9 Western European countries: Belgium, Germany, Great Britain, Finland, Ireland, Norway, Sweden, Switzerland, The Netherlands. Contacts with researchers in countries such as Austria, Scotland and Italy exist. We hope that researchers in the field will join us and that all European countries will be represented

in the future. In conjunction with the meetings, visits were arranged to places of interest for psychiatric nursing, such as old asylums and museums related to nursing history or psychiatric history. It has also been possible to visit clinical settings. The goal of the EUROPEAN PSYCHIATRIC NURSING HISTORY GROUP is to give researchers in psychiatric nursing history the opportunity to share and discuss projects, create strategies for cooperation in projects and promote the development of our network.

The EUROPEAN ASSOCIATION FOR THE HISTORY OF PSYCHIATRY (EAHP) was founded on the initiative of Dutch and English scholars. The first conference was held in 's-Hertogenbosch, Holland in 1990. Triennial conferences were held in London 1993, Munich 1996, Zurich 1999, Madrid 2002 with the final conference of EAHP taking place in Paris in 2005. The possibility of some form of continuation is uncertain.

HOP-IN HISTORY OF PSYCHIATRY – INTERNATIONAL is a mailing list open to subscribers. Join the forum by sending an e-mail to listingadm@gmail.com

Raising your interest: a survey in Europe in the 1930s

In the early 1930s, leading nurses in The Northern Nurses' Federation (NNF) attempted to conduct an international survey of nurses' work in psychiatric care.

A brief and interactive presentation about this survey will be given at the HORATIO Congress in Arnhem. We hope this presentation will stimulate the interest of the HORATIO-public for a lively tradition of comparative history in psychiatric nursing.

January 2007,
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9 - Psychiatric Nursing & Research – A Finnish example of how this is practised on small and large scales and input towards international interest'

By Professor Maritta Välimäki, University of Turku, Department of Nursing Science, FINLAND

Background

The structure of psychiatric health care system in many countries has undergone dramatic changes. Especially in the 1990's the process was enhanced as a result of pressures from an economic recession and ideological issues in North America, Europe and in many Asian countries.

Today, mental health problems are a national concern in Finland. More than 27% of adult Europeans are estimated to experience at least one form of mental ill health during any one year (Wittchen & Jacobi 2005). Mental ill health costs the EU an estimated 3%-4% of GDP (European Commission 2005). Depression is expected to be ranked second among the sicknesses having a negative influence on people's lives by 2020 (WHO 2002). About 20-25 % of Finnish adults suffer from one kind of diagnosed mental health problem in a year (Aromaa & Koskinen 2002). In 2005, the most common singular diagnosis for hospitalized patients was schizophrenia followed by affective disorders including depression (Stakes 2006).

Although the amount of mental health problems has not increased in recent years, their nature affects other problems in a society (Aromaa & Koskinen 2002). The prevalence of schizophrenia, for example, is about 1-1.5%, but it accounts for about 30% of the total cost of mental disorders (Pirkola & Sohlman 2005). Globally, schizophrenia is a high cost illness (Knapp 1997) due to the long-term nature of care and expensive medications, the cost of which has risen 21% during the last 5 years (Ministry of Social Affairs and Health 2005).

At the same time, the work environment for psychiatric nurses has become more hectic. Patients' health problems are more complicated and they are entangled with other problems in a society. Mental symptoms, drug abuse, social exclusion and burden at the workplace occur in society. Demands for efficiency and economy, the development of health technology and needs for evidence-based practices have created a new role for psychiatric nurses. The increased demands in mental health care services have caused stress and pressures among health care personnel (Xianiyu & Lambert 2006). It has

been shown that employees in mental health care and the drug abuse sector find their work most mentally demanding compared to other areas (Ministry of Social Affairs and Health 2001).

In 2003, the Guidelines of the new Target and Action Plan were published by the Ministry of Social Affairs and Health (2003). The plan gives workplaces recommendations to develop nursing practice on the basis of the present needs and future challenges. Issues that are highlighted in the practical development are promotion of the health and self-care of clients and patients, psychosocial support, enhanced roles of nursing professionals and responding to the service needs of families with children and older person. The management, education and research of nursing are dealt with from the point of view of support for nursing practice. The key objectives are to develop client-oriented services, multiprofessional co-operation, evidence-based activities and to improve the monitoring of the quality, effectiveness and costs of activities. Further, the competencies of nursing professionals are developed by systematic and long-term continuing professional education. (Ministry of Social Affairs and Health 2003.)

All health care districts, public health care centres, and elderly care units in Finland have a responsibility to implement the Target and Action Plan as part of their daily practices. To do this in coherent way organisations have to select the specific focus and goals to be developed as follows: publicise the Target and Action Plan among their health care personnel and networks; use the Target and Action Plan in recruitment process of new employees, their initiation into the job, on-the-job training, and in other vocational continuing education; and start new development projects as part of implementation process of the Target and Action Plan. (Ministry of Social Affairs and Health 2003.)

Since 2004, steps have been taken toward evidence-based practice in different medical specialities and organization. A number of working groups have also been developed to support evidence-practice. Education with different learning methods related to evidence based practice has also been organized. Further, a variety of new projects have been developed in clinical practice.

Despite extensive evidence and agreement on effective mental health practices for persons with severe mental illness, research shows that routine mental health programmes do not provide evidence-based practices to the great majority of their clients with these illnesses (Drake et al. 2001). According to Lehman and his colleagues (2004), there are several reasons for the existing gap. First, the knowledge and skills of practitioners, as well as of state mental health authorities, lag substantially behind the evidence. Hence, practitioners and service systems often continue to provide some interventions that either are unsupported by evidence or have been shown to be ineffective. Second, policies related to the expenditure of public mental health often do not hold practitioners or public mental health authorities accountable to provide evidence-based practices and to eliminate practices that do not help people. And third, public funding for mental

health services in various instances is often inadequate, or is constrained in such ways as to make support for certain evidence-based practices difficult, or is poorly invested for other reasons.

A review of the literature also suggests two main barriers to dissemination to staff: 1) individual service providers lack the knowledge and skills to assimilate these practices and 2) organisational dynamics undermine staffs' ability to implement and maintain innovative approaches. Given these barriers, three strategies to foster dissemination may be useful: 1) packaging evidence-based practices so interventions are more user-friendly 2) educating providers about relevant knowledge and skills, and 3) addressing organisational dynamics that facilitate implementation. Research on dissemination is less developed than the clinical and services research that has led to evidence-based practices. There is also a need for continued work on dissemination if evidence-based practices are to be used in the real-world. (Corrigan et al. 2003.)

What could be done to support nursing staff's abilities and motivation to work according to evidence-based practices in psychiatric services? In this paper I will describe a practical example from Finland in which an attempt was made to empower psychiatric nurses so that they can benefit from the idea of evidence-based practice.

Empowering psychiatric nurses to work based on evidence-based practice

In order to empower psychiatric nurses to work based on the idea of evidence based practice, we should be clear as to the goals of our action. We have to be aware, first, whether our aim is to produce new evidence-based knowledge, such as research results from clinical trials or systematic reviews. This ambitious goal requires, however, a strong academic research education and highly skilled research staff with a clear understanding of research methods.

Second, we may want to find high quality outcomes of clinical trials, systematic reviews or research results. This mean that we have to know how to search for high quality research results using scientific databases. We also need access to these databases, and the appropriate equipment (for example, computers, libraries, support systems etc.), and of course, we must know how to use them.

Third, we may want to learn how to read the research results related to our topic of interest. Having a huge amount of knowledge based on research is not alone sufficient to ensure that the knowldge will be implemented in practice. We have to have the capacities to critically read scientific text, evaluate its quality and relevance, and then to assess its benefits in clinical practice.

