

Mental Health Nursing and its Future: A Discussion Framework

Report from the Expert Reference Group to the
Deputy Director-General, Mental Health
Dr Janice Wilson

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MANATŪ HAUORA

EXPERT REFERENCE GROUP

Chair	Dr Frances Hughes (Professor of Nursing, School of Nursing, University of Auckland, Formerly Chief Nurse Advisor Ministry of Health)
Project manager	Helen P Hamer (Senior Lecturer, School of Nursing, University of Auckland/Nurse Consultant, Auckland District Health Board)
Report authors	Helen Hamer, Associate Professor Mary Finlayson, Katey Thom, Professor Frances Hughes and Sharon Tomkins

Expert Reference Group Representatives (ERG)

Daryle Deering	Te Ao Maramatanga, New Zealand College of Mental Health Nursing and Alcohol and other Drugs Services
Nicolas Glubb	District Health Board Managers
Kaye Carncross	Chair, National Directors of Mental Health Nursing
Martina Allen	Council of Trade Unions
Mike Loveman	Non-government organisations (until October 2004)
Barbara Lowen	Nurse educators in the tertiary sector
Representatives	Māori Caucus: Te Ao Maramatanga
Pepe Sinclair	Pacific Island Health
Mark Smith	Health Research Council – Workforce Group
Vito Malo	Service user
Sam Noble	Mental Health Commission (until January 2005)
Marie Crowe	Chair, New Zealand Nursing Organisation Mental Health Nursing Section

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EXECUTIVE SUMMARY

This project provides a strategic direction for the future of mental health nursing that will strengthen both nursing leadership and practice within the multidisciplinary clinical environment. This project was initiated by the Ministry of Health to ensure a nationally co-ordinated approach to mental health nursing. The project was overseen by an expert reference group and comprised 12 representatives from the mental health sector. The overall goal of the framework is to provide strategies to move the profession of mental health nursing forward.

The framework considers a range of key workforce issues identified by the Ministry of Health including nursing leadership, nurse practitioner, standards, skill mix, clinical career pathways, professional supervision, education, research and recruitment and retention.

Widespread consultation throughout the mental health sector took place in the development of this report. A series of questions, based on key workforce issues, guided the consultation process and generated information on the current state of mental health nursing in New Zealand. The data from the situational analysis resulted in the development of key recommendations.

The consultation process revealed inconsistency with the development and implementation of nursing leadership structures, standards of practice, clinical career pathways, and professional supervision. Consultation on nursing leadership, and the processes whereby advice and direction is fed into mental health services, highlighted the variability that exists in the District Health Board and non-government organisation sectors. Representatives argued that there is variability in the adoption and auditing of the professional mental health nursing standards. In addition, consultation illustrated that the development of clinical career pathways in New Zealand has been ad hoc, with a variety of models emerging. There is also a lack of consistency in the availability of qualified and appropriate professional supervisors for mental health nurses.

While District Health Board and non-government organisation representatives are supportive of the introduction of the mental health nurse practitioner role, little has been done to support nurses in preparing for the role or establishing appropriate nurse practitioner positions. Similarly, it was demonstrated there is overwhelming support for increased access and availability of Clinical Training Agency funded new graduate and advanced programmes for mental health nurses. However, specific strategies to enable nurses to participate in them were not consistent and varied considerably across the different organisations. Nursing research in mental health has undergone significant developments in tertiary education organisations providing postgraduate programmes. However, a research culture in mental health service providers is still developing.

Representatives explained that the current recruitment and retention problems within health organisations have had major implications for mental health services. Shortages of experienced mental health nurses have impacted on the majority of health organisations' ability to recruit and manage staff using appropriate skill mix strategies. Recruitment and retention issues also have implications for nurses being released for both new graduate and advanced mental health post-entry clinical training programmes. It is imperative that stakeholders work together to develop creative recruitment and retention strategies and new ways of working. This is particularly pertinent given New Zealand is facing increasing demands for mental health services, an alarming shortfall in mental health nurses, and increasing global nursing shortages.

Recommendations

Leadership

- Mental health nursing professional bodies should take a leadership role in supporting and developing mental health nursing knowledge and practice.
- Mental health nursing professional bodies should promote the development of nursing leadership.
- Mental health nurse leaders should be appointed in all District Health Boards and non-government organisations employing mental health nurses.
- Mental health nursing advice and direction should inform clinical and managerial decision-making for mental health services.

Mental health nurse practitioners

- Mental health nurse practitioner roles should be established in District Health Boards and non-government organisations.
- Ministry of Health should provide scholarships for mental health nurses pursuing nurse practitioner accreditation.
- Mental health nurses should be supported by their employers to pursue mental health nurse practitioner accreditation.

Standards

- All employers of mental health nurses should adopt professional mental health nursing standards.
- All mental health nursing job descriptions should incorporate professional mental health nursing standards.
- All District Health Boards and non-government organisations should annually audit the application of the *New Zealand College of Mental Health Nursing Standards* to ensure they are implemented consistently.

Skill mix

- Appropriate skill mix strategies should underpin recruitment of mental health nurses.
- Research on nursing skill mix should be undertaken in New Zealand mental health settings to investigate cost effectiveness and the implications for service users' outcomes and nurses' outcomes.

Clinical career pathways

- Employers should develop consistent clinical career pathways that are transferable between organisations.
- Clinical career pathways should be linked to nursing positions within organisations.

Professional supervision

- Employers should ensure that all mental health nurses have a formal contract with an appropriately trained supervisor.
- A national professional supervision training model should be developed by mental health nursing professional bodies and incorporated into standards for mental health nursing.
- Mental health nurses' supervision should be undertaken in work time.

Education

- The Nursing Council of New Zealand in conjunction with mental health nursing professional bodies should review undergraduate mental health education for its relevance to the mental health sector.
- All new graduates should undertake Clinical Training Agency funded new graduate mental health programmes.
- The Clinical Training Agency should increase funding for all mental health new graduate positions.
- The Clinical Training Agency should fund postgraduate diplomas for experienced mental health nurses.
- The Clinical Training Agency should increase trainee funding for release time, professional supervision, travel and accommodation.
- The Clinical Training Agency should fund masters' programmes for mental health nurses pursuing nurse practitioner accreditation.

Research

- The Ministry of Health should make seeding funds available for mental health nursing research projects.
- Professional bodies should establish mental health research networks.

Recruitment and retention

- Employers and education providers with the support of professional bodies should collaborate to actively recruit students from high schools and schools of nursing.
- Employers should co-ordinate their approaches to recruitment of mental health nurses.
- Employers should introduce Magnet principles to retain nurses.

1. INTRODUCTION

The Ministry of Health is committed to the development of the mental health workforce. This project was initiated by the Ministry of Health to ensure a nationally co-ordinated approach to mental health nursing. The report outlines a strategic policy framework for mental health nursing to facilitate the implementation of the National Mental Health Strategy and the Mental Health Commission's (MHC) *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission 1998).

The purpose of the project is to provide a national strategic framework for mental health nursing that will strengthen both nursing leadership and practice within the multidisciplinary clinical environment. The framework reviews a range of key workforce issues identified by the Ministry of Health and provides strategies to move mental health nursing forward. The framework integrates directions from government mental health strategies, policies and directions, national and international literature as well as professional nursing requirements which aim to create a sustainable mental health nursing workforce using evidence-based practice.

This chapter provides a contextual overview of the policy background and current state of mental health nursing in New Zealand. It concludes with an overview of the structure of this document.

1.1 Mental health workforce development policy

The Mason inquiry (1988) illustrated that provision of mental health services in New Zealand was problematic and inadequate. In particular, the movement away from institutional care to the provision of mental health services within the community had created considerable resource implications (Ministry of Health 1994). Consequently, mental health became one of the current Government's health priority areas. Over the last three years, the Ministry of Health has invested significantly in mental health service provision and workforce development (Ministry of Health 2000).

The Ministry of Health developed two strategic plans to guide the mental health workforce as the mental health sector moved from an institutional-based service to a community based setting (Ministry of Health 1994, 1996a). The MHC's *Blueprint* supplemented these strategies and outlined a national service development plan with a framework for key principles of good practice (Mental Health Commission 1998). The MHC's vision for a successful mental health workforce includes: a workforce sustained to respond to the needs of mental health service users; a workforce confident in its positive and unique contribution to the journey of recovery; and District Health Boards (DHBs) and non-government organisations (NGOs) driving workforce development (Mental Health Commission 1998). There have been significant changes to the mental health workforce as a direct result of these developments including a major increase in the number and type of services provided and reorientation of the knowledge and skills required (Health Workforce Advisory Committee 2002a).

Māori and Pacific nurses play a significant role in the provision of mental health services. However, these groups are significantly underrepresented in the mental health nursing workforce. The Government is committed to developing health services that are culturally appropriate and encompass the principles of partnership, protection and participation outlined in the Treaty of Waitangi (Ministry of Health 2002a, 2002e, 2002f).

Key strategic directions relating to mental health nursing are underpinned by several reports. *Towards Better Mental Health Services* (1996b) identified strategies for: Recruitment and retention; communication within the education sector; investment in training; mental health research; destigmatisation of service users; service provider responsibility; management practice; and organisational change. *Developing the Mental Health Workforce* (Mental Health Workforce Development Co-ordinating Committee 1999) focused on progressing workforce competencies, organisational effectiveness and specialised services for child and youth, and Māori and Pacific peoples. *Tuutahitia Te Wero: Mental Health Workforce Development Plan* (Health Funding Authority 2000) outlined a funding plan for workforce development in relation to the specific needs of Māori, children and young people, and Pacific people.

More recent strategic initiatives introduced by the Ministry of Health for specific areas in which mental health nurses work are included in *Mental Health (Alcohol and other Drugs) Workforce Development Framework* (Ministry of Health 2002b), *Te Puawaitanga: Māori Mental Health National Strategic Framework* (Ministry of Health 2002f), *New Zealand Health Strategy DHB toolkit: Mental health, to improve the mental health status of people with severe mental illness* (Ministry of Health 2001a).

1.1.1 National agencies involved in mental health nursing workforce development

The Mental Health Directorate has the overall responsibility for maintaining a strategic overview of mental health workforce development and advising the Ministry of Health. A number of national agencies are involved in the development of the mental health nursing workforce and are outlined below.

The Health Workforce Advisory Committee (HWAC) was developed in 2001 to provide strategic advice to the Minister of Health on the health and disability workforce (Health Workforce Advisory Committee 2003). The organisation independently assesses the current workforce capacity and outlines future workforce needs to meet the objectives of the New Zealand health and disability strategies.

District Health Boards New Zealand (DHBNZ), which represents the DHB Chief Executive Officers, is also concerned with workforce development and in July 2003 published its *Workforce Action Plan* for the sector.

The Ministry of Health and the Mental Health Commission (MHC) in partnership with the DHBs established the Mental Health Workforce Development Committee (MHWDC) to ensure national co-ordination of mental health workforce development (Mental Health Workforce Development Programme 2003). The MHWDC comprises representatives from DHBs, NGOs, service users and their families, Māori, Pacific, MHC representatives and clinicians. The Committee's purpose is to take responsibility for national co-ordination and leadership of mental health workforce development and to set targets, priorities and directions.

Established in 2001, Te Rau Matatini (National Māori Mental Health Workforce Development Programme) is funded by the Ministry of Health and aims to strengthen the Māori mental health workforce. It aims to provide sector leadership and advocacy for Māori mental health needs through the provision of analysis, evaluation and strategic development initiatives (Hirini and Durie 2003). The other national mental health workforce development centres are the Werry Centre (National Child and Youth Mental Health Workforce Development Centre) and the National Addictions Workforce Development Programme.

In addition to government agencies, professional bodies play an integral part in mental health nursing workforce development. The Nursing Council of New Zealand (NCNZ) is the statutory authority for nurses and aims to protect public interests and public safety. The NCNZ governs the practice of nursing and is therefore responsible for the regulation of the profession and the registration and enrolment process to ensure practitioners are qualified and meet national nursing standards (<http://www.nursingcouncil.org.nz/>). The New Zealand Nurses Organisation (NZNO) is the largest organisation representing nurses and health employees in the health sector. The NZNO has a mental health nurses section and its key functions are to develop policy and strategic directions for mental health nursing in New Zealand. The New Zealand College of Mental Health Nurses (NZCMHN) provides a voice to the public on mental health nursing and offers support and leadership to mental health nurses. The College also sets and maintains the standards of practice for mental health nursing (New Zealand Nurses Organisation 2001).

1.2 Mental health nursing in New Zealand

Mental health nursing is a specialised field of nursing that includes a focus on acknowledging service users' inherent resources and strengths. Mental health nurses provide a service which is designed to meet the needs of service users as well as form a partnership with family/whānau and the community. The *Blueprint* introduced the 'recovery approach' that is to be used in all mental health services. The concept of recovery is defined by the Health Workforce Advisory Committee as happening when 'people can live well in the presence or absence of symptoms of mental illness' (Health Workforce Advisory Committee 2002a, p110). For mental health nurses, this involves working in partnership with clients to promote their full participation in society, protecting service users rights, and helping service users to create supportive environments, as well as providing diagnosis and illness treatment services (Mental Health Commission 1998). NZCMHN (2004) states that mental health nurses facilitate recovery by:

- supporting service users to optimise their health status within the reality of their life situation
- encouraging service users to take an active role in decisions about their care
- involving whānau and communities in the care and support of service users.¹

1.2.1 The current mental health nursing workforce

In 2004 there were 34,660 active registered nurses and midwives working in nursing and midwifery in New Zealand. Of these, 7.7% (3052) identified themselves as mental health nurses (New Zealand Health Information Service 2004). Mental health nurses are employed in a broad range of settings that include forensic mental health, community mental health, child and adolescent mental health, primary care settings, crisis response in the community, and focused rehabilitation services for managing individuals in high dependency inpatient environments. Table 1 below illustrates the employment settings of mental health nurses in 2004.

Table 1: Employing setting of mental health nurses in 2004

Employer description	Registered nurses and midwives
Public hospital (DHB)	1853
Public community service (DHB)	804
Educational institution	20
Government agency (eg, HFA, ACC, prisons etc)	8
Māori health service provider	61
Nursing agency	29
Pacific health service provider	4
Primary health care clinic/community (non public)	50
Private or non-public hospital	41
Rest home/residential care	53
* Self employed	20
Other	84
Not reported	25
Total	3052

Source: New Zealand Health Information Service 2004

¹ Mental health nurses are committed to enhancing recovery for individual service users and developing recovery focused services. Integration of the recovery competencies (Mental Health Commission 2001), the NZCHMN standards of practice (Te Ao Maramatanga: New Zealand College of Mental Health Nursing 2004) and NCNZ competencies (Nursing Council of New Zealand 2004) within mental health nurses job descriptions is one way to achieve this. Appendix 5 provides an example of a mental health nurse practitioner position description developed by the expert reference group that integrates these components and could equally be applied to all mental health nurses. The position description was consulted upon with the Nursing Council of New Zealand and mental health professional bodies.

1.2.2 Issues for mental health nursing

Mental health nursing in Aotearoa/New Zealand has a rich history that has led to the profession's readiness to meet the complex challenges of practice in the 21st century. Until the 1970s, mental health nursing was conducted mainly in large institutions. During this period the profession was socialised into taking a custodial and maintenance approach to mental illness. New psychological interventions together with a changing philosophy of care initiated the period of community based mental health care which began in the 1970s.

Mental health nurses currently work with service users with serious mental illness who are predominantly in secondary and tertiary settings, in either inpatient or community mental health settings. Over the past two to three years there has been a move to a 'shared care' model, whereby those with enduring mental illness receive the bulk of their care from their general practitioner supported by mental health nurses from a secondary setting.

Apart from the general developments in mental health services outlined above, there have been regulatory and policy changes that have specifically effected mental health nursing. The Health Practitioners Competence Assurance Act 2003 requires the NCNZ to ensure the safety of the public and the ongoing professional competence of nurses to practise. New quality assurance provisions require mandatory demonstration of a nurse's ongoing competency, competency-based practising certificates, and stronger accountability of nurses.

In recent years, the Government has introduced strategies for the provision of mental health in primary health care (Ministry of Health 2001b). These strategies have implications for the mental health nursing workforce. The development of the Nurse Practitioner in mental health has been clearly outlined in policy guidelines and NCNZ documents. However, an implementation strategy for NGOs and DHBs is lacking (Nursing Council of New Zealand 2001a). The *Second National Mental Health and Addiction Plan* (Ministry of Health 2004b) provides a strong indication of the future role of Primary Health Organisations (PHO) in mental health services. It also emphasises the interface between primary and secondary care as an area that will significantly impact on the work of mental health nurses.

In the mental health sector 13% (404) of the nursing workforce is comprised of Māori mental health nurses (New Zealand Health Information Service 2004). Māori already play a significant role in delivering mental health nursing services in New Zealand and there is growing demand for, and recognition of, the need for services that are culturally appropriate for Pacific and Asian peoples in New Zealand also. These groups are currently underrepresented in the mental health nursing workforce. Pacific nurses represent 2% (76) and Asian nurses 3% (101) of nurses in the mental health workforce.

This national framework for mental health nursing comes at time when mental health nursing is moving into a new paradigm of care, characterised by reduced divisions between primary and secondary health sectors and by service users no longer being defined by their illnesses. It is therefore timely, to create a strategic direction that will build capacity and capability within mental health nursing.

Mental health nurses need to be supported by the infrastructure of the organisations within which they work as well as their professional organisations.² The purpose of the framework is to meet the needs identified through sector consultation and provide nurses, government and decision-making bodies with clear directions for the development of mental health nursing.

1.3 Structure of the framework

This chapter provided the context for the project and chapter two describes the methodological approach utilised for the consultation process. Chapter 3 presents national and international research and reviews current national and international best practice in mental health nursing leadership and practice. A situational analysis generated from the consultation process is provided in chapter four. Chapter 5 outlines the recommendations and strategic framework to move mental health nursing forward.

² Throughout this report three key bodies have been identified as having a voice in the representation of the profession: the NZNO mental health nurses section, the NZCMHN, and the Directors of Mental Health Nursing. Where one specific body is identified as taking the lead on a recommendation, this implies that others will be consulted on, and, with the need for efficiency, each group will have clear accountabilities for subsequent work required.

2. METHODOLOGY

The purpose of this project is to develop a national strategic framework for mental health nursing that strengthens both nursing leadership and practice. The overall goal is to create a sustainable mental health nursing workforce that promotes recovery and reflects best practice. The project was overseen by an expert reference group comprised of twelve representatives of service users, NZCMHN and its Māori caucus, Directors of Mental Health Nursing, mental health DHB managers, the Combined Trade Unions, NZNO (Mental Health Nurses Section), NGOs, nurse educators in the tertiary sector, the MHC, Pacific mental health providers, and the Health Research Council (workforce group).

The expert reference group developed a format for group discussion on a web-based facility that allowed them to submit documents and discuss the framework securely online between meetings.

2.1 Project design

The project comprises three main tasks: a literature review, a situational analysis of key mental health nursing workforce issues, and the development of a strategic framework for mental health nursing (see Appendix 2 for the terms of reference for the project).

2.1.1 Task 1: literature review

An extensive national and international review of literature was conducted to locate examples of best practices in nursing leadership, nurse practitioner roles, standards of practice, clinical career pathways, professional supervision, education, research, and recruitment and retention. The literature examined for this review was mainly accessed through online searches using the internet search engine 'Google' (<http://www.google.co.nz>) and manually on the Ministry of Health (www.moh.govt.nz), Mental Health Commission (www.mhc.govt.nz), Te Rau Matatini (www.matatini.co.nz), Mental Health Workforce Development (www.mhwd.govt.nz) and World Health Organization (www.who/mental_health) web pages. Professional nursing organisation websites were also searched for relevant information. These included the New Zealand Nurses Organisation, Nursing Council of New Zealand, NZCMHN, and the International Council of Nurses websites. Articles were also accessed through computer searches of nursing and medical databases. The University of Auckland's Philson Medical School Library and the general library were used for all manual searches and articles were found in MEDLINE, CINAHL, PsychInfo; Web of Science and ABI/INFORM databases. Key words utilised for the online and database searches included the areas of mental health nursing practice and leadership as outlined above.

2.1.2 Task 2: the situational analysis

The Ministry of Health identified the key workforce issues to be reviewed as part of the project objective. These included nursing leadership; nurse practitioner; standards of practice; clinical career pathways; professional supervision; education; research; and

recruitment and retention. A series of questions were then developed for the consultation process, based on these issues. The expert reference group distributed the questions throughout their networks within the mental health sector. The findings from the previous two tasks were analysed and given to the expert reference group members for further consultation. Analysis of the data, together with literature review, resulted in the development of recommendations.

2.1.3 Task 3: development of strategic framework

The recommendations formed the basis of the strategic framework. A draft of the report was distributed to a number of key stakeholders and the final report was submitted to the Ministry of Health. The report was peer reviewed by Dr Shirley Smoyak from the Rutgers University, United States.

2.2 Data collection

The expert reference group developed a list of open-ended questions for the purpose of consultation based on the workforce issues described in 2.1 above (see Appendix 3 for the questions that guided the situational analysis). The expert reference group members then disseminated these questions to individuals or groups within the mental health sector. The questions were also placed on the University of Auckland website. The electronic link was promoted through the expert reference group members, posted on several websites and advertised in nursing journals. Completed submissions were anonymous.

A total of 49 individuals and/or groups were involved in the consultation process. These included representatives from DHBs, NGOs and tertiary education organisations. Responses were also received from specialist mental health services including: maternal services; forensic services; child and adolescent services; alcohol and other drug services and Māori and Pacific mental health services.

A purposive sample of Māori mental health nurses participated in the consultation. Approximately fifty Māori mental health nurses were involved in several group sessions that discussed the questionnaire. This included two consultation meetings and one wananga that were undertaken by the project manager and the expert reference group member representing the Māori mental health nursing caucus of the NZCMHN. These were held in Auckland and Hamilton.

Consultation with Pacific mental health nurses was led by the Pacific expert reference group representative at several regional meetings. Fono, including the Pacific provider nursing development workshop and the Pacific nursing workforce education needs, further informed the data gathering for the situational analysis.

Other mental health professional bodies were kept informed throughout the process and were given opportunities to be part of the consultation process. These included the New Zealand Psychologists Board, the Royal Australian and New Zealand College of Psychiatrists, the New Zealand Association of Occupational Therapists, and Aotearoa New Zealand Association of Social Workers.

2.3 Data analysis

A systematic process was used to analyse the data. The key workforce issues mentioned in 2.1.2 provided the themes and the data was coded according to these themes. Analysis involved determining the 'current situation', the 'gaps' and 'strategies' for moving forward. Findings were relayed to the expert reference group for validation and interpretation.

The following chapter presents a review of the current national and international best practice literature in mental health nursing leadership and practice.

