Mental Health Nurses' Experiences of the Use of Psychosocial Interventions in Ireland:
A Multiple Case Study

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Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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Publications

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Acknowledgements

Dedication

I dedicate my thesis to all the mental health nurses whom I met during this study. Every one of you enthused and inspired me. Thank you.

And to the memory of two very important people, who were among my first teachers: Thomas James Murphy and Margaret Philomena Murphy.

Summary

Background

Traditionally, the focus for mental health service delivery in Ireland has involved a medically orientated approach. This research has taken place at a time when mental health professionals are now assumed to provide recovery-orientated care by statute as well as policy. Within a recovery practice, psychosocial interventions (PSI) are recognised and recommended internationally as they primarily focus on improving a client's mental health and preventing relapse. In the Irish mental health context, there is a dearth of information on the use of PSI and in particular the barriers to and/or facilitating factors supporting the delivery of PSI in the reality of day-to-day practice across a range of mental health care settings. Given the changes introduced by recent Irish policy reforms and the move toward recovery-orientated practice, the urgency to conduct new research on how mental health nurses (MHNs) construct their use of PSI has never been more crucial.

Aim

This study aimed to explore appropriately trained MHNs' experiences of using PSI in their care of persons with a mental health problem.

Methodology

Consistent with the goal of understanding experience, a multiple case study methodology comprising four cases guides the study, which is situated within an interpretive paradigm. Data were gathered using semi-structured interviews and observations with 40 PSI-trained MHNs and analysed thematically using Spradley's and Ritchie & Spencer's frameworks, supported by NVivo (10) software. A within-case analysis followed by a cross-case analysis of all data provided meticulous knowledge of each case.

In the course of the analysis, three overarching themes emerged:

I.   PSI-trained MHNs' understanding and use of PSI;

II.   Facilitating factors supporting the use of PSI by PSI-trained MHNs;

III.   Obstacles limiting the use of PSI by PSI-trained MHNs.

Findings

Overall, the findings conveyed that participants were receptive toward PSI, but cited many common obstacles that curtailed their daily PSI work. These obstacles, as noted in the findings, included excessive workloads/caseloads, lack of education and booster training, service users fluctuating mental health conditions, increasing demands on time, existing biomedical

influences and inconsistency of staff and poor leadership, shaped by the climate of the work environment. Additionally, the busyness of MHNs' roles can distract them from documenting care; there was more emphasis on doing routine tasks and hence an under-reporting of PSI care activities. The findings also reported that a supportive organisational culture where clinical leadership and clinical supervision were available alongside PSI guidelines all played a role in determining if PSI were implemented.

Conclusions

This multiple case study adds to the evidence by revealing both the barriers and facilitating factors to PSI implementation. Apart from organisational constraints, there is still a persistent PSI vacuum and a lack of established psychosocial skill practices in an Irish context. Arguably, it is MHNs' professional duty to raise the dialogue around PSI and be mindful of their intention behind what they do in their day-to-day work, so that the meaning of PSI engagement does not remain nebulous.

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List of Abbreviations

ABA	An Bord Altranais	PSI	Psychosocial Interventions
ACF	Acute Care Forum	RPN	Registered Psychiatric Nurse
AVFC	A Vision for Change	RCT	Randomised Controlled Trial
ACT	Assertive Community Treatment	RCN	Royal College of Nursing
ADoN	Assistant Director of Nursing	REC	Research Ethical Committee
ANP	Advanced Nurse Practitioner	RGN	Registered General Nurse
AOT	Assertive Outreach Team	SIGN	Scottish Intercollegiate Guidelines Network
BNS	Bachelor of Nursing Science	SN	Staff Nurse
DoN	Director of Nursing	SMI	Severe Mental Illness
CBT	Cognitive Behavioural Therapy	QoL	Quality of Life
CBTp	Cognitive Behavioural Therapy for Psychosis	WHO	World Health Organisation
CHBT	Community Home Based Team	WMA	World Medical Association
CIT	Community Intervention Team		
COT	Community Outreach Team		
CMHN	Community Mental Health Nurse		
CMHT	Community Mental Health Teams		
CNE	Centre of Nurse Education		
CNM	Clinical Nurse Manager		
CNS	Clinical Nurse Specialist		
CPN	Community Psychiatric Nurse		
DoH	Department of Health		
DoH&C	Department of Health & Children		
DoN	Director of Nursing		
EBP	Evidence Based Practice		
ED	Emergency Department		
EE	Expressed Emotion		
EEC	European Economic Community		
EI	Early Interventions		
FI	Family Interventions		
HSE	Health Service Executive		
HRB	Health Research Board		
ICM	Intensive Case Management		
MDT	Multidisciplinary Team		
MHNs	Mental Health Nurses		
MHC	Mental Health Commission		
MI	Motivational Interviewing		
MSc	Master of Health Science		
MHR	Mental Health Reform		
NHS	National Health Service		
NICE	National Institute of Clinical Excellence		
NMBI	Nursing and Midwifery Board of Ireland		
NWHB	North Western Health Board		
OED	Oxford English Dictionary		
ONMSD	Office of the Nursing & Midwifery Service Director		
PCCC	Primary, Community and Continuing Care Directorate		
PCT	Primary Care Team		
PG Dip	Postgraduate Diploma		
PLL	Psychiatry of Later Life		

Terms used in and coverage of the study

Throughout the study, different terms have been used to refer to people who use mental health services. These include the terms 'consumer', 'patient', 'client', and 'service user'. The term 'patient' refers to someone detained involuntarily under the Irish Mental Health Act (2001), because that is how he or she is legally defined. In the interests of inclusivity, the terms 'client', 'patient' and 'service user' have been used interchangeably throughout the study as all of these terms were used by the participants.

The term 'participant' is used in this study when referring generally to all PSI-trained mental health nurses who participated in this research.

Several terms are also used to describe mental health difficulties. The phrase 'mental health problems' (or mental health issues) is used to describe the full range of mental health difficulties that might be met with, from the psychological distress experienced by many people to serious mental illnesses.

Reflective Entries and Field Notes

Examples of reflective diary entries and Field Notes are dispersed throughout the thesis as they were used to support the study during the research process (more details in Appendix 1).

1. Chapter One: Introduction and Background

1.1. Purpose of the Study

The purpose of this qualitative multiple case study research is to explore the experiences of mental health nurses (MHNs)[1] trained in psychosocial interventions (PSI)[2] in the latter's use with persons with a mental health problem. This study is set in the context of significant policy and practice changes with mental health services in Ireland. Thus, this thesis provides the first study of the voiced experiences of PSI-trained nurses[3] practising PSI in an Irish context, utilising multiple case study design involving qualitative interviews and observations (Appendix 1, Part 2, Table 1, Field Note 3).[4] This introductory chapter discusses the competing definitions of PSI, and in particular elaborates the definition that will be utilised for the purpose of this study. It also presents an overview of the origins and evolution of Irish mental health care and services, and presents the rationale, aim and specific objectives for this study. In addition, an overview of the structure of this thesis is provided. This research has taken place at a time when mental health professionals are now assumed to provide recovery-orientated care by statute as well as policy (Mental Health Act (MHA) (Ireland) 2001, 2006). The purpose of the recovery approach is to reduce the traditional biomedical ways of working. Recovery has been defined as well-being promotion for people with mental distress (O'Hagan *et al.* 2012). PSI are aligned with the underlying principle of recovery as they are considered essential to provision of effective mental health services (NICE 2009, 2014), whereby services are planned around the needs of the service users (Repper & Perkins 2003).

1.2. Defining PSI

Training courses in PSI generally include the following therapeutic approaches under the umbrella of PSI: talk-based therapies such as CBT; family work; case management; early intervention; and dialectical behaviour therapy (DBT) (NICE 2002, 2009, 2014, Turton 2015). As is supported by research evidence, these approaches are effective and share common attributes that appear to be representative of the term PSI (NICE 2014). The PSI offered to

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1 MHNs refer to the plural rather than singular use of MHN.
2 PSI refers to the plural term.
3 PSI-trained nurses are mental health nurses (MHNs) who have undertaken taught psychosocial skills training, e.g. Cognitive Behavioural Therapy (CBT), Family Interventions (FI) etc. These nurses are known as nurse therapists and often as practitioners/clinicians. For reasons of consistency, I shall use the terms PSI-nurses, MHNs, community psychiatric nurses (CPNs), clinicians, practitioners and therapists interchangeably throughout this thesis.
4 Specific Field Notes and reflective diary entries are used to support the study as they helped put meaning to some of the findings (see Appendix 1).

clients depend on the person's illness and needs, the choice of which is supported by NICE guidelines (2009, 2014) based on matching an individual needs to specific steps of care and therapies.

Yet a quest to define PSI in the literature found the term was associated with many definitions and meanings. A starting point in defining PSI was a look at the term 'psychosocial' in the Oxford English Dictionary (OED 2004) that defines psychosocial as '... involving the influence of social factors or human interactive behaviour'. However, it was Brooker *et al.* (1992, 1994), who were the first to define the term PSI in mental health nursing in relation to family interventions (FI). The aim of FI is to educate and support families, facilitating them to acquire coping skills to assist them with the difficulties that they face. The literature also refers to PSI as denoting a broad range of interventions used by MHNs and primarily focuses on improving a client's mental health and giving them the opportunity to live and contribute in society (Doyle *et al.* 2007). In addition, Ruddy & House (2005) emphasise that PSI are based on an understanding of psychological or social factors rather than biological aspects when engaging with clients. This means that PSI can assist in identifying the impact of a client's psychosocial situation, taking into account his/her social circumstances, through a collaborative relationship with a mental health care professional. Yet, a more concise definition is offered by Bates *et al.* (2004), who suggest that these interventions engage any therapeutic endeavour involving interactive behaviour between therapist(s) and client(s) throughout the course of the interventions. This definition is regularly captured in the dementia care literature, which, from this researcher's experience, is applicable to the general mental health context.

Gournay (2009), who also focused on PSI training, extended the meaning of PSI. He suggested that PSI could be considered the main function of MHNs' roles. This supports government policy initiatives (DoH&C 2006) that state that PSI should be integral to nurses' work within mental health services. According to NICE (2002, 2009, 2014), PSI are central to delivering recovery-focused care for people experiencing mental distress. In addition, Turton (2015) states that PSI are person-centred approaches, as opposed to those symptom-based treatments comprising a group of non-pharmacological therapeutic interventions that address the psychological, social, personal, interpersonal and vocational issues associated with mental health disorders. Turton (2015) further proposes that the psychological, social, personal, interpersonal and vocational factors are interconnected, and it is the complex interplay of these factors, combined with stressors and life events, that can trigger the onset or relapse of mental illnesses. One could therefore argue that it is important to take into account these

interconnected factors when MHNs engage with a person during times of mental illness and distress.

According to many other authors, the PSI that have been developed all tend to have a focus on improvements of family functioning, decrease of rates of client relapse and the assistance of clients in moving towards self-management and recovery (Birchwood & Tarrier 1994, Brooker & Repper 1998, Gourney 2000, 2009). This suggests that PSI are underpinned by a vision of recovery and encompass specific interventions that go beyond 'a caring approach' and go much beyond 'developing coping strategies' to be used during episodes of distress or relapse.

Thus, in light of this review of a variety of definitions, it is clear that a diversity of terms is used in the literature to define PSI, suggesting that there are varied viewpoints on what constitutes PSI. Also, one could argue that PSI has been hampered by a lack of conceptual clarity. Within the context of the study, however, the definitions proposed by Bates *et al.* (2004) and Ruddy & House (2005) are most suitable and relevant (Table 2.1). This is because these combined definitions put less emphasis on the pharmacological factors, and relate to the therapeutic value of mental health nursing and the focus on the enhancement of clients' independence, while also being sufficiently inclusive for the scope of this study. This combined definition is therefore used as a guide for the selection of the literature included in this research (Chapter 2).

Table 2.1: Definition for Purpose of Study
A psychosocial intervention is a type of activity that involves a therapeutic engagement approach whereby a client and a mental health care professional works collaboratively, with the aim of enhancing a client's social and psychological functioning, to live independently in society.

Source adopted from Bates *et al. (*2004) and Ruddy & House (2005)

1.3. Irish Mental Health Care and Services

Traditionally, the focus for mental health service delivery in Ireland has involved a medically orientated approach. The focus has been on treating mental illness by reducing or eliminating clinical symptoms. The Lunacy Asylums (Ireland) Act 1821-1826 and the Criminal Lunatics Act 1838-1867 applied the terms 'insane' and 'criminal lunacy' to people with mental illness. The former Act confirmed the practice of psychiatry as firmly embedded within the walls of the

asylums (Nolan 1993). In 1825, the first district lunatic asylum was established in Northern Ireland, followed by seven more in the Republic of Ireland and another in Northern Ireland (Brennan 2014). The asylums were initially small in size and the belief at the time was that the asylums 'cured' the insane. People were admitted to the asylums until their clinical symptoms subsided or they were seen to be responding to treatment. Many of the insane were deemed incurable and they were confined without any prospect of early discharge (Kelly 2008, Brennan 2014). Also, behind the walls of the asylums, patients often did work associated with horticultural and agricultural activities. Although these activities were deemed therapeutic and beneficial to patients, the pressure upon asylums to be economically self-sufficient would have also required that patients be utilised as cheap labour (Brennan 2014). However, there was no professional psychiatry in Ireland when the asylums were first established. As the asylum system expanded, the Irish psychiatric profession started to emerge. Within the asylums, medical superintendents both controlled the treatment and care of patients and exerted control over their staff. This control and dominance extended to the care of patients outside the walls of the asylums.

In 1945, Ireland's Mental Treatment Act (DoH 1945) was introduced. This new Act led to significant changes in mental health law in Ireland by strengthening the practice and delivery of appropriate care to individuals with mental illness (Kelly 2008). The Act also saw the removal of the term 'lunatic' from mental health legislation; this was replaced with terms such as 'person of unsound mind'. Prior to 1945, the term 'keeper' was applied to those entrusted with the care of the mentally ill within the asylums. This, too, subsequently changed and the preferred term became 'attendants'. The female attendants were referred to as 'nurses'. However, these asylum nurses were still under the jurisdiction of the physician and their role was to ensure the physician's instructions were carried out with little scope for questioning practice. The care of patients was thus delivered in a custodial fashion. Accordingly, the physicians had the overall responsibility for carrying out their own professional instructions and continued maintaining control and order among inmates (Nolan 1993). It was also claimed that, in the 1950s, Ireland had the world's highest number of inmates in its mental hospitals (Brennan 2014). This increase in the incidence of the institutionalised insane was partly due to neurosyphilis and possibly increasing alcoholism and rising rates of schizophrenia (Shorter 1998).

In the 1950s, major tranquillisers were discovered, which was seen at that time as a great advance in psychiatry. These psychopharmacological changes transformed the care of some of

the most severely ill patients typically living in long-term mental hospitals. These medications could treat and eradicate behaviour and symptoms that had previously required locking individuals up. Thus, and by extension, people experiencing psychosis, for example, could also be treated in the community (Fennell 1996). Consequently, these developments further reinforced the biomedical approach and doctors gained more control and power over the care and treatment of patients with mental illness. Despite such new medications, the traditional treatments such as electroconvulsive therapy (ECT) and psychotherapy continued. This view was supported by the premise that mental distress is largely a function of some underlying pathology of the brain, some biomedical imbalance that has yet to be explained (Barker & Buchanan-Barker 2005). However, pharmacological treatment of psychiatric conditions remains a significant contemporary mental health issue (Barnett & Neel 2000), and the evidence-based medicine approach so far has been applied more often to pharmacological than to mental health interventions (Sackett *et al.* 1996). The ever-growing influence on pharmacology in mental health is leading a significant number of service users to modifying or manipulating their treatment independently of those who were prescribing such treatment (Schizophrenia Ireland 2006).

In 1973, Ireland joined the European Economic Community (EEC). This had a positive impact in advancing mental health services, bringing with it a commitment on the part of the Irish government to bring health care policies into line with its European neighbours. Subsequently, the publication of the Department of Health & Children's (DoH&C) policy document 'Planning for the Future' (1984) marked a commitment by the Irish government to a re-orientation of mental health services to meet the terms outlined by the EEC (Sheridan 2000). This policy clearly mapped out that the delivery of inpatient services should be moved from large psychiatric hospitals to psychiatric units in general hospitals, and that psychiatric nurses in community settings would work towards disbanding their custodial function and cultivating a more therapeutic role (Sheridan 2000).

As time evolved, however, it was evident that the 1945 Mental Health Act was not meeting the safeguards and rights applicable to detainees (DoH&C 1992, 1995). As a result, Ireland's mental health legislation was revamped, culminating in the introduction of the Mental Health Act 2001. This came into force in November 2006, replacing the 1945 Act. The 2001 Act changed the legal landscape significantly in Ireland, bringing it into line with international human rights standards and is still in place to this day. With the introduction of this Act, the psychiatric profession was for the first time responsible for the prevention and treatment of

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mental illness and not necessarily its cure. This Act further influenced the removal of the stigma associated with the terms 'lunacy' and 'asylums', and people were admitted to psychiatric hospital on the condition that treatment was available (Kelly 2008). The Act now offers a statutory framework for the involuntary admission and treatment of a person with a 'mental disorder' to an approved centre, usually a hospital, including a right to an independent review of their involuntary admission and continuing detention by a mental health tribunal.

Around the same time, a further safeguard established to protect the rights of the detainees was the formation of the Irish Mental Health Commission in 2002. This is an independent statutory body under the auspices of the Mental Health Act 2001, whose functions are set out by the provisions of the aforesaid Act. This Act was significant in providing stricter requirements in the detention process and shorter stays of detention for people with mental health problems than the 1945 Act.

While these recent changes were taking place in Irish mental health services, changes were also emerging within mental health nursing. The 1990s was a decade of great change for psychiatric nursing. For the first time, psychiatric nursing, which became a three-year registered nursing programme in 1994, was established. This meant that psychiatric nursing no longer had to be confined to the institutional system, and included psychiatric nursing students spending a larger proportion of clinical practice in the community (An Bord Altranais 1994). However, during the 1970s and 1980s, many nurses utilised psychotherapeutic approaches in their daily practice, for example, participating in anxiety management groups, teaching clients' distraction strategies, observing family therapy sessions and group therapy. Traditionally, clinical psychologists conducted behavioural assessments, but the nurses led the behavioural programmes under the supervision of the psychologists (Henry & Deady 2001). Yet, it became the norm that many nurses steered behavioural programmes and conducted the assessment themselves (Henry & Deady 2001). Other psychological treatments for people with psychotic symptoms focused on `social skills training' and `life skills training'. These approaches combine operant methods with social requirements, viewing social functioning as a set of skills, which have to be learned, and practised (Argyle & Kendon 1967). Thus, during 1970s and 1980s, the principles of cognitive behavioural therapy (CBT) were utilised to people with psychoses by utilising reasoning processes to modify fixed beliefs and relate them to normal experiences to reduce the fear attached to them (Kingdon & Turkington 1994). One could suggest that these approaches at that time did appear to offer a means of reducing an

individual's exposure to medication, indicating that nurses were utilising alternative approaches in practice.

Currently, psychiatric nursing students embark on a four-year degree programme in partnership with an educational institution such as a university, and a sponsoring hospital. A key influential report leading to these changes was that of the Commission of Nursing in 1998 (Government of Ireland 1998), which represented one of the major challenges to the discipline of psychiatric nursing. The terms of reference included training and education requirements; for example, the development of community mental health services and the need to provide for the development of Clinical Nurse Specialists (CNSs) and Advanced Nurse Practitioners (ANPs) according to service need. Consequently, since this report, MHNs are now required to develop their roles and take on more expanded positions (HSE 2015). This means that the advanced education and training received by MHNs have added to the expectation of the roles of MHNs.

The 2000s, therefore, was a decade that saw many advances in the development of Irish mental health services. The concept of recovery has been widely endorsed in mental health policy and is gradually proliferating as an international precedent for mental health care (Tse *et al*. 2012). However, the publication of 'A Vision for Change' (DoH&C 2006) policy framework established the major new policy direction for mental health in Ireland and set out a blueprint for the modernisation and transformation of the mental health services within the HSE. This policy document sets out more explicitly an understanding of the range of services and interventions that need providing for people with serious mental health problems (SMI)[5] and reflects a commitment to recovery-orientated practice. Therefore, since 2006, Ireland, like other nations, has adopted a recovery-orientated philosophy of working in the mental health services, with an emphasis on partnerships with service users, carers and mental health professionals (DoH&C 2006, Mental Health Commission 2007), with the service user survivor movement driving the recovery implementation. Thus, this policy framework has enabled MHNs to work in multidisciplinary teams (MDTs) in a range of settings including crisis assessment and home treatment, and with clients with long-term mental illnesses (DoH&C 2006). Further guidance documents by the Irish Mental Health Commission were published as frameworks to further the development of a recovery approach within mental health services (Higgins 2008, Mental Health Commission 2012). Recovery approaches involve accepting,

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5 Serious mental illness (SMI) in this thesis is defined as schizophrenia, schizoaffective disorder, bipolar disorder, mania and major depressive disorder.

understanding and managing the client who is experiencing persistent mental problems and distress. This necessitates change and growth, whereby the client discovers personal resourcefulness, new meaning and purpose in their life (Higgins & McBennett 2007), despite their vulnerabilities (Onken *et al.* 2007). This process need not always be a wholly negative experience, as suffering can be been seen as an opportunity for growth (Roberts 2008). Transforming the event into something that gives life new direction and purpose could thus facilitate recovery.

When 'A Vision for Change' was first published, the Mental Health Reform group was established in Ireland as an alliance to make visible public interest in improved mental health services. Subsequently, a further report was published in June 2015, with a focus on evaluating how mental health services were achieving the vision set down in 2006 (Mental Health Reform 2015). This report revealed that, even though many mental health services in Ireland have been exposed to the notion of recovery, the associated approaches and the PSI skills underpinning them, were not yet fully implemented (Mental Health Commission 2015). This means that while mental health services have accepted the ideals of recovery, they struggle to translate these ideals into policy and everyday practices. The Mental Health Commission report (2015) acknowledged that there were many reasons for this, including the fact that, in the early years after the publication of 'A Vision for Change' document, the wider restructuring of the HSE, subsequent reduction in staff and reduced availability of funding for mental health services delayed implementation.

It was both 'A Vision for Change' policy document and Mental Health Commission Quality Framework (2007) that recommended that PSI should be at the core of health care delivery in modern Irish mental health services. Other evidence also indicated that the management of mental illness should involve more than pharmacological interventions alone (Gilliam 2002, Monaghan *et al.* 2008), which is also supported in the Irish Mental Health Commission Report (2015). This particular report further reinforces that there should be more treatment options and choices for mental health clients to reduce the dependence on medication and that PSI are key to delivering recovery-focused care for people experiencing mental distress. Thus, section 1.2 in this chapter has provided more detail on defining PSI. The evidence shows that the therapeutic role of MHNs will improve if nurses adopt PSI such as CBT in their daily work (Butler *et al.* 2013). When trained MHNs have a solid foundation in the different PSI skill sets, this knowledge allows nurses to support clients through recovery and provide them with a higher quality of care (Turton 2015).

A more recent development that is also slowly emerging in Ireland is the consideration of mental health services through a trauma-informed lens. Research suggests that a trauma-informed framework reduces coercive practices in mental health settings and services (Azeem *et al.* 2011, Borckardt *et al.* 2011). In this context, the Irish Institute of Mental Health Nursing is proactive and hosted a conference in 2016 on 'Trauma-informed mental health nursing practice'. Furthermore, the institute has recently launched a position paper in early 2017 on trauma-informed practice for mental health care professionals. Hence, there are no doubt those MHNs in Ireland are central to the provision of mental health care, whose use of PSI should maximise positive outcomes for service users, carers and families (DoH&C 2006, Mental Health Commission 2015). Also, the 2010 HSE Clinical Strategy and Programmes Directorate (CSPD) strategy focus on specific PSI with the prioritisation of the following programmes: early interventions for First Episode Psychosis; early interventions in Eating Disorders; and Management of Self-Harm presentations to Emergency Departments (ED). These programmes address identified areas of high need in mental health care in Ireland and require MHNs to be highly trained and skilled in PSI practice and delivery. Despite these advances, however, there is currently still confusion among service users and non-nurse providers about the different roles and credentials within mental health nursing. MHNs also often experience role conflict between other allied professionals and the values they hold about care delivery. This can mean that the MHNs ability to apply skills is often limited as routine and that task-based approaches are more valued.