And fourth, we may want to implement the results in clinical practice. This means that we are aware of the basic methods related to the implementation process of evidence-

based knowledge in clinical practice.

All these goals are different and they need different capacities, knowledge, roles and actions related to evidence-based practice. If we are not aware of these different focuses, it may be an impossible for individual nurses to assimilate the idea of evidence-based practice.

In my example from Finland, I will describe practical experiences of how these different roles were realized in a scientific study where the aim was to develop and implement information technology in clinical practice in psychiatric nursing care and to evaluate its effectiveness from the perspective of patients, organisations, and staff.

Discussion

Confronting the demands of evidence-based practice requires both engaged and analytic ways of knowing, psychiatric nurses' abilities to generate new and innovative treatment methods besides those used and tested methods using evidence-based knowledge. At the same time, the personnel needs practical knowledge and they should be skilled in working with people experiencing mental distress and also with their family members.

Our profession needs theoretically and practically skilled personnel who are motivated to work in this demanding area. As rapid and wide-ranging changes occur in social and health care system across Europe, the psychiatric nursing profession needs a new and comprehensive vision for the role of psychiatric nurses and a commitment to patients and co-workers. Therefore, our profession should be able to identify and analyse problems using research skills.

Evidence-based practices offer significant promise for people with serious mental illness, although in practice this potential may not be realised. The effort and ingenuity put into crafting psychiatric services is also needed to disseminate and implement evidence-based approaches. Changing the mental health system, and the providers who staff it, requires interventions at several levels. As Corrigan et al. (2003) have stated, we must work as hard at implementing evidence-based practices as we do at generating good quality research.

I can summarise that in the field of psychiatric nursing, we should support each other to seek, analyse, evaluate and implement evidence-based knowledge in clinical practice together with other partners.

Intended learning outcomes:

- 1 To explain the rationale for evidence-based practice in psychiatric nursing.
- 2 To identify different angles of approach for evidence-based practice in psychiatric nursing.
- 3 To be aware of an example how research is practised in collaborative partnership with nurses on the national and international level.

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10 - “From experience to evidence and from evidence to practice” – the results of three years regional collaboration of three nations: Germany – Switzerland – Austria: An example of international cooperation

By Michael Schulz

Introduction

Psychiatric and mental health nursing developed in different ways all over the world in spite of comparable mental health problems. If we consider for example the development of mental health nursing in the context of deinstitutionalisation of psychiatry in several countries we can see a completely different situation between Germany and England: Great Britain already started developing community psychiatric nursing in 1954. In Germany, however, similar developments were in comparison less strong. Although community psychiatric and mental health nurses (CPN) play an important role in health care for mentally ill people and although the structure of community nursing seems to be effective in Germany the development in this field of nursing did not occur without ruptures and excessive demands (Schulz, Behrens 2005).

Another example is the difference between European educational systems: Accordingly, in the UK and other countries, nurse preparation for practice has moved away from the hospital-based apprenticeship system into institutions of higher education in order to foster research-based care informed by a more critical and analytical approach to nursing (Watkins, 2000). In the German speaking countries the tradition of nursing education at universities is comparatively young. In Germany this development started about fifteen years ago and today more than forty different courses of studies exist, mostly based at University of Applied Sciences and focussing on nursing management, nursing research or nursing pedagogy. However, basic training still takes place at hospital based schools of nursing.

Over a long period of time mental health nursing in the German speaking countries was isolated from professional discussions and scientific results emerging in professional scientific journals in the English speaking world. As nurses and their teachers were generally not expected to speak and read English the major barrier was mastery of the English language.

Due to factors like demographic change, the increase of chronic illness, and socio-economic problems and in light of the Bologna process of the European Union the

German speaking countries have started to train their nurses at university level. Even if there is no specific university based training course for mental health nursing in these three countries, practitioners and researchers have developed other channels to discuss issues of mental health nursing over frontiers and in a scientific way. The “Dreiländerkongresse” – “Three Countries Conferences” is an example of such an endeavour instigated by mental health experts from Switzerland (Chris Abderhalden and Ian Needham), from Austria (Harald Stefan) and from Germany (Rüdiger Bauer, Susanne Schoppmann and Michael Schulz). The conference presentations were published in the form of proceedings and made available to all mental health nurses.

Thematical focus of the conferences

To date, three conferences under the label of “Dreiländer Kongresse” have been held with each conference devoted to a special theme. The first conference - organised by Rüdiger Bauer, Michael Schulz and Petra Krause - took place in Bielefeld in November 2004 on the theme of “Interventions in mental health nursing” (Krause, Bauer, Schulz, 2004). At this first conference experts on the subject presented by invitation only and there was no call for abstracts. Prof Kevin Gournay from the Institute of Psychiatry in London delivered a paper on mental health nursing research in the UK and his colleague Dr. Richard Gray from the same institution presented on the theme of Adherence Therapy as an intervention for mental health nurses. Prof. Jean Watson (USA) spoke on Caring and Francis Biley from Cardiff presented his ideas on mental health nursing. Additionally important professionals from Germany and Switzerland also offered inputs. The Bielefeld conference was the first occasion with such a huge input from overseas which gave an important impulse to further professional and scientific discussions on mental health nursing.

The second conference took place in Bern in 2005 and was organized by Christoph Abderhalden and Ian Needham. It focused on different settings and populations who receive mental health care and was the first conference in the series with a call for Abstracts. One major highlight of this conference was Ber Oomen’s presentation of HORATIO and mental health nursing in Europe (Oomen, 2005). The response to the call for abstracts showed, that there are many people in the community of mental health nurses in these three countries, who are able to conduct good research and are capable of presenting their results in a good manner. The Bern conference also demonstrated that the community has a lot to learn regarding the discussion of professional issues.

The third conference took place in Vienna in 2006 and was organised by Harald Stefan and Nico Oud (Needham et al, 2006). The conference theme was “nursing and knowledge, mental health nursing as practice and research”. Stephen Tilly delivered an important speech on the body of knowledge in mental health nursing (Tilly, 2006). His presentation included recent discussions on the fundamentals of mental health nursing e.g. the discussions between Kevin Gournay and Phil Barker. The fact that such issues have not been addressed in the German speaking countries may be indicative of a lack of professional culture in this region. The response to the call for abstracts was

overwhelming with over one hundred submissions. Also the quality of these publications improved in comparison to the previous year even if some of the papers did not comply to academic standards.

Some benefits of the “Three Countries Conference”

In the last three years the number of conference participants has doubled from 250 in Bielefeld in to 500 in Vienna. This development may point to the fact that such an institution was missing prior to the instigation of the “Three Countries Conference”. Furthermore the recent participation of speakers from outside the German speaking region may indicate that thinking within the mental health nursing community is becoming more European and will be further promoted by HORATIO.

Experience with the congress demonstrates that the bringing together of participants from different countries allows participants to identify common areas of research and similarities in practical projects. Especially at the Vienna conference it became clear that different mental health professionals had been working independently of and unknown to each other on the same topics. Thus, one great advantage is the possibility of collaboration and the use of synergies across settings and countries.

Another important effect of the conference is the added value of the learning effect on presenters. The conference organisation was in close contact with the presenters and offered hints and tips on how to ameliorate abstracts and the texts for publication. Anecdotal feedbacks from some presenters imply that they had advanced their knowledge by presenting at the conference. Thus, a subordinate aim of the conference is to help presenters further their writing and presentation skills.

The “Three Countries Conference” endeavours to address scientific and practical issues in mental health nursing and the quality of the contributions shows a great amount of variation. This is the price paid for the conscious decision to include the voices of important actors in the domain. A new development in the Vienna congress was the inclusion of a mental health user (Prins, 2006) and other professionals associated with mental health nursing (e.g. Gabriel, 2006). In spite of the focus on mental health nursing it is our conviction that we can and must learn from the ideas of important persons, especially mental health users.