3. LITERATURE REVIEW

Mental health services have undergone significant changes over the last 30 years. More recently, workforce development that addresses fundamental components of mental health services has become a priority for health policy makers in New Zealand. Consequently, what constitutes best practice in specific areas of mental health services has become integral to the development of policy and strategic frameworks. Best practice can be defined as ‘activities and programme approaches which are in keeping with the best possible evidence that works’ (Curtis 1997, p 16).

The following presents a review of the current national and international best practices in mental health nursing leadership and practice and related workforce issues. Best practice examples are illustrated from particular workforce issues for mental health nursing and include nurse leadership, nurse practitioner, standards of practice, skill mix, clinical career pathways, professional supervision, education, research culture, and recruitment and retention. This review informed the development of the strategic national framework for mental health nursing (see section 5).

3.1 Nursing leadership

Antrobus and Kitson (1999) argued that nurse leadership should be conceptualised as a ‘vehicle through which *both* nursing practice and health policy can be shaped’ (p 746). Effective nursing leadership, therefore, occurs internally and externally. Internally, nursing leadership takes place between the political, academic, managerial and clinical domains in which nurses practice. Externally, nurse leaders engage with the broader social and political context contributing to the formation of health care policy.

This section considers literature on nursing leadership both within nursing clinical practice and the broader social and political areas. It does this by firstly providing a contextual overview of the two nursing leadership areas, followed by a review of best practice in these areas.

3.1.1 Nursing leadership in clinical practice

The Ministry of Health defines leadership as a process whereby stakeholders influence decision-making and partake collectively in the steering of an organisation. Within particular health professions, clinical leadership is essential for assuring accountability for standards of practice, quality of care and transforming evidence-based research into practice (Ministry of Health 2003b).

Restructuring of hospitals in New Zealand in the early 1990s led to the near-exclusion of nurses from managerial decision-making in health care (Ministerial Taskforce on Nursing 1998). Within the mental health sector, deinstitutionalisation has meant that acute inpatient wards are located in district hospitals and community mental services and are managed by smaller teams. Consequently, a ‘one size fits all’ approach to clinical and managerial practices has developed, in which nurses are poorly represented. Essentially, this has weakened the development of professional leadership, advice and

direction, and management of clinical practices in mental health nursing (Ministerial Taskforce on Nursing 1998).

3.1.2 Nursing leadership in the sociopolitical arena

In New Zealand, registered nurses make up 70% of the health and disability workforce. Current literature has argued the influence nurses have in the direction of health policy is disproportionate in relation to these statistics (Hughes 2001).

There are various professional organisations that represent mental health nurses. These include NZCMHN, College of Nurses Aotearoa, National Council of Māori Nurses, and the NZNO. The Nurse Educators in the Tertiary Sector, Nurse Executives of New Zealand and the NCNZ are other organisations that have a leadership role in nursing. Literature has suggested that, at times, there is a lack of consensus between these different organisations: 'there is strength in diversity – but also the risk of fragmentation and lack of unity' (Ministerial Taskforce on Nursing 1998, p 70). It has been suggested that this lack of unity might have significant implications for nursing leadership (Ministerial Taskforce on Nursing 1998).

The Ministry of Health is committed to strengthening the input of nursing advice into all levels of policy relating to the health and disability services sector. The National Directors of Mental Health Nursing was established by the Ministry in 1998 to provide national leadership for the mental health nursing workforce. The membership of the Directors of Mental Health Nursing consists of nurse leaders from DHB mental health services. The group provides advice and strategic consultation on mental health nursing issues to statutory bodies and national organisations. The group also provides support and networking for professional nursing leaders and formulates alliances within general health services across New Zealand.

Nursing leadership has become a central focus of health policy around the world. In America, the study of Magnet hospitals by McClure et al (2002) found that leadership was integral to their success in recruiting and retaining nurses. Nursing managers were considered pivotal to the success of the organisation and, as a consequence, these nurses were made to feel professionally and personally important. Middle managers were also recognised as important and were involved in conducting various training programmes (McClure et al 2002). The relationship between nursing leadership and recruitment and retention for mental health nurses is recognised in section 3.9 of this review.

Research from the United Kingdom has recognised the leadership of senior nurses as essential for the provision of quality patient care and developing a learning environment within clinical settings (Cook 2001; Cunningham and Kitson 2000; West et al 2004). Thus, nursing leadership is essential for effective professional supervision and ongoing professional development. This is discussed further in section 3.2. Worryingly, studies have also reported that nurse leaders often experience role overload, role conflict and other organisational pressures coupled with limited workplace support and mentoring (Siu 2002).

3.1.3 Best practice research

Professional development programmes

In the United Kingdom, the Royal College of Nurses' Clinical Leadership Development Programme, established in 1995, aimed to address some of the current problems senior nurses face (Cunningham and Kitson 2000). The programme focused on developing work-based and problem-focused methods of helping ward sisters and senior nurses become capable leaders. This included developing nurses' skills, techniques and personal attributes. The evaluation of this programme demonstrated that nurses benefited from the personal development programme and valued a focus on issues that related to the management of uncertainty, negative feelings, staff motivation, and development and management of others. The strength of the programme rested on the utilisation of an experiential work-based approach and the role of the expert facilitator. The researchers concluded that this type of intervention improves clinical leadership capacity and patient care (Cook 2001).

Nursing leadership training

An evaluation of a clinical leadership initiative for senior nurses in mental health services within the United Kingdom has also been reported as effective in developing clinical leadership (West et al 2004). The nurses who participated in the initiative were working in acute psychiatric care, specialised psychiatry, day care psychiatry, and forensic psychiatry. The initiative introduced a system of mentorship, education and training to improve and develop direct patient care, inter-professional communication and clinical leadership of the nursing team. The evaluation included perspectives from external representatives and the clinical leaders themselves, their mentors, their clinical nurse manager and members of their multidisciplinary team. There was consensus among the mentors and clinical nurse managers that improvements relating to collaborative working, dealing with problems and providing a therapeutic environment for patients and staff had occurred since the introduction of the clinical leader role. The team reported improvements with the management of the nursing team, patient outcomes, nursing practice, the ward culture, dealing with problems and information-giving. Overall the report indicated that an initiative such as this was beneficial in facilitating stronger nursing leadership and team work within a multidisciplinary environment (West et al 2004).

Group leadership training

Literature has suggested that a transformational leadership style is essential to effective nursing leadership (Johns 2003). The transformational style aims to facilitate individuals to work together with a shared vision that motivates both leaders and followers. Scheick (2002) illustrated the usefulness of employing a transformational group training model for nurses participating in mental health nursing programmes. The aim of this model is to increase the group leadership skills of nurses working in specialist areas. Programmes that utilise this model employ innovative group exercises as well as nursing group leader interventions. Scheick analysed students' perspectives of the programme. The study indicated that participants assumed the group leader role

as a result of the programme's focus on group participation, collaboration, and reflective learning (Scheick 2002).

3.2 The role of the nurse practitioner

International research on the role of the nurse practitioner in mental health services is pioneering work, and is largely descriptive rather than evaluative (Cornwell and Chiverton 1997). Most studies have focused on contextual issues and the development of models, standards and education programmes for nurse practitioners. The models identified in the literature are not stringently tested or based on evidence. Consequently, best practices for the development of mental health nurse practitioners are limited. This review considers literature that is useful for the development of a framework for mental health nurse practitioners.

The section begins with a contextual overview of the development of general nurse practitioners, followed by a review of international literature on the development of nurse practitioners in mental health settings.

3.2.1 The development of nurse practitioners

The nurse practitioner is an innovative role performed by registered nurses working at an advanced level of practice (Ministry of Health 2002d). International research broadly defines the nurse practitioners' role as located within primary health care. It emphasises continuing, comprehensive, holistic care and intersectoral collaboration (Keegan 1998). In New Zealand, the nurse practitioner's focus is on health promotion, disease prevention activities and the monitoring of chronic episodes throughout the service user's lifetime. Nurse practitioners work both independently and in collaboration with other health care professionals to provide a wide range of assessment and treatment interventions. They provide leadership as consultants, educators, managers and researchers and participate in the development of local and national policy development in New Zealand. Nurse practitioners may also prescribe medicines and other treatments within their speciality area of practice (Nursing Council of New Zealand 2001a).

The NCNZ (2001a) established nurse practitioner competencies which describe the skills, knowledge and activities of nurse practitioners. The NCNZ recognise registered nurses as nurse practitioners when they have a clinically-focused masters degree, have met NCNZ assessment criteria and competencies and have at least four years' experience at an advanced level in a specific area of practice (Ministry of Health 2002d). Several tertiary education providers across the country have NCNZ approved masters programmes required for nurse practitioner status. To support the introduction of the nurse practitioner role, Hughes and Carryer (Ministry of Health 2002d) conducted an international literature review. They also conducted 'road-shows' for the health sector to stimulate debate and increase understanding of the role of the nurse practitioner. In New Zealand, there are currently 14 nurse practitioners.

The Ministry of Health (2002d) described four generic models of care for nurse practitioners. These included the integrated nursing team model, nurse consultancy, independent practice and nurse practitioner in specialist services/clinics (Appendix 4 outlines these four models in detail). Nurse practitioners are essential for DHBs' development of new models of care that aim to improve the health outcomes of their local communities. The role of the nurse practitioner is supportive of Pacific and Māori models of care (Ministry of Health 2002d).

In the United States, the nurse practitioner role was implemented over 30 years ago in response to primary health care service needs in the area of infant and prenatal care. Currently, nurse practitioners have prescribing rights in 48 states and they have authority to practise independently in 20 states (Cornwell and Chiverton 1997). Literature has demonstrated that the nurse practitioner role, with prescriptive authority and autonomy of practice, is essential for innovative and effective primary health care. In New Zealand, however, the role has often been met with conflict from other health professionals (Hughes 2002).

International literature revealed that primary health services provided by nurse practitioners have generated benefits for consumers and the health sector. Specific benefits include lower cost of care, improved access to care, better management of chronic conditions, and decreased hospital admissions (Dunn 1997; Kinnersley et al 2000). Studies have stated that service users look favourably on nurses having prescribing rights and find nurse practitioners more approachable than traditional health professionals (Luker et al 1998). Research has indicated that the nurse practitioner role has increased clients' access to primary health care and allowed nurses to utilise their advanced knowledge and skills obtained (Cornwell and Chiverton 1997).

3.2.2 Mental health nurse practitioners

The mental health nurse practitioner would be ideally placed to work in specialist services with children, young people and their families, Māori and Pacific mental health, primary health care and Alcohol and Other Drugs. Their role could also include work with groups with complex needs that require intensive care co-ordination to maintain their recovery (for example, borderline personality disorder or dual diagnosis) or those with enduring mental illness (such as medication resistant psychosis) who would benefit from psychological interventions not routinely offered in the majority of mainstream services. The mental health nurse practitioner would also be ideally placed to work across the primary, secondary and tertiary health sectors and provide care that emphasises early intervention, mental health promotion and preventative strategies (Barker 2000). Appendix 5 outlines a generic template that has been developed in New Zealand that describes the standards, competencies and professional requirements for the mental health nurse practitioner.

In 2002, the first New Zealand mental health nurse practitioner was appointed, without prescribing rights, to a DHB. The practitioner's area of practice is with young people and adult community mental services. The *Primary Health Organisations Service Development Toolkit for Mental Health in Primary Health Care* (Ministry of Health 2004) demonstrated how the role of the nurse practitioner could be utilised within mental health services. Support and leadership for the profession has been developed by the NZCMHN. The NZCMHN has implemented the *Rita McEwan Nurse Practitioner Development Unit* to provide mentorship and financial support for mental health nurses applying to the NCNZ for nurse practitioner accreditation (refer to New Zealand College of Mental Health Nursing website <http://www.nzcmhn.org.nz/>).

International literature has recognised that the range of mental health needs in the primary health population is not being met by generalist nurse practitioners. Although general nurse practitioners in the primary and community settings come into contact with clients presenting mental health problems, they lack the necessary skills in psychological assessment (Torn 1996). In contrast, research has illustrated the positive effects of the specialist mental health nurse practitioner. Studies conducted in the early 1980s indicated mental health nurse practitioners focused on health education and prevention in primary health care. Consequently, when compared with physicians, the proportion of drug related visits per client and the number of prescriptions per patient were less for nurse practitioners (Cornwell and Chiverton 1997).

Torn and McNichol (1996) examined the utility of the role of a mental health nurse practitioner. They found that the role could combine nursing and psychiatry in an innovative way to fill the deficit that exists in both primary and community mental health settings. They also suggested that the mental health nurse practitioner could work with specialist mental health nurses to ensure that appropriate care is received by clients. This would benefit both the public and health care professionals. Torn and McNichol's mental health nurse practitioner model is supported in other international studies (Cotroneo et al 2001; Edmands et al 1999; Gournay and Brooking 1994).

3.3 Mental health nursing standards of practice

The terms 'standard' and 'competency' are often used interchangeably within the literature. Government regulations, however, have defined the two terms separately. This section utilises the term 'standard' as documented by the NCNZ, Standards New Zealand and NZCMHN. The term 'standard' refers to the overall expected level of performance (Standards New Zealand 2001). In contrast, 'competency' describes the skills, attributes and knowledge required of the individual health professional to meet the standard (Nursing Council of New Zealand 2001b). The expected outcome (or standard) is achieved when all criteria (or competencies) associated with the standard are met.

This section reviews the current legislation, standards of practice and competency frameworks that regulate mental health nursing in New Zealand. The mental health sector standard and NZCMHN standards are reviewed as examples of best practice in the development of mental health nursing standards. Three international examples of best practice for the development and measurement of standards of practice are also reviewed.

3.3.1 New Zealand mental health nursing standards

Mental health nurses are mandated to practice in accordance with the laws, standards and expectations of society. The *National Mental Health Sector Standard* (Standards New Zealand 2001) aims to ensure consistency in the delivery of mental health treatment and support provided to all service users of mental health services (p 5). It applies to all areas where mental health services are provided and nurses, therefore, are subject to it. Standards of practice for mental health nurses have been developed by NZCMHN (2004). The NZCMHN standards outline the expected levels of competency nurses must perform to practice in mental health and provide the basis for public accountability and evaluation of nursing performance (Te Ao Maramatanga: New Zealand College of Mental Health Nursing 2004). They define the key attributes that are believed to underlie competence in the context of mental health nursing, and specify the level of performance required, the outcomes to be anticipated and the context in which the performance will take place.

The Health Practitioners Competence Assurance Act 2003 introduced mechanisms to ensure that all health practitioners are competent and fit to practise in their professions with the intention of protecting the health and safety of the public (Health Practitioners Competence Assurance Act 2003). The Act places responsibility and accountability on the professional authorities for providing tools and ensuring that health practitioners throughout their careers are competent to practise (Ministry of Health 2004a). Effectively, the Health Practitioners Competence Assurance Act has placed responsibility on the NCNZ for setting and monitoring professional nursing standards.

The NCNZ (2002) recognises that competency assurance ‘begins with describing appropriate standards of practice for the profession’ (p 2). The NCNZ is supportive of professional groups developing professional standards specific to their specialist practice as long as they are aligned with NCNZ’s Standards for Registered Nurses and meet the requirements for Competence-Based Practising Certificates (Nursing Council of New Zealand 2002). Examples of standards currently utilised in New Zealand and the United Kingdom are outlined below. Competency frameworks for mental health nursing are discussed in section 3.5 of this review.

3.3.2 Best practice

National Standard for the Mental Health Sector

The purpose of the National Standard for the Mental Health Sector is to provide clear guidance to service providers, service users and their families as to what can rightfully be expected of mental health services in New Zealand. The report identified 18 standards that mental health professionals must demonstrate. These relate to tangata whenua, Pacific people, cultural safety, children and young people, rights of services users, safety, records and confidentiality, privacy, consumer participation, family/whānau participation, minimising the impact of mental illness, leadership and management, access, entry, assessment, quality treatment and support, community support options, and reducing discrimination and promoting community acceptance (Standards New Zealand 2001, p 3). The processes for monitoring these standards

include service provider audits and reporting as required in contracts with health funders, and independent reviews.

New Zealand College of Mental Health nursing standards

The NZCMHN standards of practice for mental health nursing are aligned with the National Standard for the Mental Health Sector (Standards New Zealand 2001) and stipulate that the mental health nurse must:

1. ensure her/his practice is culturally safe
2. establish partnerships as the basis for a therapeutic relationship with consumers
3. provide nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan
4. promote health and wellness in the context of her/his practice
5. be committed to ongoing education and contribute to the continuing development of the theory and practice of mental health nursing
6. be a health professional who demonstrates the qualities of identity, independence, authority and partnership.

The NZCMHN specifies that the mental health nurse demonstrates advanced practice when they, at a level of excellence, integrate the six standards with skills in clinical practice, leadership, management, research and education (adapted from Te Ao Maramatanga: New Zealand College of Mental Health Nursing 2004, pp 3–4).

Measuring standards of practice

O'Brien (2002/2003) argued that the six standards developed by NZCMHN are too broad and do not have measurable performance criteria. In response, O'Brien et al (2003) developed and trialled clinical indicators to determine whether the professional mental health nursing standards were being implemented in practise. The results from the study indicated there were variations in the level of the standards achieved by nurses. The study presented a methodological framework for developing culturally and clinically valid and reliable measures of clinical practice (O'Brien et al 2003, p 854).

The University of Lancashire in the United Kingdom established an internal clinical practice benchmarking group to ensure consistent high standards of care across the Royal Preston Acute Hospitals NHS Trust (Ellis et al 2000a). Benchmarking has been suggested to be integral to the development of best clinical practice. In this study, it involved implementing internal structures, such as project support and monthly meetings, to allow health professionals to share examples of best clinical practice and develop their own standards of practice. The initiative specifically focused on improving nutritional care for patients, caring for patients with mental health needs, and the safe transfer of clinically ill patients. Within the mental health setting, benchmarking activity was reported to have highlighted the importance of creating links between community and acute trusts to further develop standards of practice. The report concluded that clinical practice benchmarking improved the standard of practice in their trust (Ellis et al 2000b).

3.4 Skills mix

This section reviews the literature on skill mix in general nursing and mental health settings. Buchan (2002) has suggested that there are significant limitations with the current evidence of skill mix in the health workforce and the methodologies utilised for analysis of skill mix in health services are questionable (Buchan and Dal Poz 2002, p 579). Literature on skill mix in mental health settings is limited. Consequently, this section provides a contextual review of literature focused on the positive effects of skill mix on health care costs, clinical practice and patient outcomes. Further research on skill mix in New Zealand mental health settings would be valuable.

3.4.1 The benefits of effective skill mix

The notion of 'skill mix' has become increasingly important for health care organisations' capacity to provide cost effective health care. Skill mix involves achieving a balance between trained and untrained staff, qualified and unqualified, various occupational groups, and supervisory and operative staff in the context of cost and care considerations (Hicks and Hennessy 2000).

Literature has focused on the relationship between nursing skill mix and indications of cost and quality care. The common topics covered in research are the effectiveness of an 'all-qualified' nursing workforce compared with a 'qualified/unqualified' mix and the impact the increasing proportion of support workers might have on the cost and quality of care (Buchan and Dal Poz 2002). Research findings on cost effectiveness of skill mix have indicated that as a result of the hidden costs associated with support workers, cheaper skill mix may not be cost-effective. The hidden costs included: increased absence and turnover rates; increased levels of unproductive time associated with support workers; decreased autonomy and capacity to work independently; and increased concern reported by nurses about the increased possibility of harm caused by support workers practising beyond their technical and legislated capacity (Buchan and Dal Poz 2002).

Aiken et al (2002) reviewed the impact of effective skill mix in Magnet hospitals. They found these hospitals facilitated nurses' professional autonomy and control over practice, and fostered better relationships between doctors and nurses. The authors argued that these features of Magnet hospitals improved patient outcomes (Aiken et al 2002). Other research has confirmed these findings illustrating that better nursing skill mix or more qualified nurses improve the quality of care (Kitson 1997).

3.4.2 Skill mix in mental health services

Ashton (2004) explained that within New Zealand hospitals, mental health staffing is rigidly organised around professional groups. In contrast, community mental health services are potentially more flexible in their approach to staffing, with much of the care being provided by less-skilled mental health support workers. Ashton recommended that the mental health sector needs to develop a strategy to share the pool of skill mix across DHBs, NGOs and primary health organisations (PHOs). It was suggested that this would promote collaboration, successful teamwork and increase nurse autonomy (Ashton 2004).

Best practice examples of skill mix in mental health settings are limited. McGuinness (2003) described a local initiative in London to adjust the skill mix of community mental health nurses in community mental health teams. Although there was no specific tool identified by the author the research indicated that by altering the mix of skills in the community mental health teams, a more cost effective delivery of community mental health services was demonstrated. Specifically, it was recognised that the proportion of the senior nurses was higher than numbers regarded as appropriate for local needs. By increasing the proportion of junior staff, the cost effectiveness of skill mix was increased and caseload pressures and stress on community mental health nurses was decreased (McGuinness 2003).

3.5 Clinical career pathways for mental health nursing

A clinical career pathway (CCP) provides ‘... a structure for career development for nurses involved in practice, and advancement in such a structure provides recognition and reward for increasing expertise in frontline work with patients/clients’ (Jones 1997, p 2). Benner’s five stages of nursing practice that range from ‘novice’ to ‘expert’ underpin the structure of CCP programmes generally (Benner 1984; National Professional Development and Recognition Programmes Working Party 2004). Currently, CCP programmes have been implemented in Canada, Australia, Sweden and New Zealand (Carryer et al 2002). This section discusses CCP in the context of New Zealand and provides two examples of best practice CCP frameworks and programmes.

3.5.1 Current state of clinical career pathways in New Zealand

CCP programmes were introduced in New Zealand in the late 1980s and aimed to recognise the ‘clinical expertise of nurses and to retain professional autonomy and development’ (National Professional Development and Recognition Programmes Working Party 2004, p 4). The Ministerial Taskforce on Nursing (1998) argued that creating CCPs with appropriate ongoing education would enhance nurses’ career options and foster the aspirations of new and returning nurses. According to Trim (1994), the specific benefits of CCP programmes for employers are succession planning, leadership development, professional direction, informing the skill mix of registered nurses, and the value that mental health nurses bring to clinical and management practices (Trim 1994). CCPs, she argued, are essential for strengthening nursing leadership, developing the nurse practitioner role and effective skill mix.

The MHC and the MHWDC have provided the competency framework that employers in mental health services should utilise in the provision of appraisals, career plans and pathways (Mental Health Commission 2001; Mental Health Workforce Development Co-ordinating Committee 1999). Additionally, the NCNZ and NZCMHN have developed competency frameworks specifically for registered nurses and mental health nurses (Australian and New Zealand College of Mental Health Nurses and National Directors of Mental Health Nursing 2002; Nursing Council of New Zealand 2001b). All these documents outline the knowledge, skills and attributes that nurses must demonstrate to progress through three levels of competency, from basic to advanced and to specialist competency.