Today, mental health services in Ireland come under the umbrella of the HSE, the national Irish health service structure. The HSE came into official operation in January 2005 and was established on a statutory basis. The Mental Health Division has overall responsibility for mental health services including area-based mental health services, which consists of approved inpatient residential centres and all community-based teams, including Child and Adolescent Mental Health, General Adult, Psychiatry of Old Age, the National Forensic Mental Health Service, the National Counselling Service and the National Office for Suicide Prevention.

Although these various reports produce guidance and recommendations, there has hitherto been surprisingly little dialogue about how mental health nurse education must change in order to prepare MHNs to become agents of recovery within systems of care. It is not yet a mandatory requirement in all Irish mental health services that MHNs undertake specific PSI training, regardless of the fact that there is an increased expectation that MHNs take up more advanced roles. While the up-skilling of nurses to offer PSI skills has been acknowledged (HSE

2012, Mental Health Commission 2015), on-going training and education for MHNs in PSI is not widely available within many services and comes under many other guises. For those nurses who have undertaken PSI training, little is known about their experience or views of this training or how MHNs construct the challenges associated with using PSI in the reality of their day-to-day mental health nursing practice.

1.4. Rationale for the Study

The origins of this thesis emerged when the researcher moved from the UK to work in the Republic of Ireland as an MHN[6] in 1998 (Appendix 1, Part 1, Reflective entry 1).[7] In Ireland, it was surprising to see the number of MHNs who were still very much entrenched in the medically orientated approach and the limited use of PSI in practice, despite some of the MHNs having PSI training. A preliminary review of the extant literature (more detail will be provided in the literature review in Chapter 2) identified the potential need for research in this area. Most studies examining the topic have used quantitative approaches (Kavanagh *et al.* 1993, Brooker *et al.* 1994, McFarlane *et al.* 1995, Devane *et al.* 1998, Ewers *et al.* 2002, Ekers *et al.* 2006, Griffiths & Harris 2008, Sin & Scully 2008, Redhead *et al.* 2011), and have been mainly from the UK, with only a few studies undertaken in the Irish context (O'Neill *et al.* 2008, Butler *et al.* 2013, Maruthu *et al.* 2013). Whilst these latter studies have contributed to our understanding of PSI in practice, they do not provide an in-depth exploration of MHNs' experiences of the use of PSI in their care of persons with a mental health problem. Furthermore, little is known about the barriers to and/or facilitating factors supporting the delivery of these specialist skills in the reality of day-to-day practice within Irish mental health care settings.

Two studies conducted in Ireland have been identified as important that offered some insight and contextual referents to this study. The first of these was carried out by Maruthu *et al.* (2013) and examined the training and evaluation of PSI by nurses in one mental health region. A key recommendation of this evaluation was the need for a larger qualitative component that

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6 The terms 'psychiatric nurse' and 'mental health nurse' are used interchangeably in the text due to the following factors: In Ireland, the term 'psychiatric nurse' is used for consistency within the Registered Psychiatric Nurse Division of the register held by the Nursing and Midwifery Board of Ireland (NMBI), formerly known as An Bord Altranais. The subsequent Commission of Nursing (1998, p. 80) stated 'that retaining the distinct identity of … psychiatric nursing was essential'. The National Council for Professional Development of Nursing & Midwifery (2004) advocated the term 'Mental Health Nurse' due to the evolving and expanding role of mental health nursing in Ireland. They define this role as 'a specialist nurse working within a community mental health clinical practice setting'.
7 Specific reflective entries are incorporated to support the study; they help capture many of the findings in keeping with the qualitative approach (see Appendix 1).

could yield more fruitful information about experiences and opinions of PSI in practice. The second study was conducted by Butler *et al.* (2013) and utilised a survey to investigate the use of PSI (by 58 MHNs) following training at one Irish training institution. It was also clear from Butler *et al*'s study that in-depth views of this topic were not explored. Furthermore, only six other small-scale studies conducted in Ireland of MHNs' functions/roles were identified between 1997 and 2010. It is therefore clear from the literature that the topic of PSI from MHNs' perspective requires further attention in the Irish context. Thus, this preliminary review of the literature identified a research gap that informed the area of interest and provided an impetus for executing the proposed study.

The reform of mental health policy in Ireland now demands a clarification of the key skills and supports required for MHNs to further increase and embrace recovery-orientated ways of working. Thus, it is anticipated that the outcome of this work will provide a comprehensive understanding of the topic from the MHN perspective within the context of their work, especially the barriers to and/or facilitating factors in delivering PSI in current daily practice, and identify strategies to further support this group of nurses in their implementation of PSI. Ultimately, it is hoped this study will have the potential to make a real difference to the work of MHNs and the care of clients with mental health problems.

The next section outlines the aim, objectives and structure of this thesis.

1.5. Aim and Objectives

The aim of the study is to explore PSI-trained MHNs' experiences of using psychosocial interventions in their care of persons with mental health problems. In order to meet this aim, the objectives are as follows:

1. Explore with PSI-trained MHNs their understanding and interpretation of PSI;

2. Observe PSI-trained MHNs' use of PSI in practice;

3. Explore with PSI-trained MHNs their perspectives on the knowledge and skills necessary for PSI to be used in practice;

4. Examine with PSI-trained MHNs the factors that help or hinder using PSI as an integral part of their role;

5. Present the similarities and differences between PSI-trained MHNs' experiences across all the cases in a cross-case analysis report;

6. Inform the development of specific recommendations for mental health nursing practice, policy, nursing education and research.

Structure of the Thesis

This thesis comprises eight chapters, which organise and present the main stages of the study.

Chapter one presents the introduction and background to the study and details the background of Irish mental health care services within which PSI-trained nurses work and the significance of this research for PSI. The rationale, aim and objectives for the study are also presented.

Chapter two comprises the literature review on PSI in the context of mental health nursing, nationally and internationally. Relevant literature is reviewed in the Irish context in order to further contextualise this research.

Chapter three provides an overview of paradigms, explanation and justification of the choice of the study's philosophical orientation and selected research methodology in light of the overall research aim and its objectives. The data collection methods and the rationale for these associated components are also discussed.

Chapter four presents how the research design and method used was operationalised to attain the research aim and objectives.

Chapter five provides the context of the sites of investigation, including the demographics of the participants.

Chapter six presents the findings of the study.

Chapter seven presents the discussion of the findings with reference to relevant literature.

Chapter eight concludes the thesis, details the contribution of this research to the existing body of knowledge, the strengths and limitations of the study, and offers recommendations in relation to practice, policy, education and research.

2.   Chapter Two: Literature Review

2.1. Overview of Literature Review

This chapter presents a review of the literature on the topic of PSI in the mental health nursing context. The studies in the review were identified after completing a systematic search of the literature using the electronic databases identified in Table 2.1. The literature review comprises five sections: 1) Development of PSI; 2) Types of PSI; 3) PSI training in mental health settings; 4) Barriers to/facilitating factors in the implementation of PSI in practice; 5) PSI evidence in the Irish context.

2.2. Conducting the Literature Review

The objective of a literature review is to gather the current literature on a topic for the benefit of the reader and form a justification for future research in that area (Cronin *et al.* 2007). There are several types of literature review: the traditional or narrative literature review; the systematic literature review; meta-analysis; and meta-synthesis. For the purpose of this study, the traditional/narrative literature review approach has been used, as this approach assisted the researcher in identifying research questions, instigating the research idea and discovering gaps or inconsistencies in body of knowledge (Cronin *et al.* 2007).

Research Search Strategy

The aim of this literature review was to identify the key studies using the term PSI (Chapter 1, Section 1.2) and commonly used PSI within the mental health field (Appendix 1, Part 2, Table 1, Field Note 5). Nine databases were searched (Table 2.1). The search was applied to all resources published between 01/01/1970 and the present day, because this was considered an appropriate time frame in relation to mental health policy changes in Ireland. It was also important to consider recent research on PSI that focuses on exploring how MHNs are currently using PSI in practice, the developing role of nurses in mental health settings and how the PSI literature is utilised in the mental health field generally. To assist the researcher in remaining abreast of the current literature, email alerts were activated that were identified by the databases and the most recent re-run of searches was carried out on 02/10/2017.

Table 2.1: Databases Searched for Literature Review	
Database	Platform
The Cochrane Library	Wiley Online Library
PubMed	National Center for Biotechnology Information (NCBI)
EMBASE	Elsevier
PsycINFO	EBSCO Publishing
CINAHL	EBSCO Publishing
Scopus	Elsevier
Web of Science	ISI
ProQuest Dissertations and Theses: UK & Ireland	ProQuest
ProQuest Dissertations & Theses A&I	ProQuest

To inform the literature search, inclusion and exclusion criteria were developed using the population, intervention, comparison and outcome (PICO) model (Sacket *et al.* 1997) (Table 2.2).

Table 2.2: Inclusion and Exclusion Eligibility Criteria using the Population, Intervention, Comparison and Outcome Model		
Study criteria	**Inclusion criteria**	**Exclusion criteria**
Type of studies	Qualitative and quantitative studies including randomised controlled studies, controlled studies and surveys that address PSI in the mental health field. Articles published in English-language peer-reviewed journals and of national and international origin.	Any studies not addressing the theme of PSI in the mental health field, not allowing access to full text, not peer-reviewed and/or not published in English.
Population	Qualified MHNs working in inpatient or community settings who have undertaken PSI training and currently using PSI with clients experiencing SMI.	MHNs who had not undertaken any PSI training.
Intervention	The different types of PSI classified into four categories: psychologically/cognitively orientated; social; family interventions; and educative, potentially including stress management, self-coping skills, recovery and relapse prevention strategies.	Non-relevant psychosocial interventions.
Comparison	No intervention, usual care.	Any PSI studies lacking empirical evidence.
Outcome	Quantitative and qualitative data based on PSI in the mental health field.	Any study not addressing PSI in the mental health field.

The searches were conducted by using relevant search terms for the topic and appropriate field limiters (e.g. title, abstract and keywords) to enhance the specificity of the search. Controlled vocabulary (thesauri), such as Medical Subject Headings (MeSH) for PubMed and Emtree for EMBASE, were used in search strings, in combination with free text searching. A sample search strategy is outlined in Table 2.3. Unpublished studies were accessed through reference lists of journal articles, contact with selected authors and via some of the grey literature sources. Grey literature is a noteworthy method of locating qualitative primary studies (Pettigrew & Roberts 2006). Grey literature sources also included OpenGrey, World Health Organization ICTRP (International Clinical Trails Registry Platform), OpenDOAR, Clinicaltrails.gov, thesis and dissertations and ProQuest databases. Valuable searches were also conducted by using the search terms in Google Scholar. The process of literature searching was iterative and searches were re-run every two months.

Table 2.3: Sample Search Strategy from PubMed
Search terms:
("psychosocial intervention"[Title/Abstract] OR "psycho-social intervention"[Title/Abstract] OR "psychosocial interventions"[Title/Abstract] OR "psycho-social interventions"[Title/Abstract] OR "psychosocial approach"[Title/Abstract] OR "psycho-social approach"[Title/Abstract] OR "psychosocial approaches"[Title/Abstract] OR "psycho-social approaches"[Title/Abstract]) AND (mental or psychiatr* or psycholog*) OR "Mental Disorders"[Majr]) OR Filters activated: Publication date from 01/01/1970 to 02.10.2017 - English.

Following identification of the articles, the researcher assessed the quality of each article and its suitability for this study's aim and objectives. The quality of studies was assessed using an adapted version of two quality tools: the ReLIANT framework (Koufogiannakis *et al.* 2006) for the quantitative studies; and the Critical Appraisal Skills Programme (CASP) (Aveyard 2007) for the qualitative studies, which is widely used in nursing research. The ReLIANT framework assesses quality according to four areas: study design; educational context; results; and relevance. In this study, the educational context component of the ReLIANT tool was applied to the mental health context. CASP assesses quality across three levels: validity; results; and benefits.

The quality ratings using both quality appraisal frameworks were grouped into three categories (Table 2.4). Category 1 was considered to be of low quality, Category 2 of medium quality and Category 3 of high quality. Similar to the approach outlined in the Department for

International Development Guidelines (DoH 2014, p. 15), an arrow was used to categorise the quality of the articles: Low-quality category articles based on each of the framework's criteria were allocated an arrow pointing downwards [↓]; medium-quality category articles were allocated an arrow facing crosswise [→]; and high-quality category articles were allocated an arrow pointing upwards [↑] (Table 2.4). The majority of the studies was scored as medium (n=36), with five receiving a high score and two studies receiving a low score (Table 2.4 & Appendix 2). On many occasions, the researcher had to return to the primary articles to ensure that the information was retrieved correctly, keeping in mind the overall aim and objectives of the study.

Table 2.4: Scores Available using CASP and ReLIANT Appraisal Frameworks			
Categories	Total number of CASP Scores	Total number of ReLIANT Scores	Overall quality rating
High quality ↑	(n=2)	(n=3)	High quality: well reported and relevant to the topic and no real deficiencies in the study.
Medium quality →	(n=8)	(n=28)	Medium quality: well reported and relevant to the topic and some deficiencies in the study.
Low quality↓	(n=2)	(n=0)	Low quality: many deficiencies in the study or not relevant to the topic.

Results of Search

The results of the search strategy are summarised in Figure 2.1 that adapted the PRISMA guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analysis) (Moher *et al.* 2009). In total, 7,609 articles were identified though the nine databases (Table 2.1) and a further 14 articles were identified through other sources such as manual searches, grey literature, Google Scholar and reference lists of other studies. After the removal of duplicates and obviously irrelevant articles, 123 articles were screened. Of these, 50 articles were excluded and 73 articles were assessed for eligibility, when a further 30 articles were excluded for reasons such as wrong population (n=9) (articles that did not explicitly include MHNs delivering the PSI), wrong intervention (n=8), irrelevant outcomes (n=7) or failing to meet the PSI definition for the study (n=6). The final number of articles included in the literature review was thus 43, as these satisfied the CASP and ReLIANT frameworks (Table 2.4) in terms of quality. A table of included studies is provided in Appendix 2.

The literature highlights that there is scattered small-scale evidence specifically exploring the MHNs' experiences of using PSI across mental health care settings from a national and international perspective. The lack of exploration PSI-trained nurses' views in the context of mental health nursing practice is unsatisfactory in light of policy developments and the evolving recovery movement in the Irish mental health services. The research to date relating to PSI and mental health nursing does not inform how best those MHNs who have training in PSI utilise these interventions to inform everyday practices. Thus, research is needed into MHNs' experiences of and perspectives on PSI in the Irish context of mental health nursing, inpatient and community settings, and in caring for patients with mental health problems. This qualitative study, therefore, will be the first to explore MHNs' experiences of utilising PSI in a range of mental health care settings, using a multiple case study methodology specifically within the Irish context, and hence addressing gaps in the mental health nursing field literature.

Figure 2.1: PRISMA Flow Diagram: Identification and Selection Process of Articles
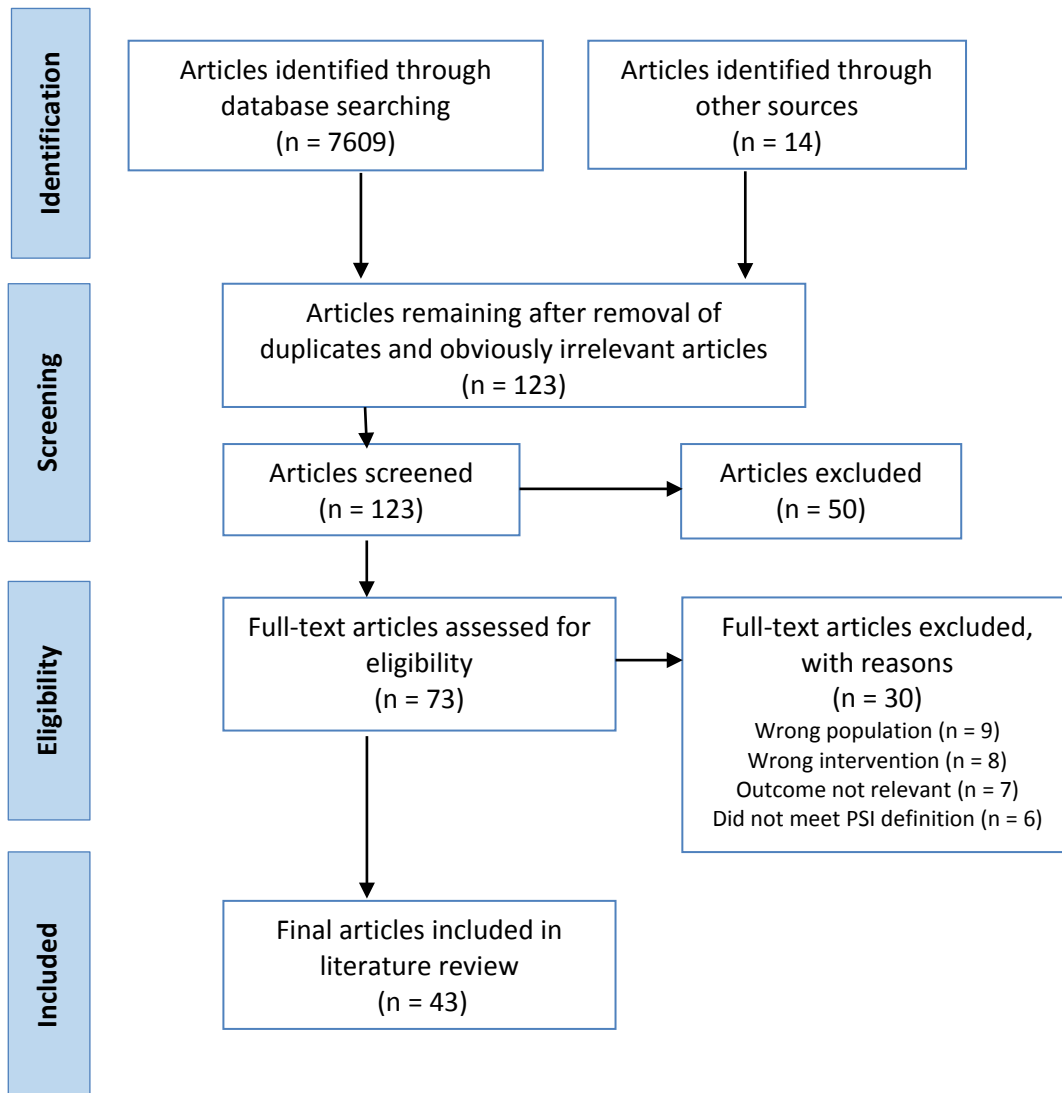
2.3. Developments in Psychosocial Interventions

This section explores the developments of PSI in the mental health field. PSI are recognised and recommended internationally and the evidence suggests that they are an essential factor in promoting recovery and preventing patient relapse (NICE 2014). This knowledge thus allows nurses to support clients through their recovery and provide them with a better quality of care (Turton 2015), while also providing them with the skills that they need to be efficient and confident clinicians (Happell *et al.* 2012).

There has been an increasing importance attached to PSI that is driven by policy influences, particularly in the UK (NICE 2002, 2009, 2014) and also in Ireland (DoH&C 2006, Mental Health Commission 2007, 2015). It is national policy in the UK that all clients with a diagnosis of schizophrenia receive PSI (e.g. CBT) as part of their care, with the aim of promoting a better quality of life (QoL). Research in Ireland and the UK shows that the uptake of PSI in routine clinical practice is limited (Gournay 1995, Fadden 1997, Farhell & Cotton 2002, Grey 2002, Sin & Scully 2008, Butler *et al.* 2013), despite these policy drivers. This may be due to the large caseloads of nurses, and the length of time it takes to accurately carry out the interventions (Kuipers 2011).

Seminal research conducted by Brown *et al.* (1972) and Zubin & Spring (1977) has been influential in the growth of PSI. Their work demonstrated the potential to develop interventions other than medication that could support clients to manage their lives in ways that lessen their tendency to develop psychiatric symptoms. Zubin & Spring (1977) developed the 'vulnerability-stress model' that has become a sound basis for PSI implementation (Gourney 1995, Tarrier & Barrowclough 1995). The application of this model has positively influenced mental illness (Gamble & Brennan 2006) and provides a foundation for managing environmental stress. This means that, if the environmental stress is reduced, the risk of patients' symptoms re-occurring is reduced, as mental illness can be conceptualised as a vulnerability that affects the client's ability to deal with stress (Gamble & Brennan 2006).

As far back as the 1960s and the 1970s, psychosocial approaches and operant approaches, known as token economy strategies, were popular, as they improved the behaviour of patients in long-stay hospitals (Healy *et al.* 2006, cited in Gamble & Brennan 2006). The evidence suggested that the clinical gains from these approaches were limited in that they were confined only to the therapeutic settings and did not address the acute distressing symptoms

of clients (Himadi *et al.* 1991). The 1970s brought more evidence for the concept of expressed emotion (EE) (Brown *et al.* 1972). This concept suggests that stressful events in the person's home environment, and particularly within the family, are associated with increased levels of relapse. Clients living in high EE home environments have greater relapse episodes than clients living in low EE home environments (Brown *et al.* 1972, Kavanagh 1992). From 1980, research also began to appear on the effectiveness of PSI for schizophrenia (Leff *et al.* 1985). Later work is identified with PSI approaches for schizophrenia that focused on the impact of the social environment on mental illness (Healy *et al.* 2006). Other studies by Lam (1991) and Fadden (1998a) showed that FI in the maintenance of schizophrenia in home environments was important.

In response to this existing research on different illnesses, it was highlighted that mental health professionals needed to be trained to meet the needs of clients. The 'Thorn' programmes, which include PSI training initiatives, have been the most familiar model for training professionals. Brooker *et al.* (1994) pioneered the first PSI training for community psychiatric nurses (CPNs) that became the blueprint for the development of PSI training across the UK. Initially, two Thorn programmes were formed, delivered at the University of Manchester and the Institute of Psychiatry in London. The title 'Thorn' was used as the start-up funding derived from the Sir Jules Thorn Charitable Trust. The original purpose was to train CPNs who worked with people with SMI and their carers, and was mainly conducted by psychologists. As the programmes developed, they became open to cross-disciplinary mental health care. The content of the programmes comprised assessment, which included outcome measures, cognitive behavioural skills, case management, psychopharmacology and assertive outreach approaches.

The first important review of PSI was conducted by Brooker (2002), who found that the training had expanded, with 600 students having completed training through 32 accredited training programmes at 25 sites across the UK. Moreover, O'Carroll & Young (2004) conducted an email survey of the Thorn courses that provided a descriptive account of the structure, content, mode of delivery, level of study and research activity related to the courses. Both quantitative and qualitative data from 13 Thorn sites were collected. Eight sites replied to the survey. The survey did confirm that the Thorn courses incorporated evidence-based psychological interventions and reflected current policy at that time and that there were more similarities than differences between the courses. The similarities between courses meant that many nurses were trained with similar skill sets, which one could argue can lead to better

client outcomes. In 2008, Mairs & Arkle's survey showed that PSI training was offered across 26 National Health Service (NHS)-funded sites in eight regions in England, with an intake of 899 NHS-funded students annually.

Presently, in Northern Ireland, Queen's University Belfast has been running a validated Thorn programme since 1997 that is open to any member of multidisciplinary teams (MDTs). In addition, many third level institutions in the Republic of Ireland offer PSI programmes that have arguably developed the Thorn initiatives in many guises; for example, CBT, family work, solution focused therapy, adherence therapy, relapse prevention and risk assessment, all of which are similar interventions. The next section of this review progresses to the different types of PSI that are available for nurses.

2.4. Types of Psychosocial Interventions

There is no universally accepted type of PSI because of their broad diversity. As mentioned previously in Chapter 1, section 2.1, PSI is an umbrella term that describes many different therapeutic models, including DBT, CBT and interpersonal therapy (Turton 2015). These models incorporate a variety of therapeutic techniques such as engagement, assessment, use of outcome measures, adherence to medication, relapse prevention and coping strategies (Mullen 2009). The therapeutic techniques can also be identified as effective evidence-based interventions that can be comprised of assertive outreach (AO) treatments, family psychoeducation, medication management, symptom management, supported employment, supported housing and social skills training (Bond & Campbell 2008). Curran & Brooker's (2007) systematic review, undertaken in the UK, identified random controlled trials (RCTs) that evaluated mental health interventions delivered by MHNs. It was clear from the review that the most common type of intervention conducted by MHNs is CBT, followed by case-management, problem-solving/brief psychological therapy and education.