Conclusion

The Dreiländer Conference is a successful model to foster contacts between mental health nurses in the German speaking countries and to further professional and scientific discussions. The conference is a platform for researchers and practitioners in the field of mental health nursing and offers an opportunity for experienced and less-experienced presenters. On important “side effect” of the conference is the opportunity

for participants to network, to exchange ideas, and to establish an interface for practical collaboration.

Preview

The 4th Dreiländer Conference in 2007 will return to its starting point in Bielefeld and will take place on the 18th and 19th October. The main theme this year will be on qualification and responsibility. Everyone is invited to participate even if he or she is not based in these three countries. For further information please consult: <http://www.pflege-in-der-psychiatrie.de/>

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11 - Learning Material for Mental Health Care Students and Professionals:

ADMISSIONS – English & Psychiatric Care

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The purpose of this paper is to present the digital teaching package Admissions (CD-ROM and Web version) about family-oriented care of acute psychosis.

The main topics of this learning program are (1) What is psychosis?; (2) Psychiatric care; (3) Co-operation with the patient's family; (4) The role of a psychiatric nurse; (5) Drug treatment; (6) Compulsory treatment and (7) Cultural differences.

This learning material has four purposes. Firstly, it can be used in the professional study of psychiatry and mental health nursing at medical and nursing schools. Secondly, it is suitable for independent distance learning by social, medical and nursing staff. Thirdly, this learning package is classified as ESP-material (English for Special Purposes). This material is particularly suitable for foreign speakers in English-speaking regions and for student nurses in countries like Finland.

Finally, this CD ROM program can be used in psycho-educational training by all service-user groups. The structure of the program has been made so clear that it is easy to analyze the background of psychiatric disorders. This program enables the patient and his/her relatives to understand the premises of psychiatric care.

This CD- project is an example of international co-operation, which can provide a variety of results and develop the teaching practices of universities in both participating countries. The teaching package consists of interviews with eight experts in nursing, medicine and family care. The contributors are from Finland, Turku University of Applied Sciences and from the U.K., University of Newcastle. The various possibilities for co-operation across disciplines have been emphasized, and experts talk about practices in the care of psychotic patients within their own culture.

12 - TIPS - The Early Treatment and Intervention In Psychosis study.

Results from the early detection work.

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Introduction and background

The TIPS study aims at studying the effects of a program for early intervention in first episode psychosis (FEP), and its implications for the period of untreated psychosis. It focuses on possible preventive strategies, the pathways to care, the Duration of Untreated Psychosis (DUP) and the course of the disease after treatment have started. Even if the treatment of schizophrenia within the last decades has made promising progress, it still is a serious mental disorder, and still with 1/3 of the diagnosed patients suffering with a chronic course even after comprehensive treatment efforts (1). Primary and secondary prevention of the schizophrenia spectrum disorders are topics within the field of research that still are not explored in all their aspects. Studies has shown that the early course of illness is the most active period of the disease, where most of the disabling consequences occur (2). The aim of a primary preventive strategy is to eliminate potential etiological risk factors or to strengthen a person's resilience to the morbid risk. The main objectives of early intervention are to prevent or delay the onset of manifest psychosis, or to reduce the severity of the illness or to try to minimise the social consequences that are involved with the disorder. For the individual involved, their families and the society the benefit of these efforts would potentially be substantial. The early detection of at-risk persons, or persons with recently developed psychotic symptoms requires that these persons are aware of the relevant symptoms and how to seek help.

Reduction of Duration of Untreated Psychosis (DUP) has emerged as an important aspect of programmes for early intervention of psychosis (3). Two recent meta-analyses (4;5) concluded that long DUP appears to be an important risk factor for poorer outcome, such as longer time to remission, fewer remissions, more psychotic relapse.

One (5) indicates that DUP in most countries is long with medians ranging from 4 weeks to 50 weeks. The first onset of psychosis is of often late in adolescence and potentially may cause major impairments. The World Health Organisation (WHO) ranked active psychosis as the third most disabling condition, higher than both blindness and paraplegia (6). Schizophrenia alone is the single most costly disorders between the psychiatric disorders as well as for the larger somatic disorders like cancer and vascular diseases (7-9). Although the rate of new cases (incidence) worldwide is low (1 per 100 000/ per year) (10), the prevalence is high due to the more chronic course of the disorder.

In some countries early intervention now is a politically supported strategy. In the UK under the NHS Plan, 50 early intervention teams have been established at a cost of £70 million pounds, so that all young people (between 14 and 35 years) who experience a first episode of psychosis are offered early treatment.

In order to achieve a comprehensive early intervention program two aspects must be considered. First a system for early recognition of potential risk factors and psychotic symptoms must be implemented. This system must address mental-health awareness, and the stigma connected with schizophrenia and other mental disorders. Further on a program with an aim to have a secondary prevention profile must address the early treatment and course of FEP/schizophrenia.

The TIPS study

The TIPS study (Early identification and treatment of psychosis) is a prospective longitudinal study of first-onset psychosis from 4 Scandinavian health care sectors with equivalent first-episode treatment programs, designed to investigate the effect of the timing of treatment in first-episode psychosis. The two health care sectors in Rogaland county, Norway (370,000 inhabitants), were the experimental sector and developed a system for Early Detection (ED), aimed at reducing DUP. Two other sectors (Ullevaal, Norway (190,000 inhabitants), and Roskilde, Denmark (100,000 inhabitants)) were the comparison sectors (No-ED) and relied on existing referral systems for first-episode psychosis.

The experimental sector was characterised by a comprehensive education and detection system designed to enhance the knowledge about early signs of psychosis within the general public, schools and among health professionals. The active period of inclusion was 1997-2000. First episode, non-affective psychosis patients were treated with the same drug and psychosocial treatment protocol across all three sites, and all patients were assessed with a common set of rating instruments at baseline, 3 months, 1, 2, and 5 years. (For further details see Melle et al (11)).

The Early Detection Programme

An Early Detection program was developed and implemented designed to bring patient with first episode psychosis into treatment in an early stage. The program in Rogaland County was implemented and carried out between January 1, 1997 and December 31, 2000. It was partly based upon the model developed by McGorry et al. (12), and had two major components. The first was an intensive education campaign about the signs of early. The second component was Early Detection teams (labelled here as the Detection Teams or DTs) located within the county psychiatric system in order to facilitate case finding, evaluation and triage.

The aim of the educational campaigns was to enhance the attitudes to and knowledge about psychiatric disorders in general, to inform about the early signs of first onset psychosis and the need of early help for such disorders, and to inform of the existence of low threshold detection teams. Multifaceted campaigns were aimed at the general population, schools (teachers and pupils) and health professionals. The use of media included ads in local newspapers, brochures, posters and commercials at the cinema and on local TV and radio stations. A web page was designed primarily as service to other professionals and as a source of information about psychosis and the project. In the TIPS project period, a total of 26 whole page newspaper ads were provided. In addition, 80% (n=300) of the county's General Practitioners underwent a 4 hours educational programme about the diagnostics of early psychosis. In the autumn of 1997 one started a school campaign, its objective being to provide knowledge about psychosis to teachers in the high schools. This was accomplished primarily through courses and lectures supported with advertisements. The county's 45 high schools (approx. 1000 teachers) were all visited on an annual basis and offered a special educational programme of lectures and videos. Special newspaper ads aimed at teachers and pupils were provided. Social workers, local community psychiatric nurses were all offered a yearly seminar, either in their own locations or at the hospital with a focus on early intervention and information about the project status. More details about the Early Detection programme has been described elsewhere (Johannessen et. al .(13)).

TIPS early Detection Teams (DT)

Easy access to clinical attention and care is a prerequisite for doing early intervention work. A low threshold for referrals encourages more referrals and more sources of referral, including self-referral. An easy-access system has no meaning if unaccompanied by guaranteed rapid and comprehensive provision of treatment. In our case, emphasis were put on integrating the early detection work and its structures into the ordinary health service systems, and not on establishing a parallel independent system which would create discontinuity and disable the service.