New legislation has confirmed the importance of competency frameworks, CCPs and professional development recognition programmes (PDRP). The Health Professionals Assurance Act (2003) requires the Nursing Council of New Zealand (NCNZ) to ensure the competency of nurses' practice. From 2005, it is mandatory for registered nurses to hold a Competency-based Practising Certificate (National Professional Development and Recognition Programmes Working Party 2004). To obtain NCNZ practising certificates, nurses must be able to demonstrate their competency in clinical nursing practice through maintaining a professional portfolio. This process has increased the importance of developing and implementing professional development recognition programmes (Carryer et al 2002).

The National Professional Development and Recognition Working Party (2004) state that PDRPs aim to ensure nursing expertise is visible, valued and understood; enable differentiation between the different levels of practice; value and reward clinical practice; encourage practice development; identify expert nurse/role models; encourage reflection on practice; encourage evidence-based practice; provide a structure for ongoing education and training; assist nurses to meet the requirements for competence based practising certificates; and assist in the retention of nurses (National Professional Development and Recognition Programmes Working Party 2004, p 5). PDRPs are intrinsically linked to CCPs and the NCNZs (2005) introduced a process whereby organisations with PDRPs can apply for Nursing Council approval in order to ensure nurses utilising their programmes have met NCNZ competency requirements of the annual practising certificates (National Professional Development and Recognition Programmes Working Party 2004).

Literature from New Zealand has revealed limited development and utilisation of CCPs. Carryer et al's (2002) research on nurses' perceptions of CCPs in a New Zealand hospital indicated that nurses have mixed views on the usefulness of CCPs. Some nurses argued that the tasks involved with CCP programmes are an unnecessary demand on their employer while others argued that it is a valuable form of professional development. Te Rau Matatini (2003) reviewed CCPs for mental health nurses in New Zealand. Their report revealed that the application of CCPs is limited to mainstream institutions and the conceptual framework underpinning CCPs is not applicable to NGOs and Māori community mental health services (Te Rau Matatini 2003). They suggested the quality and ability to implement CCP programmes is intrinsically linked to the organisation. Because NGOs do not have the same level of infrastructure in place as DHBs, resource constraints may mean that some mental health nurses may not be part of CCP programmes. The Ministry of Health (2003a) has also indicated that the historical lack of funding for NGOs has led to their inability to fully develop human resource systems and organisational development infrastructure. In particular NGO mental health nurses often have difficulties with accessing supervisors, mentors and interprofessional health staff.

In Australia, limited utilisation of CCPs has been reported to have had implications for recruitment and retention of mental health nurses and weakened nursing leadership. Clinton and Hazleton (2000a, 2000b) found that advanced mental health nurses perceived a lack of career pathways, which in turn deterred some nurses from staying in the sector. Nurses also indicated that there were financial constraints and a lack of incentives to take on senior clinical roles. Additionally, organisations were inconsistent with the appointment of senior roles such as nurse practitioners and nurse specialists. Consequently, the less experienced nurses may perceive little or no career pathway to aspire to.

3.5.2 Best practice

Clinical career pathway frameworks

Carryer et al (2002) report on a CCP framework utilised in a New Zealand hospital. The framework was focused on professional development and aimed to provide structured support and learning for clinically based nurses, facilitate the development of clinical expertise in professional practice, and provide a process of recognition and reward of excellence. The nurses were required to identify their own level of practice from five levels ranging from beginner to advanced practitioner. They had to supplement this with a portfolio of evidence that demonstrated their acquisition of the nursing competencies selected for that level. The assessment of the portfolio was completed and forwarded to a CCP committee. To evaluate the programme, Carryer et al developed and utilised a clinical career pathway evaluation tool (CCPET) to assess nurses' and midwives' knowledge of, and attitudes towards, their clinical career. The results indicated that the programme improved nurses' knowledge and attitudes towards developing and maintaining CCP portfolios (Carryer et al 2002).

CCP programmes

Evan (1998) reported on an initiative between a community health services trust and Middlesex University in London to improve career pathways for mental health nurses. The collaboration aimed to fully prepare nurses to become expert practitioners by developing practical skills and theoretical knowledge. Participants engaged in a two year programme in either an acute or community living focused pathway. The nurses had to demonstrate their acquisition of competency through the development of portfolios and by undertaking a project on enhancing client care in a specific clinical area. The author reported that the programme benefited participants by offering them a chance to fully develop their clinical and academic skills in their chosen speciality. Additionally the programme gave them a clear direction for the progression of their career. The Community Service Trust reported that participants are highly motivated nurses who on rotation facilitate a 'cross pollination' of ideas with other health professionals. This scheme was reported to have increased both recruitment and retention (Evans 1998).

3.6 Professional supervision

International literature defines professional supervision as a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice, and promote service users' health outcomes and safety (Department of Health 1993). This section provides a brief overview of current research on professional supervision and presents three examples of best practice that approach professional supervision innovatively.

The move towards care in the community is a primary focus of the National Strategy for Mental Health Services (Mental Health Commission 1997, 1998). This requires health professionals with specific skills and a broad focus (Ministry of Health 1996a). The NCNZ argued that this strategy is dependent on an adequately prepared mental health workforce and a supportive learning environment (Nursing Council of New Zealand 2004). The New Zealand Health Strategy (2000) recognised the need for increased support and supervision of health professionals (Ministry of Health 2000). In 2002, HWAC identified the importance of health practitioners' ongoing professional development which should be achieved through mentoring, practice review, supervision and in-house training. The report also suggested that clinical tutors and supervisors need their own ongoing education and development in order to keep up to date with contemporary topics and methods (Health Workforce Advisory Committee 2002b).

Several models of professional supervision have been developed. Reports suggest the most widely adopted model is based on Proctor's 'three-function interactive' approach to supervision (Stevenson 2000; Winstanley and White 2003). This model consists of three functions:

1. Formative function: the educative process utilised in developing the knowledge and skills of those supervised. This is achieved through sharing knowledge and enhancing self-awareness.
2. Normative function: the management process required to maintain safe practice and standards of care. This is achieved through discussion of cases and identification of examples of poor practice.
3. Restorative function: the supportive process whereby nurses discuss and share experiences and anxieties with peers (adapted from Walsh et al 2003; Winstanley and White 2003).

White et al's (1998) research found the nurses in their United Kingdom study had no knowledge of current models available and tended to construct their own models for supervision.

There is a large amount of international literature focused on the beneficial effects of professional supervision for mental health nurses. The Australian Government recognised professional supervision as an important strategy for encouraging professional development, providing support and improving clinical standards and the quality of care (Hancox et al 2004). Cutcliffe and Proctor's (1998a, 1998b) study argued that nurses who receive professional supervision are reflective in practice and have increased personal wellbeing, confidence, and knowledge of possible solutions to clinical problems. Other research indicates professional supervision has increased staff morale, job satisfaction and decreased stress, burnout, and staff sickness (Berg and Hallberg 1999; Butterworth and Woods 1998). There is limited evidence, however, of professional supervision working (Hancox et al 2004; Winstanley and White 2003) and many argue that the benefits of professional supervision are difficult to measure (Stevenson 2000).

3.6.1 Best practice

Collaborative supervision

Literature has suggested that professional supervision is often conceptualised by nurses as hierarchical, managerial and punitive (Walsh et al 2003). Stevenson and Jackson (2000) suggest that the distinction between the 'knowing, educated and practised supervisor and the naïve supervisor who gains insights through experiences of the supervisory process, moving systematically beyond her/his novice state to clinical competence' is highly problematic (Stevenson 2000, p 492).

In the United Kingdom an initiative coined 'egalitarian consultation meetings' aimed to take the 'super' out of psychiatric nursing supervision and develop professional supervision with joint ownership and responsibility between peers (Stevenson 2000). The initiative involved a group of eight nurses from the Newcastle City Health Trust who took part in six meetings including an evaluation session. The sessions were consultative rather than hierarchical and focused on the group discussing 'cases' in a collaborative manner. This model is similar to 'peer supervision'. The evaluation by the nurses indicated that they felt empowered and co-operative in engaging in professional supervision. This was a direct effect of the emphasis on conjoint responsibility for learning. Additionally, the nurses explained that the non-confrontational methods used in the meetings allowed them to feel confident to share comments on what they had seen and heard in therapy sessions (Stevenson 2000). Due to the small sample size these findings cannot be generalised, however the innovative model provides an example of a different approach to professional supervision that could be useful for future developments.

Group supervision

Another approach to destabilising the hierarchical nature of professional supervision is group supervision. Walsh et al (2003) reported on the development, implementation and evaluation by a small team based in an Australian community mental health service. In collaboration with a University Department of Nursing, the team of six nurses developed an innovative model that was piloted for six months in their community based workplace. All members of the group had equal input into the development of the model. The aims of the model were to develop knowledge and skills, monitor the quality of care, identify solutions to problems, improve nursing care, increase understanding of professional issues and give support to fellow clinicians (Walsh et al 2003). It was concluded that group supervision was the best method to facilitate a supportive and less threatening environment.

Education for clinical supervisors

Adequate education for clinical supervisors is imperative to ensure that professional supervision is conducted in an appropriate and supportive manner (Hancox et al 2004; Winstanley and White 2003). Research has suggested that the absence of suitable training can lead to inappropriate and punitive forms of professional supervision. Additionally, without training, the role of the clinical supervisor can become confused with the aims of line management (Hancox et al 2004).

The Centre for Psychiatric Nursing Research and Practice at Melbourne University, Australia, developed the Clinical Supervision for Health Care Professionals programme to provide appropriate education for nurses likely to take on the role of clinical supervisor. The aim of this programme was to develop nurses' skills and knowledge in professional supervision. The main objectives were to enhance theoretical knowledge and appreciation of professional supervision in mental health, enable critical analyses of various models of professional supervision, facilitate development of skills to maximise benefits of professional supervision, and facilitate understanding of ethical and legal issues associated with professional supervision. Participants in the programme reported several benefits. The nurses contended that the programme increased their understanding of professional supervision and decreased their apprehension towards taking on the role of supervisors themselves. The increased awareness of professional supervision also produced a more favourable view of both receiving and providing professional supervision (Hancox et al 2004).

3.7 Mental health nursing education

Appropriately educated and skilled staff are essential for the provision of mental health services (Mental Health Commission 1998). The World Health Organization (WHO) stipulated that to work in mental health, nurses require a 'well-developed knowledge base, along with specialist skills in both the technological and caring dimensions of mental health nursing and must be equipped with the expertise to make sound clinical judgments both autonomously and as full members of the multidisciplinary health care team' (World Health Organization 2003, p 6). In New Zealand, nurses undertake undergraduate and postgraduate education to acquire the skills and knowledge to work in the mental health sector. The following provides a contextual overview of the current education for mental health nurses. Best practices for mental health nursing education are illustrated and current national and international literature are also reviewed.

3.7.1 Nursing education in New Zealand

Training and development of health professionals is a key strategic area for the Ministry of Health. The role of the Mental Health Workforce Development Programme (MHWDP) is to address current gaps in capability, design strategies to develop new skills and knowledge, and strengthen mental health service provision in the community (Mental Health Workforce Development Programme 2003). The MHWDP has identified that changes in the philosophy of care in New Zealand have transformed the type of worker required for mental health services. The demand for recovery focused mental health workers has meant that new training to develop these skills is needed. Mental health workers are required to have specialist skills and knowledge in cognitive behavioural therapy, risk assessment, community treatment of acute illness and mental illness in children, adolescents and older people. The Māori Health Strategy (Ministry of Health 2002a) and The Pacific Health and Disability Action Plan (Ministry of Health 2002e) have outlined a strategic plan for the development of a trained, experienced and culturally competent workforce. The MHWDP is committed to developing and strengthening cultural competency in the mental health workforce. In conjunction with these specialist skills, it is vital that mental health professionals can work in multidisciplinary teams (Mental Health Workforce Development Programme 2003).

Nurses entering mental health must have undertaken a three-year bachelor's degree programme offered in one the 18 universities' and polytechnics' schools of nursing in New Zealand. Nurses registered before the introduction of the degree programme must hold a Nursing Council approved qualification, registered comprehensive nurse or registered psychiatric nurse, to work in mental health. These programmes may differ in organisational structure but all are required to meet the national standards set by the Nursing Council of New Zealand, the New Zealand Qualifications Authority (NZQA) or the Committee for University Academic Programmes (CUAP) (Ministerial Taskforce on Nursing 1998).

The first year of clinical practice marks the transition from student to practising nurse. In 1996, the National Working Party on Mental Health Workforce Development recognised that the three-year comprehensive nursing programme does not provide speciality skills in psychiatric nursing. The report argued that specialist training should be undertaken by graduates entering mental health settings (Ministry of Health 1996a). This was based on a successful pilot programme trialled in 1995 for mental health new graduates run by Capital and Coast Health and Whitireia Polytechnic (Hughes and Clarke 1996). In response, the Government introduced new graduate mental health nursing programmes nationally in 1997. Currently, to practise in the mental health sector, it is recommended that nursing graduates complete a 10-month new graduate post-entry clinical training (PECT) programme. Advanced mental health nursing programmes are also available for experience mental health nurses.

The Clinical Training Agency (CTA) purchases new graduate and advanced mental health clinical training for nurses. In 1995, the Government split funding for health education between Vote Health and Vote Education. The Ministry of Education funds all pre-entry qualifications and postgraduate qualifications with less than 30% clinical component. The Ministry of Health funds all PECT programmes with 30% or more clinically-based components (Clinical Training Agency 2001; Expert Advisory Group on Post-Entry Clinical Nurse Training 2004). The CTA stipulates that PECT training is vocational, clinical, post entry, formal, equivalent six months' full-time and nationally recognised. The NCNZ monitor and set the standards of practice for the new graduate and advanced mental health nursing programmes.

Generic undergraduate nursing programmes have been offered in polytechnics from the mid 1970s. Before this, nurses received in-service training based in hospitals. These changes have significantly affected the speciality of mental health nursing (Ford 2005). National literature has suggested that the absorption of psychiatric nursing into mainstream nursing education has minimised and marginalised mental health nursing issues. It is argued nursing students do not receive adequate skills and knowledge base in mental health nursing (Ford 2005; Prebble 2001).

More recently, the Werry Centre for Child and Adolescent Mental Health (2003) found that while adult mental health issues have been incorporated into many undergraduate nursing programmes, few have child and adolescent mental health as part of their curriculum. Peters (2003) found that child and adolescent mental health is often not included in the nursing curriculum because non-mental health teaching staff and students perceive mental health to be a 'soft option'. They also found there is a significant lack of trained tutors/lecturers and clinical supervisors with child and adolescent mental health experience (Peters 2003). This proposition was supported by a recent study on new graduates, where students perceived the mental health component and clinical exposure to mental health in undergraduate programmes to be severely limited (Finlayson et al 2005; Ford 2005).

International research confirms the New Zealand studies and has indicated that the mental health content is limited in generic nursing programmes across Australia and the United Kingdom (Bailey 2002; Brooker et al 2002; Clinton and Hazelton 2000; Wynaden et al 2000). Additionally, clinical placements in mental health are limited and vary significantly between nursing programmes. Literature has shown the importance of clinical placements for nurses' future career choices (Charleston and Happell 2004; Ferguson 1999; Happell 2001; Rushworth and Happell 2000). This will be discussed further in the recruitment and retention section 3.9.

Recently, Ford (2005) evaluated the effectiveness of new graduate mental health nursing programmes in New Zealand. It presented students' evaluations of the one-year new graduate programme offered by Auckland DHB. Students in this programme participated in rotations through four clinical placements and attended study days at Auckland University. The theoretical content was linked to their clinical practice and they received preceptorship and professional supervision. The results were positive, with 78% of students stating that the programme adequately prepared them to work in mental health settings. Students explained that the professional supervision and support they received increased their confidence and supervisors were considered as role models for mental health practice. The students valued the combination of theoretical and clinical components in the programme. It was argued that the programme expanded the students' knowledge, increased their skill base, and developed their understanding of the role of the mental health nurse in different settings (Ford 2005).

The fiscal and training value of PECT has been reviewed. A report prepared for the Mental Health Workforce Development Committee (Finlayson et al 2005) incorporated various groups' perspectives on PECT including key stakeholders, PECT graduates and service users. Overall, the responses relating to both the training and fiscal value of post entry clinical training were positive (Finlayson et al 2005).

Recommendations were made in relation to how the funding for PECT could be improved. Many of the participants stated that the Ministry of Education should be responsible for funding all education programmes and the Ministry of Health should be responsible for increasing access for the health workforce. Participants recommended that funding currently used by the CTA to purchase PECT programmes could be better used to provide training for greater numbers of trainees, fund training to postgraduate diploma level with an exit point at postgraduate certificate level, and provide more appropriate funding for release time, clinical supervisors, additional clinical experience, and travel and accommodation for trainees (Finlayson et al 2005).

The 'Blueprint for Mental Health Services in New Zealand' introduced the 'recovery approach' and emphasised a move to the provision of services within the community (Mental Health Commission 1998). The PECT report, however, illustrated that many key stakeholders perceived PECT programmes to be inappropriate for the majority of the NGO workforce and argued that the programmes need to emphasise primary health care and recovery approaches to mental illness.

Many of the results from this review confirmed findings in earlier reports related to post-entry clinical training (Clinical Training Agency 2004; Expert Advisory Group on

Post-Entry Clinical Nurse Training 2004; Health Workforce Advisory Committee 2002a; Hodges and MacDonald 2000; Matenga and Honeyfield 2003; Mauri Ora Associates Limited 2003; Ministerial Taskforce on Nursing 1998).

3.7.2 Best practice research

Service user involvement

In Canada, research has shown that involving service users in undergraduate nursing education can increase the likelihood of students choosing a career in mental health nursing (Bennett and Baikie 2003). The Memorial University's nursing programme involved a service user and lecturer collaboratively designing, preparing and participating in classroom activities. The partnership between the service user and nurse educator was focused on 'establishing relationships, enlarging perceptions, and assisting students not only to learn about mental illness but also to find common ground and empathy with the experience of others' (Bennett and Baikie 2003, p 108). The students commented on the collaborative process and stated that the involvement of a service user significantly improved their understandings of mental illness and perceptions of mental health nursing. Additionally, the service user involved in the programme explained that the student and nurse educators' encouragement helped with his recovery process.

Frisby (2001) illustrated a successful model for utilising service users in the delivery of pre-registration mental health education in the United Kingdom. The programme involved service user representatives from local mental health services in college-based sessions to evaluate students' client review presentations. The client review presentation is a process whereby students critically analyse their own assessment of service users. The aim was to increase students' awareness of service users' perspectives of their own illness while also building a partnership between mental health service users and nursing education. Students explained that the process illustrated different options available for intervention and enabled clinical decision-making and assessment skills with a service-user focus (Frisby 2001).

Mariolis et al's (2002) report on the quality of life and wellness programme illustrated an alternative to traditional settings for psychiatric nursing clinical experiences. The programme is designed to enable first-year nursing students to engage with mental health service users in a mutually beneficial relationship. The programme co-ordinators involved case managers and service users in developing the areas to be covered in the clinical placements. The programme consisted of weekly contact for two hours during the academic year. In the first hour students met informally with the clients individually. The second hour involved a structured group session where the topics of goal setting, maximising health, nutrition, positive coping, and relaxation techniques were discussed. Service users were also invited to utilise the academic setting. The students stated that the programme enhanced their learning through increasing their empathy and understanding of service users' illnesses. Additionally, after completing the programme they were less fearful about meeting with the services users. The service users also expressed benefits from being involved in the programme (Mariolis and Picard 2002).

Collaborative approaches

Literature has suggested that clinical placements are the most influential factor for choosing a career in mental health nursing (Charleston and Goodwin 2004; Happell 2001; Rushworth and Happell 2000). Research suggests that good collaboration between mental health services and education providers is integral to successful clinical placements.

Arnold et al (2003) discussed an innovative, collaborative programme between mental health services and education providers that is effective in enhancing a supportive learning environment and increasing enthusiasm for mental health nursing. The programme was developed by the University of Ballarat and Ballarat Health Services in Australia. Joint appointments were made to co-ordinate the professional supervision and delivery of the theoretical content by mental health staff. The evaluation of the programme by the undergraduate nursing students and clinical staff was positive. The students stated that they achieved their learning objectives of applying theory to clinical practice and highly valued their experience with clinicians. The clinicians were also positive, with 97% stating that their involvement enabled them to increase their knowledge base (Arnold et al 2003).

In Canada, the University of Saskatchewan's collaboration with regional psychiatric centre prairies aimed to enhance the quality of education for those who had chosen nursing within a forensic setting. Peternelj-Taylor (1996) reported that the programme is also important for established mental health nurses who supervise student nurses, and ongoing professional development. The programme provides an extensive orientation for student nurses in preparation for their clinical placement. Significant support was given to students throughout the process. Teamwork was emphasised so students felt they could rely on staff any time they were unsure of how to deal with a service user. Students had onsite supervision by a faculty member and mental health nurses working at the Centre. The staff members involved with the programme reported benefits including feelings of achievement and stimulation from working and developing relationships with students and teaching staff. Practising nurses seem to 'grow and learn as much as those who are being taught' (Peternelj-Taylor and Johnson 1996, p 27). Thus, the programme was equally important for forensic mental health nurses' ongoing professional development.

Interagency training

International literature recognises the need for education that is focused on child and adolescent health in primary health care. Sebuliba and Vostanis (2001) described a programme developed in the United Kingdom that promoted interagency child and adolescent training for primary health care staff. The training was provided to 150 health professionals who participated in a two-day introduction course followed by three days of training in the assessment and management of children and their families. Although the programme co-ordinators found some difficulties with co-ordinating training for interagency staff, the participants rated their awareness of mental health issues significantly higher as a direct consequence of the course. This indicated that the short programme was beneficial for primary health care staff.

Rural and remote area education

There is limited availability of specialist mental health services in rural or remote areas in Australia. Research has reported that nurses who lack appropriate qualifications and experience in mental health are relied upon to provide mental health services. Chang et al (2002) illustrated the development, implementation and evaluation of an effective postgraduate programme for nurses employed in rural and remote areas of New South Wales. The programme involves collaboration between a rural university, the New South Wales Health Department and several regional health service partners. To disseminate information to nurses on each training module, a variety of distance education methodologies was utilised. The nurses who participated in the programme responded positively to the programme. The authors concluded that the programme exemplified a cost-effective and suitable method for increasing rural and regional nurses skills and knowledge in mental health nursing (Chang et al 2002).

3.8 Mental health nursing research culture

This section reviews the current literature on mental health nursing research and provides an overview of strategies to improve nurses' research utilisation and participation.

3.8.1 Research utilisation and participation

Mental health nursing research can encompass various aspects related to the profession, clinical practice and service provision. Most literature has reported that registered nurses should have the ability to critically reflect on research studies, to have a basic understanding of different research methodologies and their ethical implications, and to recognise areas of their clinical practice that need to be researched to improve patient care (Parahoo 1999). There is some evidence to support the claim that service users of evidence-based nursing care generally receive better outcomes than individuals who receive routine nursing care (Happell 2004).