The different types of PSI can be classified into four different categories: psychologically/cognitively orientated; social; family interventionist; and educative (Figure 2.2). While it is beyond this literature review to describe these treatment approaches in detail, the purpose of describing some of these approaches is to provide some context for the study.

Figure 2.2: Categories of Psychosocial Interventions

Psychologically/Cognitively Orientated	Social
Cognitive behavioural Therapy	Employment
Dialectical behaviour therapy	Social skills training
Normalisation	Life skills training (independent living skills)
Focusing	Social inclusion
Influencing beliefs	Functional improvement
Coping strategy enhancement	Well-being & quality of life
Symptom reduction	Social support
Stress reduction	Spiritual support
Coping strategy enhancement	Self-help
Psychodynamic counselling	Recovery
Mindfulness-based cognitive therapy	
Early Interventions for Psychosis	
Eating Disorders & Self-Harm	
Family Interventionist	**Educative**
Psychoeducation	Relapse prevention
Communication solving	Medication management/concordance
Problem solving	Health promotion
Group interventions	Physical health monitoring

Source adapted from Morrissey, Keogh & Doyle (2008), p. 141 & Walker (2015), p. 16

CBT is a combination of cognitive and behavioural therapy that aims to change those negative thoughts of the client that lead to dysfunctional emotions and actions (Halter & Varcarolis 2014). It is a problem-focused, short-term PSI; evidence shows that it was originally used for the treatment of depression (Beck *et al.* 1979, DoH 2001). CBT has also been beneficial in the treatment of on-going symptoms of schizophrenia (Kuipers *et al.* 1997a, 1997b) and in the reduction of acute relapses (Drury *et al.* 1996). This form is often known as Cognitive Behavioural Therapy for psychosis (CBTp). The NICE guidelines (NICE 2009, 2014) recommend that CBT and CBTp should be broadly available for this client group. Despite these guidelines recommending CBT, CBTp is limited to people with schizophrenia (NICE 2009, 2014). However, MHNs can use generic CBT skills that will offer a readily accessible model for a biopsychosocial assessment and management of clients that can usefully inform general clinical skills in everyday practice (Williams & Garland 2002). Furthermore, evidence has shown that, when CBT is incorporated into nurses' practice, similar long-term improvements in health outcomes occur (DoH 2004, Poole & Grant 2005, Turkington *et al.* 2006, England 2007). Turkington *et al.* (2006) conducted a one-year follow-up of 336 of 422 randomised at baseline patients with schizophrenia and found that the participants who had received CBT from MHNs compared with those who received routine care had significantly improved insight (p=0.021) and significantly reduced negative signs and symptoms (p=0.002). The findings also revealed that participants who received CBT were less likely to develop depression, less likely to relapse, spent significantly less time in hospital and experienced delayed re-admissions. The authors

also indicated on one-year follow-up that CBT did not make a difference to psychotic symptoms, but concluded that MHNs need training using CBT for the treatment of schizophrenia (Turkington *et al.* 2006).

PSI can also include motivational interviewing (MI) skills (Mullen 2009). MI skills are strategies that borrow heavily from cognitive psychology (Miller & Rollnick 1991) and help clients to understand their motivation to change. The task of the therapist is to facilitate the client's move to a greater readiness to change behaviour (Rollnick & Miller 1995). Whereas, interpersonal therapy is actively guided by the therapist, who challenges the maladaptive behaviours and the distorted views of the client, which focuses on the 'here and now' in which an emphasis is placed on the client's social and work life. This means that interpersonal therapy ensures that the client is aware of their dysfunctional behaviour, during which the therapist becomes a participant observer and reflects the client's interpersonal behaviour. This, in turn, allows the patient to modify their behaviours and replace them with more adaptive ones (Halter & Varcarolis 2014).

Another useful and popular model of PSI is Behavioural Family Therapy (BFT) (Anderson *et al.* 1980, Falloon *et al.* 1982). This comprises of three components: family education; training in problem-solving skills; and communication skills. McFarlane (2000) suggests that multiple family models seem to be more effective than interventions for single families in relation to reducing relapse rates and increasing social functioning. Home-based BFT (Falloon *et al.* 1982) was first presented for families with high EE. The purpose of these interventions is to lower relapse rates. These involve the modification of various core elements of BFT (McGorry *et al.* 1997), delivering the therapy in a clinical setting (Randolph *et al.* 1994) and linking several families in group settings (McFarlane *et al.* 1995).

In addition, recovery-orientated practice appears as a dominant psychosocial concept featuring in most current mental health services. The psychosocial approach first entered Irish mental health services with the publication of a discussion paper on recovery by the Mental Health Commission (Ireland) (2005) and was further evident in the 'A Vision for Change' policy document. Furthermore, the Mental Health Commission published many frameworks for the development of recovery-orientated practices within Irish mental health services (Higgins 2008, Mental Health Commission 2012). The use of such practices in these services does require MHNs be trained with a wide repertoire of PSI skills in order to meet the individualised

needs of clients. 'A Vision for Change' (DoH&C 2006) captures the meaning of recovery and provides a useful and relevant definition:

> A recovery approach should inform every level of the service provision so service users learn to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks, and pursue dreams and goals that are important to them and to which they are entitled as citizens (p. 5).

Even though this definition is broad, it does acknowledge a person-centred approach to working with clients. Similarly, Stickley & Wright (2011b) suggest that recovery involves a broad set of principles that underpin a person-centred philosophy.

The next section discusses the literature as regards PSI training in the mental health field.

2.5. Overview of PSI Training Programmes

During the early 1990s, significant attempts were made to evaluate family intervention (FI) training programmes and the introduction of skills in routine practice. These were followed by further evaluations and research studies on broader generic psychosocial training skills in mental health care settings from the late 1990s. The most common PSI programmes reflected in the studies in this literature review were family based interventions, psychoeducation, CBT and behavioural interventions which support some of the categories of PSI identified in figure 2.2 in the previous section. Accordingly, this section comprises two subsections that are relevant to the research aim and objectives for this study: attitudes and knowledge of trained MHNs; and the barriers to and facilitating factors of implementing PSI in practice.

2.6. Attitudes and Knowledge of Trained MHNs

The literature in this section will first discuss much of the original research on PSI in relation PSI training on MHNs' attitudes and knowledge. The section will review fifteen studies, that have been identified as having explored attitudes and knowledge (Brooker & Butterworth 1991, 1993, Lam *et al.* 1993, Kavanagh *et al.* 1993, Gamble *et al.* 1994, Lancashire *et al.* 1997, Milne *et al.* 2000, Baker 2000, Ewers *et al.* 2002, Gray *et al.* 2003, Jones *et al.* 2005, Magliano *et al.* 2006, Carpenter *et al.* 2007, Redhead *et al.* 2011, Sin *et al.* 2013). Overall, these studies found that undertaking PSI training positively influenced MHNs' knowledge levels, as a result of which they were more confident in using PSI in their day-to-day work. Some of the same studies as well as other studies indicated that PSI training resulted in improvements in staff attitudes towards the use of PSI, in addition to increased knowledge levels (Gamble *et al.* 1994,

Ewers *et al.* 2002, Kavanagh *et al.* 2003, Brooker *et al*. 2003, Forrest and Masters 2004, Jones *et al.* 2005, Magliano *et al.* 2006, Doyle *et al.* 2007, Redhead *et al.* 2011). Other studies have also found MHNs were more positive toward caring for patients following training (Repper 2000, Brooker & Butterworth 1993, Ekers *et al.* 2006, Redhead *et al.* 2011, Sin *et al.* 2013). The reason was that the MHNs had gained knowledge that helped them to be more understanding and caring towards the clients.

2.6.1. Family Intervention Training - Knowledge and Attitudes

A number of studies have explored the experiences of participants who had undertaken FI programmes, whereby the taught components of the programmes were specific to FI and trainees had opportunities within the programme delivery to practise the FI skills for practice. All studies have reported minimal use of taught skills in practice settings.

The first one of these studies was a UK study conducted by Brooker & Butterworth's (1991), which investigated the role and function of community psychiatric nurses (CPNs) after a six-month course of FI training with three families. Two cohorts of CPNs were selected from three UK Regional Health Authorities: an experimental group (n=9) and a control group (n=9). The control group was selected by matching each 'experimental' CPN with a colleague from the same area. Outcome data were collected from both CPN groups at three measurement points: pre-training; post-training; and six months after completion of training. Results showed positive changes in the experimental group; CPNs reported improvements in the structuring of their workload and increased motivation in working with families. Consequently, this led to attitudinal improvement in relationships with service user groups, day centres and inpatient acute wards. A subsequent finding also found that neuroleptic medication prescribed for clients in the experimental group demonstrated a decrease at the six-month follow-up that was not evident in the control group. A possible explanation for this could be that the family stress strategies that were a part of the training had a positive effect in helping clients cope better, rather than their depending on the medication. In addition, the results highlighted that CPNs in the experimental group experienced an increase in their workload in relation to the monitoring of medication, in that clients who attended depot injection clinics were assessed more comprehensively. Accordingly, Brooker & Butterworth's (1991) study revealed that CPN participants had acquired new knowledge and skills and that their traditional role changed significantly. Although, this was a pilot study, the findings were positive and, clearly, clients benefitted from FI training that was undertaken by CPNs.

After Brooker & Butterworth's (1991) pilot study, the authors further evaluated the effect of PSI training on CPNs two years later (Brooker & Butterworth 1993), which contributed to the impetus to broaden PSI training for MHNs. This later study evaluated behavioural FI as part of the role of CPNs working with families who had a relative diagnosed with SMI. Ten CPNs recruited from a national advertising campaign participated in a seventeen-day PSI course over a six-month period. Data were obtained from blind rated audiotaped recordings of CPN interventions at two, four and six months post-training. The results indicated that CPNs gained increased knowledge in PSI skills, as they were positive attitudinal shifts towards people with psychosis and towards FI. Three PSI skills showed further significant improvement at six-month follow-up, namely 'assessment and review', 'feedback' and 'coping with therapeutic challenges'. However, there was no baseline assessment of the skills noted, suggesting that it is difficult to attribute the level of proficiency to the training. Furthermore, the absence of a control group and the small sample size limit the study's findings.

In a subsequent paper, Gamble *et al.* (1994) carried out a pre- and post-test study that investigated MHNs' changes in knowledge following a nine-month family training course. In this study, 12 MHNs working either in a community (n=10) or an inpatient setting (n=2) participated in the training. This study replicated previous research conducted by Lam *et al.* (1993) that reported on the impact of two pilot studies that focused on MHNs who participated in a family work-training course for clients with schizophrenia. In this study by Gamble *et al.* (1994), during the training, and similar to Lam *et al.* (1993), trainees worked in pairs with at least two families with relatives deemed more likely to relapse. A multiple-choice questionnaire and a knowledge interview were used to ascertain knowledge levels. Data were collected at three time-points: pre-training; three months post-training; and nine months follow-up after the training. The findings did report an increase in nurses' knowledge of FI and of clients with schizophrenia, which was maintained by the trainees after the nine-month follow-ups. Similar results were found by Lam *et al.* (1993), who reported an increase in nurses' knowledge of schizophrenia and family work. Additionally, similar findings was noted in a bigger study conducted by Kavanagh *et al.* (1993) that followed up 45 trainees working in one organisation in Australia to assess their understanding of FI with clients with schizophrenia and their relatives. Trainees were asked about the application of skills, and their knowledge was tested through using an *ad hoc* postal questionnaire developed by Kavanagh & colleagues. The implementation evaluation revealed that trainees benefitted from increased knowledge levels following the training and that 69% of the trainees applied the skills with at least one family. The data also conveyed that only 18% of trainees had applied the interventions with

more than three families. However, 80% of trainees used these interventions at least once a month in areas of practice other than family sessions. One could argue that this training provided some transferable skills in practice. Remarkably, the trainees' recall of the material that they had been taught in a 30–35 hour training programme was poor. This, however, could explain why only four of the therapists had applied FI skills after the two years of training. Also, it was not clear from Lam *et al*.'s (1993) study how long newly acquired knowledge was retained and what features helped to preserve learning of the skills.

Furthermore, findings that are more recent were reported in a FI survey study conducted in an UK mental health service led by Sin *et al.* (2013). These researchers also utilised a self-rated questionnaire that evaluated clinicians' attitude, knowledge and behaviour post-training, in which clinicians participated with the aim to increase FI implementation. The trainees were provided with two FI training models: PSI (Thorn); and BFT (Meriden). In total, 55 mental health clinicians participated in the training. The questionnaire was distributed to all the participants and data were collected at three time-points: pre-training; post-training; and five months after the FI training. Consistent with the findings in previous studies (Brooker & Butterworth 1991, 1993, Lam *et al.* 1993, Kavanagh *et al.* 1993 & Gamble *et al*. 1994), this study by Sin *et al.* (2013) also highlighted positive outcomes in attitude and knowledge, as well as increased competence in the skills in working with families. The limitations outlined by Sin *et al*. (2013) included disappointment at the low response rate at follow-up, and it was of concern that response rates at five months were very low, with only 29% and 34% of initial respondents subsequently responding. However, the researchers acknowledged that the low response rates could have been because the trainees were returning to their workplace after the training and extra demands were put on them. A restructuring of the services was also happening at that time, so, one could argue that this further affected the response rates.

2.6.2. General PSI Training – Knowledge and Attitudes

A number of studies (Lancashire *et al.* 1997, Milne *et al.* 2000, Baker 2000, Ewers *et al.* 2002, Gray *et al.* 2003, Jones *et al.* 2005, Magliano *et al.* 2006, Carpenter *et al.* 2007, Redhead *et al.* 2011, Sin *et al.* 2013) have also explored knowledge and attitudes of participants who had completed programmes, which were under many guises of PSI. This was mainly because the content in the delivery of programmes were very broad in that they did not focus on PSI skills specifically, such as FI and CBT. However, the studies, which are detailed below, appeared to be benchmarks for developing further PSI for practice settings.

The first rigorous study in this category to report was an pre-test and post-test evaluation of the effects of PSI training on knowledge and skills of twelve CPNs over a period of nine months by Lancashire *et al.* (1997). Trainees had to complete three specific PSI modules within a programme that involved spending two days a week practising PSI and undertaking formal teaching in the classroom with four clients from the trainee's caseload. For example, after trainees received the KGV scale training (Krawiecka *et al*. 1977), the reliability of their ratings was evaluated by having them rate the severity of symptoms demonstrated in six videotaped interviews carried out with volunteer patients. The trainees' ratings were found to be comparable to ratings by a panel of five teaching staff. A baseline assessment before PSI implementation and a follow-up assessment were conducted 12 months later. It was clear from the findings that the trainee's knowledge and skills had increased because of the training. This was evident as the clients who received PSI from the trainees in the program showed significant improvements reductions in the KGV total symptom score in positive symptoms, and in affective symptoms. In addition, the clients showed a significant increase in the overall social functioning score (Birchwood *et al.* 1990) after 12 months. One can suggest that this study showed that the nurses were able to apply the new knowledge and transfer the taught skills into practice, as they were notable client benefits in terms of reduced symptomatology.

Additionally, Milne *et al.* (2000) have described a systematic evaluation that utilised a longitudinal, quasi-experimental design, which focused on a short version of a Thorn PSI programme (Chapter 2, section 2.3), delivered on-site in the UK to 45 mental health professionals. A baseline assessment immediately prior to the training was completed. The post-training assessment and the evaluation were concluded with a three-month follow-up assessment. The results showed a significant increase in participants' knowledge levels despite the fact that the student's knowledge of PSI methods and principles was only measured for a small sub-sample (*n*=14). Moreover, positive attitudes to the PSI methods following the training were apparent. Evaluation of the integrity of the training was based on observational data, collected with the Process Evaluation of Training and Supervision instrument (PETS; Milne *et al*. 2000b). This 13-item instrument allowing a profile of the training process to be obtained and a reliability check to be conducted. As with the Kavanagh *et al.* (1993) study, the researchers acknowledged that one limitation was the reliance on self-reported data in relation to the transfer of skills in practice following the training. Thus, caution is needed when interpreting the results as regards whether trainees were applying PSI proficiently following training. Importantly, Milne *et al*. (2000) found that the training had a positive impact on the transfer of learning to the practice settings. Similarly, Baker's (2000) small scale study, that

evaluated a three-day PSI training package with 17 staff in an inpatient unit, found positive results in using PSI skills and staff gained increased knowledge as a result of the training. In Baker's (2000) study, after one month, a post-course evaluation was distributed to all the participants; this evaluation continued to show that staff had an interest in using PSI.

Also, two years later, Ewers *et al.* (2002) provided and investigated the impact of 20 days of PSI training on knowledge, attitudes and burnout rates in a group of forensic MHNs in the UK over six months. Compared to the studies of Milne *et al.* (2000) and Baker's (2000), Ewers *et al*. had a process for randomization. Of the 33 staff who met the inclusion criteria to participate, twenty volunteered and agreed to participate in the PSI training. The twenty who participated were randomly allocated to either the experimental PSI training group (n=10) or a waiting list control group (n=10). On completion of the training, participants in both groups were again invited to complete the two measures of knowledge and attitude. Trainees' knowledge was assessed utilising a 30 item multi-choice question paper developed by experts in PSI (Lancashire *et al*. 1997), and the attitudes were assessed using a measure developed by the first author of the study. The third measure used was the Maslach Burnout Inventory (Maslach *et al*. 1996). In the group that received training, there was a significant improvement in knowledge and attitudes towards clients with SMI and a significant decrease in staff stress and morale, whereas scores in the control group worsened. The authors, however, acknowledged that the significant increase in both knowledge and attitude could have been because the main researcher who worked on the unit conducted training and data collection, which may have biased the results. It is also unclear why 13 members of staff did not consent to participate.

A subsequent study by Gray *et al.* (2003) evaluated the effect of a ten-day medication-training programme for 52 community mental health nurses (CAMHs) in the UK that investigated whether medication management training is effective in improving the clinical skills of nurses. The medication management programme was developed by clinicians, service users and academics, which provided the training. This was a follow up study as a result of a survey of 250 CMHNs conducted by Gray *et al.* (2001). The survey reported that CMHNs wanted more clinical skills training in the area of maintaining medication compliance. A ten-minute role-play task (Scott *et al*. 1999), pre-and post-training was completed by the MHNs that was videotaped and blindly rated by an independent rater using the Cognitive Therapy Scale (CTS) (Vallis *et al*. 1986). Knowledge was assessed pre- and post-training developed for the study using a multiple-choice medication management questionnaire. MHN trainees also completed a satisfaction with training questionnaire at the end of the programme. The findings showed

significant improvements in MHNs' knowledge of medication management. As a result, their increased knowledge helped MHNs apply the skills to the patients on their caseload. These findings suggest that the participants had good opportunities to practice the skills in the training. One could argue that the more exposure trainees have to PSI training the more skills develop.

The findings of these small studies, moreover, are supported by other larger studies. For example, Brooker *et al*. (2003) who also focused PSI training investigated the impact of PSI training on the career trajectories of psychiatric nurses and other mental health professionals. In Stage 1, a postal questionnaire was sent to 141 students at two PSI training centres. In stage 2, a sub-group (n=96) who undertook the training and who were still engaged in clinical practice was followed up in more detail via a further structured questionnaire, and a separate questionnaire was sent to the manager of each of the former trainees. Overall, the findings conveyed significant attitudinal changes such as increased optimism in engaging with families, while enhanced motivation and knowledge were gathered in relation to the different interventions. This study revealed that continuing motivation to implement taught PSI skills was highly linked to the supportiveness of local managers and working in a supportive team. It was also reported in Brooker *et al*.'s (2003) study that the teams with a higher 'supportiveness' score were embedded in organisations that had established a PSI strategy for training and implementation. Whereas, a study conducted by Jones *et al.* (2005) evaluated the impact of PSI training on 70 staff including MHNs, health care assistants and occupational therapists in an adult inpatient service in the UK. None of the MHNs had completed any prior training in PSI. The purpose of the training was to equip mental health staff with the knowledge and skills to utilise PSI for clients with SMI. Similar to Brooker *et al*. (2003), the results from Jones *et al*. (2005), reported that there was a significant gain in knowledge following the PSI training; thus, improvements in clinical practice were noted. Furthermore, MHNs were able to raise knowledge levels, as all staff who had completed a PSI training programme had received additional training in CBT and had access to continued supervision and support to develop their skills further. These findings suggest that nurses who received specialised training and were provided with supervision proved more successful and positive in using PSI skills in practice. These results as regards supervision are further supported by other researchers in the field (Randolph *et al.* 1994, Brooker *et al.* 1994, McFarlane *et al.* 1995, Sin & Scully 2008).

In another study, Magliano *et al.* (2006) reported the findings of a study involving 46 participants from 23 Italian mental health centres. These researchers investigated the delivery

of psychoeducational interventions for people with psychosis and their families. In total, 38 of the 46 participants completed the training. A range of mental health professionals who had not received any previous training in psychoeducational interventions was selected for training. Ninety-one families of service users with schizophrenia were selected and randomly assigned to receive the intervention immediately after the training (44 families) or in six months (37 families). Following training, participants reported an increase in knowledge levels in delivering the interventions to families and particularly in working with MDTs. However, the authors acknowledged that the study design did not allow the researchers to identify variables influencing trainees' attendance at the training, which would have strengthened the findings. In contrast, Carpenter *et al.* (2007) used a mixed design that employed observational and self-report measures that investigated the impact of CBT and FI training and other generic PSI on a postgraduate Community Mental Health programme at a university in the UK. Kirkpatrick's (1967) framework was utilised as a structured framework to help apply the learning of skills. The programme was taught and delivered in six modules totalling 32 days over two years, and two cohorts of 36 trainees participated in the training. Some of the trainees were working with service users with more severe symptoms and behaviour problems. Each trainee was provided with one hour per fortnight of individual clinical supervision by a member of the programme team (minimum 20 sessions). Carpenter *et al.* (2007) showed significant increases in students' knowledge of CBT and FI after the training, which contributed positively to the application of skills in practice. This was regardless of the fact that specific PSI such as FI and CBT were only one component of the teaching on the programme syllabus. One of the reasons for this could be the fact that the feedback from the trainees was related to the relevancy of the topics addressed, followed by an appreciation of a variety of teaching methods, that was delivered by stimulating and knowledgeable trainers. In addition, the service users indicated that they appreciated the PSI working of the trainees.

Similarly, an evaluation of ten-day training CBT programme was conducted by Ekers *et al.* (2006) with the aim of equipping 17 non CBT-trained workers (nurses =15, social workers =2) in mental health teams to deliver CBT interventions. The programme was organised and delivered mainly by the first author with the support of other mental health specialists in the clinical areas. A self-report multiple-choice 'CBT knowledge' questionnaire (Myles & Milne 2001) was given to the mental health care workers on the first and last day of the CBT training. Additionally, the 'Barriers to Change Questionnaire' (BARCQ) (Corrigan *et al*. 1992) was distributed at the completion of the CBT training and 6 months later. Suitability of the training was assessed utilising the 'Training Acceptability Rating Scale' (TARS) (Davis *et al*. 1989), and a

self-rating of CBT practice tool (Myles & Milne 1997) was used to ascertain the trainees' views of the impact of the CBT training. Similar to other studies such as Ewers *et al.* (2002), Jones *et al.* (2005), Magliano *et al.* (2006) and Carpenter *et al.* (2007), the main findings of Ekers *et al*'s (2006) study revealed that knowledge of CBT interventions was increased post-training and this was maintained at a six-month follow-up. However, this study acknowledged that there were no notable changes in attitude and knowledge gain after the last six months of the training. One reason could be that the trainees were able to maintain what they learned at the beginning of the course, as the latter course components of the training concentrated on improving the practical clinical skills and supervision. Nonetheless, one could suggest that there was a possibility that inherent attitudes were being developed during this time.