The low threshold DTs consisted of psychiatrists, psychologists, psychiatric nurses and social workers. They were on call from 8 am till 4 pm., Monday to Friday. Outside these hours there was an answering machine. On weekends the doctor on call at the psychiatric hospital had the detection functioning, assessing emergency cases.

When a potential fist episode call came, the DT did an initial assessment over the telephone, and the first decision was whether or not a psychiatric problem existed. If it were a possible psychiatric case, the DT would meet the patient and/or the referring persons wherever it was convenient, at home, in a GP's office, at school, or at the DT's office. The teams were highly mobile and work with an active outreach attitude. Easy access were accomplished through a "24-hour guarantee of assessment", meaning that the patient would be met by the DT within 24 hours after first contact, except for non-emergency cases on weekends. In most cases the assessment were carried out within a few hours.

Upon receipt of a referral or initial phone contact, the standardised screening procedures were followed. A telephone triage interview were first conducted to determine; 1) existence of any potential psychiatric illness, 2) description of clinical problem, 3) treatment status, 4) presence of DSM-III-R prodromal symptoms of schizophrenia, 5) screen for psychotic symptoms, 6) screen for drug use, 7) determination of deterioration in functioning, and 8) whether the person has a first-degree relative with a severe mental illness. If a potential prodromal or psychotic episode was suspected, a face-to-face Positive and Negative Syndrome Scale (PANSS) (14) interview were offered by the detection team member within 24 hours. All patients considered to have a possible diagnosis of a non-affective, first-episode psychosis then received a scientifically based evaluation by a specialised assessment team. The Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID-I/P) (15) was used for diagnostic purposes. Patients meeting the inclusion criteria entered the study and receive the standard treatment protocol, after giving informed consent. Patients who were not eligible receive information on how and where to find adequate help. Non-psychotic disorders patients were referred to the ordinary outpatient units.

Subjects

Inclusion criteria: Living in the catchment area of one of the four health care areas; 18- 65 years of age; meeting the DSM-IV criteria of schizophrenia, schizophreniform disorder, schizoaffective disorder (narrow schizophrenia spectrum disorders) or brief psychotic episode, delusional disorder, affective psychosis with mood incongruent delusions, psychotic disorder NOS; actively psychotic, PANSS score of four or more on P1 (delusions), P3 (hallucinations), P5 (grandiose thinking), P6 (suspiciousness) and A9 (unusual thought content); not previously adequately treated; no neurological or endocrine disorders with relationship to the psychosis; no contraindications to antipsychotic medication; understands/speaks one of the Scandinavian languages; IQ over 70; willing and able to give informed consent.

874 persons with psychosis-like symptoms seeking help from the psychiatric services were screened by the study's assessment teams (131/100 000), 378 met the study inclusion criteria, 281 patients gave informed consent, 140 from the No-ED and 141 from the ED sector (11) .

Measures

Assessment teams consisting of clinically experienced and trained research personnel made all evaluations. The structured clinical interview for the DSM-IV (SCID) was used for diagnostic purposes; symptom levels were measured by the Positive and Negative Syndrome Scale Score (PANSS). The duration of untreated psychosis (DUP) was measured as the time from onset of psychosis (first week with symptoms corresponding to a PANSS score of four or more on P1, P3, P5, P6 or A9) until start of adequate treatment. Suicidal behaviour was assessed by asking the patients during the assessment interview whether they had experienced any suicidal thoughts, plans or attempts at the point of index contact, and if they had had any suicidal thoughts, plans or attempts in the period before index contact. Severe suicidality was defined as plans and attempts, based on the high level of association between plans and later attempts (16).

Results

In the ED area DUP was reduced by 1,5 years in mean, to 0,5 years (median 5 weeks), compared to the situation before the project (17) . DUP was found to be significantly lower in the ED area (median 4.5 weeks) than in the comparison sites (No- ED sectors) (median 16 weeks). It is concluded that the ED strategies have been successful in changing the population's help-seeking behaviour. Patients coming from the ED area were younger, were more likely to get a narrow schizophrenia diagnosis and to have drug abuse than patients coming from the No-ED area. The ED area group had a significantly lower symptom level across all symptom areas (11). There were high levels of suicidality both in the period before and at start of first treatment. Patients coming from the ED site reported significantly less suicidal behaviour than patients coming from the No-ED site. The difference was particularly marked for severe forms suicidal behaviour (suicidal plans and attempts) (16). At one year follow up we find that positive and general symptoms, global assessment of functioning, quality of life, time to remission, and course of psychosis at 1 year after the start of treatment were not different between ED and no-ED groups. Outcome was significantly better for the ED area for negative symptoms (18).

In the Early Detection sector 1/3 of the included patients were referred via the DT's as first contact point with the psychiatric system over the 4-year period of active inclusion, (19). The frequency of new contacts with the detection teams, were about one per day. Out of 1921 contacts, 107 individuals had a first-episode, psychosis. The DT's recruited younger males, with longer DUP, and with more substance abuse and better functioning, compared to the group recruited through the ordinary hospital system.

Conclusion

The TIPS Study indicates that well planned educational campaigns and the establishing of low-threshold Detection Teams enables the mental health care system of bringing patients with their first episode of psychosis in to treatment much earlier than otherwise and with lower levels of symptoms. The study also clearly indicates that an early detection program that lowers the threshold for first treatment contact can reduce the rate of serious suicidal behaviour at this point. The ED, no-ED differences at baseline become attenuated by 1 year but not the difference in negative symptoms, suggesting secondary prevention in this domain of psychopathology.

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13 - A nurse leading Department of Eating Disorders in Lithuania.

Dear ladies and Gentleman and colleagues nurses in the Mental health.

In this presentation I take you all to my home town and institute and tell you about my nurse leading department for Eating Disorders and how Internationality has been a great instrument by gaining knowledge and experience.

First of all, let me introduce myself to you. I am Snieguole Samuscenkoviene, a mental health nurse from Vilnius, the capital of Lithuania where I have been working at the mental health centre for eleven years. I started in the department of psychotherapy in which I got a lot of experience, its methods and also with the group therapy. I use the experience gained in my everyday work. One and a half year ago I was invited to work in the Department of Eating Disorders. There are more possibilities for me to work independently, apply and improve my knowledge in psychotherapy. Presently, I am the head nurse and conduct art therapy groups, also work with patients individually. That's all about me, now I would like to say a few words about my country, the hospital I work in the Department of Eating disorders and the team. Currently, in Lithuania we have nine psychiatric hospitals and many (about 63) centers of mental health that people with mental disorders and having severe emotional experience or crisis can come to. Over the last decade Lithuanian psychiatric hospitals have been associating with foreign psychiatric hospitals and organizations. In 2003 our Centre started implementing the international project "Vasaros MATRA" (MATRA stands for the support program of Ministry of Foreign affairs of the Netherlands for Eastern and central Europe). Taking into account the recommendations of the World Health Organization and other international organizations, the aim of this program is to reduce the number of beds in a psychiatric hospital and reform the system of psychiatry in Vilnius and other towns to create a modern network of psychiatric services in the community, to bring the psychiatry of Lithuania closer to the models of psychiatric help care created in the countries of the European Union. The only department of psychotherapy in Lithuania and the only department of Eating disorders in the countries of the former Soviet Union established in our hospital, do a lot of work to help their patients with minimal medication, and applying methods of psychotherapy. These departments have quite a few patients both from Lithuania and from foreign countries.