The Ministry of Health has identified mental health nursing research as integral to improving practice and for professional development (Mental Health Workforce Development Programme 2003). Phillips (2003) explained that research is central to nurses CCPs and that some employment contracts have included a research function within their CCP frameworks. Advancement along the competency continuum (beginner to advanced) requires development in practice, knowledge, skills, leadership and research. The NCNZ has stipulated that advanced nurses must demonstrate their application of clinical leadership and research development within their clinical practice. NZCHMN professional standards of practice confirmed the importance of research in mental health nursing practice (Te Ao Maramatanga: New Zealand College of Mental Health Nursing 2004).

Evidence-based nursing is recognised as integral to effective clinical practice and the Government has developed specific strategies for collation and analysis of mental health information (Ministry of Health 2004c). *The Report of the Ministerial Taskforce on Nursing* (1998) argued that research needs to be utilised at a practice level for nursing practices to be evidenced-based. National research has reported that evidence-based research projects need to be adaptable and flexible to meet the challenges of specific organisational capacities, economic environment and the changing needs of the health environment (Phillips 2003).

National literature on the current state of mental health nursing research is limited (Phillips 2003). The Ministerial Taskforce on Nursing argued that although there is a growing interest in research by nurses, only a small percentage is published (Christensen 1997; Ministerial Taskforce on Nursing 1998). While international literature is relevant to mental health nursing practice, there are specific issues related to the New Zealand context. Literature has recognised that there is minimal research that has examined Māori and Pacific mental health issues, a lack of research that is specifically driven by Māori and Pacific researchers, and limited utilisation of culturally specific methodologies (Phillips 2003, p 7).

International literature has suggested that there have been various efforts within nursing to promote research utilisation. These include the establishment of unit-based and hospital-wide nursing research committees, the development of formal models to promote research within organisations, and speciality sectors prioritising the use of research findings in practice (Appleton 1998; Jacobson 2000). Additionally, literature has reported that there has been an increase in journals specifically focused on mental health nursing which has indicated that there has been an increase in the amount of research published and greater interest in mental health nursing research from within the speciality. Research priorities identified within international literature include support, holism, mental health nursing practice, quality care outcomes, mental health aetiology, and mental health delivery systems (Phillips 2003, p 4).

Despite these initiatives, studies have suggested that a research-practice gap has remained in nursing. In 1995, McKenna stated that nurses have failed to utilise research findings in their clinical practice and recent research has indicated that this problem remains (McKenna 1995). Jacobson (2000) argued that this is because nurses lack the time to review research and have limited administrative and physician support (Jacobson 2000). Other research has indicated that nurses attitudes and inability to question the underpinnings of clinical practice is a major barrier to the utilisation of research (Jacobson 2000). Recently Happell (2004) stated that nurses consider themselves insufficiently equipped to conduct research and do not actively implement research findings in practice. Often, she argued, nurses are not confident enough to utilise their research findings and challenge medical colleagues and organisational managers.

Research has indicated that nurse academics and graduates of mental health nursing programmes have limited involvement in research. Nurse academics reported that they feel a lack of support and encouragement often as a result of the importance placed within their faculty on clinical and teaching work. Further, nurse academics have explained that the major factors impeding their participation in research include difficulties in acquiring research funding, negative attitudes towards participating in research and a lack of confidence in research skills (Gething and Leelarthapin 1999). Parahoo (1999) reported on graduates of a programme in Ireland. The nurses stated that although they received sufficient training in research based practice, they did not report higher rates of research utilisation than a controlled sample of other nurses who did not receive the training. Rates of research utilisation reported in the study were significantly lower for mental health nurses.

3.8.2 Best practice

Strategies for individual nurses

Jacobson (2000) reported on a model for research utilisation that encouraged nurses to examine their everyday practices, assess existing research, and develop, implement and evaluate changes to research-based practice. The 'power of one' model places the onus on individual nurses to examine their practice, identify resources to increase their research base, and evaluate their effectiveness. The report outlined several resources that nurses should utilise and provided strategies for developing nurses' research capability. Strategies included locating knowledgeable health professionals and educators within nurses' own clinical settings and local universities, accessing recent journal articles on research findings, membership of professional organisations, and utilisation of websites on research-focused government agencies (Jacobson 2000).

Sullivan (1998) also described several innovative evidence-based information systems co-ordinated in the United Kingdom and the United States of America for mental health nurses. These included the Cochrane Library, the Centre for Reviews and Dissemination and the National Register. The Cochrane Library is an electronic database that is updated regularly and holds reports on efficiency, controlled trials and research methodology. The Centre for Reviews and Dissemination is facilitated by the University of New York and reviews and disseminates results from clinical studies and

the National Register is a database that includes all the current research conducted by the National Health Service in the United Kingdom (Sullivan 1998).

Research centres

In Australia, there are several centres that have been developed to improve the research capabilities of mental health nurses. Clinton (1998) reviewed the four main centres in Victoria, Queensland and Sydney. The centres had various objectives and focused on mental health policy, developing research and education, supervision of students, quality assurance and conducting original research. The outputs from the centres have been positive. Annual reports have illustrated that the centres have facilitated increased revenues and secured various grants and funding and increased the production of articles, books, book chapters, reports, PhD and Masters theses (Clinton 1998). Greenwood and Gray (1998) confirmed these findings, illustrating the benefits of intersectoral initiatives in Western Sydney that increased research productivity, improved intersectoral relationships, and heightened visibility and appreciation of nursing and nursing research.

Happell (2004) provided an example of best practice in establishing a centre to foster mental health nursing research in Melbourne. The Centre for Psychiatric Nursing Research and Practice was developed to address the research-practice gap and increase research utilisation in mental health clinical settings (Happell 2004). The centre is managed by the University of Melbourne and Melbourne Health and funded by the Department of Human Services. The centre is committed to developing programmes and initiatives that aim to bridge the gap between practice, research, education and professional development. The programmes promote research in psychiatric nursing and have a consumer-focused goal. The centre facilitates linkages between mental health nurses from different workplaces, specialities and geographical locations. Specific programmes implemented by the centre included nursing clinical development units, a clinical research fellowship programme, and general research activities such as clinical research projects, a collaborative psychiatric nursing conference, and dissemination of research information. Anecdotal evidence has suggested that participation in the centre has encouraged nurses to identify the relevance of research to their clinical practice and allowed nurses to establish and maintain a research agenda (Happell 2004).

Strategies for university-based nurses

Gething and Leelarthapin (1999) reported on a strategic initiative to promote research participation among nurses employed as academics at the University of Sydney. The Faculty of Nursing first appointed a research co-ordinator and then introduced strategies to promote research. The main strategies implemented included the development of a faculty research management plan, research performance indicators, research skill workshops, a faculty seeding grant system, a university grant scheme, research mentorship, research colloquia, a faculty research day, and preparation of a book on research and administration of scholarships for PhD study. These strategies were developed and implemented in three steps. First, the research co-ordinator conducted a needs analysis and in response developed the strategies. Secondly, the strategies were implemented and any changes were assessed. Thirdly, two years after the strategies

were implemented a follow-up survey was undertaken to determine the level of research skills and participation among staff. The results indicated an increase in nurses' perceived research skills and confidence.

3.9 Recruitment and retention of mental health nurses

The World Health Organization (2001) identified serious problems globally with the recruitment and retention of mental health workers. In New Zealand, the Mason Report (1988) argued that the shift away from institutional care to the provision of mental health services within the community created significant resource implications (Ministry of Health 1994). In response, the Government introduced *Looking Forward* (1994) (the National Mental Health Strategy) and *Moving Forward* (1997) (the National Mental Health Plan). These documents identified recruitment and retention of mental health staff as a major strategic workforce issue, with a particular focus on workforce shortages and training for Māori services, children and young people's services, Pacific services, and alcohol and drug services (Ministry of Health 1994, 1996a). The *Blueprint for Mental Health Services in New Zealand* supplements these strategic documents by guiding all current service development (Mental Health Commission 1998).

In 2001, HWAC reported that DHBs continued to have difficulties with the recruitment and retention of mental health nurses (Health Workforce Advisory Committee 2002a). Consequently, recruitment and retention remained one of the main strategic imperatives for the mental health sector (District Health Boards New Zealand 2003; Ministry of Health 2002c). The four centres for mental health workforce development – Te Rau Matatini, the Werry Centre, the Mental Health Workforce Development Programme and the National Addiction Centre – ensure work is done towards progressing recruitment and retention as it relates to their specific areas (Ministry of Health 2004b). Current government objectives include assisting DHBs and NGOs to produce medium to long-term solutions to national and regional problems across all services. The aim is to create efficiency and effectiveness through regional and national collaboration. Initiatives focused on attracting mental health nurses to the sector are outlined as a main priority area (Ministry of Health 2002c).

A recent report prepared for the Mental Health Workforce Development Committee (2005) describes several issues impeding recruitment within the mental health sector, these include:

- poor processes (communication difficulties, delays in process, the quality of the candidates and organisations) hinder recruitment
- financial pressures can affect recruitment
- poor recruitment practices have their own costs
- the poor media perception of mental health makes it difficult to recruit workers into the sector (Hatcher, 2005 p 39).

Much of the literature reviewed by Hatcher suggested that there is an unco-ordinated approach to mental health recruitment and retention: 'individual organisations and

individual workforce groups have developed strategies of their own for retention and recruitment' (Hatcher 2005 p 50).

The following reviews literature that could be useful in developing a national strategy for mental health nursing recruitment and retention within the New Zealand context. Specific strategies for the recruitment and retention of mental health nurses are also discussed.

3.9.1 Best practice research

Organisational strategies

The Magnet hospital programme, established in America, recognised hospitals embodying best practices for recruitment and retention of nurses during the national nursing shortage of the 1980s (Aiken et al 2002; Aiken et al 1994; Lafer et al 2003). Hospitals that displayed particular organisational features in relation to administration processes, professional practice and professional development were awarded Magnet hospital designation (Magnet New Zealand 2004). Magnet New Zealand was established in 2003 to facilitate the development of the Magnet Recognition Program and Magnet principles in New Zealand. American research on nursing outcomes of Magnet hospitals indicate that these hospitals have lower rates of nurse burnout, higher rates of nurse job satisfaction and decreased nurse turnover (Lafer et al 2003).

In addition to the Magnet hospital programme, Lafer et al (2003) report further organisational best practice in recruitment and retention of nurses in the United States of America. Based on a comprehensive review of the evidence, strategies recognised to improve work conditions for nurses include:

- improve pay and benefits
- increase staffing levels
- involve nurses as equal partners in determining appropriate staffing levels
- prohibit mandatory overtime and maximise scheduling options
- provide nurses with a meaningful and effective voice in shaping workplace policies
- increase access to internal and external education
- support efforts of nurses to represent themselves through collective bargaining.

The organisational principles embedded within the Magnet recognition programme and other literature exemplify strategies useful for the development of a national framework for the recruitment and retention of mental health nurses.

Marketing strategies

International research generally acknowledges that mental health nursing is difficult to 'sell' as a career. A campaign for the future of nursing, funded by Johnson and Johnson, is underway in Australia and the United States of America in an attempt to address the ongoing shortage of nurses. This campaign aims to improve the image of nursing and encourage more school leavers to choose nursing as a study option. It also focuses on encouraging nurses who have left the profession to return to it (Johnson and Johnson 2003). Although aimed at nursing in general, this campaign provides a best practice approach that could be utilised in the development of a national recruitment strategy for mental health nursing in New Zealand.

In relation to marketing strategies for recruitment of mental health nurses, Hazelton (2000) argues that innovative approaches need to be developed in order to 'capture the imaginations of students and directly influence decisions to enter mental health nursing at the point of graduation' (p 99). An example of such an innovative approach is currently being developed by the Victorian State Government through production of videos that feature six psychiatric nurses as they complete their daily activities. The videos are designed for distribution to schools and tertiary educators (News 2002).

Educational strategies

Research suggests that innovative nursing programmes have the potential to increase the level of recruitment into mental health. Prebble (2001) argues that recruitment into mental health nursing is severely limited by the current structure of undergraduate nursing degrees in New Zealand. The quality and quantity of the mental health components within nursing education is often limited.

International studies indicate that education that increases students' sense of knowledge and competence has the potential to increase the level of recruitment into mental health (Durkin 2002). Durkin (2002) demonstrates other ways in which nursing programmes have effectively led to nurses choosing the mental health area to work:

- providing students with opportunities to attend team conferences led by psychiatrists
- providing students with the opportunity to interact 'one-on-one' with clients
- providing students with appropriate experience in mental health services
- allowing students to attend activities with a client (Durkin 2002).

The American Association of Colleges of Nursing (2002) also focused on providing strategies for nursing colleges aimed at boosting nursing enrolments. Frase-Blunt (2002) summarises some of these strategies which include:

- recruitment from within the nursing colleges by attracting students who are already doing other undergraduate programmes
- the employment of advertisements to raise the profile of nursing courses
- targeting high school students by offering courses that result in credits towards nursing courses provided in nursing colleges

- conducting ‘shadow days’ where high school students spend a day ‘shadowing’ a nurse in the hospital setting
- hiring dedicated recruiters
- promoting the image of nursing to school guidance counsellors through mental health nurses attending school guidance counselling conferences and sending promotional material to counsellors (Frase-Blunt 2002).

In the United Kingdom, two West London mental health trusts implemented a nurse rotation scheme to improve the recruitment, retention and training of their nursing staff. The scheme consists of a two-year rotation and is comprised of a part-time, work-based degree course facilitated by the School of Health at Middlesex University. The work-based courses develop nurses’ knowledge and skill in contemporary interventions in mental health care and small-team management. A specialist clinical supervisor from each of the rotation areas is provided for each nurse participating in the course. An evaluation of this scheme showed that the programme attracted 25 nurses, with 11 nurses stating that they would not have considered working for the mental health trusts had the scheme not been implemented. The scheme secured financing for two more groups of nurses and exemplifies best practice in addressing nursing staff shortages within mental health.

Targeting strategies

The American Association of Colleges of Nursing reported several effective strategies for increasing recruitment and retention of nurses in nursing programmes (American Association of Colleges of Nursing 2000b, 2002a). One of their strategies focuses on improving the recruitment and retention of men and minority students in nursing degree programmes. This approach involved nursing schools utilising a combination of traditional marketing methods, targeted outreach campaigns, and strategic planning to expand student diversity. Although these programmes are focused on recruitment and retention in general nursing, the strategies could easily be applied to mental health nursing. Two examples of this best practise are illustrated below.

- Washington State University implemented a recruitment strategy that specifically targeted Native American Communities. The university employed a member from the Nez Pride tribe as a recruitment co-ordinator within the nursing school. Additionally, the University received funding to launch the Aid Latino Community to Attain Nursing Career Employment project. This community-based initiative targets Hispanic and Native American nursing students and provides 100 students each year with mentors and encouragement as they progress through their degree. The programme provides incentives for Spanish-speaking students to pursue a nursing career within their own communities (American Association of Colleges of Nursing 2000b, 2002a).

- The University of Texas Health Science Centre wanted to increase the numbers of men enrolled in their nursing programmes. They held a forum for existing male nurses to identify why they became interested in nursing. Participants recommended that recruitment brochures should ‘play up the macho aspects of nursing’ and that ‘flowery’ or ‘feminine language’ should be omitted. The university reported that having taken on many of the recommendations discussed in the forum, enrolments of male nurses at the Health Science Centre has increased to comprise 29% of the student population (American Association of Colleges of Nursing 2000b, 2002a).

In Canada, the Law and Mental Health (LAMH) programme has implemented a successful model for recruitment and retention of forensic psychiatric nurses. LAMH is based within the Centre for Addiction and Mental Health (CAMH) in Toronto and provides comprehensive services to people suffering from mental illnesses who have come into contact with the law. The model consists of several stages. Stage 1 involved posting all positions internally within the organisation to provide all nursing staff at CAMH with the opportunity to apply for the position with LAMH. The second stage involved a series of external strategies including: Attending nursing job fairs; guest lecturing at colleges and universities on forensic nursing; advertising in national and local newspapers; offering student placements within LAMH; and presenting papers and posters at international nursing conferences. Finally, long-term retention strategies were implemented. These included extensive orientation and ongoing training programmes for recently recruited nurses. In doing this, LAMH created incentives for nurses applying for positions within the programme; they receive free education specifically tailored to their role in forensic nursing (Pullan and Lorbergs 2001).

3.9.2 Mental health nurses who are service users

Research has suggested that mental health nurses are at a greater risk of having mental illness compared with the general population (Thomsen et al 1999). The Health Practitioners Competence Assurance Act 2003 requires registered nurses to disclose if they have a physical or mental illness that may affect their fitness to practice. Although any information provided to the Nursing Council of New Zealand remains confidential, some nurses may perceive this process as increasing the risk of stigma and discrimination from their employer and colleagues. Consequently, the recruitment and retention of mental health nurses who are also service users is a challenge for the sector. This section reviews current literature on this issue.

The Ministry of Health and the Mental Health Commission are committed to facilitating anti-discrimination activities in New Zealand. In 2003, the Ministry of Health introduced *Like Minds, Like Mine* which aimed to stop discrimination against people with mental health problems. One of the objectives of this plan was to advocate non-discriminatory policies and practices within organisations that are responsible for mental health services (Ministry of Health 2003c, p 7). The report explained that:

Mental health service workers themselves may be undervalued and marginalised, so it is important that they have the opportunity to contribute to improving the status of people with experience of mental illness – which will consequently improve their own status (p 11).

Similarly, international literature has stated that working with severely mentally ill service users combined with organisational factors and more involved management processes have created considerable stress for mental health nurses (Heim 1991; McLeod 1997; Nolan et al 1995). Dallender et al (1999) discussed the impact of the mental health work environment on psychiatrists and mental health nurses. Their study found that nurses who have developed stress-related problems were those who received limited support and those who frequently worked by themselves.

Prosser et al (1996) identified that nurses who work in community settings are more vulnerable to poor mental health outcomes than hospital-based nurses. Thomsen et al (1999) concluded that the mental health of nurses has significant implications considering that they are entrusted with the care and recovery of some of the most vulnerable people in society.

According to the *Like Minds, Like Mine* strategic framework for improving policies and practices in mental health services, workplaces should utilise support groups that work to reduce discrimination in mental health treatment and services (Ministry of Health 2003c). International research has suggested that improved management that confirms the value of the staff and the contribution they make to health outcomes is essential to alleviating stress (Dallender et al 1999). Best practice strategies to improve the recruitment and retention of mental health nurses who are also service users, need to be researched further.

3.10 Conclusion

This literature review has presented existing literature on mental health nursing in relation to nursing leadership, nurse practitioner, standards of practice, skill mix, clinical career pathways, professional supervision, education, research culture and recruitment and retention. The review provided a knowledge base for the development of the situational analysis outlined in the next chapter.

4. SITUATIONAL ANALYSIS

This section presents an analysis of the information generated from the consultation process and illustrates the current situation of mental health nursing in New Zealand. Representatives' feedback on workforce issues including nurse leadership, nurse practitioner, standards of practice, skill mix, clinical career pathways, professional supervision, education, research culture, and recruitment and retention was analysed and the findings are presented here. The situational analysis formed the basis of the following strategic directions chapter.

4.1 Mental health nursing leadership

The role of mental health nurse leaders is vital and can lead to better service user outcomes and improved nursing morale (Ministerial Taskforce on Nursing 1998). Strong nurse leaders are also important for attracting and retaining a stable nursing workforce (Aiken et al 2002) and for leading, supporting and developing mental health nursing.

4.1.1 Situational analysis

Consultation with stakeholders and mental health nursing colleagues confirmed that nursing leadership in mental health services is currently variable, locally determined and ad hoc in approach. Those consulted were asked to describe the nursing leadership within their organisations and how nursing advice and direction is provided to mental health services.

Nursing leadership

Those consulted reported major variations in the nursing leadership provided in their organisations. The main concern from representatives of both DHBs and NGOs was the lack of leadership structures. They also reported that where there were mental health nurses in senior positions the roles were often administrative or advisory with no recognition of their leadership potential by management. Some suggested they were merely token positions.

DHB representatives reported there were plans being developed in their organisations to rebuild nursing leadership structures, many of which were disestablished in favour of generic management during health sector restructuring in the 1990s. Some DHBs are also attempting to provide leadership training for their senior nurses, for example, financially supporting the nurses to attend postgraduate leadership programmes.

Respondents from the NGO sector voiced concerns about nurses not being able to move into senior leadership positions within their organisations, and the models of care being used. One reported their NGO used a managed care model whereby non-clinicians manage nurses and medical staff. The NGO nurses also reported feeling isolated from their mental health colleagues in the DHB sector.

At a consultation meeting with the Māori mental health nursing caucus of the NZCMHN, concerns were raised over the lack of leadership for Māori mental health nurses. They discussed the low numbers of Māori nurse educators and nurse specialists available for coaching and mentoring Māori nurses.

Likewise, the Pacific nurses were also concerned about the lack of Pacific senior nurses in the roles of nurse practitioners, charge nurses, and Directors of Nursing. They discussed the lack of Pacific role models at senior levels to motivate Pacific nurses, represent Pacific issues and advise senior management about Pacific issues.

Advice and direction

In the majority of DHBs nursing advice and direction is fed into mental health services at a variety of different levels from directors of mental health nursing, nurse advisors, nurse leaders, nurse consultants, clinical nurse educators, clinical nurse specialists and nurses at the coal face. Formal processes are in place in most DHBs with senior nurses being part of senior management and clinical teams. However, in some DHBs the processes are not clear and those consulted reported there was little evidence of nursing advice and direction being fed into mental health services.

There was considerable variation in the responses from the NGO representatives consulted. The majority did not believe that nursing advice and direction was being fed into the mental health services they provided though DHB nurses do sometimes provide clinical supervision and there are often informal links through service and consumer forums and other networks.

Consultation with service users indicated that they would like to work alongside nurse leaders to support mental health nursing and strengthen the voice of service users in management decisions.

The Māori caucus advised that in NGOs there is no clear nursing hierarchy for advice and direction. They explained that there is not a clear structure for nurse leaders who have a 'usual case load' as well as taking on a role of professional leader. Furthermore, there is professional isolation for nurses across the board, and sometimes 'a Māori service is estranged from mainstream services, even though there is sourcing at a strategic level'.

The Pacific nurses working for a DHB reported that the advice and direction comes from 'the DHB mental health nursing area' and their nurse leaders are easily accessible for advice and supervision of nurses within their organisation.

4.1.2 Conclusion

The consultation on nursing leadership for mental health services, and the processes whereby advice and direction is fed into mental health services, highlighted the variability that exists in the DHB and NGO sectors. The contribution that senior skilled nurses can contribute to the development of mental health services is very often not acknowledged or appreciated.

Following the introduction of generic management during the constant restructuring of the last 15–20 years, opportunities for the development of leadership in the profession have been lost. As well, key positions for Māori nurse leaders are not available especially in the NGO sector where an increasing number of Māori nurses are employed. Pacific nurses too face this disparity.