By contrast, in 2000, Repper evaluated a 12-month postgraduate certificate PSI course as a case study, with a one-year follow-up period. In this study, seven members of a multidisciplinary team participated, while four of the students were MHNs. An embedded case study design was utilised that drew on experimental and qualitative methods. Two of the aims were to examine the development and use of skills and knowledge among student trainees from different professional backgrounds with different types of experience and training and to identify the factors that either contributed to or impeded the implementation of skills and knowledge taught on the programme. All the trainees were required to nominate four clients with whom they intended to work intensively for the purpose of the programme assessment. Data were collected using statistically validated instruments to measure client outcomes, for example, the Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham 1962) was selected for use because it was specifically designed for a population with predominantly psychotic diagnoses and the Social Functioning Schedule (SFS) (Birchwood 1983). Additionally, semi-structured interviews were used to give a more detailed description of the implementation of skills taught in the programme from the perspective of clients, carers and trainees. The findings clearly indicated that all the trainees who had different work situations had experienced positive changes in attitude and gained increased knowledge towards people with psychosis following the training. Client outcomes, in turn, improved, as trainees utilised PSI skills more effectively. Despite these positive developments, Repper (2000) acknowledged that, while all the trainees reported implementing taught skills during the follow-up year, there were many challenges in the application of the skills due to a lack of appropriate clients or because the trainees were working in unsuitable work environments. This aspect of the findings will be discussed in more detail in section 2.7.

Moreover, Doyle *et al*. (2007) that reported similar findings conducted also a quasi-experimental pre/post-test design study. This study aimed to provide MHNs and non-nursing staff in a forensic unit in the UK with knowledge and skills to transfer PSI into practice. Compared to Repper's (2000) study, the training in Doyle *et al.*'s study was delivered over 16-weekly three-hour periods. Participants were randomly assigned to either cohort one (trained) (n=14) or cohort two (waiting list control) (n=12). The results showed a significant increase in knowledge in the trained group, which was measured by a 20-item multiple-choice questionnaire developed by Lancashire *et al*. (1997). This questionnaire measured knowledge of schizophrenia, psychoses and psychological activities. A significant increase was also noted as regards improvements in attitudes in the training group compared to the control group. Attitudes were assessed using a 20-item measure validated for use in a previous similar study (Ewers *et al.* 2002). These findings are also consistent with other research (Bradshaw *et al.* 2007) that revealed an increase in general knowledge about SMI, and enhanced attitudes towards clients when workplace clinical supervision was integral to PSI training for MHNs.

Conversely, Forrest & Masters (2004) conducted a qualitative study that included seventy trainees across four different PSI programmes. Data were collected by utilising semi-structured interviews and course evaluations. The strongest theme reported by the participants was an improvement in attitudes. Additionally, data revealed positive attitudes in an earlier follow-up study by Brooker *et al.* (2003) that comprised trainees who had undergone training in PSI at two training institutes, one undergraduate (n=85) and one postgraduate (n=72), between 1995 and 1999. Trainees were asked to rate themselves compared to pre-training via a structured postal questionnaire. Ninety-three of the respondents gave examples of attitudinal shifts; the examples that were most frequently reported included an increased understanding and appreciation of collaborating with families and clients in a more engaged way and better client outcomes.

A subsequent study conducted by Redhead *et al.* (2011) provided PSI training at two levels to staff working in low-secure mental health units (LSU) in the UK, one of which was for qualified nursing staff (n=12) and lasted eight months, consisting of sixteen half-day sessions, while the second level was aimed at the unqualified staff (n=10) who were provided with 8 half-day sessions. Nurses assigned to the control group continued to work on the LSU as usual and received no additional intervention. While, nurses who were assigned to the experimental group joined a PSI training programme, which included CBT approaches for symptom

management. Knowledge, attitudes and burnout were assessed before and after the training. The assessment of knowledge was assessed under exam conditions using a 20-item multi-choice question (MCQ) paper, which was marked by the first author. The attitudes were assessed using an 'Attitude to PSI scale' (Richards & Everitt 1999), and levels of clinical burnout was measured by the 'Maslach Burnout Inventory' (Maslach *et al*. 1996). Also, 44 care plans of the trainees were randomly selected and audited by using a PSI skills list developed by Everitt (1999). Overall, the findings reported that there was an increase in knowledge and improvements in attitudes for the qualified trainees among the experimental group compared to the control group. In addition, the burnout scores were positive. As regards the service users care plans, results indicated an increased in the reporting of PSI by the qualified trainees. This finding supports Doyle *et al's* (2007) study that also audited care plans and showed an increase in PSI documented pre- and post-training. Furthermore, in Redhead *et al's.* (2011) study, in the experimental group with the unqualified staff, significant increases in the knowledge and attitude scores were shown compared with the control group at the post assessment. The burnout scores for either group of unqualified staff showed change in a negative direction on most of the burnout subscales, and a moderate increase in emotional exhaustion was noticeable. The explanation for this in Redhead *et al*.'s study could have been that the unqualified staff became more cognizant of their existing practices during the PSI training; this could have increased their stress levels, thus leading to higher levels of emotional exhaustion and depersonalization on the burnout scores. The care plans that were audited in Redhead *et al's.* (2011) study showed an increase in the delivery of PSI in practice, however, this finding does not support previous research such as Kavanagh *et al*. (1993) and Fadden (1997). The reasons given were that care plans is more accurate than self-report alone, and that the previous research studies only focused on FI rather than PSI more broadly.

To conclude, in general, the research studies discussed were mainly quantitative, quasi-experimental designs and the absence of a control group significantly limited the findings in most of these studies. From a methodological standpoint, the majority of these studies involved small sample sizes and reliance on self-reports in order to determine the extent of transfer of PSI to practice. Moreover, the training provided in most of the studies was very brief, while the follow-up periods were too short. Thus, it is difficult to ascertain from these studies the degree to which knowledge, attitudes and skills were transferred into the reality of routine practice. However, one study conducted by Repper (2000) that had a qualitative element, utilising a single case study approach evaluated a 12-month PSI programme that had a one-year follow-up. This study identified that the transfer of skills happened as a result of the

clients with whom they work intensively for the duration of the training programme, which helped confidence with skills development and consistently in the therapeutic relationship. It is also evident from the reviewed studies that there is a link to benefits in education for MHNs and patient outcomes. The next section discusses the literature that focuses on barriers to and the facilitating factors of implementing PSI.

2.7. Barriers to and Facilitating Factors of Implementing PSI in Practice

In this section, seventeen studies have been reviewed that have investigated barriers to and facilitating factors of implementing PSI in MHNs' day-to-day practice (Kavanagh *et al.* 1993, Fadden 1997, Devane *et al.* 1998, Repper 2000, Milne e*t al.* 2001, Bailey *et al.* 2003, Brooker *et al.* 2003, Forrest & Masters 2004, McCann & Bowers 2005, Bowers *et al.* 2005b, Sin & Scully 2008, Griffiths & Harris 2008, Mullen 2009, Crowe *et al.* 2010, Prytys *et al.* 2011, Jolley *et al.* 2012 and Fisher 2014). The barriers mainly comprise of the lack of time and limited staff to carry out the interventions, inadequate PSI training, lack of support in the organisations, reliance on medication, unsuitable families, lack of clinical supervision, large caseloads and busy workloads, whereas, the facilitating factors for PSI implementation included sufficient PSI training whereby MHNs gained good knowledge levels and experienced attitudinal shifts working with service users, access to clinical supervision, support from managers in the organisations, small workloads and PSI protocols to support nurses in practice.

The first study to report on was conducted by Kavanagh *et al.* (1993), referred to in the first section of this chapter, and which specifically examined the implementation of taught skills and identified a number of barriers to implementing FI skills in practice. One of the barriers that participants reported on was the belief that there was insufficient training, meaning that therapists were not skilled enough to integrate the skills into practice. The results also showed there were a number of organisational barriers such as lack of service provision and management support, alongside limited finance and an inadequate number of staff dedicated to delivering FI. Staff also experienced conflicting demands of caseloads; no allowance was made for supporting staff with their existing workload. Participants in the Kavanagh *et al.* (1993) study also reported that clients were overly medicated. Consequently, this meant that clients were unable to participate in the FI therapy. Mullen (2009), who studied the literature on PSI in acute mental health settings (more details of which are given later in this review), also indicated that there was an over-reliance on medications that prohibited patients engaging in PSI. However, it was clear from the study of Kavanagh *et al.* (1993) that the

organisational/working environment dictated whether FI was delivered and implemented in practice, which further suggests that barriers occur when MHNs work in environments that do not support the use of PSI.

In a similar study to Kavanagh *et al*'s (1993) findings that also investigated the application of taught skills, Fadden (1997) surveyed eighty-six therapists who had undertaken training in BFT. Of the 70% who responded, 70% reported that they had utilised BFT in their work, but the mean number of families seen per therapist was only 1.7. Again, a smaller number of therapists (8%) was seeing a high proportion of the families treated (40%). The study showed that the community MHNs used this intervention the most (68%), followed by psychologists (63%) and occupational therapists (50%), while inpatient mental health nursing staff (26%) and social workers (29%) used it least. The findings further showed that barriers such as the different locations of work, difficulties in finding suitable families, different professions and the availability of other trained staff appeared to have an adverse impact on the implementation of these FI. Other common barriers related to lack of time and the limited scope to use FI in other areas of the therapists' work. One could suggest that therapists may have lost FI skills if they did not have the opportunity to use them regularly. One further finding conveyed by Fadden (1997) was the lack of clinical supervision of trainee therapists following training in the clinical areas. Even when supervision was accessible at times to suit trainees, they did not attend supervision because they did not have the time or because they were not engaging with families at that time. Similar to Kavanagh *et al.* (2003), one of the main barriers was the lack of support to using PSI in the working environment. There is also evidence in Repper's (2000) study that a lack of support from management and lack of clinical supervision created further barriers to staff implementing PSI in their daily work. Also, in relation to family intervention training, Kavanagh *et al*. (1993), and Fadden (1997) have similarly concluded that selection of trainees is critical.

A subsequent study conducted by Devane *et al.* (1998) found many barriers to the successful delivery of the skills. The researchers evaluated the PSI skills of 34 MHN participants carrying out CBT with clients and their families in two health districts in England and Wales. The first stage of this study was the development of a Cognitive Therapy Checklist scale (CTC) (Young & Beck 1980) and a Schizophrenia Family Work Scale (SFWS) (Lam 1991 - unpublished). Also, a sample of twenty tapes of clinical sessions from previous trainees who had completed Thorn training was listened to and scored using the two scales mentioned, which allowed modifications to the scales to be made, thus increasing their validity. The second stage aimed

at using the adapted scales to assess MHNs' clinical skills. Half of the participants were about to undertake the training programme (the experimental group) and half were a matched sample of MHNs not undertaking specific training (the control group). As with Kavanagh *et al.* (1993), these barriers included the lack of skills following FI training and time constraints, regarding which Fadden (1997) reported that the extra demands of the MHNs' work took precedence over PSI. Devane *et al.* (1998) also revealed that the managers were not supporting the FI roles in which MHNs were currently working. This has implications for practice as reduced support can decrease MHNs' motivation to use the skills and, subsequently, skills can diminish over time (Repper 1998, 2000). This is especially important given that MHNs work with families who have relatives with SMI in the community.

Similarly, Bailey *et al.* (2003) investigated the effectiveness of an FI training programme that also revealed many barriers. Data collection methods included a questionnaire that had been developed and used in the Kavanagh *et al.* (1993) study ten years earlier, which was supplemented by focus groups. Fifteen health care professionals, who had completed a one-year training programme and who worked in both inpatient and community settings, participated. The study identified that each trainee would deliver FI to an average of 3.5 families within an average of twenty-six months post-training. At first, the trainees worked well with families using the interventions; however, as time progressed, they experienced barriers such as a decreased amount of referrals, little time with a busy workload, a lack of co-workers and negative attitudes from management towards the value of FI. In particular, staff experienced poor engagement of clients and families in the inpatient setting. The negative attitudes towards FI of the managers in the study of Bailey *et al.* (2003) were also a consistent finding in the two previous studies (Kavanagh *et al.* 1993, Devane *et al.* 1998). Conversely, the facilitating factors in improving implementation of FI in Bailey *et al.*'s (2003) study included the co-working in monthly sessions with other professionals in sessions, and the MDT working leading to increased FI referral rates. However, the study has drawn attention to a number of barriers that could be considered in helping other clinicians working in this field.

In addition, in Brooker *et al.*'s (2003) study, trainees and managers were asked to rate barriers to the implementation of PSI. In ascending order of citation, the main barriers were perceived to be large caseloads, a lack of understanding from other staff of what was involved in delivering PSI, insufficient staff trained in PSI, lack of time to carry out the interventions, decreased availability of suitable clients or families, limited access to supervision and lack of an organisational strategy. However, the study found that the facilitating factors to PSI

implementation involved motivating mental health professionals to include the need for a smaller caseload, local manager support and recognition that a high proportion of clinical time is needed for PSI and MDT support.

In contrast, Milne *et al.* (2001) evaluated the transfer of PSI training within ten NHS Trusts in the UK with qualified mental health clinicians, mostly MHNs. Seven managers took part (representing a 70% response rate), including 155 clinicians, all of whom had received PSI training (a 52% response rate from the 299 staff sent questionnaires). The main barriers reported were the difficulty to the transfer of skills by managers due to organisational constraints and that there was a lack of resources to help clients. Whereas the facilitating factors included access to clinical supervision, peer support from the course members during the training and, most importantly in this study, support from the trainees' managers. In addition, a supportive work environment was perceived as beneficial as there was a shared belief amongst staff about the vision of PSI for staff and clients (Fadden & Heelis 2011). Furthermore, trainees believed that the training provided adequate content, which facilitated their development of the necessary PSI skills for transfer to practice. Overall, this study reported more facilitating factors in helping this skills transfer. Alongside other studies such as Kavanagh *et al.* (1993), which reported that, among the 45 therapists who participated, knowledge gain in the CBT training was difficult to recall when delivering the skills in practice, Fadden (1997) also found there was a lack of support from managers and reported that using the skills was challenging due to the difficulty finding appropriate clients. However, the research conducted by Milne *et al.* (2001) was a pilot study, which means caution is again needed when drawing definite conclusions.

A subsequent study carried out by Milne *et al.* (2003) evaluated a 10-day Behavioural Analysis and Intervention Training and Support (BAITS) programme that took place at a large psychiatric hospital in the UK. The study involved 25 staff, mostly MHNs, who were allocated to either an experimental group (n=18) that received the training over a seventeen-day period or to a waiting list control group (n=7). This latter group did not receive any training either before or during the study period. In addition, focus groups that ran weekly throughout the staff training period were conducted with seven self-selected clients who had a diagnosis of SMI to provide their views of the care they received. The trainees reported using significantly more of the BAITS in the six to nine month period post-training than they had done prior to the training. The successful implementation was due to a favourable working environment in which the trainees found that they received excellent support from the organisation in the

transfer of skills. The BAITS manual was also a useful resource for the trainees and an additional supporting factor in motivating staff using the PSI skills. The PSI methods were applied in routine practice with an average of seven residents per staff member. By contrast, Kavanagh *et al.* (1993) and Fadden (1997) have shown a far more modest transfer of skills in practice. Furthermore, in Milne *et al.* (2003) study, because of the trainees using the skills, the clients reported overall that they experienced fewer symptoms and as a result had better social skills and social functioning, which increased their quality of life. These results compared favourably with a group of service users in another area who received the standard care, where trainees had not received this specific training. However, there were no significant changes reported by the clients in the standard care group.

Part two of a paper conducted by Forrest & Masters (2004) (mentioned in the previous section) has discussed the findings from the evaluation of five short PSI training programmes. Among the difficulties experienced by participants were that the training was delivered in different ways, at different depths and there were different trainees in the programmes. This resulted in participants having insufficient time to construct the material before engaging with clients, which suggests that the training was inadequate in the transfer of the taught skills into the participants' day-to-day practice. This finding contradicts those of Milne *et al.* (2001) that suggested the training was adequate. The former finding is reinforced in a study by Griffiths & Harris (2008) that found staff had difficulty using the taught skills in practice following training. However, the participants in Forrest & Masters' (2004) study also perceived that there were some 'hidden' facilitators of the learning. They believed that the training validated their practice, while increasing confidence levels and changing attitudes when working with service user and carers, all of which is corroborated by other studies (Brooker & Butterworth 1993, Repper 2000, Magliano *et al.* 2006). In general, the Forrest & Masters (2004) study demonstrated that training was important and positive aspects of the training were highlighted.

Furthermore, another important study conducted by McCann & Bower (2005) evaluated the roll out of PSI training to qualified psychiatric nurses and unqualified mental health staff on seven acute psychiatric admission wards. PSI were delivered on-site in the clinical areas over a three-year period. Supervision and role modelling of CBT techniques were conducted by the researchers who worked with staff on the inpatient environments. The barriers to PSI implementation involved delays in releasing nurses for the training; nurses who attended had difficulty engaging in the process, as the demands on the acute units were high. Moreover, the

acute areas often had to rely on temporary staff that resulted in high staff turnover, which meant that there was an inconsistency in nurses' delivery of effective CBT or FI. These findings are comparable with Fadden's (1997) and Sin & Scully's (2008) research (more details of Sin & Scully's (2008) study are given below) that also found that workload demands and staff shortages were barriers to PSI application. Similarly, a review by Macleod *et al.* (2011) reported that, after nurses complete training, the titles and experiences of nurses vary. One could argue that when nurses get promotion to manager status, they are no longer required to use these skills, as they are no longer directly involved in patient care. McCann & Bowers' (2005) study also involved training cohorts of students from the same areas. This would suggest that training staff together makes it easy and less challenging for nurses to partake in the training; thus, together managers could facilitate nurses to support each other implementing PSI methods. Other evidence supports more therapists being trained together in one location (Fadden 1998, Mullen 2009). Facilitators subsequently noted in McCann & Bowers' (2005) study included the importance of good leadership and management styles and sufficient training.

As well, Bowers *et al.* (2005b) developed a PSI training package for staff across the UK with the aim of reducing absconding rates in fifteen acute inpatient locked units. A questionnaire was developed for an audit. After a period of four months, the post-intervention questionnaire was distributed and followed up with phone calls. The study revealed that eleven of the wards reduced their absconding rates. However, as in previous research findings (Kavanagh *et al.* 1993, Devane *et al.* 1998), the lack of management support was a dominant barrier, as the researchers anticipated that the ward managers would be instigators in implementing the PSI package of skills, but this was not evident in practice. This meant that the staff implemented PSI without any support. This might suggest that staff were motivated and had a vision of what PSI could bring in terms of influencing practice. However, a salient supportive factor reported in Bowers *et al.*'s (2005b) study was that the communication styles of nurses showed a significant positive impact on client behaviour in relation to absconding risks, despite the fact that patients on these wards were more likely to be compulsorily detained in hospital and to have frequent episodes of absconding. This study further highlighted that a supportive work environment, alongside well-defined packages of PSI, facilitates MHNs in providing good quality PSI that can improve patient outcomes.

A subsequent study conducted by Sin & Scully (2008) focused on a survey evaluation of education and the implementation of CBT and FI in one mental healthcare trust in the UK.

Training was provided to mental health nursing staff, including fifteen trainees and eleven service managers. As with the Milne *et al*'s. (2001) study, trainees noted that a facilitator to delivering the skills was the support structures that were in place within the organisation; these included support from specialist clinical staff with experience of utilising PSI, access to clinical supervision and having relevant policies in place. Furthermore, managers were able to obtain additional funding to backfill the PSI trainees' time away from the clinical areas. This meant that staff shortages were not an issue in clinical teams. However, these findings are not supportive of previous studies (Kavanagh *et al.* 1993, Devane *et al.* 1998, Bowers *et al.* 2005b), suggesting that managers' support is dependent on organisational/working environments and the locations where clinicians work. From a methodological standpoint, Sin & Scully's (2008) study also showed some weaknesses as no measures were obtained pre-training for comparison purposes after the training, which was also the case in Bower *et al.*'s (2005b) study. Despite being a relatively small and uncontrolled study, the findings from Sin & Scully (2008) showed positive results, 86% of respondents reporting that they had delivered CBT and 93% that they had delivered FI. The number of sessions, however, delivered by mental health nursing staff was not clear from Sin & Scully's article, nor were there details of the session content or evidence of recorded sessions by the service users.

Mullen (2009) also studied the literature on PSI in acute mental health and found two particular barriers to CBT skills application: Custodial approaches to care; and an over-reliance on medications. The adverse side-effects of some medications such as drowsiness were reported as a barrier, which meant that the medication effects worked against the MHNs engaging with clients (Sullivan *et al.* 2007). As with McCann & Bowers (2005), this review identified that acute settings are often busy, chaotic and stressful places that challenge MHNs and, as a result, nurses often do not feel empowered to use PSI. These factors, combined with the challenges of working with severe mental health problems, can explain why nurses may adopt a custodial approach to care, as a way of coping with managing a busy environment.

In contrast, a UK study conducted by Griffiths & Harris (2008) utilised a telephone survey with managers and PSI-trained staff (n=15) working in nine teams on AO in the Northwest of England. AO (sometimes known as Assertive Community Treatment or ACT) is an evidence-based model of case management, specifically designed to meet the needs of service users with SMI who, for a variety of reasons, do not willingly engage with services (Fleet 2004) and who may need frequent admissions to hospital. This study also highlighted that there was less than half of the PSI-trained staff had access to regular clinical supervision. This finding was

comparable with existing research studies (Brooker *et al.* 2003). Furthermore, as with many findings in previous studies (Kavanagh *et al.* 1993, Devane *et al.* 1998, Bailey *et al.* 2003, McCann & Bowers 2005), inadequate time to deliver PSI and staff having difficulty with the transfer of new taught skills to current caseloads were reported. Brooker *et al.*'s (2003) findings also suggested making caseloads smaller as this facilitates PSI by giving staff increased clinical time to focus on the application of skills. Consequently, this motivates and encourages staff to use PSI more effectively in their day-to-day practice. This finding is also referred to in a review led by Macleod *et al.* (2011) that showed smaller caseloads facilitated clinicians' involvement in more intensive outreach and visits to clients, and in practising PSI skills. The findings of Griffiths & Harris (2008) also revealed that trainees had full support from AO managers, in that there were supportive structures in place post-training for AO staff. As with the findings of Magliano *et al.* (2006), the study acknowledged that an implementation plan and training strategy for staff helps in facilitating successful implementation of PSI in practice.

Additionally, a systematic review conducted by Crowe *et al.* (2010) in New Zealand drew attention to how MHNs played an important role in integrating PSI in practice settings. In this review of group psychoeducation, FI and CBT interventions, a noted facilitator was the availability of manualised protocols. These protocols supported MHNs in providing a structured approach to PSI. It was evident that PSI were particularly beneficial when used alongside medications, which was a further motivating factor for the MHNs. In contrast, findings from a recent UK study conducted by Prytys e*t al.* (2011) that investigated the attitudes of four community mental health teams (CMHTs) affecting guideline implementation. (NICE guideline for schizophrenia). Twenty CMHT care coordinators participated in interviews (11 were nurses, 6 social workers and 3 occupational therapists). Overall, participants reported mixed views about the guidelines. Some participants had concerns about the reality of implementing them in their daily working, due to time constraints, high caseloads and lack of specialist staff. Additionally, some participants mentioned talking therapies as an alternative option for treatment; many of them reported that medication had an important function in achieving positive outcomes for clients with psychosis. Also, some accounts included unease that CBT might be considered a cure-all approach rather than a holistic package of treatment. Moreover, participants echoed that the clients who benefits from talking therapies would tend not to have severe mental health issues and less psychotic symptoms. This meant that the participants had negative attitudes towards the recovery of clients with psychosis. In particular, staff stress and burnout were significant barriers. These findings were reiterated in

many other discussed studies (Farhell & Cotton 2002, Brooker *et al.* 2003, Fadden 2007, Sin & Scully 2008, Bulter *et al.* 2013).