The informational centre of eating disorders was established in Vilnius, capital of Lithuania on July the first 2001, thanks to the organization "Global Initiative in Psychiatry". The founders of this centre were Brigita Baks and Ilona Kajokiene. The two of them started work in the in patient day care department. As the results of the work performed only by the two workers according to them were not significant, they decided to expand the day care department and recruit a bigger team. It was joined by

a physical activity specialist a doctor dietitian a psychiatrist – psychotherapist and a nurse. Having more staff on the team improved the results of treatment significantly; therefore it was decided to further expand this service. As you all know, the effectiveness of treating eating disorders is based on a complex treatment and on the team work of specialists. This method of therapy is applied in the countries of Western Europe, and in the only Centre of Treating Eating Disorders and information in Eastern Europe. Treatment is conducted in groups and consists of 3 successive stops which may need to be repeated. These are: 1. Therapy of motivation – positive motivation for treatment; 2. Intensive program; 3. Supporting therapy – consolidation of skills in order to prevent relapse. Sessions of intensive program include: cognitive – behavioral psychotherapy, psychomotorical therapy, a group of body picture, consultations of a doctor dietitian and nutrition planning, art therapy, film therapy, a group of social skills, task group a snack before supper. They take place in the 20 “chair” day in patient department- thus enabling the client/ patient to be treated without interrupting his/ her every day activities and to stay with families. It is attempted that the client feels responsibility for the process of his/ her treatment. In 2005, a now 5 “bed” Department of Eating Disorders was opened. The specialists working at the Centre are qualified in dealing with the problem of eating disorders, all having experience of training abroad (Holland, Canada, England): doctors psychiatrists – psychotherapists, psychologists – psychotherapists, a doctor dietitian, a specialist of applied physical activity and nurses. Joining actively in the activity of the Centre are the students of psychology and other volunteers. The center of ED also provides out patient services. In addition, there is an informational center under the Centre of ED service, which performs preventive work, provides information about eating disorders organizes trainings, seminars, prepares reports for conferences, carries out researches, develops methodic for treating ED, publish scientific articles, facilitates doctors training courses at the center and creates and implements preventive projects at schools. EDC actively cooperates with centers in Holland, Great Britain, supports establishment of similar centers elsewhere in Eastern Europe, also in other Lithuanian towns. In the course of the “MATRA” project, a number of consecutive services for those with eating disorders have been successfully accomplished. A perfect team has been recruited. Most of the team members, in the course of the “MATRE” project, actively cooperated with Rintveld ED department at Altrecht’s hospital, had their experience. The team gained a lot of information, experience, new ideas, which are now being successfully applied in work with patients. The most important thing gained from this cooperation is the principles of team work which enable each member feel of equal value both in the team and in their work with patients, therefore the results achieved are better, moreover, and certain specialists have applied the knowledge gained in their professional field. Doctor dietitian Ausra Jauniskyte applies the inpatient diet system which she adopted from the Dutch specialists and adapted to our Centre. Everything was arranged according to the methods seen during the training, the names of the diets are the same, the slight difference being in calories and, of course, in the food itself, which is adapted to the Lithuanian situation. The specialist of the applied physical activity Jurate Upskute – Seporaitiene brought from the same hospital very good ideas

and methods how to work with the patients so that their perception of body picture would be restored. For that purpose she uses a special mirror (which resembles the one used by the Dutch specialists) created at the centre's order. With the help of this mirror the patients are to realize how greatly are able to realize how greatly their perception of body picture and the real body perception have changed. She also uses various exercises which help to accept oneself and feel one's body, to see the body as a unit and not the separate, most annoying part of it.

In the course of the project, several nurses from Rintveld ED department visited our Centre, sharing their experience both with the team and with the whole staff of the hospital. They told about their work, its specific character, organization of work patient care, nutrition peculiarities. We compared that with our work, found much in common, yet there were differences as well. There are things that we use, but they have never seen, and there are also certain things that we implemented only following their visit (day openings – closings, case management, cognitive – behavioral therapy application in nursing). They talked a great deal about the criteria of the Gordon nursing plan, presenting examples of how to use that in practice. In our hospital, we also make up similar nursing plans using more or less the same criteria of description, yet of different stylistics. In Lithuania, nurses are trained according to the model of “Roper 12 vital activities”.

Now, I would like to dwell on the specific character of the work of mental health nurses and present the department's daily routine. We start the day by having breakfast the nurse and the patients together (at other meals as well). Then we have a day opening with all patients of the department, nurses on duty and department's psychiatrist – psychotherapist taking part. At the opening, each patient's state is discussed and the plans for the day are talked over afterwards, the doctor gives individual consultations, we also have various tests made, specialists' consultations and communication with nurses and patients admission until noon. Each nurse takes care of 5 – 6 patients and is their case management becoming the patient's representative as long as the patient is undergoing the treatment at the department. Everyday, we have team meetings at which we discuss current matters or problems concerning patients, also group activity. On Fridays, we hold the team's main meeting, where we discuss all the patients in greater detail. The relatives of the patients who seem to be the most troublesome are invited to take part at those meetings. We also evaluate the whole week's work, our failures or achievements and analyze our relationships. In the afternoon, after having lunch dinner, the patients go to the sessions in groups conducted by various specialists and nurses with special training. Every day we have 2 – 3 group sessions, the patients being divided into 2 groups – those with anorexia and bulimia. Sessions of psychotherapy take place. Psychologist – psychotherapist conducting the class applies the principles of cognitive – behavioral therapy, which are very effective in treating eating disorders. The specials of the applied physical activity conducts sessions in groups of psychomotorics and body picture. During the psychomotoric group the patients are taught relaxation, breathing

exercises, the bulimic group also take physical exercises in the hall built thanks to the Dutch Rotary club. In the groups of body picture we work at the perception of one's body, self-esteem. The task group is conducted by a nurse. Here the patients set small, but most sore tasks which they could possibly carry out, and little by little build up their self – confidence, and as we put it, strengthen their healthy “self” not allowing the routine illness to overcome. A dietitian Doctor conducts the group of nutrition planning during which the patients gain a lot of information about eating disorders, healthy way of eating, consequences of irregular eating. The patient's eating diaries are checked and nutrition plans are corrected if necessary. The patient's questions are also answered. The group of social skills is conducted by a nurse. The recovering patients here learn to adapt to their social surroundings they are encouraged to communicate. I myself conduct the art therapy group which I will present a bit later. During the film therapy the patients watch subject films or programs and share their impressions or emotions aroused. On Fridays we hold the patient's “big” group which is conducted by a nurse on duty. During this group, all the organizational matters are discussed; the whole week's work and emotional changes are summarized. After the classes, the patients of the department together with the patients of the day in patient department and the nurse have a snack meal in the canteen. If there are no more sessions, the patients have some free time, while the nurses take care of the paperwork, look through the medication prescribed and describe the groups. At the closing of the day, the patients and the nurse summarize the day, the patients share their impressions, problems and emotions they experienced during the sessions afterwards, the patients have supper, while day shift nurses wind up with the working day and activities after the night staff arrives and the shift changes. The patients have free time, they watch TV, communicate. At 10 p.m. they get ready for bed. That's the day of the team and the patient's.

Now I would like to talk about the art therapy group I conduct. There are many types of art therapy. Not long ago I conducted the group of music and art therapy, but now it's only art. Art therapy is one of the trends of psychotherapy where a patient expresses his/ her inner world by means of art. In this group the patients express their inner states, experiences and emotions in pictures. Before the group, I meet with my colleagues and discuss with them the previous groups and the emotions aroused there. When I come to the group I ask the patients whether they have any suggestions concerning the topic. If they don't, I suggest my topic which most often springs up while discussing patients with my colleagues. Then the patients draw for 20 minutes and afterwards look at one another's drawings and talk about them. It's seldom that they address each other personally. That makes communication easier for those who find communicating a bit difficult. On the other hand, the members of the group are concentrated on the drawing which is being discussed and, in this sense, are very close to each other's emotional cognition. Most often, I don't interpret the drawings of the group's members; I only help them to better understand the hidden meanings of the drawings. With this aim in view, I try to create a friendly, open atmosphere, where the patients feel safe and are taught to critically take both the positive and the negative remarks made by the members of the

group. In this group, I encourage free associations about drawings. At the beginning of the group I always stress that artistic abilities of the members won't be evaluated, so they are free to openly express their feelings.