4.2 The mental health nurse practitioner

The role of the mental health nurse practitioner has the potential to contribute to health gains by offering innovative and more efficient ways of working. The mental health nurse practitioner role is an advanced role that builds on experienced nurses' expertise and provides nurses with a new career option. It is hoped it will contribute to the retention of expert clinical nurses (Ministry of Health 2002).

The challenge for mental health service providers is to establish the role and ensure that mental health nurse practitioners become a valuable and substantive part of the health workforce. Currently there is one mental health nurse practitioner working in a New Zealand DHB.

Nurses pursue nurse practitioner accreditation as individuals. They undertake preparation for Masters degrees at their own expense and in their own time, and they prepare their portfolios and make their formal application to the Nursing Council of New Zealand to for accreditation. Appendix 5 outlines a generic template that has been developed in New Zealand that describes the standards, competencies and professional requirements for the mental health nurse practitioner.

4.2.1 Situational analysis

Those consulted were asked if there were plans to implement the mental health nurse practitioner role in their mental health service and, if so, what their processes might be. The majority of respondents reported their organisations support the role in principle but generally there were no processes in place for its introduction.

DHB representatives advised that business cases still need to be prepared for the introduction of the mental health nurse practitioner role and in some cases working parties are being developed. They contended that achieving nurse practitioner status is no guarantee of being employed in the role.

Both DHB and NGO representatives discussed how the role could enhance the delivery of appropriate services and benefit service users. The role could include mental health nurse practitioners working across primary, secondary and tertiary services and making links between DHBs and NGOs.

It was recognised that introducing the role would require changes to the current funding streams for providers and that current collective agreements do not include salary steps for nurse practitioners. One NGO representative stated that their management

supported the idea of introducing the role and would subsidise the postgraduate study for nurses who wish to pursue mental health nurse practitioner accreditation.

The Māori mental health nurses consulted reported that future Māori mental health nurse practitioner roles are envisaged, particularly managing rural nursing clinics. However, they acknowledged that work needs to be done to develop the rural sector's capacity to support the cost of employing Māori mental health nurse practitioners. They also recommended joint positions between PHO and DHB providers. Establishing these positions, they suggested, would provide a career pathway for Māori mental health nurses, and bring a research capability and influence for future Māori mental health nurse practitioner development.

The Pacific mental health nurses supported the introduction of the role in their organisations. They envisaged mental health nurse practitioners being able to bridge the gap left by not having sufficient Pacific psychiatrists. They suggested mental health nurse practitioners would be ideal as first points of contact for clients and their families.

Consultation with service users highlighted the need for ongoing attention to the physical health needs of mental health service users. The mental health nurse practitioner model of practice (see appendix 4) illustrates how mental health nurse practitioners may incorporate providing care for mental ill service users within the broader spectrum of health care, recognising the relationship between psychological and physical health. As the influence of mental health nurse practitioners impacts on primary mental health generally, it is envisaged that early detection of mild to moderate mental health symptoms, recognition of help-seeking behaviour, and an increased range of preventative interventions, may reduce the risk of seriously debilitating illnesses. Partnerships between mental health nurse practitioners, service users and academic settings could be further developed to promote the realisation of mental health nurse practitioner service user led mental health services in the future.

The NZCMHN offers some support for mental health nurses intending to apply for accreditation through the Rita McEwan support agency.³

4.2.2 Conclusion

The introduction of the mental health nurse practitioners is recognised as an important step in acute and primary mental health services and as a bridging role between primary, secondary and tertiary services and with NGOs. While DHBs and one NGO are supportive of the introduction of the role, little has been done to support nurses in preparing for the role or establishing appropriate positions for them. This will inevitably require some changes to the ways services are currently delivered but with the present shortage of mental health nurses and other health professionals these changes would have real advantages for service users.

³ The unit provides mentorship and financial support to mental health nurses wishing to apply to the Nursing Council of New Zealand for nurse practitioner endorsement (refer to <http://www.nzcmhn.org.nz/>).

4.3 Mental health nursing standards

Professional nursing standards are a way of measuring the quality of nursing practice and delivery of nursing care. They also provide the basis for public accountability. While DHBs' and NGOs' adoption of the National Mental Health Sector Standard is mandatory, currently the adoption of the professional, or the College of Mental Health Nursing's mental health standards is not.

4.3.1 Situational analysis

Respondents were asked whether professional mental health standards were implemented in practice within their organisations. They were also asked if their organisations had used clinical indicators to audit the standards.

Representatives of all but two of the 21 DHBs indicated that professional mental health standards were implemented in some form within their organisations. However, the nature of implementation was variable. It ranged from standards merely receiving lip service or superficial attention, to them providing a basis of a framework for organisations' clinical career pathways and/or written into professional development recognition programmes.

While acknowledging the presence of standards within their organisations, the degree of articulation with practice varied across respondents. Some DHBs 'post' them for staff attention and reference or treat them as 'guides' while others go further and incorporate standards into position descriptions or use them as the basis for developing practice competencies for staff appraisals and performance reviews. The degree of implementation was sometimes difficult to ascertain accurately as auditing is not always undertaken. It was also noted that workload issues could create situations where standards, despite being adopted, were skirted in practice.

Wide variation was also evident in responses from the NGO and AOD sectors. For example, while one NGO respondent identified that the mental health standards were not used in their organisation another NGO representative reported that standards were definitely acknowledged in policy documents. Other NGOs not only acknowledged mental health standards but were using them to develop an assessment tool for monitoring and auditing purposes.

In the specialist areas, such as alcohol and other drugs, standards were often developed for the specific area rather than using professional mental health standards.

The NZNO respondent recognised the need for professional bodies to reach consensus on professional mental health nursing standards.

In response to questions about the auditing of the standards, representatives of two-thirds of the DHBs reported that no clinical indicator audits of the college standards had taken place in their organisations. Another DHB representative reported that an audit would be of low priority as standards are a point of reference but not integrated as guiding principles for the design of services.

4.3.2 Conclusion

Currently, there is variability in the adoption of the New Zealand College of Mental Health Nursing Standards by DHBs and NGOs. This varies from 'lip service' through to the use of the standards and their associated competencies for assessing practice and being part of professional development recognition programmes. There is also variation in auditing of the standards. The variability in adoption of the standards has implications for clinical career pathways, professional development and retention of mental health nurses.

4.4 Skill mix

Skill mix strategies are important for quality and safety and for the provision of cost effective services. The skill mix required in inpatient acute services and community services differs somewhat according to the needs of the service users. However, the current shortage of experienced nurses impacts on both these areas with less experienced nurses and support workers often being responsible for providing care.

4.4.1 Situational analysis

Those consulted were asked if their organisations have strategies to measure the skill mix of registered mental health nurses. Twenty representatives of the DHB sector responded to the questions. Of these, only three reported that their DHBs actively employ specific skill mix measurement strategies. These approaches include skill mixing being undertaken informally through clinical nurse educators and leaders, through to the use of specific IT systems and formulae. While the two NGO respondents said they did not have strategies to measure skill mix, they did have informal processes that were usually carried out by the team leader or clinical nurse specialist. Representatives from the AOD sector did not report any strategies for skill mix. This may be due to a more pressing need to simply fill vacancies.

The lack of specific skill mix strategies across the sector may reflect other recruitment and retention issues. For instance, a representative from a provincial DHB said that staff shortages meant you 'take what you can get' in terms of skill because of the lack of available staff. Others reported that they don't get many applicants from experienced nurses because they are often put off by the poor salary. Echoing the first and last points, the NZNO representative reported that many experienced mental health nurses have been lost to the profession because of poor working conditions and pay. As a consequence of shortages of experienced mental health nurses in some areas, skill mix opportunities are not available. The DHB which uses a formula to determine skill mix for each shift found this approach was often compromised as it was difficult to attain on some shifts.

4.4.2 Conclusion

The current shortage of experienced mental health nurses has impacted on the majority of health organisations' ability to recruit and manage staff using appropriate skill mix

strategies. This places DHBs and NGOs in the unenviable position of often having to 'make do' with whatever staff are available to them. This in turn has a detrimental impact on staff retention.

4.5 Clinical career pathways

Clinical career pathways were introduced in New Zealand in the late 1980s as a mechanism to recognise the clinical expertise of nurses and to retain professional autonomy and development. The specific benefits to employers are: succession planning, leadership development, professional direction, informing the skill mix of registered nurses and the value that mental health nurses bring to clinical and management practices (Trim 1994).

4.5.1 Situational analysis

In response to questions about the clinical career pathways for mental health nurses in their organisations, those consulted provided details on the different forms these took and often provided some evaluation of their operation and effectiveness.

Those providing information from the DHB sector described wide variability in the adoption and operation of CCPs. Where CCPs were in place, these took a range of forms. In a few cases, these were generic in nature and did not have a specific mental health orientation. A well structured CCP in one DHB operated along Benner's four-tier model of competency, with leadership and education roles available beyond the top tier; participation was compulsory and competency was remunerated.

An alternative trend to CCPs was the adoption of professional development recognition programmes (PDRP) in some DHBs. Contract negotiations in 2003 were cited as the motivation for the shift from a CCP approach in one case. Again the operation of these differed with variation in degrees of commitment by the organisation, compulsory participation, tagging of remuneration to progress, and quality of guidelines, information and processes.

Emphasising professional development does not always correlate to career progression. Organisational structures and traditional approaches limit CCP and PDRP opportunities. Another issue raised was the need to balance academic and clinical elements in any career pathway approaches or professional development programmes. Where no such programmes were in place questions were asked as to how nurses could conceive of a progression process to nurse practitioner or clinical nurse specialist status. In some cases nurses were left to construct their own pathways.

A key issue identified in the alcohol and other drug sector was the trend to specify roles in generic terms, for example as clinical or case managers rather than as nurses. This trend extended to the supervisory level as well. Nurses might fill a clinical position but not be paid on the PDRP nursing pay scale.

Though efforts are underway in some areas of the NGO sector to develop some form of career pathway, those who responded indicated that at present there was no formalised

career pathway other than experience of the job and the opportunity to move between areas (for example, inpatient and adult community).

The Māori caucus stated that cultural competencies need to be merged with CCP clinical competencies. Also of concern is a lack of Māori assessors for portfolios. Pacific mental health nurses, reflecting what they described as their 'holistic view on life', identified the need for CCPs to balance academic pursuits with a high level of practice/experience.

4.5.2 Conclusion

The literature supports the view that providing a structure for career development, advancement, recognition and reward may be an important factor for the recruitment and retention of mental health nurses. However, as Trim (1994) found, the development of CCPs in New Zealand has been ad hoc, with a variety of models emerging. It would seem from the current evidence that this remains true with a lack of consistency in the provision of CCP structures. Though the NGO sector has yet to take a position on CCPs and PDRPs (Ministry of Health 2003a), efforts are currently underway in the DHB sector. Prompted by legislative changes, these are aimed at reviewing the framework for the approval of PDRPs and creating standardisation across CCPs.

4.6 Professional supervision

Professional supervision is important for ensuring the competence of mental health nurses and promoting their ongoing professional development. Effective supervision ensures that mental health nurses have the therapeutic competence to maintain themselves as effective clinicians. Ideally it provides time away from their practice environment to meet with an experienced practitioner of their choice to engage in guided reflection on current ways of practising (Burrow 1995; Department of Health 1993; Loganbill et al 1982; Winstanley and White 2003).

4.6.1 Situational analysis

Those consulted were asked to describe how nurses in their organisations access professional supervision. There is considerable variability in the ways supervision is provided for mental health nurses in both the DHB and NGO sectors. The forms of supervision discussed included individual supervision accessed either internally or externally, group supervision, and/or peer supervision.

The main issues that arose included variability in the quality of supervisors available to nurses, lack of databases or knowledge of available qualified supervisors, irregular supervision, and financial constraints limiting the availability of external supervisors resulting in nurses often having to rely on managers who are frequently neither nurses nor clinicians, for supervision. Some respondents noted a resistance to supervision in their organisations. These issues are explored briefly below.

While several DHBs expected all their mental health nurses to participate in professional supervision, there was an overriding concern about the insufficient numbers of nurses qualified to provide professional supervision. This applied in many DHBs as well as NGOs. Few organisations have ensured they have sufficient numbers of supervisors by supporting nurses to attend approved training courses. There was also concern that while there was recognition by managers that mental health nurses should receive professional supervision there was no attempt being made to assemble a data base or list of available supervisors. The majority of nurses reported having to find their own supervisors. The NZNO representative advised that there is often a waiting list for qualified supervisors.

Very often nurses receive supervision in an ad hoc way, when they can be released from the clinical environment or when their supervisor is available to meet with them. Group supervision and peer supervision were models suggested for overcoming this problem.

Financial constraints were identified as barriers to nurses accessing supervisors external to their organisations by both DHB and NGO nurses. This often means nurses either miss out altogether on supervision or they are obliged to use inappropriate supervisors.

Nurses from the NGO sector reported that due to the low numbers of nurses employed in the sector and the team structure used, managers were often their only source of supervision. The managers, who are seldom nurses, are very often not trained as professional supervisors and they have a hierarchical relationship with the nurses. One NGO representative reported she had a reciprocal arrangement with their local DHB. She received professional supervision from a DHB nurse and she also provided supervision for the DHB nurses.

Not all nurses value the opportunity to receive supervision. According to one DHB respondent: 'There is an historical mistrust or resistance to supervision [and] 'reflection' as part of the supervision process is perceived as 'threatening' in some areas'.

To improve both access to and the quality of supervision one DHB is piloting group supervision for inpatient unit staff, and training for peer supervision is being introduced for all community mental health teams.

Two nurses from the alcohol and other drug specialty area reported that supervision is given from within their teams and this was not always by another nurse. They stated that accessing supervision outside the team with a nurse had been refused by the organisation.

Māori nurses highlighted the importance of support and endorsement of the cultural aspects of professional supervision for Pākehā. Māori and Pacific nurses also discussed the need for cultural supervision to support their professional supervision. To address this, Māori nurses have adopted the *awhioawhio* model to support them with the complexity of current practice (Te Rau Matatini 2003).⁴

⁴ This model, based on the *awhio* (a cycle within a cycle) forms the basis of a professional supervision model.

4.6.2 Conclusion

Professional supervision for mental health nurses is a core requirement under the Health Practitioners Competence Assurance Act 2003 to ensure competency, 'fitness' to practice, and gain an Annual Practising Certificate. It is an important process for professional support and learning that promotes individual responsibility for one's own practice and enhances the protection and safety of service users (Department of Health 1993). The lack of consistency in the availability of qualified and appropriate supervisors should be a concern not only for the profession but also for mental health service providers.

Different forms of supervision are available and it is imperative that sufficient numbers of experienced mental health nurses are trained to provide the most appropriate forms for their colleagues across the sectors. The supervisors should also be provided with ongoing professional development including education and support (Health Workforce Advisory Committee 2002a).

4.7 Education

Due to changes in the settings, underpinning philosophy and delivery of mental health care, the Government considers ongoing education, training and development a key strategic area for mental health (Mental Health Workforce Development Programme, 2003). The Ministry of Health's Clinical Training Agency (CTA) purchases and funds new graduate programmes as well as clinically focused programmes for experienced nurses working in mental health and its specialty areas. By 2006 all these programmes will be at level eight on the New Zealand Qualifications Authority's framework.

Some DHBs offer their new graduates their own in-service programmes that involve the development of 'foundation' skills, orientation and mentoring in addition to the CTA funded new graduate programme. Others offer them as an alternative, while DHBs without access to the funded programmes only offer their own in-service programmes.

The first year of clinical practice for newly registered nurses marks the transition from student to practising nurse. The new graduates have received a broad based education in their undergraduate nursing degrees that prepares them to be beginning practitioners for all areas of nursing. The Clinical Training Agency new graduate programmes for nurses entering mental health provide them with the specific skills and knowledge required to work in the mental health areas of practice. Not all new graduate nurses access these programmes.

The Clinical Training Agency also purchases and funds post-entry clinical training (PECT) programmes for mental health nurses who have been in mental health and/or its specialist areas for at least two years, to provide them with advanced skills and knowledge and prepare them to practise at an advanced level.

This section will discuss the support provided by employers for nurses undertaking the new graduate programmes, for experienced nurses undertaking the advanced

programmes, and suggestions from those consulted about possible new directions for post-entry clinical training programmes.

4.7.1 Situational analysis

New graduate programmes

The key stakeholders and DHB and NGO nurses consulted were asked about the training and support their organisations provide for new graduate mental health nurses.

The majority of DHB representatives reported that their organisations provide support for their nurses undertaking the new graduate programmes. The extent of the support varies between the DHBs, but ideally includes clinical supervision, regular group supervision, access to dedicated programme leaders, preceptoring, and mentoring, as well as orientation programmes.

Concern was voiced about the outcomes of the different programmes being offered to new graduates especially as the in-service programmes are not academic and are not recognised nationally. It was also recognised that it is difficult for new graduates with families to work full-time and concurrently study at postgraduate level.

DHB representatives reported that new graduate programmes that do not have a clear new graduate co-ordinator position, or preceptor role, threaten the quality of the programme and support for their new graduates. In one DHB the in-service part of the new graduate programme is poorly resourced and lacks a focus on the development of clinical skills. Study days are frequently cancelled with new graduates expected to fill in for staff shortages, and there is no effective mentoring by experienced nurses. For example, on the admissions ward there are no nurses with more than four years' experience.

NGO representatives reported that training, support and mentoring are provided by their organisations. One representative stated that their organisation has only recently employed new graduates.

An iwi Māori organisation representative stated that new graduates are more inclined to work in the medical centre rather than in mental health.

The Pacific respondents reported that new graduates are introduced to orientation, preceptoring, clinical mentoring and reflective practice early in their careers. Their organisation employs proactive measures to support and promote biculturalism and cultural understanding, and Māori and Pacific nurses and/or managers are included in their New Graduate Advisory Committee where there is genuine participation and inclusion in the programme and forum.

The NZNO representative advised that although there are a number of new graduate programmes available, these are often not clinically supported. New graduates are often expected to work full-time and do overtime due to staff shortages, as well as study. They contend that there are a number of areas in the sector where a new graduate is the

only registered nurse on duty and this is stressful and quickly leads to burnout. They were also concerned about retaining new graduate in areas that are understaffed.

Advanced PECT programmes

Those consulted were asked to describe the strategies their organisations have in place to enable mental health nurses to participate in PECT training. They were also asked what directions and advice they would recommend for the future of PECT purchasing for mental health nursing. The majority of responses came from NGO, DHB and tertiary education representatives.

There was considerable variation in the enabling strategies reported within the DHB and NGO sectors. This ranged from nurses being encouraged and well supported to nurses being unaware of the availability of CTA funded PECT programmes, and the shortage of nurses making it difficult to release nurses for study days.

The majority of DHB representatives reported that nurses in their organisations were supported to undertake PECT programmes with several DHBs also providing transport and accommodation support where necessary for nurses attending study days, and mentoring and support by senior nurses.

There is also variability in expectations within services. In some DHBs specialist mental health services expect their nurses to undertake the PECT programmes while in others nurses are not even aware such programmes are available. It was also reported that in some services the nurses have to take the initiative as there is no commitment for staff to undertake further education. Suggestions were made that participation in PECT programmes should be an integral part of performance reviews.

The shortage of nurses and high workloads often make it difficult for nurses to be released for study days and this has implications for nurses being able to complete their programmes. This particularly applies to the specialty areas of liaison psychiatry, maternal mental health and community mental health centres.

The NGO sector was less likely to have enabling strategies in place. One NGO representative reported that PECT funding was aligned with their training and development funding.

The Pacific mental health service encourages their staff to undertake PECT programmes and supports them by providing some funding and study leave. They also experience problems with replacing staff while they attend study days due to the scarcity of Pacific mental health nurses.

Recommended directions for future PECT purchasing

When asked for direction and advice on future PECT purchasing for mental health nursing there was overwhelming support for the continuation of the programmes, and recommendations that programmes should be extended to include postgraduate diploma and masters' qualifications. Nurses also recommended there should be more flexibility

in terms of papers available within the programmes, especially for the specialty areas, Māori and Pacific mental health, and primary mental health care.

Nurses from the NGO sector were keen for their nurses to have access to PECT programmes, especially iwi services. Both Māori and Pacific representatives argued for PECT programmes that recognise their models of practice and are relevant for their nurses and consumers.

Suggestions were made for the CTA-funded programmes to be used as a recruitment strategy for new graduates, to attract registered nurses working in other areas into mental health, and those who are no longer practising as nurses.

Recommendations were made for increases in funding for release time and supervision of trainees, and for travel and accommodation for nurses living at a distance from the education providers.

The Māori, Pacific and tertiary education representatives recommended that they should be represented on the committees making decisions about PECT purchasing. The tertiary education representatives also advised ongoing evaluation of the outcomes of PECT programmes, more involvement of service users and their families/whānau, and the development of a funded education pathway for mental health nurses that can be linked to clinical career pathways.

While a national approach to PECT was understood to be important it was suggested that there should be flexibility to recognise local needs as well.

4.7.2 Conclusion

The mental health new graduate programme has been successful in providing a number of new graduates with opportunities to establish strong foundational skills, and the advanced programmes have provided experienced nurses with opportunities to expand their knowledge and skills to practise at an advanced level. These programmes also provide nurses intending to pursue nurse practitioner accreditation with building blocks towards completion of their masters' degrees.

The consultation process demonstrated there is overwhelming support for CTA-funded new graduate and advanced programmes for mental health nurses and suggestions have been made for future purchasing that could lead to increased access and availability of PECT programmes and enhanced health outcomes for service users.

The current situation whereby limited numbers of new graduates are accessing CTA-funded new graduate programmes has implications for the preparedness of new graduates to provide the level of care required to ensure service users have the best possible outcomes. Currently the CTA has contracts with three of the 21 DHBs and five education providers for 124 new graduate placements. Where DHBs and NGOs are offering their own in-service programmes for new graduates, their development is often compromised due to staff and funding shortages.

While there was an acknowledgement of the value of PECT programmes for experienced mental health nurses, specific strategies to enable nurses to participate in them were not consistent and the extent of the support varied considerably across the different organisations, both DHBs and NGOs.

The shortage of mental health nurses has implications for nurses undertaking both the new graduate and advanced mental health programmes in terms of being able to replace nurses while they are attending their study days. While it was argued by some that increased funding would help remedy the situation others argued that there are just not enough adequately skilled nurses to employ as replacements.

Many of the recommendations for future purchasing echo the findings identified in the recent evaluation of PECT programmes (Finlayson et al 2005). In particular, those consulted consistently recommended CTA funding should be extended to include postgraduate diplomas and several suggested masters' programmes. They believed PECT programmes are a valuable recruitment and retention strategy and providing a more extended funded education pathway would inevitably improve retention rates for service providers and have positive implications for service user outcomes.

4.8 Mental health nursing research culture

Mental health nursing research focuses on mental health nursing practice to improve the outcomes of consumers of mental health services. It encompasses a continuum from health promotion and health prevention to interventions for people with serious and complex needs. It is imperative for mental health nurses to develop and be part of a research culture to ensure they provide the best nursing care to consumers of their services. Furthermore, for a profession to remain viable and valued it needs to provide evidence of the effectiveness of its members' practice.