Furthermore, Jolley *et al.* (2012) evaluated a CBT training package for mental health service staff. The evaluation comprised a pilot programme (2003-2005) (n=17) and subsequent three intakes of staff (n=41) (2006-2008). Overall, 19 nurses participated in the training. From 2006, the training programme had run as an accredited Postgraduate Diploma in an institute of Psychiatry. The factors related with successful completion of the programme and with delivery of interventions one year following training were also investigated. Therapy competence was measured utilising the Revised Cognitive Therapy for Psychosis Rating Scale (R-CTPAS, Rollinson *et al*. 2008) and the Cognitive Therapy Scale (CTS, Young & Beck 1980). The R-CTPAS comprises 21 therapy components derived from a manual developed by Fowler *et al*. (1995). Service users independently rated both the therapist and the CBT, utilising a 3-point scale (Kuipers *et al*. 1997a) ranging from 0 (not satisfied) to 2 (very satisfied). Overall, the trainees were highly satisfied with the training and commented on positive outcomes with their client groups. In addition, the managers of the trainees reported increased confidence, increased skills and improvements in the clients as a result of the training. Despite the high training investment, and the implementation of CBT by the trainees during the training, the one-year follow-up discovered that it was difficult for the clinicians to implement the skills if they returned to a coordinating role in their area of work. This role involved managing a heavy workload in which there was no protected time for skills development, regardless of formal agreements with managers and on-going supervision. In other words, many of the trainees had to revert to their same role and function prior to the training. There is no doubt that one could argue that this decreases clinicians' motivation and interest in training, which further affects the delivery and implementation of PSI.

Conversely, a subsequent larger study conducted by Fisher (2014) in Australia examined 528 practising MHNs' use of psychological therapies while working in public or private sectors in the community, general practitioner (GP) practices or inpatient services. The term 'psychological therapies' is often used in the literature in relation to PSI in other countries (DoH 2006a, Callaghan 2009, Gourney 2009). In this study, two research methods were chosen: Delphi surveys of consumers and practising MHNs; and an online survey of MHNs, which was developed from the Delphi surveys and from previous questionnaires assessing the use of and the attitudes towards psychological therapies and CBT (Corrigan *et al*. 2001, Le Fevre 2001, Wilson & White 2007). However, only the findings from the survey are reported in

Fisher's (2014) article. The findings showed that there were significant differences depending on where nurses worked and whether they had received any formal training in the PSI therapies. For example, MHNs who worked in the public sector were more likely to experience organisational barriers such as lack of time within their workloads, limited staff to carry out the therapies, high staff turnover, low staff morale, lack of confidence, increasing documentation, lack of training and clients who did not comply with the approach. Interestingly, the barriers are comparable to UK and Irish literature in areas such as the difficulty of identifying 'suitable' clients, insufficient time, lack of skills and managers not supporting nurses using the interventions (Farhell & Cotton 2002, Brooker *et al.* 2003, Fadden 2007, Sin & Scully 2008, Butler *et al.* 2013). In contrast, nurses who worked in private hospitals reported barriers such as inadequate skills and funding shortages. The nurses who had received former training reported that clients' mental illness symptoms were too severe and impacted on their ability to deliver the skills in practice. Fisher (2014) did acknowledged that the online survey limited confidence in relation to the generalisation of findings, as the sample was not randomly selected.

In summary, of the seventeen studies reviewed, it is evident that there are on-going and persistent barriers to the delivery and implementation of a range of PSI in practice across many countries such as the UK, Australia, Italy and New Zealand. Specifically, in many of the studies, there was a lack of support from managers and organisations (Kavanagh *et al.* 1993, Devane *et al.* 1998, Bailey *et al.* 2003, Bowers *et al.* 2005b, Griffiths & Harris 2008). However, a few studies also found that managers facilitated clinicians using PSI in practice. In addition, more recent studies conducted by Prytys *et al.* (2011) and Jolley *et al.* (2012) have continued to draw attention to similar barriers to the return to the workplace after training, such as lack of protected time, heavy caseloads, high workload and lack of support. Thus, the reviewed studies in this section have shed more light on the extent of these barriers and facilitating factors for MHNs, allied health care professionals and the mental health services that are challenged with the endorsement of PSI for better client outcomes. If managers and stakeholders become better informed about the implementation issues, they should be in a better position to take on board how best to invest in mental health nursing, so that MHNs are supported in the offering and implementation of PSI. The majority of these studies reviewed were conducted in community and inpatient settings (Appendix 2). From a methodological standpoint, many of the studies suffer from a small sample size and the reliance on self-reports in order to determine the crucial question of PSI transfer to practice.

The next and final section of the literature review discusses the literature pertaining to PSI skills in the Irish context, followed by a summary of the chapter.

2.8. PSI Evidence within the Irish Context

This section introduces a series of relevant Irish studies to further contextualise this research. There are a limited number of published Irish studies exploring MHNs' experiences of the use of PSI in practice, and in particular since the publication of the policy document 'A Vision for Change'. A total of eight studies (Jackson & Stevenson 2000, Cowman *et al.* 2001, Deady 2005, McCardle *et al.* 2007, O'Neill *et al.* 2008, MacNeela *et al.* 2010, Butler *et al.* 2013 and Maruthu *et al.* 2013) were located that were relevant to this topic (Appendix 2). The studies in this section are divided to studies pre- and post' 'A Vision for Change' (2006). It was evident that the studies conducted by Jackson & Stevenson (2000), Cowman *et al.* (2001) and Deady (2005) were completed before the publication of the policy document 'A Vision for Change' and, most importantly, while mental health services were still governed by the 1945 Mental Health Act. It was also clear that PSI was not a term used pre 'a Vision for Change' in the Irish context, but the activities conducted by many nurses clearly fall under the umbrella term of PSI. Overall, many of the findings in the studies were consistent with existing studies from other countries, particularly the UK.

Studies Prior to 'A Vision for Change'

The first study to report on is a qualitative study conducted by Jackson & Stevenson (2000). The purpose of this study was an exploration of service users' need for nurses in mental health services using grounded theory (Holloway & Todres 2010). The study sample comprised psychiatric nurses, social workers, service users, psychiatrists, carers and allied health professionals (13 groups, n= 92). Even though this study was not exclusively conducted in the Republic of Ireland, focus groups were conducted within three sites in Ireland; therefore, it has relevance to the Irish context. The other focus groups were conducted at three sites in the UK and two sites in Northern Ireland. This study conveyed that doctors seek nurses' views because nurses have a better knowledge of clients and that other professional groups can rely on nurses' knowledge as a way to observe the mental health state of clients. Conversely, social workers and doctors believed the nurses adopted a 'mother figure' attitude towards service users, in which context many service users described that they were comfortable with nurses identifying their needs for them. It has to be argued that this is a move away from the collaborative nature of using PSI. Another important finding was the issue of time. The time

available for the client can be impacted by other nursing responsibilities such as client admissions, administering medication, paperwork, meetings and talking with other clients. Thus, nurses were unavailable to clients to complete these other tasks. These findings resonate with earlier research in the UK on FI (Fadden 1997, Devane *et al.* 1998) that also found that the additional work demands upon MHNs took precedence over anything else, all of which were obstacles in implementing nursing skills. Another important finding reported in Jackson & Stevenson's (2000) study was the belief that clients were reluctant to interrupt nurses who appeared busy doing other things. This also has implications for mental health nursing practice in relation to busy working environments. In summary, this study highlights the value of psychiatric nurses to services users at that time. In terms of current policy implications, the article gives context to how mental health services have evolved since 2000 and helps to compare and contrast MHNs' roles prior to the 'A Vision for Change' policy document with current mental health nursing practice. Also, a key strength of this study was the diversity of sites in the collection of data.

The second important study was conducted by Cowman *et al.* (2001) in one region in Ireland, which looked at all grades of psychiatric nurses in practice with a view of what psychiatric nurses do on a day-to-day basis. This was a large study (n=155) conducted across a range of clinical environments that used a multi-method qualitative approach. The methods included non-participant observation, self-reporting through an activity log and documentary data. This study highlighted the independent therapeutic nurses' roles that often take place in isolation from the psychiatrist involvements and interference. The findings also asserted that, although some skills in the psychiatrist nurse's role are common to other professions, some features are unique. For example, participants perceived that they had a significant role in education, dispensing and administrating medication to patients in a range of settings. Furthermore, the observational data showed that the nurses have been involved in a large number of administrative and organisational responsibilities, such as managing patient finance and liaising with finance departments. The participants were very aware and accepting of the importance of documentation in terms of care planning. Of particular note in the study's findings was the nurses' ability to be constantly present, which helped to maximise opportunities to interact with patients and thus utilise their skills that were timely and appropriate to the patients' needs. This, no doubt indicated a move away from the custodial approach to care, and one could claim that Cowman *et al.*'s (2001) study gives an excellent insight into the multifaceted role of psychiatric nursing in that there was more scope to the role of the psychiatric nurse than suggested by their professional title. Similar to Jackson &

Stevenson's (2000) findings that revealed that psychiatric nurses have a great breadth and depth of knowledge about patients and that they were often the key people providing information in MDT meetings as regards decisions about patient care issues. Regardless of the fact that nurse roles are wide-ranging, Cowman *et al*.'s study highlighted that participants found it challenging to articulate specifically what their roles involved. However, one could argue that the psychiatric nurses who participated in Cowman *et al.*'s (2001) study were using PSI in their day-to-day practice at that time which later became associated with the recovery movement.

A subsequent smaller qualitative descriptive study was conducted by Deady (2005) that explored attitudes and values of Irish-trained psychiatric nurses. Data were collected in eight one-to-one interviews. Some contradictoriness was noted in the findings, as some participants believed that they had better quality interpersonal skills, which enhanced therapeutic relationships with clients by comparison with other disciplines. However, data also showed that participant psychiatric nurses were working within a dominant biomedical model that limited opportunities for MHNs to develop. Participants also reported that nurses often avoided telling clients about the side-effects of certain medications for fear of non-compliance. A similar finding was highlighted in Mullen's (2009) research that found that MHNs were using custodial approaches to care, but also an over-reliance on medications was reported. Additionally, as with the study by Cowman *et al.* (2001), psychiatric nurses had difficulty in expressing explicitly what their roles involved compared with other health care disciplines. An explanation for this could be the fact that the nurses in this study had received no extra training since professional qualification, and at which time such training was conducted in an apprenticeship-style that focused on symptoms rather than truly engaging in interventions other than, for example, titrating antipsychotic medication. One could suggest that some nurses were still relying on traditional ways of working to inform their practice by focusing on symptoms; however, this contradicts some findings in Cowman *et al.*'s (2001) study, as it was evident that this research was a useful starting point in identifying discipline-specific activities of the psychiatric nurse during this decade.

To conclude, in consequence, the absence of appropriate mental health legislation and policy meant that the psychiatric nurses within these studies (Jackson & Stevenson 2000, Cowman *et al*. 2001 and Deady 2005) were working with little to support their practice, which puts the findings of these studies into further context for this present study.

Studies Post- 'A Vision for Change'

The following five studies were conducted post 'A vision for Change' (2006) policy document. These studies showed that the MHNs' activities were more focused on the psychosocial activities as advocated by 'A Vision for Change', which helped to support MHNs in their practice.

McCardle *et al.* (2007) conducted the first national survey of CPNs and their client care activities in Ireland (n=203, response rate: 57.1%). This study was undertaken a year after the 'A Vision for Change' publication. A combination of a questionnaire survey and direct observations were used to collect the data. The findings from the observations showed that CPNs were mainly engaged in the assessment of clients, medication management, health promotion and client and family support. The findings showed little evidence that CPNs conducted any formal cognitive, behavioural or family work. Nurses were more inclined to focus on physical and practical problems as opposed to educating clients about psychiatric symptoms. Furthermore, participants reported that large caseloads were potentially an obstacle to delivering PSI with their client groups. Consequently, there was less time spent with clients. Similar findings in relation to how large caseloads limited nurses' time for offering PSI to clients in their daily work was reported in research executed by Brooker *et al.* (2003), Forrest *et al.* (2004) and Magliano *et al.* (2006).

In a subsequent study, O'Neill *et al.* (2008) explored the roles and perspectives of MHNs toward clients with SMI and their carers following the completion of PSI training. Two focus groups with four participants in each of the groups participated. MHN participants reported improved client outcomes because of the training as they developed positive attitudes toward the clients. Therefore, attitudinal changes experienced by participants empowered clients to develop skills in identifying stressors and coping strategies. Similar findings were reiterated in Forrest & Masters' (2004) study that also described improvements in clients' quality of life because of the interventions. However, participants in O'Neill *et al.*'s (2008) study reported a drawback with implementing the skills, in that it took a long time to see the impact of offering PSI to clients. In other words, PSI did not provide immediate results and required time. At the same time, clients and carers were observed to have less anxiety during the focus group interviews. The findings also illustrated that participants experienced higher levels of confidence and that knowledge and skills had increased. Even though this was a small-scale study, it did report similar findings to previous studies in the UK such as Jones *et al.* (2005),

Brooker *et al.* (2003) and Magliano *et al.* (2006) which also found increased knowledge gains and confidence after trainees completed PSI training.

In contrast, a study conducted by MacNeela *et al.* (2010) identified PSI in mental health nursing that were relevant to routine care by exploring their content and patterns. This study comprised 37 MHNs who were recruited from the community (n=22) and acute hospital settings (n=15). A think-aloud task performance design (Ericsson & Simon 1993), and data were collected by using four case simulations. For example, in line with the think-aloud approach, for each case simulation, focused tasks were devised in which participants were invited to describe the current situation of the client in the presented case and recommend next steps in the nursing care of the client. In other words, nurses' judgments about a client were introduced first, followed by the PSI upon which they drew. The identified psychosocial care themes were dialogue, reassurance, encouragement and structured engagement. The data described that more experienced nurses were more likely to recommend PSI, while some other nurses described their role as being minimal in developing collaborative relationships with clients. One explanation for why the more experienced nurses recommended PSI could be that they had more time to develop the skills and were therefore more confident, while less experienced nurses delivered care in a directive and authoritative way rather than focusing on specific PSI activities with clients. This finding is similar to that of Jackson & Stevenson (2000) and Deady (2005), who also found that the staff approached clients with a 'mother figure' attitude rather than working collaboratively with their clients. Nonetheless, the findings of MacNeela *et al.* (2010) describe recent mental health nursing care within an Irish context. The researchers did acknowledge that the observations of actual nurse-client interactions are required to confirm whether nurses have a different approach in practice. Hence, this present study has built on this current research by using observations that focus on nurse-client interactions and their PSI activities.

A more recent quantitative study by Butler *et al.* (2013) also explored PSI in mental health nursing practice. This survey was mailed to MHNs (n=58) who completed PSI training between 2005-2010 at one Irish training institution. The results indicated statistically significant increases in the use of PSI following PSI training; the least used interventions were CBT and FI, but the core elements of PSI such as assessment and outcome measures, medication concordance therapy and relapse prevention were utilised. Conversely, increased awareness of relapse indicators, improved coping skills and fewer admissions to hospital were all perceived outcomes for service users. The barriers to implementation included high caseload

demands, decreased availability of clinical supervision and time constraints, all of which were comparable findings to other studies such as that of McCardle *et al.* (2007) and Griffiths & Harris (2008). Reported responses also conveyed that there is a need for nursing leadership to make PSI mandatory and that dedicated PSI-nurses should be recruited to all MDTs. These findings were also reported in Sin & Scully's (2008) research, which showed that a PSI programme leader who had sole responsibility for PSI developments made a positive impact on PSI implementation. A further recommendation made in Butler *et al.*'s (2013) study was the need for supporting PSI guidelines, clinical supervision and auditing of the interventions by senior nurse managers.

A subsequent investigation by Maruthu *et al.* (2013) of the training and evaluation of PSI was conducted by questionnaire with 100 MHNs (response rate: 23) in one mental health service in Ireland. A study tool was developed based upon Bloom's (1956) taxonomy to measure the nurses' level of knowledge, attitudes and skills. The training was run by rostering MHNs to the training days and using experienced nurses from within the service. The results showed that there was no difference between the mean scores of the MHNs who attended the training and those who had not. However, the nurses who had undertaken training more recently in 2013 achieved the highest mean score in relation to knowledge, attitude and skills, while the MHNs who undertook the training in 2012 achieved a higher mean score in relation to the three domains than those who trained in 2011. This indicates that nurses' levels of knowledge and skills reduce as the years pass, which arguably further suggests that skills deteriorate without regular continuing education. This finding is comparable with those of Repper (1998), which also suggested that skills disintegrate over time if nurses do not have access to on-going education and updating of skills. However, Maruthu *et al.* (2013) concluded that PSI training, such as continuing education, would help to update skills. Remarkably, there was no difference of the MHNs who attended the training since 2011 regarding levels of knowledge, attitudes and skills; however, the authors acknowledge that the questionnaire had limited scope for measuring the complex level of knowledge, attitude and PSI skills. A recommendation from this evaluation was that focus group interviews should be considered for future studies. Similarly, the study by Butler *et al.* (2013) recommended that a larger qualitative study be carried out in future studies.

To conclude, while all of these studies have contributed to knowledge of the topic in Ireland, only the studies of O'Neill *et al.* (2008), MacNeela *et al.* (2010), Butler *et al.* (2013) and Maruthu *et al.* (2013) have explicitly focused on PSI training and the implementation of PSI

skills in practice. One could suggest that these research studies were shaped by the 'A Vision for Change' (2006) publication, which contributed to MHNs utilising PSI in some settings. A table of the eight studies located in Ireland pertaining to the topic is presented in Appendix 2, which helps to illustrate the limited PSI research in Ireland in this important field. Notably, both Butler *et al's* (2013) and Maruthu *et al's* (2013) research supports the present study that has focused on the qualitative dimension.

2.9. Summary

This review presents a body of literature that has reviewed PSI training for working with clients experiencing mental health problems. At the outset, this chapter presented the developments in PSI training and the types of PSI, followed by PSI in different practice settings and finally proceeded by the PSI evidence within the Irish context. The reviewed studies portray sufficient evidence for the incorporation of PSI and PSI training for MHNs in mental health settings. However, it is clear that most of the research on this topic was mainly from the UK, with some from Australia, Italy, New Zealand and Ireland.

In particular, this review has identified that PSI training comes in various forms both in regards to the focus and the length of training. Yet, it is challenging to determine what type of training is necessary to attain specific levels of knowledge and skills in the mental health field. Additionally, it is clear that many studies have repeatedly highlighted barriers to the implementation for a range of PSI, and it is evident that the same barriers are encountered across FI and CBT type interventions. Commonly reported barriers include large caseloads, restricted time to carry out the interventions, inadequate training and lack of organisational support in the day-to-day work environment, all of which need addressed by organisations. To a lesser extent, the review has identified that a number of factors contribute to the successful transfer of skills and learning into practice; on-going clinical supervision, peer support and a supportive working environment, whereby nurses are able to practise the learned skills after training.

What has also become patently clear through the review of the literature on this topic is that MHNs require on-going training in order to keep abreast of the rapid changes happening in practice, mental health services and research. Overall, the review has identified that PSI training in all its guises has a broadly positive effect on beliefs and attitudes, and as a result, this may lead to new knowledge, which can positively influence patient outcomes. Accordingly,

this study functions as a response to the gap in knowledge within the Irish context on this important topic. In light of the changes and the reconfiguration of Irish mental health services, this study will seek a clarification of PSI-trained nurses' skills, and how these nurses are prepared for the changing times ahead. Therefore, evidence from this study has the potential to contribute to new knowledge and will afford a clear understanding of MHNs' experiences of PSI going forward for Irish mental health services.

In the following chapter, the methodology and research methods of the present study are discussed.

3.   Chapter Three: Research Methodology

3.1. Introduction

This study aimed to explore PSI-nurses' experiences of using PSI with clients in day-to-day mental health nursing practice. Thus, this chapter provides an overview of paradigms, explanation and justification of the choice of the study's philosophical orientation (interpretivism) and selected research methodology (multiple case study) in light of the overall research aim and its objectives. The chapter will also outline how interpretivism and multiple case study methodology shaped the study. The data collection methods and the rationale for these associated components are also discussed.

3.2. Overview of Paradigms

In this study, once the research topic was in view, the process of how to go about investigating it had to be considered. Thus, the first step in the execution of this study was to identify an appropriate paradigm to address the research objectives and the chosen methodology for the topic. No one paradigm or philosophical framework is 'correct' and it is the researcher's choice to determine the correct paradigmatic view, and how this informs the research design to best answer the question under study (Weaver & Olson 2006). It was important for this study to select a philosophical paradigm that not only informs the research aim but also unites the research to the mental health nursing field (Agee 2009). Interpretivism was deemed the most suitable paradigm in the conduct of the study; this paradigm will be explained in more detail as the chapter progresses.

There is little consensus regarding the terminology and classification of paradigms (Patton 2002). The term 'paradigm' refers to a worldview or all-inclusive way of experiencing and thinking about the world, incorporating beliefs about ethics, values and aesthetics (Kuhn 1962, 1970), or general perspective on reality (Khun 1979, Polit & Beck 2012). Each paradigm is informed by philosophical assumptions regarding what is believed about the nature of reality (ontology), ways of knowing about that reality (epistemology) and a set of appropriate systematic approaches that can be used to study that reality (methodology) (Hamilton & Corbett-Whiter 2013). Numerous paradigms may be employed to explain reality and applied as a framework for research studies. However, the philosophical assumptions underpinning a qualitative study can expect to be challenged by proponents of competing paradigms (Guba & Lincoln 2005). Thus, the researcher in this study needed to coherently articulate the rationale

for the selected paradigm and how the philosophical assumptions of the researcher are reflected in the chosen methodology.

The next section, therefore, discusses interpretivism as the selected paradigm along with the rationale and its application for this study.

3.3. The Interpretive Paradigm: Rationale and Application

Interpretivism is a paradigm that has its origins in the fields of psychology and sociology (Denzin & Lincoln 2003). The Chicago school of sociology in the 1920s and 1930s was the first to establish its basic ideas, with which the sociologist Herbert Blumer and the philosopher George Mead are most closely associated (Denzin & Lincoln 2003). It is further associated with Max Weber (1864-1920), who proposed that, in the human sciences, we are universally concerned with 'Verstehen' (interpretive understanding) and 'Erklären' (explaining). Thus 'explanation and understanding' reflect 'the researcher's understanding of the participants own understanding of his or her experience' (Hovorka & Lee 2010, p 3). This means that the researcher's responsibility is one of interpreter reflecting a subjectivist stance (Guba 1990). Moreover, inherent within interpretivism, there is no absolute truth; rather, 'the truth' has a relative personal value according to how the individual perceives and interprets it. In other words, this suggests that meaning is unique to this paradigm and that reality is different for everyone. The interpretive paradigm also asserts that more than one truth exists (Guba 1990), suggesting ontologically that reality is multidimensional (Guba 1990), and is constructed through shared meanings and understandings (Denzin & Lincoln 2011). Therefore, interpretivists view reality as socially constructed and hold that there are multiple realities. Within the context of this study, this was important, as the participants were able to construct their meanings surrounding PSI in different ways and therefore share multiple realities and truths regarding PSI use and implementation. Additionally, the interpretive paradigm as the underpinning philosophical approach for this study allowed the opportunity to acknowledge and explore the importance of contextualising with each trained PSI-nurse their interpretation of utilising PSI in the milieu of their working environments.

Most importantly, this paradigm was considered the best means of addressing the research objectives in exploring the issues that PSI-nurses experience in their daily work. The objectives of this study outlined in chapter 1, section 1.5 include an exploration of the MHNs' understanding and interpretation of PSI; the identification of what activities they engage in

during their daily practice under the remit of PSI across different contextual settings; the identification of their views as to the skills and knowledge needed to implement PSI; and an exploration of their views as to the factors that facilitate or hinder their use of PSI in practice. A key focus, therefore, was on capturing MHNs' subjective understanding and interpretations of PSI and their implementation of these interventions across a range of real-life settings and contexts, including community and inpatient mental health settings. As advocated by Thorne *et al.* (1997), in order to understand the contexts, it is important that the phenomenon (PSI) be studied in a natural setting where the participants work. This also meant that the researcher was able to become part of the research. For example, it was also considered important that, as a former MHN, the researcher was able to use her prior experience as an aid to understanding these contexts and perspectives and make attempts to interpret as well as describe the data. Specifically, the interpretive paradigm provided a practical framework and structure to guide the researcher's entry into the research field, as it helped put emphasis on the human meaning of the experiences and behaviours of the PSI-trained nurses in terms of how they navigate the demands of practice. This further justified the interpretive paradigm as suitable to explore PSI in the organisations and contexts in which the nurses practised them.