Looking at the past period and the present situation we are convinced that our efforts we will inspire other nurses in Europe and beyond in taking an active approach and setting an example for this wonderful profession.

Thank you very much for your attention.

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14 - Psychological complaints

Intercultural Nursing in Mental Health, an exploration of problems and approaches and an example in the Ggz Nijmegen / Netherlands

We keep quite many values on our health and we do everything to be healthy, but we became once in a while or so an ill person; either physically, either or psychologically.

If we get ill, we do everything to recover again. If we are ill we should make an appointment with the general practitioner. The new developments on the medical territory help to cure or to prevent us from the physical illnesses. Think, for instance, of modern medical equipment that becomes set-in for the investigation and for the exporting of the finest surgical interventions. Only as we become psychological ill it is another story. Also here the first step begins at the general practitioner. But the next steps are simply complicated. This because most patients have to trouble to accept that they are psychologically ill. Moreover is the organization of mental health court complicated. At least i think it is much more difficult. In the Netherlands, psychiatric patients treated as well ambulant as clinically.

As patients no longer in home situation can live with ambulant help then become they taken up. During clinical treatment, multidisciplinary is worked. Nurses have however a special place in the attending team. We are from the first moment concerned by the care. We step intermediary on and they look after the interests of the patients. We are responsible to take care for 24 hours. We receive as first the blows of aggressive patients. We speak the patients regular. We are confronted at first with a suicidal patient. We are responsible for the continuity of the care. We see to the patients with various cultural backgrounds. We do not see all patients from own bottom only also for the not western patients resident in the Netherlands. But we as nurses have sometimes the tendency to underestimate our contribution in the total psychological care.

Working with psychological patients is advised to be tolerant very much, and not pre-judgment of character. You work not only on basic of your knowledge but also intuitive. Combinations of these two factors see how you can do your work optimal. If we work with Dutch patients then we have more knowledge about the background of these patients. Only as we work with not western patient then the knowledge is much less Sometimes we don't know how we must approach a not western patient and what we can expect from the patient; and then we can interpret their behaviour and illness phenomena. Also not western nurses have equal problems if they work with westerns and not western patient. I should explain below about not western patient.

Who are the not western patients?

In the Netherlands live almost 2 million not western Dutchmen. By a coarse division, we can divide them in 3 groups.

- 1: Generation guest workers
- 2: Refugees
3. Divers group

1: Generation guest workers After the Second World War, Europe faced with shortage of manpower on industry, so that's the reason labours from other countries as immigrant workers began to work here. The intention was that these foreign workers after some years would go back to the country of origin. In fact not only those workers didn't go back to their own countries but also their families were brought in. Children of these foreign workers went to school and found themselves as their own native home.

2: Refugees. Since the signing of the treaties of Geneva is the Netherlands oblige to let refugees closed. The reason concerns they usually ask for political asylum; for example: Iranian people who fled after Islamic revolution.

3. Divers group. This group is very various. Most members of this group its furrow work or for the human formation come to the Netherlands.

Psychological complaints

The members of these groups have the chance to develop psychological complaints towards each other. But the first group is mostly difficult to bring in card psychological problems. A large extent of group's cohesion and the existence of a taboo atmosphere over the discussing of psychological problems are hindering factors through which the members of this group with their psychological problems don't show outside. Also this group has the tendency of having psychological problems to somatogenic. Sometimes they do not know what the psychological complaints are. They have an own manner of the uttering of the illness. Much depressed patients complain over head and stomach-ache. In fact, headache does stands central not the depression. It is known that the factors as cultural background, race and religion can effect even the manner of pain perception and pain expression. Someone that has headache does sometimes best to let see that he burden of it, otherwise he thinks that he can't credibly comes over. Such behaviour is stamped as a theatrical behaviour in the western culture. Serious psychological illnesses as schizophrenias sometimes are reproached in bad minds, blasphemy and others. Patients and the families do not wave very in the psychiatry. They give own meaning at their complaints. They see their illness sometimes as a punishment from God. They seek rather alternative help in their own world. For example: a healing prayer.

The children of these immigrant workers, the second and third generation, have other problems. These children grow up between two cultures. They must adapt them behaviour on the roles of the parents on the other hand they have to follow the roles of the society.

This means is pulled from two sides. In the eyes of Dutchmen they are immigrants, and in the country of origin they became seen as a Dutchman. They belong actually no place. They swing between two cultures and have no basic. They hit in disarray and have little trust in self and in the society. Majority of this group have adaptation and identities problem. They are vulnerable and therefore their psychological problems often rises, added, boys have bigger chance to become criminal.

2. Refugees. This group mostly come here on adult age, either alone or with their families. They are often highly educated and a large numbers of this group can acclimate here and they are active in this society. A group of refugees develops psychological problems as well. Because of political activities, most of the time, they can't trust people around them. They miss family and friends support and they feel left on their fate.

Research has seen that schizophrenia under immigrants often prevents then under indigenes. What I mean is to say, immigrant often do not carry the gene that a cause is for schizophrenia. But the change in surroundings and living conditions, being left out from social support in combination with presence of biological marker are the most predictable factors for the developing of psychological problems. Refugees do not live in groups form, therefore they mostly are vulnerable group. One difference with the group of immigrant workers is that the refugees through the relief and accompaniment by their arrival are in contact with the Dutch people and get medical care if they need. These contacts help the employer of the relief centre to observe and recognise psychological problems. But this group don't easily accept help and care. Because in their homeland, they were mentally very strong men and fought for their ideals.

How is to work the furrow western nurses with not western patient? Firstly I try to sketch an image how is for a not-western patient to seek and accept help of the western nurses. Imagine, you come from another continent, you do not speak the local language or understand well, you are unknown with the organization of the care, and become psychological ill person, you feel yourself unsafe, you trust nobody, and you have almost nobody who can support you. You don't know how to ask for help, and can trust your nurses. You do not know if nurses understand you or take you seriously. Because your image is sketched by politics which is quite awful and negative. You do not know how negative reports given by media influenced the relief workers and their manner of working with not-western patients. For these reasons seeking and accept of help approaches with difficulty.

Nurses get experiences to see for the not western patients sometimes different or with difficulty. We try to approach mostly the western and not western patients in the same manner. In Our observations and report we have sometimes the tendency to judge the behaviour of a not-western patient from western standards and values. Naturally there are many agreements and similarity between these cultures but also the differences are not small. Sometimes we have our judgment already clearly before we examined the quality of behaviour. It is not informed how someone carried by himself facet in a

particular situation within a particular culture. While according to DSM IV by describe behaviour and by diagnosis we must pay attention to the cultural back grounds of the patient.

I try to make clear by an example what I mean. Quite long time ago came an Iranian patient on our division. She was depressed. Her son had committed suicide. He was jumped down from 9th floor. She was witness of this event. This tragic event was too much for her. She was taken to hospital somewhere and then in our hospital. It had been reported she was hysterical and theatrical woman, because she cried quite loudly and fell faint. I found it very misery that in the report that through a psychologist written, no attention given to the cultural aspects of this woman.

This patient cried and mourned as every mother in Iran who lost a child. As it have to be.. As we know in opposite the western culture, in some cultures let men see easily their emotions but they don't talk so much or easily shows their feeling. Men cry loud, hit itself, sing, clap, and sometimes dancing. In some cultures is the loss of a beloved person a sad event and in some cultures it is a celebration. The mourning trial and rituals are different in various cultures. Naturally we do not know how to loss process in other countries is. But we can ask the patient how It goes in his country.