4.8.1 Situational analysis

Those consulted were asked to describe the research culture in their organisations. Educators advised the development of mental health nursing research has been promoted by the Ministry of Health. In 2004, the Ministry provided funding for two Chairs of Mental Health Nursing to build on current mental health nursing infrastructure at the two universities with the largest involvement in postgraduate mental health nursing education. One professor has been appointed at the University of Auckland and alongside this appointment the School of Nursing has hosted the development of a faculty-wide multidisciplinary Centre for Mental Health Research, Policy and Service Development (CMHRPSD). The aim of the centre is to build research capability and capacity within a strong mental health infrastructure.

Through a multidisciplinary and collaborative approach, the centre is enabling mental health nurses to access competitive funding and be part of national and international research initiatives in a wide variety of areas that incorporate a range of disciplines and stakeholders. Member nurses will not only be equipped with expertise and experience in research related activities, but their research will have positive benefits for the development of mental health nursing practice and service user outcomes.

The development of the centre has provided a focus for supporting research students and collaborating with clinicians and service users and it will encourage the development of Māori and Pacific researchers.

All universities teaching mental health nursing have strong research cultures underpinning their undergraduate and postgraduate programmes and their academic nurses are actively encouraged to increase their research involvement following the introduction in 2003 of performance-based research funding.

Mental health nursing research was reported to be an integral part of the work of the Centre for Evidence-based Nursing Aotearoa (CEBNA). CEBNA promotes an evidence-based approach to improve the effectiveness of clinical practice and positively influence health outcomes.

The growing numbers of mental health Masters and PhD students throughout the country has led to increasing research collaboration between education and clinical providers. While many nurses become interested in research through participation in research projects, others are researching as part of their degrees and still others are becoming part of research teams.

Education representatives discussed the difficulties they face in securing competitive research funding. It was generally recognised that without track records they were unlikely to be successful in their applications. There was recognition of the need to collaborate with experienced researchers.

It was suggested that a multi-centre collaboration between postgraduate mental health nursing educators, mental health nursing leaders in practice and service users be developed to provide a focus for mental health nursing research in New Zealand to improve clinical practice and health outcomes and raise funds for scholarships for research students.

Some DHB and NGO representatives reported that the research culture in their organisations is mainly reliant on individual nurses undertaking postgraduate education. However, some organisations are supporting the development of journal clubs and research forums and/or attendance and presentations at national and international conferences. Several nurses reported they were unaware of a research culture in their organisations.

The Pacific nurses reported a newly developing research culture and a real commitment to developing it further.

4.8.2 Conclusion

Recent initiatives such as the provision of funding for two Chairs in Mental Health Nursing, the development of the Centre for Mental Health Research, Policy and Service Development and CEBNA have boosted the profile of mental health nursing research.

However, the importance of a mental health research culture within many service provider organisations is not yet a priority.

Further development of the existing CMHRPSD and development of similar centres in other geographical locations could promote a wider research culture that would include educators, clinicians and service users and provide a supportive environment for greater numbers of postgraduate research students.

4.9 Recruitment and retention of mental health nurses

Despite extensive efforts by government agencies, recruitment and retention of mental health nurses remains a key issue for the provision of effective mental health services. The ad hoc approach to recruitment identified by Simon Hatcher and colleagues (Hatcher 2005) was demonstrated in the consultation undertaken for this report. There is no consistency between the recruitment approaches used by DHBs despite major New Zealand reports over recent years outlining the difficulties and recommending nationally consistent strategies (Health Workforce Advisory Committee 2002a; Ministerial Taskforce on Nursing 1998; Ministry of Health 1994, 1996a).

Retention of mental health nurses is dependent on health organisations having clear organisational goals adhered to by all staff; clear understanding of roles and competencies; good management and employee relations; good human resource management systems that allow for performance appraisal and reward; exit interviews to gather information about why staff may be leaving or unable to be recruited; and supervision and support (Mental Health Workforce Development Co-ordinating Committee 1999).

Poor recruitment and retention strategies for mental health nurses result in inadequate numbers of skilled and knowledgeable staff and inappropriate skill mix. This inevitably leads to lower quality care and poorer health outcomes for service users.

This chapter will discuss the current mental health nursing context in terms of recruitment and retention strategies. These will include specific strategies identified for Māori and Pacific mental health nurses, and specialty areas such as forensic mental health, child and youth, and alcohol and other drugs. It will also discuss the retention and return to work of mental health nurses who are also service users.

4.9.1 Situational analysis

Recruitment

The stakeholders and others consulted were asked about the strategies their organisations use for recruiting and retaining mental health nurses. They were also asked about the specific strategies used for recruiting and retaining Māori, Pacific and Asian mental health nurses and those targeting specialist areas such as forensic mental health, alcohol and other drug, and child and youth. There was considerable variation reported in the degree to which nurses are actively recruited for mental health services. The key recruitment strategies included active recruitment of nursing students and

school students; national and international drives using media, the web and recruitment agencies; sponsorship for undergraduate programmes; and financial and other human resource incentives.

DHB respondents advised they actively encourage nursing students to consider mental health as their area of specialty. They do this by visiting the educational institutions where the students are studying, providing them with information about mental health services and mental health as a career option. Aware that students spend very little time in mental health clinical placements during their undergraduate programmes, several respondents advised that they use strategies such as recruitment forums, open days, and directing staff to personally encourage students while in mental health clinical placements to consider a career in mental health.

Those consulted reported some DHBs made extensive and repetitive use of media advertising both in New Zealand and overseas in nursing publications and newspapers to attract experienced mental health nurses. They also reported extensive use of website advertising. In addition, some DHBs provide orientation and open days for nurses interested in moving into mental health.

NGO representatives reported the use of financial incentives such as income protection insurance, employee assistance programmes, and contributions to child care costs; they also 'shoulder-tap' mental health nurses in the DHB sector.

Strategies used to recruit nurses for the specialist areas reflect those discussed above with special emphasis on overseas recruitment as there are insufficient nurses available in New Zealand with adequate experience. Those consulted also reported 'poaching' colleagues from other mental health areas.

The Clinical Training Agency funded Post-Entry Clinical Training programmes provide nurses in the specialty areas with focussed postgraduate learning opportunities. Employers of nurses in these programmes are provided with funding for release time for study days and support for fees, travel and accommodation for the nurses to attend the study days.

Traditionally, other disciplines have not always appreciated the contribution mental health nurses can contribute to some specialist mental health teams in the community, for example child and family services. In recognition of this the Werry Centre has been established to recruit and prepare nurses for this specialty area.

A recruitment strategy for the specialist areas suggested by an education provider involved the undergraduate programmes ensuring students have opportunities to practise across a wide range of mental health specialty practice areas. These, it was suggested, should include child and youth, substance abuse, psychiatric liaison, therapeutic communities, forensic, Māori mental health, early intervention and rural community health.

Recruitment of Māori mental health nurses

The ageing of the Māori mental health nursing workforce is a pressing concern. The majority of Māori mental health nurses came through hospital-based training and are due to retire within the next 10 years.

It was recognised by most respondents that specific strategies to recruit Māori mental health nurses were required due to the low numbers available. Despite this, few DHBs or NGOs reported such strategies.

Individual DHBs reported strategies such as recruiting staff, including managers and professional leaders, to reflect the population base. In one DHB area Māori make up 30% of the population and by actively recruiting senior staff to reflect this, there has been a positive impact on the number of Māori mental health nurses recruited in the past year.

The importance of Māori role models was discussed as well as encouraging Māori and Pacific nursing students by providing clinical placements with Māori and Pacific mental health teams. The new graduate programme was also reported as a useful strategy for recruiting Māori and Pacific nurses.

Another more general strategy used by at least one DHB is to offer sponsorship for those currently working in the service as unregulated carers, for example health care assistants (HCAs), to enter nursing programmes. As many HCAs are Māori or Pacific this particular recruitment strategy has helped to enhance the numbers of Māori and Pacific nurses entering mental health in some areas.

The Māori caucus respondents recommended that the tertiary education sector visit high schools and encourage Māori youth to consider mental health nursing as a career. They suggested taking young Māori mental health nurses with them to encourage Māori youth into the sector. They also suggested that the NGO sector should be marketed 'as the sector to work in' and stated that there needs to be Māori on interview panels for new graduates.

An alcohol and other drug representative reported that in their organisation a specifically Māori team is responsible for recruiting nurses. They were however unsure as to how many Māori mental health nurses are employed in the service.

A NGO respondent reported that 'financial incentives' were the only strategy their organisation uses for recruiting Māori mental health nurses.

Recruitment of Pacific mental health nurses

The majority of DHB respondents reported that there were no specific recruitment strategies for Pacific mental health nurses in their organisations.

One Pacific mental health service provider reported that their organisation offered clinical placements for Pacific students and they discussed career pathways with the students while on placement if they were interested in pursuing mental health nursing.

Other Pacific mental health service respondents reported specific initiatives based on findings from Pasifika human resources research. These include being present at nursing expos and job fairs, and implementing comprehensive consultation and decision making within their organisations.

It was suggested church and community groups should be used to promote recruitment for Pacific as well as Māori mental health nursing and as mentioned above active recruitment should take place in the undergraduate nursing programmes.

Retention

Key retention strategies include support for postgraduate and in-service education and professional development, the introduction of Magnet principles such as strong nursing leadership.

Support for ongoing education, both postgraduate and in-service, was identified by those consulted as an important retention strategy. However, there was also recognition that fiscal constraints and low numbers of staff result in financial support not always being available and nurses not always being released for study days.

PDRP and annual performance appraisals were identified as important retention strategies. These encourage recognition of skill and expertise and nurses are assisted to develop, with their line managers and/or professional leaders, individualised plans to provide support and promote opportunities for them to develop professionally.

Professional supervision was acknowledged to be an integral part of professional development and an important strategy whereby mental health nurses have the opportunity to reflect on their practice, develop confidence, new knowledge and skills and maintain standards. It is important for the development of a supportive environment.

Magnet principles have been introduced in some DHBs and other health organisations in New Zealand as an attempt to stem the outflow of nurses, and this was identified as a positive retention strategy for mental health nurses.

Several other strategies related to the organisation of nurses' work were discussed. These included managing workloads, offering flexible hours and flexible rosters, having high discharge rates and rotating difficult clients between nurses. It was recognised however that it is difficult to provide flexibility when there are staff shortages. This results in nurses working overtime, a reliance on casual pool and agency staff, and leads to increased dissatisfaction, burnout and eventually more nurses resigning.

Strategies discussed by NGOs included providing opportunities for ongoing professional development, external and internal supervision, training related to risk factor, competitive salaries, other financial incentives, supporting enrolled nurses with assistance to undertake undergraduate nursing education, and opportunities for nurses to become team leaders.

Retention has become a real concern in some acute inpatient specialty services as senior nurses have been recruited for community services where it was reported nurses view the community 'to be a more exciting and innovative place to work and more attractive to staff'. This has resulted in acute inpatient services being staffed by younger, less experienced nurses who are facing increasingly violent and stressful situations.

Debriefing opportunities were identified as important strategies for providing nurses with opportunities to reflect on critical incidents in day-to-day practice and provide a means to manage the risk of stress and burnout in the workplace.

In the consultation process, respondents reported few strategies specifically for the retention of Māori mental health nurses. One reason given was that such a strategy could be 'construed as providing 'special' treatment for this group, and may present problems for Māori nurses because it could lead to confusion between cultural and professional roles'.

In some DHBs Māori mental health services and/or Māori advisors attempt to support Māori nurses by providing them with cultural supervision and encouraging them to participate in Māori staff meetings.

Only one retention strategy for Pacific mental health nurses was reported. A Pacific mental health service said they try to make the work environment friendly and supportive for their nurses.

Recruitment and retention of mental health nurses who have been service users

Recruitment of mental health nurses who have also been service users would increase the potential pool of nurses and provide the service user perspective that is so keenly sort in mental health services and education. Concerns were expressed about the readiness of the health sector environment to support and include these nurses without employers and colleagues acknowledging peer and institutional discrimination and stigma towards these nurses. Nurses, as well as other service users, it was argued, have a right not to be defined and confined by their diagnosis and symptoms but to have a lifestyle of their choosing within an inclusive community and workplace.

Those consulted suggested service users should be encouraged to enter the under graduate nursing programme with flexible pathways being provided to allow time off when needed. It was also suggested that anti-discrimination work should first be done with education providers, and service users should be included on the interview panels.

Other suggestions centred on creating safe, supportive and non-judgemental work environments where nurses who have been service users can be involved in the decision making related to their employment conditions. Concern was also expressed for the safeguarding of clients in the nurses' care. It was stressed that there should be zero tolerance to rumours, horizontal violence and discrimination.

A Pacific respondent suggested there should be recognition and acknowledgement of the mental health nurses' experiences as a positive learning process not something to fear.

4.9.2 Conclusion

The strategies currently undertaken by the DHBs and NGOs reflect the strategies reviewed in the literature (Johnson and Johnson 2003; Lafer et al 2003; Magnet New Zealand 2004; News 2002) but they are applied in an ad hoc way. There is not a consistent national strategy that recognises both the current and future needs of the mental health workforce to ensure New Zealand will be able to provide the numbers of nurses with appropriate skills to staff its DHB and NGO mental health services.

The worldwide shortage of nurses and mental health nurses in particular, does not bode well for the provision of mental health services in New Zealand. While international recruitment strategies may be useful in the short term it is imperative that New Zealand develops its own mental health nursing workforce. This should involve the joint efforts of education and service providers and service users to identify and address the underlying issues and develop a national strategy for both the retention and recruitment of mental health nurses.

Employing nurses who have also been service users is a strategy that would increase the pool of experienced mental health nurses available for the sector. An important retention strategy is to recognise the underlying causes of stress and burnout that often lead to mental health nurses experiencing mental illness problems (Heim 1991; Nolan et al 1995; Schaubroeck and Gangster 1991; Thomsen et al 1999).

Work environments can reduce the vulnerability and impact of work-related stress by providing all mental health nurses with 'active' strategies such as the acquisition of psychosocial skills, professional supervision, and management practices that structure working environments so that confirmation of the value of staff and the contribution they make to health care is regularly communicated (Dallender et al 1999).

5. STRATEGIC FRAMEWORK

Registered nurses form the largest group in the mental health workforce and therefore have a major role in the provision of mental health services. Inevitably their care has a significant impact on health outcomes for service users. This framework has been developed to provide a strategic direction for the future of mental health nursing at a time when the health care environment is changing and there is a real shortage of nurses.

The framework aims to strengthen nursing leadership and practice within the multidisciplinary clinical environment where mental health care is provided. It will provide direction for the development of mental health services, for employers of mental health nurses, and nurses themselves. It will also inform service users about the role of mental health nurses.

The framework has been developed following analysis of the current situation for mental health nurses and further consultation with Māori and Pacific stakeholders, service users and their families/whānau, professional bodies from other related disciplines, and the expert reference group. It integrates directions from the government's policies and directions for mental health, as well as professional nursing requirements.

Māori and Pacific nurses play a significant role in the provision of mental health services. These groups, however, are currently significantly underrepresented in the mental health nursing workforce. It is imperative therefore that Māori and Pacific are recruited in significant numbers to provide culturally appropriate care for *tangata whaiora* and Pacific service users, both of whom are over represented amongst service users (Health Workforce Advisory Committee 2002a, 2002b; Ministry of Health 2000, 2002c, 2002f, 2004b).

5.1 Leadership

Recommendations

- Mental health nursing professional bodies should take a leadership role in supporting and developing mental health nursing knowledge and practice.
- Mental health nursing professional bodies should promote the development of nursing leadership.
- Mental health nurse leaders should be appointed in all District Health Boards and non-government organisations employing mental health nurses.
- Mental health nursing advice and direction should inform clinical and managerial decision-making for mental health services.

Mental health nursing professional bodies and clinical nursing leaders have a key role in leading changes in the ways mental health services are provided and ensuring nurses are

adequately prepared for these changes (Mental Health Commission 1998). Service users should be an integral part of the decision making related to such changes.

With the ongoing shortage of nurses it will be important that nurses take a leadership role in the reconfiguration of the mental health workforce (Mental Health Commission 1997) to ensure that service users achieve the best possible outcomes. Māori and Pacific nurse leaders should be an integral part of this.

Mental health nursing professional bodies will take an active role in developing leadership amongst nurses. This will take the form of leadership development forums, being involved in leadership education programmes, encouraging nurses to take leadership roles within professional organisations, and succession planning for regional and national mental health leadership positions.

It is imperative that employers of mental health nurses establish nursing leadership structures to provide support and direction for nurses, policy advice and direction for the development of clinical and organisational services, and to ensure that nurses' specific knowledge and skills are recognised and utilised in multidisciplinary teams.

Nursing leadership in health organisations is a key Magnet principle (Aiken et al 2002). McClure and Hinshaw (2002) found strong nursing leadership to be integral to the success of Magnet organisations in recruiting and retaining nurses.

5.2 Mental health nurse practitioners

Recommendations

- Mental health nurse practitioner roles should be established in District Health Boards and non-government organisations.
- Ministry of Health should provide scholarships for mental health nurses pursuing nurse practitioner endorsement.
- Mental health nurses should be supported by their employers to pursue mental health nurse practitioner endorsement.

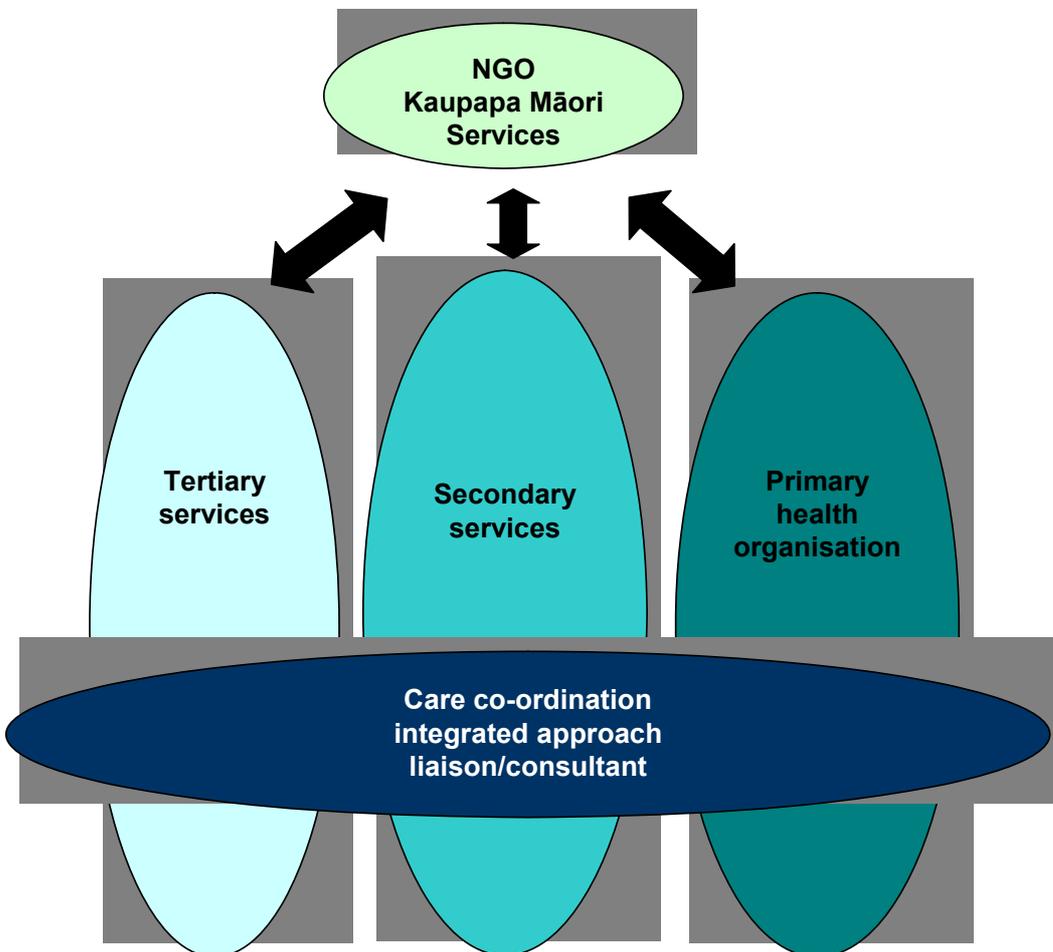
In line with the *Blueprint*, the introduction of mental health nurse practitioner roles is important for bridging the move from existing ways of providing services to developing and implementing new ways of working. Nurse practitioners are qualified to work as autonomous practitioners as well as in collaborative relationships with colleagues from other disciplines.

The development of the mental health nurse practitioner has also highlighted the need for the recovery competencies (Mental Health Commission 2001), the NZCHMN standards of practice (Te Ao Maramatanga: New Zealand College of Mental Health Nursing 2004) and NCNZ competencies (Nursing Council of New Zealand 2004) to be integrated into mental health nurses professional practice framework. Appendix 5 provides an example of a mental health nurse practitioner position description developed by the expert reference group that integrates these components and could

equally be applied to all mental health nurses. The position description was consulted upon with Nursing Council of New Zealand and mental health professional bodies. Mental health nurse practitioners' preparation will provide them with the skills necessary to assume the role of responsible clinicians, providing their clients with continuity and consistency of care. They will also be able to work alongside consumer consultants to provide service users with knowledge and skills, as well as advocacy and role modelling from the consumer consultant's perspective.

The introduction of mental health nurse practitioner roles will be fiscally prudent for providers of mental health services. Providing consistency and continuity of care will not only improve access to appropriate services for service users, it will lower prescription costs (Cornwell & Chiverton 1997; Torn 1996) and reduce the inefficiency of the 'revolving door' factor for service users (see Figure 1).

Figure 1: Mental health nurse practitioner model of practice



Hughes 2004

The introduction of the role requires ring-fenced money and an implementation strategy to ensure the innovation contributes to reducing inequalities and improving health gains (Ministry of Health 2000, 2002d). A planned approach will allow visibility, evaluation,

and role modelling and support the required culture change that will be necessary for sustained development (Carryer and Hughes 2005).

The appointment of mental health nurse practitioners will require investment by both the Ministry of Health and employers to support nurses to complete their Masters degrees, prepare their portfolios and make their applications to the Nursing Council for accreditation. This investment will increase the numbers of mental health nurse practitioners in the short term and will promote the Government's realisation of its policy objectives for mental health service users, especially those affecting Māori and Pacific.

Mental health nurse practitioners will have a key role in providing clinical leadership and promoting clinical excellence in nurses' practice. The mental health nurse practitioners will contribute their knowledge of research and policy development, and clinical expertise to develop new ways of working at the interface of the primary, secondary and tertiary sectors (Ministry of Health 2002d).

5.3 Standards

Recommendations

- All employers of mental health nurses should adopt professional mental health nursing standards.
- All mental health nursing job descriptions should incorporate professional mental health nursing standards.
- All District Health Boards and non-government organisations should annually audit the application of the New Zealand College of Mental Health Nursing Standards to ensure they are implemented consistently.