Other paradigms also were carefully considered. For example, both positivist and post-positivist paradigms were considered, but excluded because of their focus on context stripping and their lack of focus on exploring human perceptions and subjective interactions (Guba & Lincoln 1998), which were key requirements needed to address the research aim of the current study. The positivist paradigm also considers that reality exists as a structured and ordered phenomenon that can be studied and observed. This paradigm is regularly associated with modernism, the scientific method (Dash 2005) and quantitative research approaches (Polit & Beck 2012). Post-positivism is viewed as a variant of this former positivism, but asserts that reality is imperfectly achievable due to the limitations of human understanding (Guba & Lincoln 1994). Hence, for this study, it was important that the researcher did not control the environments in which nurses worked or the way in which they practised PSI, so this was another reason for not considering a post-positivist paradigm. The interpretive approach was chosen as the most appropriate as it was also necessary for the current research to know that PSI were being described by those who have experience using these interventions. In Ireland, PSI are relatively new to many nurses due to the evolving recovery movement within the mental health services. Accordingly, the topic of PSI could be best understood through interpretivism as it provided an opportunity for the voices, concerns and practices of the participants to be heard and observed (Weaver & Olson 2006), and further offered the

possibility of obtaining interpretations about the barriers and facilitating factors to using PSI in real life.

According to Weber (2004), interpretivists view the researcher and object of research as inseparable - what is observed is bound up with life experience. This further reinforces that the meaning of experiences and behaviour is central to interpretivism (Schwandt *et al*. 2000, Robson 2002, Creswell 2003, 2007) and to this study. With the interpretive paradigm, knowledge of the world is believed to be the result of an intentional process on the part of the researcher, as an attempt to make sense of the world (Weber 2004). Consequently, the information that arises from this ontological position is transactional, personal and swayed by temporal, historical and cultural contexts (Guba & Lincoln 1994). Based on these factors, interpretivism is well aligned with the focus of this current research. Additionally, as the focus is on the meaning of experiences and behaviours of MHNs undertaking PSI in the real world of practice, which are situational and context-dependent. With this in mind, the interpretive paradigm was selected as it was the most suitable approach to elucidate the exploration of the PSI-nurses' experiences in the conduct of this study.

In the next section, the key components of the case study methodology, the rationale for selection and the application of same will be outlined.

3.4. Case Study Research Methodology: Rationale and Application

Before discussing case study research methodology, it is important to acknowledge that there are a number of different research methodologies that can be utilised to guide the overall plan and conduct of a study. Common methodologies include random controlled trials (RCTs), ethnography, phenomenology, grounded theory and case study (Creswell 2003). Although RCTs provide the clearest scientific evidence of attributable effect (Sackett *et al.* 1996), this approach does have limitations as a means of evaluating clinical interventions, services or training. Clinicians have been slow to adopt this method within their everyday clinical practice due to concerns that RCTs do not answer 'real life' questions in real life situations (Multer *et al.* 2003). Thus, an RCT was not deemed suitable to meet the aim and objectives of this study.

Furthermore, phenomenology, ethnography and grounded theory methodologies were considered, but were not suitable, as they did not fully address the study's objectives. For example, a phenomenological study would have revealed findings that were based on MHNs'

expressions of lived experience (McConnell-Henry *et al.* 2009); however, since there was no intention to probe deeply into such lived experiences, this approach was not thought appropriate. Ethnography seeks to describe the structure of culture rather than provide a description of people and their social interactions (Streubert & Carpenter 1999). As the cultural aspects of the MHNs' environments were not the focal point of the study, however, this approach was also rejected, By contrast, the focus of grounded theory is to understand the basic social process and social structures of a phenomenon (Polit & Beck 2012) with the purpose of constructing a theory generated inductively from the data concerning the issues of importance in people's lives (Glaser & Strauss 1967, Glaser 1978, Strauss & Corbin 1998). It was not the intention of this study to seek an understanding of the social processes and structures regarding the MHNs' perspectives and experiences of using PSI; therefore, this methodology was unsuitable.

The other type of methodology that has a comparable qualitative approach is case study research. The first decision in using this approach is to determine whether a case research study will incorporate single or multiple cases in answering research questions. A single case study is suitable when one case is utilised in examining a critical or unique case to test a theory. A multiple case methodology is appropriate when two or more cases are selected to investigate a contemporary phenomenon that will allow comparison of cases to be reported on (Yin 2014). For the purpose of this study, a multiple case study approach was deemed most suitable to explore the nature of issues such as the working context in the offering of PSI by the nurses. Also, due to the lack of previous PSI evidence within a qualitative perspective, the multiple case study methodology allowed flexibility in relation to gathering data in multiple sites and yet was sufficiently robust to ensure that the study's objectives were addressed.

It was also necessary for this study to think through the differing perspectives that exist concerning case study methodology (Crowe *et al.* 2011) and determine which case study expert definitions were most relevant for the purpose of this research. For this current study, the general definitions of the term 'case study' given by Stake (1995), Robson (1993) and Yin (2009) were used to guide and underpin this research as their definitions were most congruent with the study's aim and objectives, as summarised in Table 3.1.

Table 3.1: Definitions of Case Study Research	
Stake (1995)	'A case study is both the process of learning about the case and the product of our learning' (p. 237)
Yin (2009)	'A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (p. 18)
Robson (1993)	'A case study is a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real-life context using multiple sources of evidence' (p. 52)

Source adapted from Crowe *et al.* (2011), BMC Medical Research Methodology, 11**(**100), 1-9.

Stake's (1995) definition of a case study methodology is based on a literature review that forms the basis of the research aim and objectives and the theoretical paradigm chosen for this study. For the current study, the execution of the literature in Chapter 2 allowed the researcher the opportunity to select cases that were relevant and corresponded with the research objectives and the chosen interpretive paradigm. The two other definitions (Robson 1993, Yin 2009) have two distinguishing features that are constant: 'a contemporary phenomenon' and 'a real-life context', which was significant for the purpose of the current study. The reason is that the topic of PSI related to the 'contemporary phenomenon', and it was important to establish with PSI-trained nurses the extent to which PSI were utilised in the reality of everyday working practice, i.e. the 'real-life context'.

In this study, what was required was a pursuit of new insights into the PSI facilitators and barriers for the MHNs within their settings, as the unpredictable nature of mental health care presents numerous challenges in that the environment in which MHNs work can be volatile due to clients' mental health conditions and organisational constraints. Therefore, this multiple case study methodology was a good combination and well-placed to capture new understandings of the PSI issues in the various contexts of real-life everyday practice for the MHNs. Moreover, it was important for this research that there was an opportunity to explore a selection of relevant sites where the nurses worked and to provide an explanation of such sites. This was in terms of what, how, and why the phenomenon [PSI] are the way it is in the PSI-trained nurses' real working lives, in which it was especially important to draw comparisons between the sites (Yin 2009), as little was known, particularly within an Irish context, about utilising PSI by trained PSI-nurses in the context of routine care. Thus, it was essential to address the entire components of the research objectives (Chapter 1, section 1.5),

as there was a need to focus on interpreting the narratives reported by the nurses, probing their intended meanings and understanding of the uniqueness of using PSI in their entirety across a range of mental health care settings. In particular, this methodology helped to take account of the different contextual settings in exploring the complexity of the issues (the MHNs' use of PSI) under a number of different circumstances in which the MHNs worked, the types of PSI activities they engaged in with their clients, and any problems or difficulties that influenced their ability to conduct PSI. Therefore, the multiple case study approach was well-placed to capture this multiplicity of perspectives, especially where the researcher had no control over such as they unfolded during the research (Stake 1995, Richie & Lewis 2003), as well as fitting with the guiding interpretive paradigm for the study.

In particular, within the current mental health services, practice is grounded in and influenced by a drive to inform mental health practice. Thus, the literature review in chapter 2 highlighted that certain issues within mental health organisations may cause conflict, creating tensions for MHNs within their daily work, such as poor leadership and lack of organisational support. Articulating the nature of these tensions is challenging. However, the multiple case study approach provided a useful investigative methodology in providing explanations that furthered an understanding of the practices through which these tensions can be managed. In this study, this further meant that it was important not only to consider the voice and the perspective of the participants, but the context and extent to which PSI happens in practice. Therefore, for this study, the multiple case study methodology has been presented through the opportunities to study a research phenomenon [PSI] in-depth in its 'real' setting (Yin 2014).

Case selection played a central role in this multiple case research study, as Stake (1995) suggests that defining a case is a vital step in this type of methodology. Four cases were chosen for the purpose of this study (Figure 3.1). For instance, a case can be defined as an individual/several people, a group, a project, a programme, an event/organisation, an implementation process or an organisational change in a bounded context (Yin 1994, Stake 2006). In effect, the case is the unit of analysis (Miles & Huberman 1994) that determines where data is to be collected. For the purpose of this research, the unit of analysis was each individual MHN's experience of utilising PSI within the bounded context of mental health nursing services (Figure 3.1). Hence, the study's four cases were selected on the basis that these were most likely to provide the deepest insights within the mental health context (Stake 2006). Such a selection strategy echoes Flyvbjerg's (2006, p. 230) 'information orientated approach' to the identification of cases. Moreover, it was important that the selected cases

were relevant to the issues and topic of interest (Yin 2003a) since, as endorsed by Gerring (2007), it is better to select cases for their typicality rather than their convenience. When applied to this study, both rural and urban cases were selected (Figure 3.1), as these were considered typical, representative and accessible cases that were similar to each other and, hence, that provided a diversity of issues relating to the topic. These cases also allowed the topic to be explored on more than one research site, permitting comparison and cross-case analysis (Stake 2006), which in turn helped an exploration of the themes, similarities, and differences across the cases under study (Eisenhardt 1989). Also, for the current thesis (Figure 3.1), embedded sub-units of analysis (Yin 2014) situated within the four main cases that corresponded to the research objectives allowed an opportunity to further examine and illuminate the four cases in more detail, as endorsed by Yin (2014), which was important in achieving greater confidence in the overall study's findings (Yin 2014).

Furthermore, in this study, Stake's (2005) four defining features of qualitative case studies were considered important: 'holistic'; 'empirical'; 'interpretive'; and 'emphatic'. In the context of this study, 'holistic' meant that the interactions between the phenomenon and its contexts were connected, in that data were collected in the settings where the MHNs worked. 'Empirical' indicated that the focus was on gaining knowledge on the experiences of MHNs' use of PSI by means of the observations and interviews in the research field (section 3.5). 'Interpretive' meant that the current research was considered as a two-way interaction between the researcher and participants in exploring the topic. Lastly, the 'emphatic' feature helped in obtaining the emic (inside) perspective of the participants. In other words, the emic perspective allowed for those descriptions that were meaningful to the participants within their context of utilising PSI in mental health nursing. It further meant that the researcher was not imposing a structure of their own that might have misled the ideas of the participants (Holloway & Galvin 2017).

The application of the major components of the planned multiple case study as described above is presented in Figure 3.1.

Figure 3.1: Planned Application of the Components of Multiple Case Study

Research Aim
An exploration of PSI-trained MHNs' experiences of using PSI in their care of persons with a mental health problem.

Study Context
Four research sites (cases) where nurses work.

Case 1
Research Site (Urban)

Unit of Analysis *

Subunits of Analysis *

Case 2
Research Site (Rural)

Unit of Analysis *

Subunits of Analysis *

Case 3
Research Site (Rural)

Unit of Analysis *

Subunits of Analysis *

Case 4
Research Site (Urban)

Unit of Analysis *

Subunits of Analysis *

Objectives
(Subunits for all four cases) *

1. Explore with PSI-trained MHNs their understanding and interpretation of PSI;

2. Observe PSI-trained MHNs' use of PSI in practice;

3. Explore with PSI-trained MHNs their perspectives on the knowledge & skills necessary for PSI to be used in practice;

4. Examine with PSI-trained MHNs the factors that help or hinder the use of PSI as an integral part of their role;

5. Present the similarities and differences between PSI-trained MHNs' experiences across all the cases in a cross-case analysis report;

6. Inform the development of specific recommendations for mental health nursing practice, policy, nursing education and research.

*Unit of Analysis - each MHN's experiences.
*Subunits of Analysis - MHNs' use of PSI in practice (related to the study's objectives).

The information presented in Figure 3.1 highlights the key components of this thesis. As discussed above and as illustrated in the diagram, the 'case' is the research site where the MHNs work. The 'unit of analysis' is each individual nurse's experience of PSI in practice, bounded within the context of the research site, i.e. mental health services at each of the respective four sites. The four cases have their own unique history and functions, incorporating a number of contexts such as institutional, economic, administrative and physical. Additionally, each of the four cases constitutes a single entity, but has its own

subsections (grades of staff, specialisms, professional qualifications and levels of education). This means that the nature of the cases is situational and influenced by many happenings (complexities in PSI practice). The 'subunits of analysis' refer to the PSI and the way in which the MHNs deliver PSI; in the diagram, these are situated within each case and are a focus for the objectives of this study.

The discussion that follows will present data collection methods and will further elaborate the data collection methods chosen for this multiple case study methodology, while Chapter 4 will discuss their detailed implementation.

3.5. Data Collection Methods: Rationale and Application

Data collection methods are the means used for gathering data. It is important to choose the most appropriate methods based on the chosen research aim, philosophical paradigm, and methodology of the topic that is being examined (Crotty 2003). In this study, the methods chosen were semi-structured interviews and non-participants' observations, as the purpose of this study was to ascertain MHNs' experiences of using PSI in the context of working with clients with mental health problems. However, alternative methods of data collection were carefully considered, including focus groups, but evidence has shown such groups may lack anonymity and outlying opinions may be suppressed due to group dynamics and strong personalities dominating discussions (Polit & Beck 2012). Thus, focus groups would not have addressed the research objectives in full, and as advocated by Yin (2009), 'one of the most important sources of case study information is the interview' (p. 106).

Therefore, the one-to-one interviews were considered key to enable each MHN who had the relevant PSI experiences to share their story (Charmaz 2006), whereas, the observations were important in order to verify with MHNs what they reported about how their use of PSI were being offered to the clients in the actuality of their daily work. Due to the researcher's own lack of direct involvement as an MHN in day-to-day care, it would have been difficult to report on MHNs' views of their work through the interview or non-participant observation alone (Clarke 2009). Thus, multiple methods of data collection were necessary and most appropriate in exploring the topic of PSI, one reason being that a particular strength of case study research is its flexibility, as it allows for the application of a broad range of research methods (Casey & Houghton 2010, Yin 2014, Carolan *et al.* 2016), and there is no particular sequence in which different sources of data need to be collected. Furthermore, the use of multiple data collection

methods allowed for the triangulation of evidence, which helped to compare data to decide if it corroborates (Patton 2002, Creswell 2003), thus, providing breadth in comprehending the data relevant to addressing the research objectives. Triangulation involves using two or more methods to study the same phenomenon (Denzin & Lincoln 1998, Holloway & Wheeler 2010, Hentz 2012), which, in this research, was PSI. Hence, for the current study, the multiple sources of evidence increased the case study depth (Luck *et al.* 2006), that helped enhance the confidence and credibility of the research findings and conclusions (Cronin 2014, Yin 2014). Additionally, the use of both data collection methods helped to uncover any inherent biases that the researcher may have been unaware of in the conduct of the study (Thurmond 2001), especially when only one researcher was examining the phenomenon. The data collection methods used in the study is discussed in more detail in the next section.

3.5.1. Semi-Structured Interviews

In order to find out how MHNs used psychosocial approaches in their daily work, it made sense to interview them individually. It was important in this study to find out specifically how PSI are offered by MHNs and their understanding and interpretation of PSI within the context of their employed organisations. However, the choice of interview type was considered in relation to the research objectives, research paradigm and the methodology. According to Rubin & Rubin (1995), qualitative interviewing is closely associated with the interpretive paradigm. This is because understanding emerges through interaction and put emphasis on the meaning in context. Interpretive interview researchers try to elicit participants' views of their world, and to reconstruct and understand their meaning in order to develop an in-depth understanding of the world and others (Rubin & Rubin 1995). Hence, this highlights the suitability of semi-structured interviews for a study underpinned by the interpretive paradigm.

Consistent with multiple case study methodology, the semi-structured one-to-one interview was identified as most useful because this method helped to obtain the necessary data that provided the knowledge required in achieving the study's objectives (Cohen *et al*. 2011). In this study, it was most important that each participant be allowed the opportunity to have a purposeful conversation, thus permitting in-depth dialogues with each nurse to explore their experiences of applying PSI with their clients (Polit & Beck 2012). Emphasis was placed on facilitating participants to talk freely about their experiences in the context of a shared open discourse (Parahoo 2006, 2014). Therefore, the interviews helped provide verifiable verbatim records of the PSI-nurses' own words.

In the context of this study, the semi-structured interview format also permitted the use of a general interview guide that comprised key areas to be covered in the interview (Holloway & Wheeler 2010) (Appendix 6). This guide allowed the pursuit of specific lines of questioning while still being open to individualised approaches, which allowed MHN participants to identify in their own words what they felt was relevant to their use of PSI within a range of mental health care settings. It further allowed that each participant narrative was illuminated (Ryan *et al.* 2009), while also maintaining systematic direction in the interview process (Cohen *et al.* 2011). Moreover, these types of interviews were compatible with the interpretive paradigm deployed for the study (Drake *et al.* 1998) and helped in obtaining data as regards the multiple realities of PSI in daily practice. Thus, the one-to-one interview format served to provide a more in-depth meaning of PSI from the participants' perspectives that lead to an increase in the generation of knowledge about the topic (Whiting 2008, Smith *et al.* 2009).

Furthermore, for this study, a pilot interview (more details in Chapter 4, section 4.5) was conducted prior to commencing the collection process to test the interview guide questions and to ensure that they were generating data that would assisted in addressing the overall aim and components of the research objectives, as outlined in Chapter 1, section 1.5. As suggested by Fontana & Frey (1994), good interview technique involves forming a rapport with participants through engaging in 'ordinary conversation', which was considered essential for the present study. This meant that the researcher was able to make the participants feel at ease by facilitating a comfortable interaction during each individual interview in order for them to have a purposeful conversation in regards to their views about PSI.

There are, however, a number of disadvantages associated with interviews, including the fact that they can be demanding and time-consuming in relation to the interviewer's skills (Holloway & Wheeler 2010). In this research, these issues were overcome by planning the interview schedule with the gatekeepers and participants well in advance of the conduct of the interviews. There is also the drawback that participants may respond in a way that might be considered socially desirable or will please the interviewee (Holloway & Wheeler 2010). In this research, this drawback was avoided (Carr 1994) by informing the participants about the study details in advance, who were given assurances about the guiding ethical principles, such as anonymity and confidentiality (Polit & Beck 2012) (More details are given in Chapter 4, section 4.2.2). Also, the interview guide that was utilised contained the important components to be covered (Holloway & Wheeler 2010) that, as a result, assisted the steering of questions that facilitated providing the knowledge required to address the research objectives.

3.5.2. Non-Participant Observations

While the use of the interview relies largely on the verbatim accounts of what MHNs said about their PSI daily tasks, it was important for the purpose of this study to rely not just on what participants say about PSI in interview situations, but also on observation (practice observations). This was because this data collection method helped verify what the MHNs said about what PSI they offered and whether they utilise a different approach in their day-to-day routine practice. Additionally, to add to the study's robustness, this data collection helped in that there was an ease in knowing that the participants were not providing data as a way to please the researcher. In particular, in order to address objective two for the study that was directed at observing the PSI-trained MHNs' use of PSI in practice, it was also decided to obtain examples of what MHNs were doing across the cases by observing them. Thus, this method allowed first-hand the phenomenon under study, in that the non-participant observations helped reveal the intricacies of the context in which nurses worked and the extent to which PSI are delivered in real time by the nurses. As advocated by Booth (2015), observational work is an active process by which data about people, behaviours, interactions or events are collected. The focus of data collection through observation is to obtain rich information that can add an increased understanding to the topic under study (Booth 2015), which was considered essential for this research.

For the current study, an observational guide developed from the literature (Spradley 1980) was adapted to focus the observations in order to find out what types of PSI activities and interactions MHNs undertook with their client groups. The guide comprised nine observational categories: space; actors; activities; objects; acts; events; time; goals; and feelings (Appendix 7). For this study's purposes, three of Spradley's categories (acts, activities, and events) were collapsed into one category, that of 'behaviour', as this category helped capture the topic under study. Furthermore, it is important to note that, while the three categories fell into the larger category (behaviour), these nine observational categories above were maintained and applied to guide the observations. The observational data were carefully recorded as per the guide within hours of the observations as endorsed by Polit & Beck (2012). This supports Becker & Geer (1970)'s proposition that observational data permit the adjudication of what 'really' happened, who stated that '[t]he point is that material can be reported in an interview through such a distorting lens, and the interviewer may have no means of knowing what fact is and what distortion is of this kind' (p. 138). Accordingly, the non-participant observation in this study made it possible to verify those descriptions, i.e. the examples of the PSI work offered by

MHNs to their clients. As suggested by Casey (2004), the non-participant observer role is most frequently used in nursing research studies.

It was also important to consider the researcher's role within the case settings during the collection of the observational data, as participant observation is most often represented as not just the observation of participants. As proposed by Gold (1969), the researcher can be positioned anywhere within a range from complete observer to complete participant (Table 3.2). Gold's (1969) observational continuum provides a structure, thus, when applied to this study, the researcher assumed the observer-as-participant role (Gold 1969) (Table 3.2, highlighted in bold), as an intended goal was to observe the types PSI used by nurses with their client groups and to avoid adversely causing disturbance during the observations. Consistent with Gold's (1969) typology, the researcher as the observer sat to one side, while the MHN engaged with the client. This observer-as-participant role further allowed the researcher to spend a limited time with the participants, without seeking to become part of the culture, but in order to observe the phenomenon [PSI] for a short period (Gold 1969). This reflects nicely Gadamer's (1996) typology that describes how the role of the observer is to metaphorically sit in the audience and be entranced and absorbed by 'the play'. Edvardsson & Street (2007) suggest that the researcher must use all the senses such as movement, sound, smell, touch and sight to put questions to the play and embody the situation. In other words, in this thesis, the observer-as-participant role provided the researcher with the ability to observe broadly in order to capture the true essence of how MHNs use PSI activities and interact with their clients. Whereas, the participant-as-observer and the complete participation roles were deemed unsuitable for the purpose of this research. As the participant-as-observer involves the researcher becoming more involved in the observations, a relationship can be developed with the participants and the observation is conducted overtly, which was not suited for this thesis. A complete participation role involves a high level of involvement, as the researcher fully participates in the activities of those being observed, either overtly or covertly, and attempts to act as one of the group. This described role would not have been suitable in addressing the overall study's aim.

In contrast, Adler & Adler (1998) refer to three other role positions in observations, including that of peripheral member researcher, active member observer and complete member observer (Table 3.2). For the current study, the researcher's role was conceived as that of the complete member (Table 3.2, highlighted in bold). The reason for considering this position was that the researcher (observer) was able to observe but not participate in any of the PSI care

activities and still be immersed in the settings. The peripheral member is concerned with the researcher being involved in daily or near-daily contact, whereby interactions vary from casual acquaintance to close friendship with participants. The active member role is chiefly concerned with playing a more dominant and functional part in addition to an observational role. These roles were not considered suitable for this study. Both Gold's (1969) and Adler & Adler's (1998) observer roles complemented each other and helped inform the best observer role to take to achieve the aim and objectives of this multiple case study.