Or quite fast is said that a patient is chaotically or he has adaptations problems. But if you ask the patient to explain her/his behaviour and if you tell the patient what we expect from him then he tries to conform at the valid standards.

Working with not western patients is not necessary difficult if we know how we can approach them and how we can communicate with them. It is known that talking about your feeling in other language is very difficult; it is more difficult when you have psychological problems. The Dutch language consists of many sayings. By a verbal communication we used whole many sayings. For people from other countries is quite difficult to understand this expressions. Not western patients have the tendency to say yes. Even they don't understand what we are talking about because they want be polite. Conversations may happen on a simple manner. Perhaps the use of less sayings will prevent misunderstandings. Most of not-Western patients have also trouble with the formulating of a problem and help questions. Sometimes they do not know what they want and what they can expect of the nurses.

Also nun-verbal communication asks necessary attention. Not Western patients use many gestures as an aid. Therefore they can come quite fast busily over. Nurses should be careful with their nun-verbal communication. Some gestures have totally someone else meaning in other cultures. Also the body language is important. In the eyes of not-western patients Dutch nurses come sometimes quite keeping distance because they move a bit, or they let show little their emotions.

We see working with not-western patients isn't always simple. For not-western nurses is not easily to work with western and not western patients either.

I work not also with Dutch patients but also with not westerns patients. When I started to work by GGZ Nijmegen. I didn't know not so much about mental disease and the Dutch culture, I knew I must learn so many about mental problems.

So I asked so many questions from patients and my colleagues. I compared all the time the values of Dutch people with my own values and I was looking for similarities and differences. Sometimes I was confused because of differences. As a not-western nurse you can get problems in your work with western patients. Sometimes Dutch patients discriminate and disqualified you. Sometimes they don't trust you. Sometimes they don't want to speak with you because they have doubt about your capability before they speak to you. I can remember me a patient says I was stupid because I have an accent speaking Dutch. And I must say I have learned so much about myself because of this patient. They trigger my curiosity. There are also so many Dutch patients who respect me and accept me as I am.

Many years ago I was speaking with my colleague about a patient. He said that the patient had a relapse because she was raped by her husband. I thought it was misunderstanding. How can a woman raped by her husband. He gives me some explanation and I understood if women say no, and if her husband makes love with her she is raped. I remember my reaction very good. I said oh my God how many Islamic women are raped daily by their husband. If you are Moslem you must obey your husband. You have no right to refuse your husband. It was very difficult situations for me. I had many questions about that situation and I had to find the answer on all that. After a while, I had my own answer. Perhaps you don't agree with me. But my conclusion was that Islamic women are not raped. Because they are Moslems and they believe in Islamic rules. And secondly they don't live in Netherlands and Dutch rules don't count for peoples who live outside of Netherlands.

After 4 years it was again the same dilemma. A patient with a not western background told me that she must have sex with her husband. And she was very sad because of her husband and it was very unpleasant for her to have sex with him. She was depressed. I spook this patient many times. But she doesn't say she was raped. I didn't know what I had to do, or think. Was this patient raped because she lives in Netherlands or she is not raped because she is Muslim? I couldn't speak with my colleague about this situation because the patient had asked me. It was embarrassing for her if another people knew it. It was very hard to me to keep secret this information. Because we have the custom to speak together about difficult situation in our team. But this was confident information from the patient. But after all years I asked myself, is this patient raped? I haven't any answer yet. We have so many difficult situations. But we can not find a explanation about everything. I think sometimes we must just accept things without any explanation.

How is to work the furrow not western nurses with not western patient?

This patient comes from several countries. But sometimes this patient feels solidarity with me because I am not Dutch. For this reason they want more contacts with me. I remember there was a patient who had to cry when I had a day off. They expect more help from you as a not western nurse. They think you do understand them better. They think you accept them more than a western colleague. But it is also very satisfied if you can do something for them. They give you whole much secretive information. But they don't want you to pass that information to others.

Colleagues

We see not only for western nurses is working with not-western patients difficult but also for the not western nurses is sometimes difficult to work with not western and western patients. To help the patients with psychological complaints from other cultures you need particular knowledge and skills. If you wish to help not western patient therefor it is advisable to employ not western nurses in this field.. To make easier of the accessibility of the not western patients in the psychiatric care, GGZ Nijmegen pay more attention at the take of the not western colleagues.

Just accepting of not western colleagues the preservation of these colleagues earns necessary attention. Sometimes there are problems in cooperation between western and not western colleagues. The problems that are in cooperation are mostly mutual. To prevent or solve these potential problems there is a list set up by employees that you can approach in case of problems by GGZ Nijmegen..

In our organisation the number of not western employees increased. We have regular referees about the intercultural aid. We feel to help not western people with psychological problems but also to prevent that men become ill. For this reason from division prevention we give courses for not western inquires and their children. GGZ Nijmegen is very active in intercultural aid

Finally: Working with not western patients can also be interesting too. It is important that we pay attention helping this group. To increase the expertise of the nurses it is extremely recommended to pay attention on this issue during training - perhaps with a block intercultural aid. Naturally it is impossible to know everything about so much different cultures. But we can learn how to approach not western patients. The target is that you give the patient the feeling that you understand him that you take him seriously. There is also little scientific proof about the effect of aid relation on the treatment of this group. Perhaps scientists must stimulate to do more research about the effect of this relationship.

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15 - Leading Mental Health Nursing.

A Market and Non Market Based Approach to determining strategy Consideration for National Organisational and Team Leadership

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The PowerPoint presentation version.

Introduction

- This presentation will be about the object not the subject of leadership
- There are over 40 theories and 1500 definitions of leadership
- Leadership is fundamentally about achieving objectives through people
- We can lead well but achieve wrong or harmful objectives – history is scattered with successful but toxic leadership
- Therefore we need to be confident our leadership objectives are sound, ethical, of value and effectively targeted

Strategic Analysis

- Nurses are one of a wide range of economic resources that are deployed in the treatment of disease
- From the perspective of Porter's 5 Market forces – nurses are a supplier of labour knowledge and skills to the healthcare industry.
- Our value to the industry is based on the basic principles of resource availability and competition from close substitutes
- Determining the leadership objectives for the nursing profession in each of our countries should be based on a proper understanding of the dynamics of our healthcare markets, and non market factors such as human rights, regulation, legislation, codes of practice and so forth.

The European Context

- 49 countries in the region
- 27 in the EU, 3 candidate countries
- EU = 495 million people – 17% of worlds population
- 23 languages spoken in the EU
- GDP per person in ppp terms ranges from \$58000 to \$11000

- 20% of the disease burden caused by mental health
- Health spend varies between 2 and 11% of GDP and mental health spend between 0% and 20% of these budgets.
- 9 out of the 10 countries with the highest suicide rates are in Europe
- Mental health service models range from institutions with caged beds to modern community based services
- Beds per 100000 people vary from 13.8 to 174
- Nursing workforce varies from no specialist training to dedicated pre-registration training

The WHO mental health action plan for Europe, 2005

- I. Foster awareness of the importance of mental well-being.
- II. Collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process.
- III. Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery.
- IV. Address the need for a competent workforce, effective in all these areas.
- V. Recognize the experience and knowledge of service users and carers¹ as an important basis for planning and developing services.