Adopting the New Zealand College of Mental Health's Nursing Standards and incorporating them in all mental health nursing job descriptions will provide employers with baseline levels of practice and create consistency in mental health nurses' practice.

The College's standards are aligned with the National Mental Health Sector Standard and adherence to them will promote high levels of culturally and clinically safe practice that is current and based on evidence, and will promote mental health for all New Zealanders. It will also assure the rights of people with mental illness and result in improved health outcomes (Te Ao Maramatanga: New Zealand College of Mental Health Nursing 2004).

Regular auditing of the National Mental Health Sector Standard and the New Zealand College of Mental Health Nursing Standards will ensure a consistency in the level of mental health services being provided across the mental health sector (Standards New Zealand 2001). Making sure the standards are implemented consistently will support the Government's strategy for mental health and its commitment to the *Blueprint*.

5.4 Skill mix

Recommendations

- Appropriate skill mix strategies should underpin recruitment of mental health nurses.
- Research on nursing skill mix should be undertaken in New Zealand mental health settings to investigate cost effectiveness and the implications for service users' outcomes and nurses' outcomes.

Adopting appropriate skill mix strategies for recruiting mental health nurses will ensure organisations have appropriate levels of skill mix to ensure there is leadership at the various levels of the organisation, the ongoing professional development of staff, and the provision of safe and appropriate care. It will also contribute to lower turnover of nurses (Buchan and Dal Poz 2002). It is acknowledged that the current shortage of experienced mental health nurses will make this difficult in the short term but initial investment in innovative recruitment practices will prove to be fiscally prudent and have positive implications for service users in the long term.

Research needs to be undertaken in both mental health inpatient units and community mental health facilities to determine the cost effectiveness of the various skill mix patterns and the implications for service users and the nurses caring for them. This will provide an evidence base for the development of skill mix strategies.

5.5 Clinical career pathways

Recommendations

- Employers should develop consistent clinical career pathways that are transferable between organisations.
- Clinical career pathways should be linked to nursing positions within organisations.

As recognised by the Ministry of Health (1996b), the development of consistent clinical career pathways that are transferable between organisations is important for enhancing career options, providing nurses with clarity about the progression they can make in their careers in mental health, and will guide them in their decision making related to further education. Clinical career pathways are important for both the recruitment and retention of nurses at a time when there are so many employment choices (see Appendix 6 for a suggested clinical career pathway).

The transferability of clinical career pathways is important because nursing is a mobile profession with nurses both changing their areas of specialty and often moving to different geographical locations. Consistent clinical career pathways that are transferable between organisations will mean that nurses will not be disadvantaged when moving. Furthermore, the improved mobility of nurses could benefit employers through the transferability of skills and knowledge.

Linking clinical career pathways with nursing positions will provide nurses with clarity about the levels of experience, the competencies and the educational qualifications required to progress through their careers. Likewise it will provide employers with clarity about the knowledge and skill level they can expect of nurses according to their position on the clinical career pathways.

5.6 Professional supervision

Recommendations

- Employers should ensure that all mental health nurses have a formal contract with an appropriately trained supervisor.
- A national professional supervision training model should be developed by mental health nursing professional bodies and incorporated into standards for mental health nursing.
- Mental health nurses' supervision should be undertaken in work time.

In accordance with the Health Practitioners Competence Assurance Act 2003 mental health nurses are required to demonstrate that they are 'competent and fit' to practise and professional supervision is an integral part of this. While taking part in formal professional supervision is the responsibility of mental health nurses, providing supervision opportunities has historically been accepted to be part of employers' responsibilities.

Formal contracts with appropriately trained supervisors will ensure commitment by both parties to regular review of clinical practice issues and maintenance of competency.

Supervision will be undertaken during working hours as it is an integral part of guaranteeing the quality of service provision. While supervision with colleagues within the same organisation is likely to be cost efficient for larger organisations, nurses working in specialist services or in smaller organisations may need to access supervisors from outside their organisations. This could be done on a quid pro quo basis to expand the pool of appropriate and available supervisors. The latent effect is likely to be a 'cross-pollination' of ideas and practices.

While individual supervision is currently the dominant approach, there are very real benefits in group and peer supervision models (Jackson 2000; Stevenson 2000). At a time of shortage of appropriately trained supervisors the latter two models should be considered.

A national training programme for supervisors will ensure a standardised approach to the quality of supervision provided to nurses and will ultimately have a positive impact on service user outcomes (Hancox et al, 2004; Winstanley and White 2003).

5.7 Education

Recommendations

- The Nursing Council of New Zealand in conjunction with mental health nursing professional bodies should review undergraduate mental health education for its relevance to the mental health sector.
- All new graduates should undertake Clinical Training Agency-funded new graduate mental health programmes.
- The Clinical Training Agency should increase funding for all mental health new graduate positions.
- The Clinical Training Agency should fund postgraduate diplomas for experienced mental health nurses.
- The Clinical Training Agency should increase trainee funding for release time, professional supervision, travel and accommodation.
- The Clinical Training Agency should fund masters' programmes for mental health nurses pursuing nurse practitioner accreditation.

While it is acknowledged that KPMG in their 2001 review recommended that baccalaureate level mental health nursing education should remain with the three-year comprehensive programme, the sector reported ongoing concerns about the preparation of new graduates for practice. These included lecturers not always being current in their practice knowledge, having appropriate experience or being adequately educated for their role.

Better co-operation between the mental health sector and the education providers will create access to clinical placements that offer good quality preceptorship and a variety of experiences for students. These can be found in the broader mental health sector not just in acute inpatient and community services as is currently the practice. Research has shown that clinical placements are the most influential factor for students choosing a career in mental health (Charleston and Goodwin 2004; Happell 2001; Rushworth and Happell 2000). In addition, service users should take part in undergraduate teaching to provide students with their perspective and their experiences of being recipients of mental health services (Bennett and Baikie 2003; Frisby 2001; Mariolis and Picard 2002). Joint appointments between mental health education providers and mental health service providers will ensure currency of knowledge and practice.

Even with better preparation at baccalaureate level, all new graduates should undertake Clinical Training Agency-funded new graduate programmes to ensure the development of the specific knowledge and skills necessary for working in recovery-focused mental health services. This will also provide nurses with a nationally recognised and transferable qualification that will contribute to their ongoing postgraduate education and career planning.

The Ministry of Health fully funding all new graduate positions will enable District Health Boards and non-government organisations to provide clinical experience for

greater numbers of new graduates who will in turn contribute to their services. This will increase the pool of appropriately prepared nurses for recruitment to permanent positions and encourage retention of both the new graduates and current mental health nurses by relieving some of their workload.

Increasing Clinical Training Agency funding to postgraduate diploma level with an exit point at postgraduate certificate level, will enable more experienced mental health nurses to continue their education and align them with their clinical career pathways. This will also allow the alignment of educational qualifications with clinical practice positions.

Increased funding for all Clinical Training Agency trainees for release time, supervision, travel and accommodation will provide incentives for employers and reimbursement for trainees (Finlayson et al 2005). While recognising the current shortage of appropriately skilled nurses, increased funding will encourage employers to replace trainees while attending study days, provide appropriately prepared professional supervisors, and reimburse nurses for travel and accommodation expenses incurred while attending study days.

Funding experienced mental health nurses, who intend to pursue nurse practitioner accreditation, to complete their masters' degrees will increase the pool of mental health nurse practitioners. As discussed above, this will have important implications for increasing access to appropriate services for those with mental illness, reducing inequalities and improving health gains. Precedence has already been set for this with the Ministry of Health funding scholarships for rural primary health care nurses intending to pursue nurse practitioner accreditation.

The additional funding required for these changes would be freed up if the Ministry of Education became responsible for funding the postgraduate programmes and the Ministry of Health was just responsible for funding nurses' access to the programmes. As suggested in the recent review of CTA-funded Post-Entry Clinical Training programmes the '[f]unding currently used to purchase PECT programmes could be used to provide training for greater numbers of trainees, fund training to postgraduate diploma level with an exit point at postgraduate certificate level, fund student fees and provide more appropriate funding for release time, clinical supervisors, additional clinical experience, and travel and accommodation for trainees' (Finlayson et al 2005, p 36).

5.8 Research

Recommendations

- The Ministry of Health should make seeding funds available for mental health nursing research projects.
- Professional bodies should establish mental health research networks.

The Ministry of Health providing seeding funds will enhance the capacity and capability of mental health nursing researchers, assist in the development of track records, and encourage the development of postgraduate research nursing students.

By professional bodies taking an active role in establishing research networks, emerging mental health nurse researchers will have access to mentorship, and will have opportunities to become part of established research teams. Establishing research networks will enhance collaboration between nurses in clinical practice and educators to develop practice knowledge and provide evidence on which to base practice (Mental Health Workforce Development Programme 2003) As well as encourage the development of teams to apply for national and international funding. Research networks will also encourage the development of Māori and Pacific researchers and research that examines Māori and Pacific mental health issues.

Further development of mental health research centres will also increase the research capacity and capability of mental health nursing researchers and lead to increased visibility of mental health nursing and mental health nursing research (Clinton 1998; Greenwood and Gray 1998).

5.9 Recruitment and retention

Recommendations

- Employers and education providers with the support of professional bodies should collaborate to actively recruit students from high schools and schools of nursing.
- Employers should co-ordinate their approaches to recruitment of mental health nurses.
- Employers should introduce Magnet principles to retain nurses.

Collaboration by employers, education providers and professional bodies, with the support of service users, is necessary to promote effective recruitment strategies to ensure New Zealand will be able to provide the nurses it needs over the next 10–20 years to staff its District Health Board and non-government organisation mental health services. Collaborative approaches to students at high schools and schools of nursing will increase the pool of potential mental health nurses. Strategies could include a focused national approach using television advertising and documentaries, videos, presentations by young and enthusiastic mental health nurses including Māori, Pacific and Asian nurses. Some of these strategies were discussed in Hatcher et al (2005).

Recruitment should aim to ensure that the mental health nursing workforce reflects the cultural diversity of service users. This will require focused recruitment strategies that will attract Māori and Pacific into the profession, and attract Māori and Pacific who are no longer employed as nurses into mental health.

Over the next 5–15 years New Zealand is not only facing a general ageing of the population but also a change in the ethnic composition of the population. This will create greater demands on health services and on the health workforce. The New

Zealand nursing workforce is also ageing and as well nurses are being actively recruited by other countries to meet their shortfalls (Cornwall and Davey 2004).

It is therefore imperative that the underlying issues causing the recruitment and retention problems in mental health are identified and remedied. The findings from two current research projects, *Patient Outcomes and Nursing Workforce Implications* led by Dr Mary Finlayson, and *The National Cost of Nursing Turnover Study* led by Dr Nicola North, while focusing on hospital nurses, will contribute to an understanding of the issues. Recently, the *National Cost of Nursing Turnover Study* has been extended to include selected mental health units in District Health Boards and non-government organisations.

Consistent and co-ordinated strategies developed by District Health Boards and non-government organisations are required to recruit skilled mental health nurses, nurses from other specialty areas, and nurses who are also service users and wishing to return to nursing. For the latter two, appropriate programmes will need to be established to assist them to develop necessary skills and they will require appropriate, mentored clinical placements. Nurses recruited from other specialist areas who are not registered as comprehensive nurses will need to complete Nursing Council approved programmes, and nurses who are also service users will need to be provided with supportive mentors and professional supervisors and have strategies in place to ensure their safety and their clients' safety.

Research has proved that the introduction of Magnet principles results not only in better patient outcomes but also in better nursing leadership, better organisation of nurses' work, higher rates of job satisfaction for nurses, lower rates of nurse burnout, and lower rates of turnover (Aiken et al 1994; McClure et al 2002). Magnet principles are consistent with 'best practices' used by human resource departments in large organisations. They focus on organisational development, quality improvement and management and leadership principles. Organisations that have adopted Magnet principles have found that resulting organisational changes have had a positive impact and improved quality across all disciplines and throughout the organisations (Aiken et al 1994; McClure et al 2002).

5.10 Conclusion

Adherence to the recommendations made in this framework will facilitate the implementation of the Government's strategy for mental health including the *Blueprint*. It will enhance the quality of mental health care provided by District Health Boards and non-government organisations and result in improved health outcomes for service users.

It is imperative that stakeholders work together to develop creative recruitment and retention strategies and new ways of working. This is particularly pertinent given New Zealand is facing increasing demands for mental health services, an alarming shortfall in mental health nurses, and increasing global nursing shortages.

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APPENDIX 1: MODELS OF NURSING CARE DELIVERY IN MENTAL HEALTH

Models of nursing practice include primary nursing, team nursing, task nursing (usually carried out under medical instructions), case management, and shared care (Gray 1998; Keegan 1998; Manthey 1988; Rigby 2001; Rohde 1997; Ryan 1988). This appendix outlines primary nursing, team management, case management models of nursing care delivery in mental health.

The model of primary and team nursing seems to be supported as an organisational model of nursing in settings such as acute inpatient units. The pros and cons of both are summarised in the box below.

Primary nursing

Pro:

- satisfaction with the work higher
- reinforces autonomy and personal accountability
- defines the role of the mental health nurse with greater precision
- the interdisciplinary team notes a high quality of nursing care and interdisciplinary treatment plan
- the primary nurse acts as leader, clinician, educator and resource person
- reduced involvement in generic administrative duties
- increasing understanding of person's problem and positive attitude towards client, and families express more confidence in the clients care
- allows the therapeutic relationship to develop.

Con:

- not suited to nurses who are from a group orientation to their work,
- the primary nurse has less knowledge about the overall client population
- effects of staff sickness, holidays and shift work could affect the continuity of care
- targets need to be set about how much time can be spent with client.

Team nursing

Pro:

- access to co-workers and supervision was of greater satisfaction to the nursing staff
- emphasises sharing and co-ordination with others, nurses with varying skills and knowledge can pool their expertise to provide care to a larger group of individuals
- and a greater knowledge of the overall client population is evident.

Con:

- not suited to nurses who are from an individual orientation to their work
- there are higher levels of role conflict amongst staff
- significantly greater amounts of time in nursing meetings and at report.

Case management is also a common model utilised in mental health nursing, predominantly in the community settings (Rohde 1997). Case management is defined as the provision of *direct* care to clients with serious mental illness in the community providing the full continuum of care. There are many clinical models of case management, each underpinned by its own philosophical assumptions. These include the strengths model, the brokerage model, assertive community treatment and others (Simpson 2003). The new paradigm of recovery focused care challenges all nurse case managers to understand and critique the model of case management used, ensuring they move towards one of collaboration and partnership in care and recovery (Anthony 1993).

APPENDIX 2: TERMS OF REFERENCE FOR THE EXPERT REFERENCE GROUP

The overall goal is to develop a national strategic framework for mental health nursing that will strengthen both nursing leadership and practice, and create a sustainable mental health-nursing workforce that reflects best practice. The framework will integrate directions from mental health strategies, government policies and directions, as well as professional nursing requirements. The framework will facilitate the implementation of the National Mental Health Strategy as well as the Mental Health Commission's *Blueprint*.

The Ministry of Health is keen to ensure alignment of any national mental health workforce development initiatives with national and local workforce development, and in so doing to add value to the role of the district health boards. The development of a national framework for mental health nursing will be conducted in a collaborative way, with wide consultation with the mental health sector.

Vision

The implementation of a sector owned national framework for psychiatric/mental health nursing in Aotearoa/New Zealand that supports the following: a co-ordinated nursing workforce that has influence across all disciplines, is robust, promotes best practice, reflects the culturally diverse consumer/tangata whaiora population, has a specialist identity, body of knowledge and skills, and appropriate values and attitudes that fosters the potential for recovery (in the presence or absence of mental illness) for service users.

Purpose

We are a national group representing the sector of mental health, working collaboratively to support and shape the preparation of a report for a national framework for mental health nursing. Our key objectives are to ensure national consultation, in our individual groups, to meet our unique culture and reflect our partnership with Māori. This group acknowledges Māori aspirations for improved health outcomes and actively supports Māori leadership and participation in this forum.

The group will:

- act as the overall monitoring body for the development of a national report for the sector
- consult and support activities within their sector that relate to the free flow of information for the report
- conduct a gap analysis
- create channels of communication with other key stakeholders within their sector
- read and respond to draft documents developed for the report in a timely manner

- integrate directions from mental health strategies, government policies and directions, as well as professional nursing requirements
- ensure that the framework will facilitate the implementation of the National Mental Health Strategy as well as the Mental Health Commission's *Blueprint*
- through the Chair (and project manager) the group will report to the Ministry of Health and key stakeholders by providing meeting minutes and briefing papers.

Membership

Chair: Dr Frances Hughes (Chief Nurse Advisor, Ministry of Health)
 Project Manager: Helen P Hamer (Senior Lecturer/Nurse Consultant)

Expert reference group representatives (ERG):

Martina Allen	CTU (union representative)
Mike Loveman	NGO provider
Barbara Lowen	Nurse education in the tertiary sector
Representatives	Māori caucus: Te Ao Maramatanga
Pepe Sinclair	Pacific Island health
Mark Smith	Health Research Council – workforce group
Vito Malo	Consumer
Sam Noble	Mental Health Commission
Marie Crowe	NZNO mental health nurses section
Daryle Deering	NZCMHN and AOD
Kaye Carncross	Chair, National Directors of Mental Health Nursing
Nicholas Glubb	DHB managers

Secretariat

Provided by the project manager. The project manager is responsible for:

- timely and accurate communication
- monitoring progress against the terms of the project contract and objectives
- reporting (through chair) to the Deputy Director General and briefing the Minister of Health.

Appointment processes

All ERG members will be nominated and appointed by the chair or key contact person in the organisations and professional groupings listed above. The Chairperson is responsible for chairing meetings. If there are an equal number of votes at a meeting, the Chairperson shall have the casting vote.

Cessation of membership

An individual will cease to be a member of the ERG if:

- the person leaves the organisation that he/she represents

- there is evidence that they have brought the National Framework for Mental Health Nursing project into disrepute or disclosed information without following agreed process
- non-attendances at meetings important to project progress, and with no substitute representative
- members who do not meet deadlines or respond to requests in a timely fashion, will be replaced by another representative chosen by the Chair.

The project manager shall maintain, in as up to date form as practicable, a register of members containing the names, occupations and addresses of all members.

Rules of engagement

- Free and frank discussion.
- Any conflicts of interest that arise are to be clearly stated, preferably discussed in the group, or privately through the Chair.
- Members must meet any deadlines set for input or accept the final results of the report. A group member can register a disclaimer through the Chair (before final release), clearly stating which parts or all of the final report they cannot support.
- Media releases made on behalf of the ERG will only be issued by the Chairperson, following discussion with the Ministry of Health.
- The Ministry of Health may make comments to the media from time to time about the National Framework for Mental Health Nursing, through the Chairperson of the ERG.
- Communication between ERG members will be by telephone, e-mail and through the Ministry of Health website.

Meetings

Frequency

Two meetings of the ERG, initial meeting 30 March 2004, the second meeting will be on 17 August 2004.

Costs associated with meetings

All travel costs to meetings will be met by the project manager.

Quorum

The quorum for a meeting shall be physical representation from more than 50% of current membership.

Voting

Voting will only be used if resolution can not occur through discussion, or if progress of report preparation is being held up. Voting for office bearers shall be by secret ballot. All other voting will be by show of hands or email and every member shall be entitled to vote. In the case of equality of votes, the chairperson of the meeting shall have a second or casting vote.

Amendments to terms of reference

The National Framework for Mental Health Nursing terms of reference is a living document, which will be reviewed on a regular basis. Any written changes will occur through executive voting processes.

Tasks of the ERG

1. Undertake a gap analysis and identify the key nursing workforce issues that need to be actioned. This should involve but not be limited to:
 - a) current nursing structure within organisations, both DHB and NGO, and hence career pathways for mental health nurses
 - b) strategies to develop stronger research culture and nursing leadership within mental health nursing
 - c) how nursing advice and direction is currently included in mental health services
 - d) the application of professional mental health nursing standards in practice
 - e) what approaches are implemented nationally to the provision of training and support for first-year graduate nurses and to their ongoing career opportunities
 - f) current activities in professional clinical supervision for nurses
 - g) the skill levels/competencies of nurses
 - h) skill mix of registered nurses
 - i) models of nursing practice within specialty settings
 - j) recruitment and retention of Māori, Pacific Island and Asian nurses
 - k) integration of ANZCHMN standards and indicators into mental health nursing and organisational practice where nurses are located
 - l) need for direction and advice on future PECT purchasing for mental health nursing, in the framework of the PECT nursing review
 - m) approaches within organisations to enable nurses to participate in PECT training
 - n) the role of the nurse practitioner within mental health services
 - o) recruitment and retention of nurses into specific mental health areas, e.g. children and young people.

2. Develop strategies based on these directions and requirements, to move mental health nursing forward.
3. Submit a report to the Deputy Director General and Mental Health by February 2005.

Stakeholders

It is important that the project maintain links with, and receives advice from the following:

- District Health Boards (DHBs)
- DHBNZ
- non-government organisations (NGOs)
- relevant directorates within the Ministry of Health including:
 - Māori Health
 - Pacific Health
 - Mental Health
 - Sector Policy (link with Health Workforce Advisory Committee)
- consumer organisations and families
- CTU
- Māori
- Pacific Islanders
- Ministry of Health
- national nursing organisations
- Nursing Council of New Zealand
- other professional groups including psychologist, occupational therapists, social workers and psychiatrists
- Mental Health Commission
- mental health development programme
- Health Research Council
- representatives from the mental health workforce.

Other stakeholders may become apparent during the course of the project and these should be included as appropriate.

APPENDIX 3: QUESTIONS FOR THE ERG TO GUIDE THE SITUATIONAL ANALYSIS

1. Briefly describe the nursing structure within your organisation (indicate DHB and NGO) and provide information on the career pathway for mental health nurses.
2. Briefly describe the nursing leadership structure, and future plans if any, to enhance this?
3. How is nursing advice and direction given to mental health services in your area?
4. What is the current/past research culture within mental health nursing in your area?
5. Are professional mental health nursing standards implemented in practice?
6. What is the provision of training and support for first-year graduate nurses?
7. What do you provide for their ongoing career opportunities?
8. How do nurses access professional clinical supervision?
9. How do you currently measure the skill levels/competencies of nurses?
10. Do you actively have strategies to measure the skill mix of registered mental health nurses?
11. What strategies do you use in the current recruitment and retention of mental health nurses, particularly Māori nurses?
12. What strategies do you use in the current recruitment and retention of Pacific Island and Asian nurses?
13. Do you integrate the ANZCHMN standards of practice into mental health nursing and organisational practice?
14. Have you taken part in the clinical indicators audit of the above standards? Do you intend to?
15. What direction and advice on future post-entry clinical training (PECT) purchasing for mental health nursing would you recommend?
16. What strategies do you have within your organisation to enable nurses to participate in PECT training?
17. Do you plan to implement the role of the nurse practitioner within your mental health services? If so, how?
18. How do you currently recruit and retain nurses into specific mental health areas, e.g. children and young people?
19. What can be done to encourage both the recruitment and retention of people with experience of mental illness that are, or wish to be, mental health nurses?