Table 3.2: Continuum of Qualitative Observation			
Non-participant Observation	──────────────────▶		**Participant Observation**
Gold (1969)			
Complete Observer	**Observer as Participant**	Participant as Observer	Complete Participant
Adler & Adler (1998)	──────────────────▶		
Peripheral member Researcher	Active member Researcher		**Complete member Researcher**
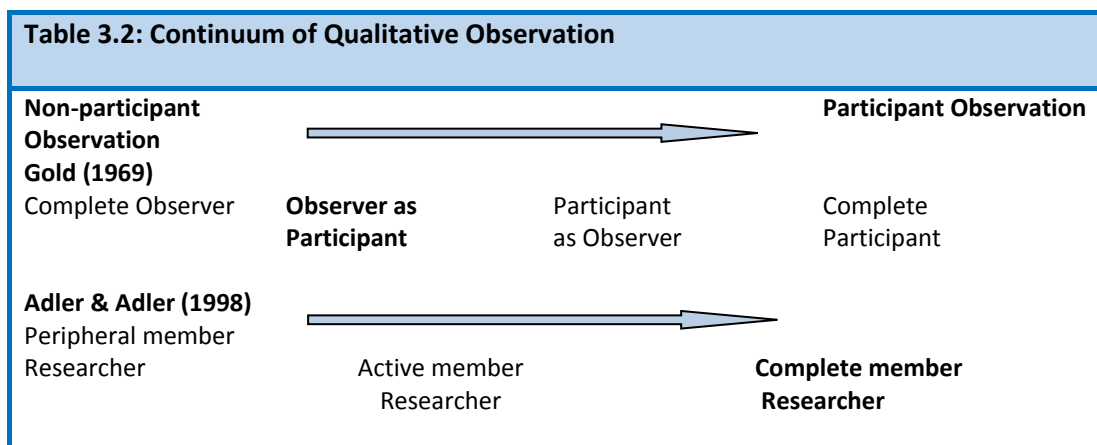
Furthermore, in this study, three types of observational positioning were considered: single; multiple; and mobile (Polit & Beck 2004). In order to make sure that the researcher was able to obtain the necessary data in answering the overall research aim and in addition not influence the observational process, the multiple positioning role was considered the most suitable. This was because it was best matched to allowing the researcher to spend adequate time in the four cases (settings) while having a broader view of observing individual PSI-nurses' interactions while delivering care. A single positioning approach was deemed unsuitable, as this position would have only have allowed observing the PSI activities of the nurses at one site, which did not fit with the multiple case study methodology chosen for this study. By contrast, the mobile positioning role would only have provided an opportunity to follow participants during a given activity or observation period, which was not adequate with obtaining an in-depth picture of the use of PSI by the nurses in their daily work. More detail on observation periods for this study is provided in Chapter 4, section 4.6.

For the purpose of this study, time sampling and event sampling were also considered, as these are two important features of non-participant observations (Polit & Beck 2004). Time sampling denotes selecting a certain period during which observational data are gathered and

randomly or systematically selected, while event sampling involves data being obtained for a particular interaction or event. For this study, event sampling was thought the most fitting approach, as the observations permitted data to be obtained from specific MHNs' PSI interactions during sessions with clients. Additionally, event sampling helped in attaining the necessary data that was considered important in meeting objective two of the study that aimed at observing the PSI-trained MHNs' use of PSI in practice. On this basis, observation as a research method is employed in a variety of ways in multiple case study research (Yin 1994, Stake 2005).

There are also some drawbacks when utilising observations as a method of data collection, as there is always a risk that observational behaviours may impinge upon practices, eventuating, for example, in Hawthorne and halo effects (Adler & Adler 1987). Mulhall (2003) aptly argues that it is highly likely that most professionals are too busy to maintain behaviour that is fundamentally different from normal practice, while Patton (1990) recognises that the observer effect is overstated, as participants habitually forget the researcher's presence. Applied to this study, every effort was made to minimise these potential drawbacks. For example, time was spent prior to the collection of data in the research sites, so that participants became familiar with the researcher's presence (Guba & Lincoln 1994, Gerrish & Lathlean 2015). Moreover, a reflective diary was kept, which assisted in maintaining continuous awareness of the research process and the effects on the overall research findings. Appendix 1 provides excerpts of reflection for the current study.

3.5.3. Field Notes

The inclusion of Field Notes was considered important in this multiple case study as they helped in the research process and the conduct of the study. Specifically, for the current study, Field Notes made it possible for the researcher to move out of the research area and write them at home as this was a place that was conducive to thinking about what was pertinent to the data collected and the research overall, since, according to Hammersley & Atkinson (2007), Field Notes have 'the power to evoke the times and places of the "field" and call to mind the sights, sounds and smells of "elsewhere" when read and reread at home' (p. 176).

Field Notes were utilised in this study by adopting Spradley's (1980) framework, which comprise of three types: condensed accounts; expanded accounts; and a fieldwork diary. In the context of this study, the condensed accounts were the brief Field Notes that were written

to provide general descriptions of the processes that informed how the study was conducted, whereas the expanded accounts related to lengthened Field Notes that were specific to the researchers' feelings and thoughts during the conduct of the research. The fieldwork diary involved the recording of detailed excerpts on particular reflections that were pertinent to the researcher's thinking during the research process that helped to explain data. This validates Stake's (2006) suggestion that engaging in Field Note writing in multiple case study research assists in identifying patterns that will explain the given data. Hence, the Field Notes in this study served to increase the integrity of the research findings (Chapter 4, section 4.9). Appendix 1 provides exemplars of Field Notes during the process of the research.

3.6. Summary

In this overview, the philosophical underpinning, methodology and methodological considerations, and data collection methods utilised in the present study, along with their rationale, have been discussed. Interpretivism was the most suitable paradigm for the study, and multiple case study was the most appropriate methodology. The primary data collection methods utilised was semi-structured interviews and non-participant observations. Using both methods of data collection was important for the study as they supported the bringing together of the context and meanings of the PSI-nurses' experiences (Perry 2009), and assisted with the corroboration of data. Thus, the use of the two methods helped to offset the weaknesses inherent in using each approach in isolation (Yin 2014).

Drawing on the research ideas presented in this chapter, the next chapter discusses how the methodology was implemented in the execution of this study.

4. Chapter Four: Research Design and Method

4.1. Introduction

In this chapter, detail is provided as to how the research design and method was operationalised (Figure 4.1). In this research, a multiple case study was utilised as the methodology to explore PSI-trained nurses' experiences of using PSI in their day-to-day practice. To remind the reader, Figure 4.1 provides a summary of the research design that includes both the aim and objectives for this study.

Figure 4.1: Summary of Research Design and Method		
Methodology	**Research Aim**	Sources of Data Time Frame
Qualitative multiple case study underpinned by the interpretive paradigm using 4 cases (these constituted the research sites where the nurses work).	An exploration of PSI-trained MHNs' experiences using PSI in their care of the person with a mental health problem.	**Literature Review** ⇕ Jan 09 – June 16 **Ethical Approval** ⇕ Aug 11 – April 12
Research Objectives: 1. Explore with PSI-trained MHNs their understanding and interpretation of PSI; 2. Observe PSI-trained MHNs' use of PSI in practice; 3. Explore with PSI-trained MHNs their perspectives on the knowledge and skills necessary for PSI to be used in practice; 4. Examine with PSI-trained MHNs the factors that help or hinder using PSI as an integral part of their role; 5. Present the similarities and differences of the PSI-trained MHNs' experiences of all the four cases in a cross-case analysis report; 6. Inform the development of specific recommendations for mental health nursing practice, policy, nursing education and research.	**Observational Guide** (Adapted from Spradley 1980) **Space** (context, surroundings) **Actors** (who was present?) **Behaviour** (acts, units of behaviour, activities,(what were they doing?) events (what's happened?) **Objects** (what were they using?) **Times** (when did it start and end?) **Goals** (what were actors trying to achieve?) **Feelings** (what did actors seem to feel?) **Interview Guide** Could you tell me what your understanding and meaning of what PSI are all about? Could you tell me what knowledge and skills do you think are necessary for PSI implementation? Could you tell me your experiences of using PSI to your work? Could you tell me about the factors that help or hinder you using PSI in your work? Is there anything else that you would like to say about PSI in your practice?	**Data Collection** Established relationship with research settings and participants. ⇕ May - Sept 12 **Preparation of interview and observation schedules** ⇕ July 12 - Sept 12 **Pilot** ⇕ Sept 12 Conducted non-participant observations (19 hours; 20 mins.) and semi-structured interviews (40). ⇕ Oct 12 - Nov 13 **Data Analysis** Early data analysis and preparation of themes. ⇕ Dec 12 - Dec 13 Data analysis, synthesis and discussion. ⇕ June 14 - May 16

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4.2. Case Selection

Case selection is the term used within case study design; this term is equivalent to 'population and sample' in qualitative research (Gerring 2007). In this study, the focus on case selection was to select MHNs who were trained PSI-nurses in four cases that constituted the research sites where the nurses worked and who were currently using PSI as an integral element of their practice. Thus, purposive sampling was used in this study to ensure that the participants had experience of the phenomenon being studied (Morse *et al.* 2002, Creswell 2007). It appeared appropriate and feasible to locate the sample of cases from the HSE, as this provided an opportunity to gain access to the most pertinent cases, and thereby gather rich and relevant information (Miles & Huberman 1994). Accordingly, four cases were selected strategically and purposefully with consideration of the aim and objectives of the study and available resources. In addition, in order to maximise diversity, participants were accessed from these locations, as this ensured that relevance was not limited to one particular region or service and represented a cross-section of experience and qualifications of participants. Ensuring diversity of insights is essential in case study research (Abma & Stake 2014) and a sign of its rigour (Anthony & Jack 2009). In this study, the Directors of Nursing (DoN) at each research site agreed to be gatekeepers and sought individuals that fitted the criteria for participation (Chapter 2, Table 2.2).

4.2.1. Sample and Setting

The study was designed to interview 40 PSI-trained nurses in four cases that constituted the research settings where the nurses work. The research settings (cases) were both inpatient and community settings, including day hospitals, day centres, outpatient facilities and inpatient units. Two of the cases were rural settings (Cases 2 & 3) and two were urban settings (Cases 1 & 4). Of the 40 nurses, seven were interviewed across inpatient settings and 33 were interviewed across community settings. In addition, seven of these 40 nurses were observed during a clinical encounter with a client: five from community settings; and two from inpatient settings (Table 4.1). It was anticipated that this would generate the required data to address the study's aim and objectives, although it was also acknowledged that there would need to be some flexibility to increase or decrease numbers according to the needs of the study. A multi-disciplinary team meeting was also observed to help further contextualise the study (Table 4.1). Table 4.2 outlines the different participant types and the total number of interviews and observations across the four cases. Sixteen of the cohorts were CNSs; 12 were staff nurses; 10 clinical nurse managers (CNMs); and two were ANPs.

Table 4.1: Overview - Data Collection Methods and Participants			
Data Collection Methods	**Participants**	**Community Total**	**Inpatient Total**
Semi-structured one-to-one interviews	PSI-nurses - 40 Interviews	33	7
Non-participant observation	PSI-nurses - 7 (19 hours, 20 minutes)	5	2
	MDT Meeting	1	
Field Notes (contextual data)		⟵⟶	

Table 4.2: Participant Type, Total of Interviews and Observations			
Research Cases	**Participant Type**	**Total No: Interviews**	**Total Hours: Observations**
Case 1	Staff Nurses	4	90 minutes (6.4.6: Chapter 6)
	Clinical Nurse Specialists	3	90 minutes (6.4.7: Chapter 6)
	Clinical Nurse Managers	5	
Case 2	Clinical Nurse Managers	3	
	Clinical Nurse Specialists	6	180 minutes (6.4.4: Chapter 6)
Case 3	Clinical Nurse Managers	2	110 minutes (6.4.8: Chapter 6)
	Clinical Nurse Specialists	4	
	Staff Nurses	1	180 minutes (6.4.2: Chapter 6)
Case 4	Staff Nurses	7	
	Clinical Nurse Specialists	3	90 minutes (6.4.1: Chapter 6)
	Advanced Nurse Practitioners	2	360 minutes (6.4.3: Chapter 6)
	Multidisciplinary Team Meeting		60 minutes (6.4.5: Chapter 6)
			1160 minutes = 19 hours, 20 minutes

4.2.2. Ethical Approval and Considerations

For this study, ethical approval was initially sought from Trinity College Dublin, the Research Ethical Committee (REC), and the four HSE research sites. The application forms required explicit descriptions of the way in which participants would be guaranteed confidentiality and privacy, and how the consent of participants was going to be obtained, along with how they would be recruited (Appendix 1, Part 1, Reflective entry 5).

Samples of the informed consent form (Appendix 4), the participant's letter of invitation (Appendix 4) and the study information leaflet (Appendix 4) were required for submission to

all the committees. The researcher ensured that all study findings and any additional reports were anonymous. The ethical process, including the completion of all the ethical forms to the ethical committees, negotiating access and building relationships with the research sites, took over 11 months to complete (Appendix 1, Part 2, Table 1, Field Note 4). Table 4.3 provides a summary of the Ethical Approval Committees.

Table 4.3: Summary of Ethical Approval Committees		
Committee	**Committee Comments**	**Date of Approval**
Faculty of Health Sciences, Trinity College, Dublin	Approved without further audit	16th August 2012
Hospital Research & Ethics Committee (Research Site 4)	Approved to proceed	21st June 2012
Hospital Research & Ethics Committee (Research Site 2)	The study has undergone expedited review; the REC Chairman has given approval for the study	19th June 2012
Hospital Research & Ethics Committee (Research Site 3)	Approved	11th July 2012
Director of Nursing due to TCD approval (Research Site 1)	Approved	18th Jan 2013

The researcher was aware of the guiding principles that addressed issues such as confidentiality, privacy, equity, integrity, respect for people's rights, dignity, beneficence and non-maleficence (An Bord Altranais 2007). The ethical principles of the Helsinki Declaration (World Medical Organisation 1964) governing research with human subjects and the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (Nursing & Midwifery Board of Ireland 2014) were the ethical frameworks that guided the research. In this study, the ethical issues concerned personal safety, ensuring informed consent, privacy and confidentiality and the researcher's role. These particular ethical issues are expanded upon in the next section.

4.2.2.1. Personal Safety

The issue of personal safety relates to the physical safety of the participants, which needs to be guaranteed, so that the participants are not subjected to any personal embarrassment or humiliation. In this study, this involved ensuring that the personal self-esteem of the participants was protected and that any questions asked were free from embarrassment and non-threatening. It was also important that nothing be reported in the study that could be seen as an invasion of the privacy of participants (Singleton & Straits 1999).

4.2.2.2. Informed Consent

Informed consent arises in relation to the need to ensure that participants feel free to participate or refuse to participate in the research. According to the Royal College of Nursing (RCN) (2011), it is central to the conduct of ethical research. Informed consent is a legal imperative in research (Mason & Laurie 2011) and was obtained by all participants in this study. Once the participants received the letter of invitation, the information for the study and the consent form (Appendix 4), the researcher did not contact them until a week later, the reason being that it was important that the participants had ample time to consider their participation in the study (RCN 2011). It was also important that the participants were provided with sufficient information to enable them to make an informed choice. This involved them having good information about the purpose of the study, the nature of the involvement of the institution in the study and the identity and background of the researcher (Tutty *et al.* 1996). This researcher was a former MHN; this helped to recognise any changes in the process, i.e. observing if the participants were at ease, did they feel under pressure due to time constraints and so forth. At all times, the participants' wellbeing was given priority over this research study.

Observation was utilised as a data collection method. However, one challenge that this method presents is the issue of consent. For example, in the current study, it was not necessary to gain consent from the clients, because it was very clear that it was the MHNs who were being observed in their daily work, not the clients. This supports arguments that consent is not required from patients in such circumstances (Moore & Savage 2002, Griffiths & Harris 2008). According to Moore & Savage (2002), some patients become anxious and disturbed when approached to sign up to informed consent. Instead, the researchers in Moore & Savage's (2002) study read the information and consent form to the patients before agreeing to being observed. Conversely, Griffiths & Harris (2008) asserted that they did not need to obtain verbal or written informed consent from the patients, since the patients were unwell and thus it was deemed they should not be annoyed with the study details and the consent process. This suggests that the necessity of obtaining written informed consent may not always be deemed to be in the best interests of the patient.

4.2.2.3. Privacy and Confidentiality

Confidentiality is the principle that research data in which individual participants can be identified should not be passed on to other people without the explicit consent of those

participants (Polit & Beck 2012). Thus, participants required a guarantee that their personal details would not be disclosed. In particular, case study research requires detailed reporting of the study sites; the presentation of the results using a case-by-case arrangement may pressurise issues of confidentiality (Large *et al.* 2005). When applied to this study, genuine care was taken that a general description of the cases was outlined, as the need to maintain the anonymity of the cases was crucial; thus, the researcher avoided descriptions that were too detailed (Chapter 5, section 5.2). According to Clarke *et al*. (2015), cross-case reporting may be an alternative, as this does not reveal each case individually, and subsequently the confidentiality of the research sites can be preserved. This was upheld in this study and will be explored later on in the thesis (see Chapter 5).

Confidentiality of the participants and data were maintained by assigning code numbers to the digital recordings of the interviews, observational and Field Note data (prior to data entry and/or submission to the transcriber, who also signed a confidentiality agreement) (Appendix 9) to protect the identity of the participants. The researcher transcribed 30 interviews, while a professional transcriber transcribed 10 interviews. The transcripts were then checked for accuracy. The master list of participants' names, bearing these numeric identifiers, was stored securely and separately from all other data. All data files were password-protected and stored in the researcher's office in accordance with the Data Protection (Amendment) Act (Government of Ireland 2003). No information cited in the report, for example demographical data, was identifiable by anyone involved in the study. All data is retained in a secure storage drawer within this researcher's facility for five years after the completion of the research, whereupon it will be destroyed.

4.2.2.4. The Role of the Researcher

Another important dimension in the ethical conduct of research of this nature is the issue of the relationship between the researcher and participants. In this study, this required a careful degree of sensitivity on the part of the researcher to ensure that participants were not compromised in any way, because it was possible that some of the participants may have known each other as peers or colleagues. This required the researcher to be careful not to become attached to the participants in a way that might compromise the objectivity of the researcher. According to Patton (1990), the researcher's insight, reflections and ideas about events becomes an important aspect of a database, contributing to the validity of the qualitative analysis. In the context of this study, it was important to remain open to the experiences of the participants. In keeping true to the interpretive paradigm for this study,

which by definition acknowledges a role for interpretation, the researcher's reflective Field Notes (Appendix 1) that recorded details of the nature and origin of any emergent interpretations proved valuable during this process. In addition, the reflective accounts of the researcher's reactions, feelings and thoughts assisted in maintaining a useful perspective during the research process, while staying true to the integrity of the study. As a result, the process of reflecting and the writing of Field Notes helped in the gaining of a deeper insight into the participants' experiences (Appendix 1, Part 2, Table 1, Field Notes 15 & 16).

4.3. Gaining and Negotiating Access

Once the four cases were selected (Section 4.2), the process of gaining and negotiating access to participants was needed. When full ethical approval was obtained from all parties, a letter to the DONs in each research site (4 cases) seeking access (Appendix 4) that explained the purpose of the study, asking for permission to access PSI-trained MHNs who they thought fulfilled the inclusion criteria (Chapter 2, Table 2.2). Following permission, access to conducting the research was negotiated with a number of gatekeepers. The gatekeepers included: DON, Acting Director of Nursing (ADON), CNMs and MHNs. The strategies to gain access to the research sites was influenced by fostering a good non-threatening relationship with all the stakeholders, and reassuring them that as little disruption as possible would be made during the data collection process. This supports evidence that refer to the process of managing one's identity and image, and convincing gatekeepers that the researcher is nonthreatening when it comes to gaining access (Waddington 1994).

However, a considerable amount of time and effort was needed to gain access with the gatekeepers and participants in the research sites (Munhall 2007). The initial process was gaining consent and support from the organisations; this was achieved by emailing and meeting with all the DONs in the four research sites. Two informal information sessions were conducted at team meetings at the request of the DONs in two of the research sites. These informal sessions enabled MHNs the opportunity to become more familiar with the purpose of the study. The DONs and other staff were present during these meetings; this helped reduce the sense of coercion, and to act as advocates for the MHNs. The researcher's contact details were made available to everyone; they were asked to get in touch if they wanted to participate in the study.

4.4. Recruitment of Participants

Following the process of gaining access to the research sites, the recruitment of participants was conducted. Once permission was granted to access the sample from the DONs of the organisations, a letter of invitation (Appendix 4), along with a detailed information sheet (Appendix 4), a demographic questionnaire (Appendix 8), and a consent form (Appendix 4), were all sent to the participants by email or letter. The majority of the letters were sent by email, as the DONs had forwarded email addresses. However, when an email address was not available, letters to the participant's work place was sent. Once a response was received from nurses indicating an interest in being involved in the study, potential participants were contacted via email or telephone; suitable times and dates were arranged. The inclusion criterion for involvement was talked through with the participants prior to arranging the times.

4.5. The Pilot

A pilot interview was conducted in September 2012 so that the interview schedule was well rehearsed before conducting the interviews in the real study and to ensure that responses given answers research objectives (Smith *et al.* 2009). This was also done as to avoid leading questions by the researcher (Bryman & Cassell 2006). However, during the interviews in the current study, the order and wording of the questions varied at times (Power *et al.* 2010), depending on the nature of the interviews as more clarity was needed at times around some of the participant responses (Corbetta 2003). The pilot was conducted in an acute inpatient unit whereby one MHN was interviewed for a period of approximately 60 minutes. It highlighted a few issues that were considered for the main study, for example, a compact digital recording device was purchased as the recording device used was too cumbersome. This meant that once the device was recording, it was easier for participants to ignore. Following the interview, the questioning style had to be given some consideration. No changes were necessary to the interview schedule or the interview process. The pilot interview generated rich data that helped draw out meaning for the researcher that facilitated with subsequent interviews in the main study.

4.6. Observation and Interview Process

Approximately two days before the agreed date for the observations and/or interviews, the researcher contacted the participants by telephone or email to confirm if they were still available to take part in the study. As the participants involved were carrying busy caseloads, particularly within the community setting, the scheduling of the interviews and observations

was conducted in advance. It was emphasised that the study details would be explained again on the day of the observations/interviews before they signed the consent forms. The researcher checked that each participant who agreed to take part had the time and venue organised. For those participants who agreed to be observed, they had to confirm that permission had been obtained from the client about the researcher's presence in their session. For the participants who were called, this helped to promote rapport, and allowed the participants to ask any other questions or worries that they may have had.

The researcher arrived an hour before the time, checked out the venue and tested the digital recorder. In addition, the necessary forms and paperwork were organised; the consent forms, the study information leaflets and the demographic questionnaires were made available. The observations focused on the MHNs' PSI activities with their client groups and the observational information was recorded within hours of the observations. During the observations, the researcher sat to one side, while the MHN engaged with their client in a quiet room. More details on the observations are in Chapter 3, section 3.5.2.

The interviews were also conducted in quiet and relaxed environments, mainly in the nurses' workplaces, as this was more convenient for the participants. Each PSI-nurse had booked a room in advance. The venues were all away from the ward area in the inpatient settings to reduce the amount of interference from the ward situation. In relation to the community, the interviews were conducted in a booked meeting room or the participant's office with a 'Do not disturb' sign on the door. More details on the interviews are in Chapter 3, section 3.5.1.

The researcher also psychologically prepared prior to participant's arriving by focusing on the interviews/observations at hand and recorded some reflective and field notes (Appendix 1). When the participants arrived, they were thanked for their time and commitment. A brief introduction was conducted by the researcher; the purpose of this was to inform the participants again about study' aim, sharing of credentials and informing them about the researchers mental health nursing background. The consent form (Appendix 4) was read again and signed before the commencement of the interviews/observations and they were asked also to refer to the information leaflet to ensure that they understood what was involved (Appendix 4). Also, they were asked to complete a demographic questionnaire (Appendix 8) that was completed at the end of the interviews; the participants knew in advance about this form. Having achieved the consent to take part in the semi-structured interviews, the

participants were asked to reflect and talk about their experiences fluently while the conversations were digitally recorded.

The researcher wore casual clothing during the data collection phase, adopted a relaxed style and reassured the participants that the interviews were informal and that there were no right or wrong answers. The researcher was the only one that gathered the data; this helped consistency and credibility in executing the study. After about three interviews, it came clear that it was necessary to explain to the participants that the digital recorder needed checking periodically to see that it was recording. This was to confirm reassurance for the participants that the researcher was interested in what they had to say. Also, it was noticed that the participants were able to disclose information without any pressure; they had the opportunity to qualify their answers and explain in depth the underlying meanings of their responses (Polit & Hungler 2004). This led to the participants spontaneously raising issues that revealed more information as the interviews progressed. This indicated that the participants were relaxed and at ease at partaking in the study. Shortly after each interview, a member checking process was conducted by recapping with each participant by providing a summary of the interview by reflecting on the notes taking during the process. This was to assure accuracy of information obtained and to obtain an agreement about the content. These further strengthen the credibility for the study (Chapter 4, Section 4.9).