Understanding the market

- **Non Market factors**
 - The Who plan nicely summarises the non market ethical issues that should be being championed in every country
 - Individual countries economic and health data provide the local operating context
 - e.g. the starting point, the level of investment, and therefore priorities
- **What is the healthcare industry structure like**
 - Monopolistic, single state controlled providers
 - Competitive, lots of providers, lots of choice insurance and privately funded
 - Oligopoly, few big providers control 80% of market, insurance or state funded.
 - Will help us understand attitudes to change, efficiency, organisational priorities, and our power within the market place.
- **What is market for suppliers of labour, knowledge and skill like**
 - Many suppliers with few barriers to supplying the market
 - highly competitive, low value
 - Few suppliers, high barriers to supplying the market
 - low competition, high value
 - Helps us understand our worth and bargaining power in the market

- **End customers**
 - What do healthcare customers want from healthcare suppliers
 - How much power do customers have over providers to push for quality and lower prices
 - Who makes the purchasing decision
 - Do customers have choice
 - Are customers organised
 - Helps us to understand customer expectations, and determine the quality of the services we need to provide if we want to satisfy and retain customers
- **Market Barriers**
 - How easy is it for other providers to come into the market
 - How is the market regulated
 - Helps us predict future competitive pressure, also whether entrepreneurial opportunities exist.
- **Substitutes**
 - Are there substitutes to using the healthcare provider's services e.g. complimentary treatments, folk medicine, self help,
 - Helps us understand that if even if lack of competitors, customers may make other choices, if our provision too expensive, not safe, not of adequate quality.

Understanding Market Power

	Few nurses	Many nurses	Many nurses and substitutes
Monopoly	Limited power	Weak power	No power
Oligopoly	Moderate power	Limited power	Weak power
Competitive market	High power	Moderate power	Limited power

Understanding the Value Chain

- Assessment and investigation of someone with symptoms
- Diagnosis of illness
- Prescription of appropriate medical treatments and interventions
- Non medical treatment inputs – psychological therapies, rehabilitation, etc
- Supply and dispensing medicines
- Administration of medicines
- Monitoring of medicines
- Personal care and support while ill
- Provision of accommodation where necessary
- Health education
- Social assessment
- Sourcing and providing social care and support resources
- Managing and coordinating the direct healthcare resources and inputs
- Provision of back office support functions for health employees
- Provision of support functions for the health buildings, equipment and supplies
- Provision of facilities in healthcare environments – catering and cleaning
- Managing the infrastructure resources for the provision of healthcare
- Provision of education for healthcare staff
- Manufacturing of physical healthcare treatments and diagnostic, and monitoring equipment

Our current position on the value chain

- **Traditionally low to mid level tasks**
 - Meds administration
 - Symptom monitoring
 - Personal care
 - Management and coordination of direct care resources
 - Maintaining ward environment
 - Entertainment and recreation
 - Patient information and education
- **Moving up the value chain**
 - Assessment/investigation and diagnosis
 - Prescribing medical treatments
 - Prescribing and delivering psychological interventions
 - Management and coordination of wider sets of resources

Too Posh to Wash – Leading Nursing in the wrong direction

- In the UK in the 1980's the profession of nursing decided to cease training enrolled nurse (a lower level nursing grade), move training into higher education, and make student nurses supernumery.
- Thatcher/Major Government may have brought the plan because profession sold on recruitment grounds wanted to sweeten the nursing lobby – political commitment to increasing middle classes.
- Healthcare employers needed substitutes loss of enrolled nurse and student workers. Could not afford to substitute with all registered nursing workforce.
- Increase in employment of untrained healthcare assistants.
- Market in vocational qualifications for healthcare assistants developed.
- Nurses gave up hands on element of personal care element of the value chain, but retained supervisory responsibilities.
- 10-20 years on – concerns requality of basic care – “too posh to wash” move to regulate healthcare assistants.
- Nurses seen as too academic.
- Could be argued nursing leadership – took nursing into an area which was not in the healthcare value chain, and added no value to the employer or the customer.
- In addition nursing lost hold on core competence of care and opened up supplier market for lower less qualified suppliers.
- Nurse education also moved out of personal care and left this to vocational education.

Implications for nursing leadership.

- Macro – need to work with national policy makers to determine if want to reclaim this part of the market.
- Mezzo – need to ensure workforce and policy and procedures around this area of care are able to provide safe care. Work with education providers to ensure nurse education does not become to esoteric.
- Micro – ward leaders to ensure basic care elements are maintained and ensure nursing workforce are targeted on value adding activities.

Psychotherapy – Trying to move up the value chain outside of service providers business models

- 1968 in the UK government report psychiatric nursing today and tomorrow claimed psychotherapy should be part of the role of psychiatric nurses.
- Nurses have aspired towards this ever since but were not trained at pre-registration to fulfil this role effectively.
- 1982 syllabus geared towards person centred therapy and behaviour therapy – psychotherapies for less severely ill people.
- 1990's saw focus of statutory providers focus on serious mental illness, nurses psychotherapeutic training not geared to this market. Education providers moved towards new focus.
- Inadequate access to post grad training to fulfil new psychotherapeutic role
- Seldom are employed in jobs which are designed to facilitate psychotherapeutic practice.
- Nursing aspirations for psychotherapeutic practice out of synch with employers business models.
- Employers do not employ mainstream nursing resource to deliver this part of the value chain. They employ dedicated teams to do this, usually populated by people with verifiable evidence of training in a psychotherapy.
- Mainstream nursing is not rewarded at a level commensurate with those who are dedicated to work on this part of the value chain.
- Lower level therapy jobs being developed for low cost briefly trained psychology graduates.
- Nursing squeezed out of psychotherapy element of value chain.
- Nursing could in theory add value if properly trained and jobs structured properly – but may not be able to do rest of value chain – other therapists do not care manage, monitor medicines, do social interventions for example.

Implication for leadership.

- Macro – to politically review expectations of nurses and psychotherapy
- Mezzo – Clarify organisational expectations, regarding nursing and psychotherapeutic practices throughout the organisation. Ensure staff trained and facilitated to practice at the level expected.
- Team – realistic job descriptions, service philosophies/operating procedures clear of level of therapeutic practice offered, effective supervision.

Nurse Prescribing – moving up the value chain to meet employers needs

- Late 1990s saw range of new workforce practices to help manage demand for healthcare, and reduce costs.
- Nurse prescribing flagship reform, to this end.
- State changed legislation to allow and provided training.
- Medical resistance as might reduce their market power.
- Nursing resistance – don't want to pick up doctors cast offs, not clear whether higher financial reward comes with responsibilities.
- Patient's want reform as gives better access.
- Employers want reform as helps manages demand for service, and gives substitute to expensive doctors and makes good use of highly qualified nurses who appear to be under utilising medical skills and knowledge.
- Possible results 10 years on limited uptake of nurse prescribing in mental health, qualified nursing numbers dwindling in favour of lower grade posts for care, and medical or associate medical staff for prescribing.

Leadership Implications

- Macro – need to work with government departments and national leaders to further support the uptake and implementation of nurse prescribing.
- Mezzo – establish business cases and programs of work to implement with in organisations.
- Micro – encourage and make space for nursing staff to be trained to be prescribers, set up operational procedures that allow you to make best value of nurse prescribing.

In Conclusion

- Nursing Leaders need to be clear about their objectives.
- Nursing Leaders need to keep firmly in mind that nurses are an economic input into the process of healthcare and the production of well being.
- A set of three brief case from the UK seem to indicate that the profession of psychiatric nursing has not been well oriented to the market and the value chain for psychiatric care and treatment.
- Nursing leaders should determine and or test their objectives against the healthcare market, and non-market factors, and understand where in the value chain nurses may make the most competent and best value contribution.
- Taking a market and non market perspective can help determine a strategic direction for leadership at national, organisation and team based level.
- Not addressing the needs of the healthcare risks the profession of mental health nursing becoming anachronistic and irrelevant. Not addressing the non market issues means we may work in unethical ways or try to achieve things before the political will is in place.

This book is the complete collection of presentations during the foundation congress of Horatio, European Psychiatric Nurses in march 2007. It gives an impression of the wider field of Mental Health Nursing; its experiences and developments.

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