APPENDIX 4: MODELS OF NURSE PRACTITIONER PRACTICE

Model 1: integrated nursing teams

A team of nurses and nurse practitioner provides, co-ordinates, and manages health promotion and disease prevention across the continuum of care. For example, integrated primary health care nursing teams working out of primary health organisations provide risk assessments, first-contact care, care co-ordination of clients with enduring conditions, and services for whānau, hapu, iwi and Māori communities.

Model 2: nurse consultancy

The nurse practitioner works independently and refers clients to other health professionals, where required. Collaborative practice arrangements and care decisions may also dominate. For example, nurse practitioners can work within hospital settings, or between primary and secondary, and secondary and tertiary health care services, or between non-government organisations. Provides leadership to nurses and referral to other disciplines.

Model 3: independent practice

The nurse practitioner is self-employed and establishes their own independent practices offering care and services direct to the public. For example, nurse practitioner contracts themselves to provide services to other agencies, hospitals, primary health organisations, non-government organisations, and direct to clients.

Model 4: nurse practitioner specialty services/clinics

The nurse practitioner is the recognised lead health professional within the health care team for establishing and managing specialty clinics/services for a particular health specialty and/or population group. For example, pain management, anaesthetists, wound management, rehabilitation, disease management (Ministry of Health 2002).

APPENDIX 5: MENTAL HEALTH NURSE PRACTITIONER POSITION DESCRIPTION

The nurse practitioner will:

Practice competency	Processes and activities	Quality indicators
Leadership	<ul style="list-style-type: none"> • Provides clinical leadership to within the MHMDT, PHC practitioners and also to nurses within mental health and other settings • A resource and advisor for complicated/complex service user/tangata whaiora cases • Would be expected to undertake roles under the MHA once competency have been met and approved by DAHMS, i.e. responsible clinician • Shows leadership in regards to information and decision-making on risk management systems within the service • Takes a leadership role in complex situations across settings and disciplines • Demonstrates skilled mentoring/coaching and teaching • Leads case review and debriefing activities • Initiates change and responds proactively to changing systems • Participates in professional supervision. 	<p>Improved quality of care of service user/tangata whaiora.</p> <p>Leads the integration of care across the continuum.</p>
Integrates recovery competencies into practice at an advanced level	<ul style="list-style-type: none"> • Understands recovery principles and experiences in the Aotearoa/New Zealand and international contexts • Recognises and supports the personal resourcefulness of people with mental illness • Understands and accommodates the diverse views on mental illness, treatments, services and recovery • Has the self-awareness and skills to communicate respectfully and develop good relationships with service users • Understands and actively protects service users' rights • Understands discrimination and social exclusion, its impact on service users and how to reduce it • Acknowledges the different cultures of Aotearoa/New Zealand and knows how to provide a service in partnership with them • Has comprehensive knowledge of community services and resources and actively supports service users to use them • Has knowledge of the service user movement and is able to support their participation • In services has knowledge of family/whānau perspectives and is able to support their participation. 	

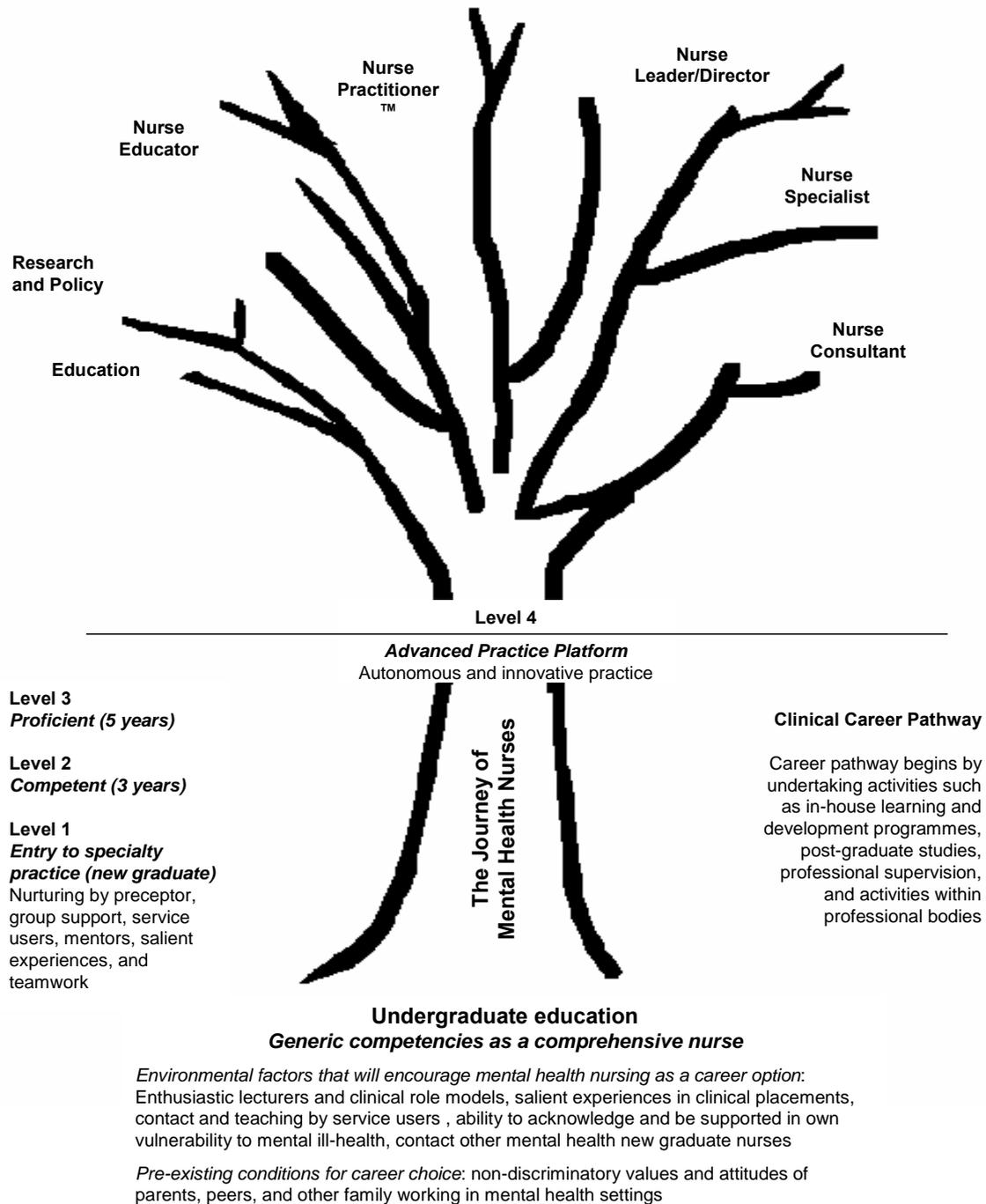
Practice competency	Processes and activities	Quality indicators
Articulates scope of mental health nursing practice and its advancement	<ul style="list-style-type: none"> • Define the scope of independent/collaborative nursing practice in health promotion, maintenance and restoration of health, preventative care, rehabilitation and/or palliative care • Applies diagnostic enquiry processes, respond to actual and potential health needs and characteristics of the particular population group • Applies and adapts advanced nursing knowledge, expertise and evidence-based care to improve the health outcomes for service user/tangata whaiora across the care continuum within the scope of practice • Generate new approaches to the extension of nursing knowledge and delivery of expert care with the service user/tangata whaiora groups in different settings. 	<p>Evidence of audit processes and results analysis</p> <p>Evidence of consultation liaison</p> <p>Provides information and evidence of knowledge and practice development</p> <p>Provides education to the profession and services on practice developments</p>
Shows expert mental health clinical practice working collaboratively across settings and within interdisciplinary environments	<ul style="list-style-type: none"> • Demonstrates culturally safe practice • Uses professional judgement to: <ul style="list-style-type: none"> – assess the service user/tangata whaiora’s health status – make differential diagnoses/implement nursing interventions/treatments – refer the service user/tangata whaiora to other health professionals • Develops a creative, innovative approach to service user/ tangata whaiora care and nursing practice • Manages complex situations • Rapidly anticipates situations • Models expert skills within the clinical practice area • Applies critical reasoning to nursing practice issues/ decisions • Recognises limits to own practice and consults appropriately, facilitating the service user/tangata whaiora’s access to appropriate interventions and therapies • Uses and interprets laboratory and diagnostic tests • Operates within a framework of current best practice and applies knowledge of pathophysiology, pharmacology, pharmacokinetics and pharmacodynamics to nursing practice assessment/decisions and interventions • Accurately documents and administers assessments, diagnosis, intervention, treatments and follow-up within legislation, codes and scope of practice 	<p>Develops appropriate cultural links with organisations</p> <p>Identifies resources available to develop and support your practice</p> <p>Identify processes used to keep updated</p> <p>Clear file audit process</p>

Practice competency	Processes and activities	Quality indicators
	<ul style="list-style-type: none"> • Evaluates the effectiveness of the service user/tangata whaiora's response to prescribed interventions, appliances, treatments and medications and monitors decisions, taking remedial action and/or referring accordingly collaborates and consults with the service user/tangata whaiora, family and other health professionals providing accurate information about relevant interventions, appliances and treatments • Manages a caseload of service user/tangata whaiora with complex needs • Conducts full comprehensive assessments of service user/ tangata whaiora, both mental, social, physical (including physical examinations) • Act as a resource to nurses and members of the multidisciplinary team • Anticipate service user/tangata whaiora's and nurses' needs in a rapidly changing environment • Work with service user/tangata whaiora and MDT members to create to develop new models of practice based on recovery model • Advocate for recovery processes through clinical care • Provide clinical supervision and assessment • Role model innovative and creative practice • Undertakes ongoing professional supervision. 	<p>Able to identify and measure outcomes</p> <p>Provide cases for review</p> <p>Describe a recent practice innovation</p> <p>Describe how best practice is supported, role modelled and developed</p>
<p>Develops and influences Health/ socioeconomic policies and practice at a local and national level</p>	<ul style="list-style-type: none"> • Recognises the status of the Treaty of Waitangi as the foundation of health for New Zealand • Contributes to and participates in national and local health/ socioeconomic policy • Demonstrates commitment to quality, risk management and resource utilisation • Challenges and develops clinical standards • Plans and facilitates audit processes • Evaluates health outcomes and in response helps to shape policy. 	
<p>Shows scholarly research inquiry into nursing practice</p>	<ul style="list-style-type: none"> • Evaluates health outcomes, and in response helps to shape nursing practice • Demonstrate ability to, critique and lead mental health research, to improve clinical outcomes for service user/ tangata whaiora • Have strong preventative and mental health promotion perspective and this philosophy will be a distinguishing feature of their approach • Foster a culture of inquiry and reflection • Articulates current literature/research on mental health • Proactively challenges practice and care models to emulate best practice guidelines for mental health 	<p>Demonstrates evidence-based practice in the specialty area</p>

Practice competency	Processes and activities	Quality indicators
	<ul style="list-style-type: none"> • Disseminate knowledge and promote effective use of resources • Encourage team members to review literature and incorporate the findings of sound research into practice through scholarships • Encourage nursing team to demonstrate evidence-based practice • Initiate research projects that will improve mental health and nursing practice • Involves with and leads MD mental health research, which includes ability to seek assistance and funding for projects beneficial to area of practice • Attend and contribute to local, national and international conferences 	Evidence of initiating a research project
Prescribes interventions, appliances, treatments and authorised medicines within the scope of practice	<ul style="list-style-type: none"> • Uses professional judgement to prescribe • Collaborates and consults with, and provides accurate information to, the service user/tangata whaiora, the service user/tangata whaiora's family and other health professionals about prescribing relevant interventions, appliances, treatments or medications • Prescribes and administers medications within legislation, codes, scope of practice and according to the established prescribing process and guidelines • Understands the use, implications, contra-indications, and interactions of prescription medications with each other and with alternative/traditional/complementary medicine and over-the-counter medications/appliances • Understands the age-related implications of prescriptive practice on service user/tangata whaiora within the particular scope • Evaluates the effectiveness of the service user/tangata whaiora's response to prescribed medications, and monitors decisions about prescribing, taking remedial action and/or referring accordingly • Demonstrates an ability to limit and manage adverse reactions/emergencies/crises • Recognises situations of drug misuse and acts appropriately • Understands the regulatory framework associated with prescribing, including the legislation, contractual environment, subsidies, professional ethics, and roles of key government agencies. 	

Practice competency	Processes and activities	Quality indicators
<p>Communication Effective communication contributes to the achievement of desired outcomes for the service user/ tangata whaiora</p>	<ul style="list-style-type: none"> • Mediate and negotiate contentious issues/concerns • Consult with nurses, managers and other disciplines to improve service user/tangata whaiora outcomes and continually evaluate service delivery • Facilitate ongoing communication within nursing team • Role model excellence in verbal and written communication. 	
<p>Team role/ relationships Interaction with the health care team promotes best possible outcomes for the service user/ tangata whaiora</p>	<ul style="list-style-type: none"> • Establish effective relationships with stakeholders, nurses and other personnel within service and across service boundaries • Maintain an environment which encourages clinical debate • Maintain an influential role in multidisciplinary team • Takes responsibility for the initial psycho-education work with service user/tangata whaiora, significant others and health professionals in the primary sector • Transitions the service user/tangata whaiora (once stable) either back to the GP or to the care of another PDN or member of the community team • Develops with the primary health sector. 	<p>Provides examples and case whereby collaboration has occurred with the multidisciplinary team for the benefit of the service user/ tangata whaiora</p> <p>Is able to provide case example of process and activities achieved</p> <p>Clear processes for transition and referral identified</p>
<p>Quality development/ risk management Contributes to quality development and risk management</p>	<ul style="list-style-type: none"> • Contribute to organisation wide projects and initiatives that will benefit service user/tangata whaiora the company and nursing • Trouble shoots in areas not moving to plan • Anticipate risk and intervene to change outcome • Contribute to the continuous quality improvement (CQI) process. 	<p>Is a member of the senior clinical team for service</p> <p>Provides evidence of involvement in quality initiatives or activities, e.g. audit processes, policy development</p>
<p>Professional development Assumes responsibility for continuing development of practice</p>	<ul style="list-style-type: none"> • Develops a portfolio of clinical research interests • Seek feedback on performance from nursing team • Recognise limitations and seeks ongoing personal/ professional development • Contribute to appraisals process in service • Establish goals with nursing team to support areas needing development • Support nurses to progress on the career pathway • Advise unit management of resources needed to support nursing development • Belong to professional body/s to maintain currency in nursing developments. 	<p>Evidence of affiliation to a professional body</p> <p>Provide evidence of achievement of PDP objectives and proposed plan for the coming year</p>

APPENDIX 6: CLINICAL CAREER PATHWAYS FOR MENTAL HEALTH NURSING



GLOSSARY

Adults	For the purposes of the targets, aged 20 years and older. In practice the distinction between children/young people and adults is not so clear cut. It is not unusual for a person under 20 years to use adult mental health services and some people over 20 years continue to use children's and young people's services when appropriate. The World Health Organization extends the definition of adolescents to the age of 24 years.
Alcohol and other drugs (AOD)	A comprehensive service providing assessment, treatment, information and referral for people who need assistance in changing their substance use patterns (Mental Health Services Specification/Common Base Definitions Project 1997).
Assessment	The systematic and ongoing collection of information about a client to form an understanding of how a client thinks, behaves, and feels, and to identify the client needs. Assessment forms the basis for the development of a diagnosis and an individualised treatment and support plan, in collaboration with the client, their family, whānau and significant others.
Awhiowhio	A CCP specifically for Māori mental health nurses (awhiowhio) which incorporates levels of practice.
Best practice	Treatment and support practices which are based on evidence of effectiveness and merit use throughout the sector.
Blueprint (for mental health services)	An agreed document that defines the parameters of comprehensive mental health services provision, with a focus on specialist mental health services.
Carer	A family member or friend who provides care or support on a voluntary basis or for a nominal payment.
Children and young people	For the purposes of the targets, aged less than 20 years. In practice, the distinction between children/young people and adults is not so clear cut. It is not unusual for people under 20 years to use adult mental health services. The World Health Organization extends the definition of adolescents to the age of 24 years.
Clinical Career Pathway (CCP)	A structure for career development for nurses involved in practice, and advancement in such a structure, provides recognition and reward for increasing expertise in front-line work with service users.
Clinical Training Agency (CTA)	A business unit within the Ministry of Health responsible for funding advanced health professional training that meets the post entry clinical training (PECT) criteria.
Community Mental Health Team (CMHT)	Team comprising a mix of different health professionals and support workers which provides assessment, treatment and support for people with mental illness.

Consultation – liaison function	Significant contact with/between mental health professionals (employed in a mental health service) and other agencies/persons providing a service where mental health services are not the lead agency.
Directors of Mental Health Nursing	A national group of professional nurse leaders of mental health services (DHB provider arm and private hospitals) and supported by the Ministry of Health to promote through national leadership, the development and maintenance of a professional mental health nursing workforce that is responsive to service users needs, national and international trends. Provides authoritative comment on mental health nursing issues, strategic consultation, support and networking for professional mental health nursing leaders across New Zealand.
Discharge planning	Process of assessment and preparation with the service user for their exit from a service or transfer to another service.
Family	Relatives, whānau, partners, friends, or others nominated by a person with mental illness.
Forensic services	Mental health services delivered by a multidisciplinary team to mentally ill offenders, alleged offenders, or those who pose a high risk of offending. These people require varying levels of care. The care is based on a comprehensive assessment and provided across a range of facilities/settings.
FTE	Full-time equivalent staff.
Health Research Council	Crown entity responsible for funding of health research on behalf of the Government.
Iwi	The people of the local area.
Kaupapa Māori services	Services provided by Māori for Māori. Māori centred services which are offered within a Māori cultural context.
Level IV	Level IV (or V in some areas) usually dedicated to a team and a level of advanced practice that approximately 20 percent of the staff nurse workforce will achieve. Level III and II positions are awarded to competent and proficient nurses, with at least three to five years' experience, and constitute the bulk of the nursing workforce. Other titles may include administrative positions such as leader/advisor or research nurse. Therefore combining a level of practice pathway with career structure seems to be the common approach across the country.
Mental disorder or illness	A significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder (Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Services 1991).

Mental health	Mental health is the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice (Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Services 1991).
Mental health problem	A mental health problem is a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health.
Mental Health Research and Development	A project funded by the Ministry of Health and administered by the Health Research Council which aims to use research and development to identify ways that will improve.
Mental health services	Organisations whose primary function is the provision of care, treatment, and support and education for recovery to people with mental illness, or mental health problems.
Mental health support worker	Non-clinicians who work with people with mental illness.
Mental health workforce	For the purposes of <i>Moving Forward</i> , the mental health workforce includes the drug and alcohol workforce unless otherwise stated.
Ministry of Health	The Government agency whose functions are to: provide strategic policy advice and ministerial services to the Minister of Health; monitor sector performance; and administer legislation and regulations.
Multidisciplinary team	Group of mental health staff who co-operate to provide a range of treatments and supports for the service user.
National Mental Health Standards	An overall strategy for mental health covering the Government's goals, principles, and objectives for mental health services. It is set out in two key documents: <i>Looking Forward: Strategic Directions for Mental Health Services</i> published in June 1994; and <i>Moving Forward: The National Mental Health Plan for More and Better Services</i> published in June 1997.
Te Ao Maramatanga: New Zealand College of Mental Health Nurses (Inc)	To represent the professional interests and promote and develop the identity of psychiatric and/or mental health nurses who work in mental health settings in Aotearoa/New Zealand. To promote and develop nursing codes of ethics, education and practice which are culturally safe and encompass the three articles of the Treaty of Waitangi and the principles of Kawa Whakaruruhau, and to form links with other professional bodies.
Te Rau Matatini	Te Rau Matatini is a national Māori mental health development organisation funded by the Ministry of Health and was launched in March 2002. Te Rau Matatini has been established to ensure that Māori mental health consumers – tangata whaiora – have access to a well-prepared and well-qualified Māori mental health workforce.

NZNO mental health nurses section	The NZNO mental health nurses section is a professional interest-group for mental health nurses who are members of the New Zealand Nurses Organisation. This national organisation has members working in a wide-range of mental health nursing positions, and provides a communications network on issues pertaining to mental health nursing. The section encourages and supports research into mental health nursing, strategic, educational and professional development, and to communicate and liaise with other mental health organisations at a national and international level.
Nurse practitioner™	An autonomous practitioner within a specialty scope of practice for a complex population group, who has a sophisticated level of advanced practice skills with or without prescribing rights.
Nurse educator	A role that supports the professional (levels of practice) and the professional educational development of the nursing team.
Nurse specialist	A role that has at least 50% clinical case load and expectation of leadership for nursing and other disciplines in ‘cutting edge’ clinical best practice, research and practice development for those service users with complex needs.
Nurse consultant	A role that leads the practice of nursing in a particular service promoting best practice guidelines, workforce development and research.
Older person or older adult	Person aged 65 and over.
Pacific peoples	Diverse service user group including Tongan, Samoan, Fijian, Cook Island, Tokelau, and Niue peoples.
Pacific people’s services	Services provided by Pacific people for Pacific people. Those providing the service may be independent service providers, or teams within mainstream services.
Prevention	This focuses on reducing the prevalence and incidence of mental disorders.
Prevalence	Total number of people with the illness or disorder.
Primary health care service	Services for individuals and families which service users have direct access to. They are the first point of contact with health services, and are also responsible for services for people with milder mental illness, e.g. general practitioner.
Primary prevention	Aims at reducing incidence of the illness or disorder and other departures from good health. It can be defined as the protection of health by personal and community-wide efforts.
Rangatahi	Youth.
Recovery	Living well in the presence or absence of mental illness and the losses that can be associated with it.
Secondary health care services	More specialist services that people access when their needs are unable to be met by primary care services.

Secondary prevention	Aims to reduce prevalence by shortening the duration of the illness or disorder. It can be defined as the measures available to individuals and populations for early detection and promotion and effective intervention.
Service provider	Organisation or individual practitioner who provides a direct health or support service to service users, their families, and their carers.
Service user	A person who experiences or has experienced mental illness and who uses or has used mental health services.
Strategy	The planning, purchasing and delivery of mental health services in New Zealand.
Taha hinengaro	Mental and emotional health.
Taha tinana	Physical health.
Taha wairua	Spiritual health.
Taha whānau	Family health.
Tamariki	Children.
Tangata whaiora	People seeking wellness, or recovery of self.
Tangata whenua	People of the land or region; hosts; the indigenous people of New Zealand (Māori).
Te Tiriti o Waitangi	The Treaty of Waitangi.
Tikanga Māori	Māori knowledge and practices.
Tino rangatiratanga	Self-determination.
Treatment	Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.
Whanau	A family or an extended family/group of people who are important to the person who is receiving the service.
Whanau ora	The health of the family.