The interviews ranged from 50 minutes to one hour (Appendix 1, Part 2, Table 1, Field Note 13), and the observations ranged from 30 minutes to two hours. After each interview, the digital recordings of the interviews were uploaded onto the researcher's private laptop that was used only for the purpose of the thesis. Once the voice data files had been uploaded, the original file was deleted. Each uploaded file was given an unidentified code that included the order that the interviews were conducted, for example, case 1, participant 3 and so on. The recordings were then transcribed verbatim with meticulous accuracy and uploaded into QRS NVivo software package where the highest standards of ethical principles and respect for the participants were upheld.

4.7. Data Management

Computer-assisted qualitative data analysis software (CAQDAS) has been developed to help in the handling, storage and manipulation of the data in studies (Bringer *et al.* 2004, MacMillan & Koenig 2004, Silverman 2010). When applied to this study, QSR NVivo was the chosen

CAQDAS, as it assisted in the management of the data (Bringer *et al.* 2004, Bazeley 2007, Bazeley & Jackson 2013), served to facilitate a clear data analysis process and offered a consistent overview of data (Richards & Richards 1994, Morrison & Moir 1998). As Fielding & Lee (1998), explain, qualitative researchers 'want tools which support analysis, but leave the analyst (researcher) firmly in charge' (p. 167).

4.8. Data Analysis Strategy

This section details the process undertaken in analysing and interpreting the data (Appendix 1, Part 2, Table 1, Field Note 12). Analyses were derived from a multiple case study that comprised semi-structured interviews and non-participant observations. In keeping with the interpretive paradigm (Chapter 3, section 3.3), undertaking the data analysis based on Ritchie & Spencer's (1994) framework provided foundations that allowed the themes to emerge. This framework was considered consistent with the multiple case study approach and thus allowed a systematic approach throughout the analysis process. It features two types of analysis: within-case analysis; and cross-case analysis (Miles & Huberman 1994, Creswell 1998, Stake 2006). Within-case analysis involves outlining a thorough description of each case and themes, while cross-case analysis allows themes to emerge across cases (Chapter 6). The framework consists of a five-stage process comprising several cycles of the stages (Table 4.4). The process is outlined below.

Table 4.4: Ritchie & Spencer's (1994) Framework	
Stage 1: Familiarisation	Within-case analysis (comprises cycles 1, 2, 3 & 4)
Stage 2: Identifying a thematic framework	
Stage 3: Indexing	
Stage 4: Charting	
Stage 5: Mapping and interpretation	Cross-case analysis (comprises cycles 5, 6, 7 & 8)

This framework enabled data collection and analysis to occur simultaneously (Silverman 2010), which was undertaken by moving between both data sets in an attempt to make meaning regarding the overall study's aim and objectives (Ridenour & Newman 2009). When applied to this study, non-participant observations informed the interviews and vice versa, whereas the reflective diary entries and Field Notes further guided data collection (Appendix 1). The interviews continued until no more new information was found. According to Guba & Lincoln (1989) and Guest *et al.* (2006), this is when saturation is reached. In this study, saturation was

achieved when the researcher was confident that a sufficient depth and breadth of information was accomplished (Bowen 2008). According to Moore & Savage (2002), this is a matter of the depth of data rather than frequencies in qualitative research.

It was also important that the researcher's reflective diary and Field Notes that were kept during the analysis process were regularly referred to. This process was undertaken so that no new information was developing and data saturation was accomplished. As regards the observational data, only seven participants agreed to participate, including an observation of a MDT. It is possible that a broad depth and breadth was not fully accomplished; however, the interview data complemented this data. This process was continued until it was ascertained that all relevant insights into the different contexts were obtained and no further themes materialised. Additionally, regular discussion with an expert in qualitative research helped in illuminating the voices of the participants, while acknowledging the research context and taking cognisance of the researcher's role in the research process overall. This was in keeping with Gilligan's (2011) understanding that acknowledges the '… importance of everyone having a voice, being listened to carefully, and heard with respect' (p. 24).

The identified objectives shaped the formulation of questions that formed the semi-structured interviews (Figure 4.1 & Appendix 6). An audit trail (Appendix 10) was kept, on which the trustworthiness and credibility of a study were established; every step of the analysis was accounted for with diagrams and text during the various cycles of the analysis. The demographic data were also considered during the analysis (Chapter 5, Table 5.1), as they added meaning to the overall data.

With the help of a transcriber, the researcher transcribed a majority of the digital interviews verbatim. This process was completed to enhance familiarity with the data and to add to the rigour of the findings. The observations were typed up shortly after the observation episodes and read several times. The Field Notes and reflective accounts were also typed up. All the transcripts and observations were given codes to maintain confidentiality. Additionally, all data sets (interviews, observations, field/reflective notes) were imported into NVivo for analysis. The four cases were set up separately in NVivo (Figure 4.2) as this satisfied the different stages of Ritchie & Spencer's (1994) framework.

Figure 4.2: Setting up of Coding Framework (Ritchie & Spencer 1994)
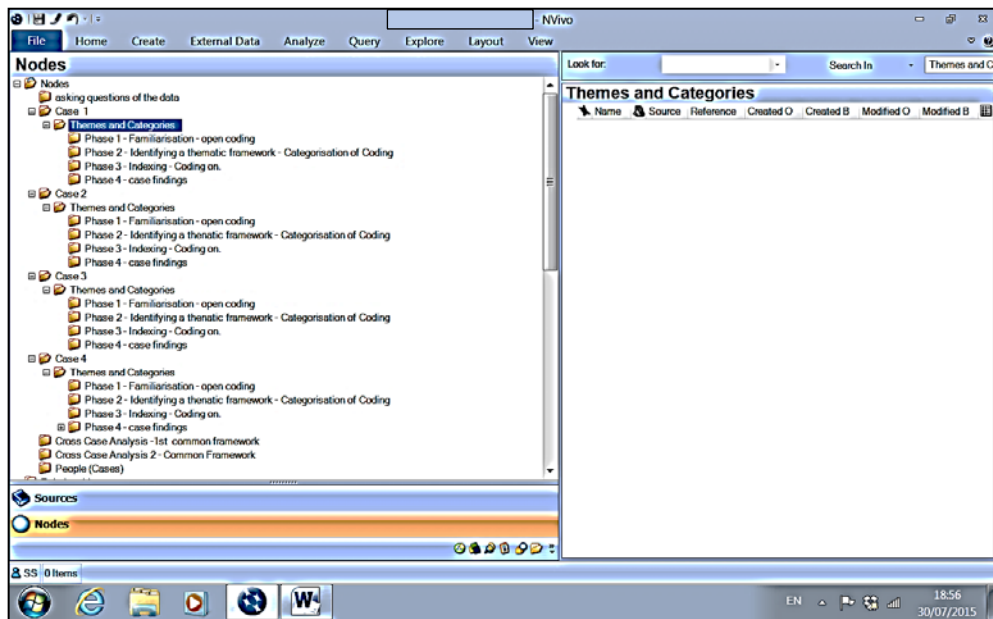
Stage one of this framework involved a 'familiarisation' with the data. This was achieved by the contents of both the interviews and observations being analysed together and similar data identified. The Field Note data were conducted separately due to their different purpose, which information assisted with the contextual aspect of the topic. The following process was followed with all the interviews.

- Listened to the audiotape;
- Transcribed the audiotape;
- Read the transcribed interview data while again listening attentively to the recordings;
- Scrutinised all data for any references that had the potential to identify people, places or institutions. Removed any identifying components and analysed each case separately in keeping with Ritchie & Spencer's (1994) framework.

4.8.1. Within-Case Analysis

The within-case analysis of the findings included stages 2, 3 & 4 of Ritchie & Spencer's framework as follows: 'Identifying a thematic framework' and 'Indexing' & 'Charting' (Table 4.4). These stages comprise the following cycles (1, 2, 3 & 4).

Cycle 1: This cycle involved open coding (Figure 4.3), which included broad participant-driven open coding of the transcripts, supported by definitions to reduce the data into general broad themes. This process was repeated for each of the four cases within NVivo.

Figure 4.3: Cycle 1: Opening Coding

Organisation of each of the four cases in keeping with Richie & Spencer framework (different phases)

Opening coding based on research objectives
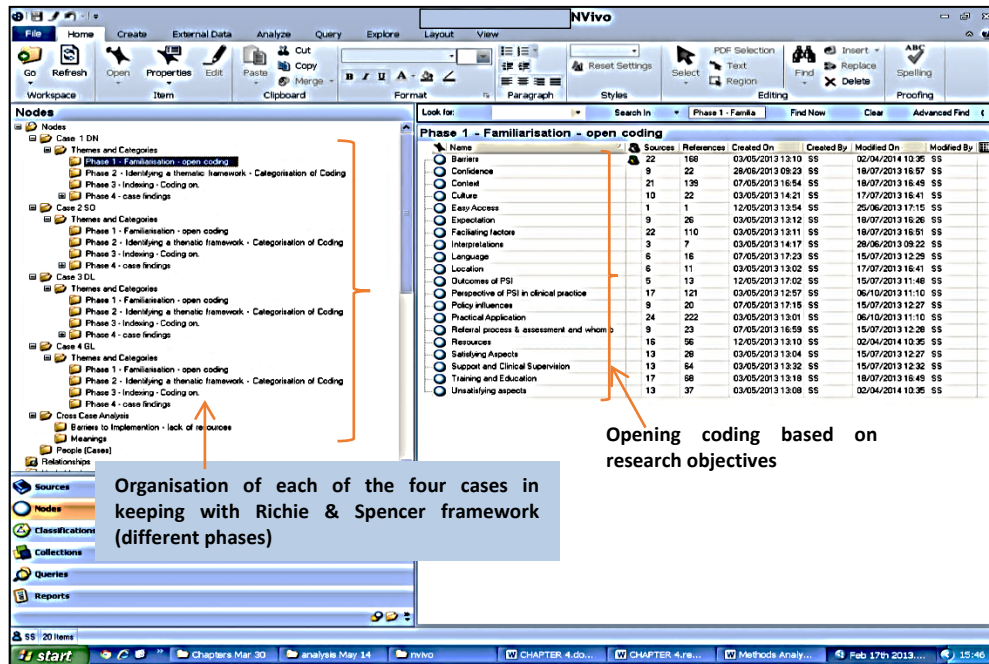
Cycle 2: This cycle involved the 'identification of a thematic framework' (Figure 4.4) stage. This was achieved by categorising the codes identified in cycle 1, re-ordering and organising them into theme categories into the framework in a way that made sense to further the analysis of the data. This cycle also included distilling, re-labelling and integrating themes to ensure that the labels accurately reflected the coded content, taking into account the study objectives.

Figure 4.4: Cycle 2: Identifying a Thematic Framework

This symbol represents a written memo against the themes.
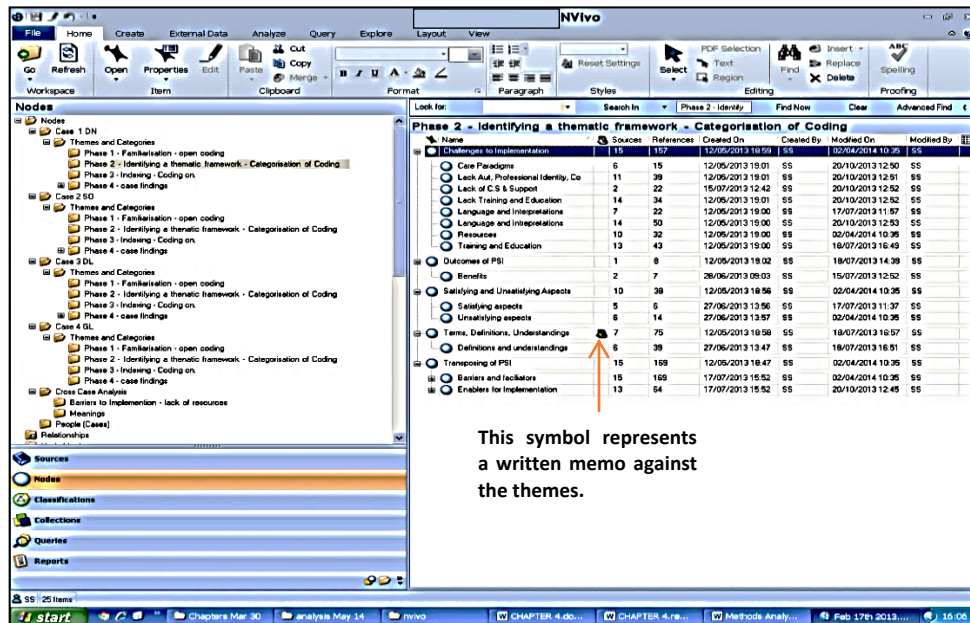
Cycle 3: This cycle concerned 'coding on' (Figure 4.5), which, in terms of the framework, was the 'Indexing' stage. This stage broke down the restructured themes into sub-themes from the previous cycle to offer a more in-depth understanding of the participants' responses (Strauss & Corbin 1998). Memoing within NVivo became very useful during this stage, allowing a focus on the relationship between themes and their properties as the relationship become evident. Additionally, the conducting of the memos helped the researcher to clarify some of the thinking processes during the analysis of the data (Figure 4.5.1).

Figure 4.5: Coding On
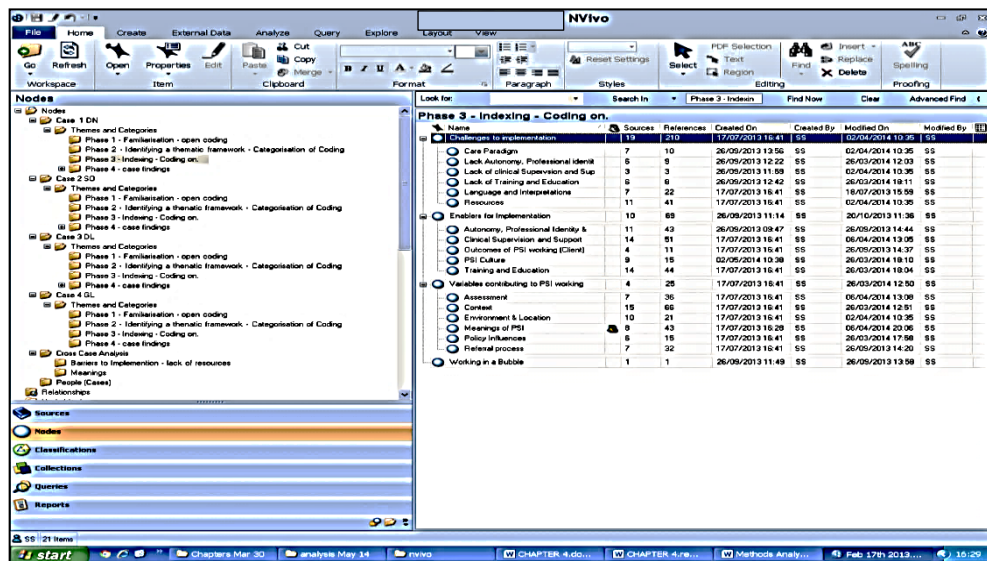
Note: These steps were repeated for cases 2, 3 and 4.

Figure 4.5.1: Examples of Memoing
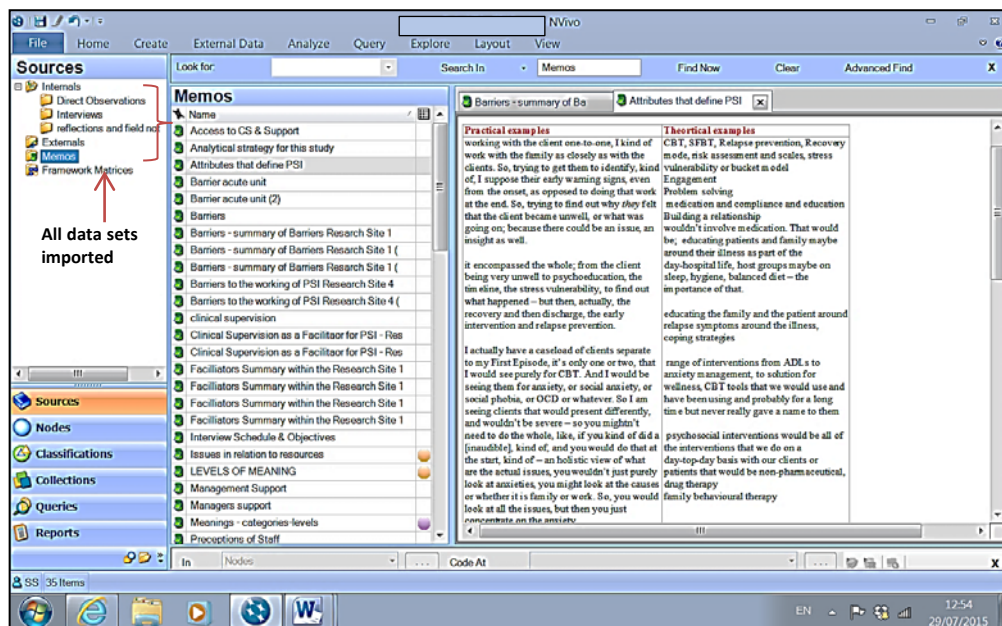
Cycle 4: This stage was the 'Charting' stage of the framework. This involved moving back and forward with the data in order to offer a synthesis of the content (case by case); for example, when further information emerged from the data that did not fit with the pre-identified themes, it was a matter of updating and adapting the themes to be true to the data. There was a perpetual working and reworking of the data until the main themes became stable in a way that seemed to account for the presentation of the data. At this stage, an independent qualitative researcher verified the main themes. Additionally, the researcher continually engaged in reflectivity that helped in upholding the voices of the participants while acknowledging the research context, and in taking cognisance of her role in the overall research process. Subsequently, a case-by-case write-up was undertaken, which helped compile the cross-case analysis findings chapter.

4.8.2. Cross-Case Analysis

The cross-case analysis of the findings included stage 5 of Ritchie & Spencer's (1994) framework as follows: 'Mapping and Interpretation' (Table 4.4). This stage comprises the following cycles (5, 6, 7 & 8).

Cycle 5: This cycle involved data reduction that comprised consolidating main themes into conceptual maps of the final themes to report the findings.

Cycle 6: This cycle involved revisiting the study's objectives, in order to keep focused on the main aim of the research. This cycle also meant writing further analytical memos (mostly in NVivo, but some were reported in a reflective diary) to accurately summarise the content of each of the main themes. These memos covered the following similarities and differences:

- Considering background information recorded for the participants and any patterns that may exist in relation to participants' responses;
- Considering PSI in the context of practice with the literature, as well as identifying gaps in the literature.

Cycle 7: This cycle was a confirmation of the final main themes and sub-themes. This involved the researcher testing and revising analytical memos to self-audit proposed findings by seeking evidence in the data beyond textual quotes that supported the stated findings, and seeking to expand on deeper meanings embedded in the data. It also involved the questioning of data

and drew on the similarities and differences across and between themes and cross-tabulation with demographics, observations and the relevant supporting literature (Figure 4.6).

Figure 4.6: Final Thematic analysis
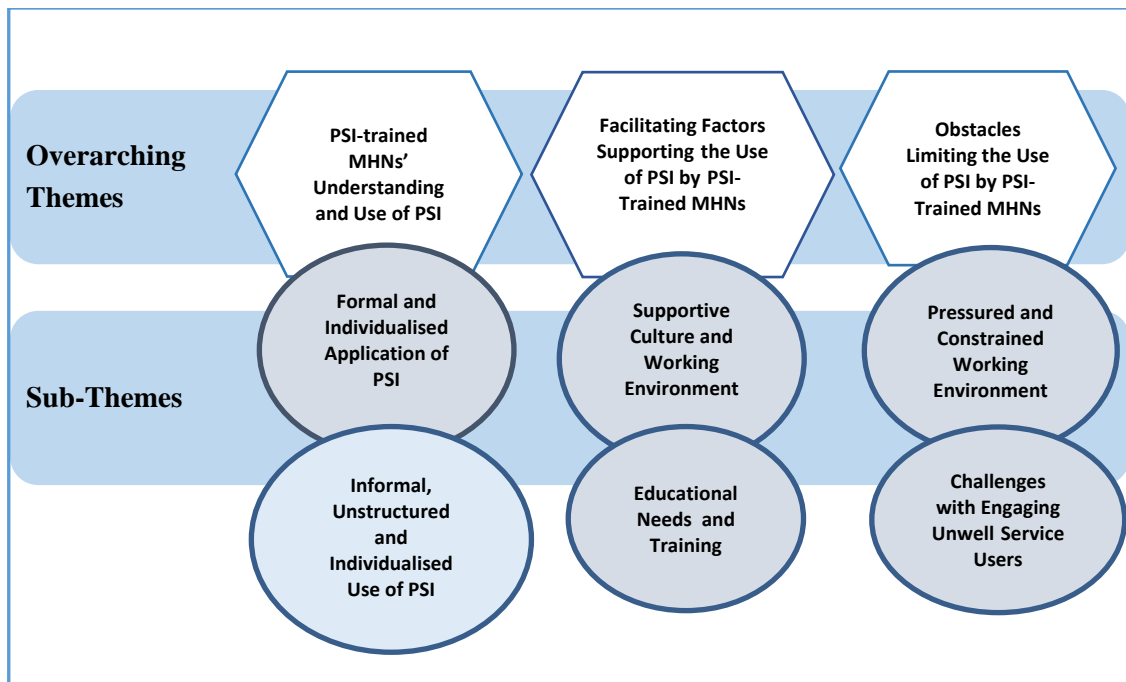
Cycle 8: This involved the writing-up of the cross-analysis report, namely the findings and discussion chapters (Chapters 6 & 7), during which the similarities and differences between the cases were reported on. The next section discusses the quality controls for the study (Appendix 1, Part 1, Reflective entry 10).

4.9. Quality Controls for the Study

Qualitative studies tend to be mostly exploratory and discovery-orientated, and thus one can never be sure which track the journey into data analysis will take. This means that it is difficult to measure the quality of qualitative research because of its diversity (Mays & Pope 2000, Guba & Lincoln 2005). Hence, qualitative researchers seek to achieve the generation of an account of method and data that can endure independently, so that another experienced researcher might analyse the same data in the same way, arriving at the same conclusions and generating a believable and consistent account of the topic (Mays & Pope 1995). For the purposes of this study, a combination of the research by Whittemore *et al.* (2001) and Jorgensen (2006) into evaluating qualitative studies was used as a quality control to guide this research. These quality controls consist of credibility, authenticity, criticality and integrity.

1. Credibility: The criterion of credibility substitutes the idea of internal validity, giving the researcher confidence as regards the 'truth' of their findings. According to Lincoln & Guba (1985), credibility refers to whether the results of the research mirror the experience of the participants in a convincing manner. This study's credibility was strengthened by using four controls (Table 4.5). The first control was the use of member checks (Lincoln & Guba 1985); this was deployed when the participants verified and clarified interpretations directly after the interviews in relation to the accuracy of the interview content and, following the observations, issues were clarified and expanded upon during the interviews with the participants. The second control was addressed by the on-going observation and triangulation of data (the use of multiple sources of evidence, observation & interviews) by establishing data patterns. The third control was addressed by the researcher having sufficient engagement with the field of study. Finally, the fourth control was achieved by the researcher transcribing 30 interviews, which increased familiarity with and enhanced in-depth understandings of the data.

2. Authenticity: The criterion of authenticity was achieved utilising three main controls. The first control was addressed by preserving reflective awareness through the utilisation of a reflective diary. The second control was accomplished by means of an independent audit through discussions with an experienced qualitative researcher during the analysis phase and with academic supervisors. These discussions identified discrepancies that did not make sense in relation to the data from an independent perspective and thus highlighted areas that required further exploration. The third control involved the guidance of an expert in case study design (Professor Robert Stake), who helped with data quality, which was achieved by both the literature and the direct correspondence.

3. Criticality and Integrity: This criterion was achieved by outlining a description of the contexts in which the participants worked and a description of the research settings (Chapter 5). The purpose of this was to provide enough information for readers to judge the applicability of the findings to other settings. A clear audit trail was maintained (Appendix 10) concerning this study from beginning to end, along with a clearly documented process of the analysis (Mays & Pope 1995). Field Notes and reflective accounts were upheld in the form of a diary; this assisted the researcher in staying true to the integrity of the study (Appendix 1). Additionally, a recognised framework for analysis was used. Table 4.5 provides a summary of the criteria controls for the study.

Table 4.5: Criteria Controls		
Credibility	**Authenticity**	**Criticality & Integrity**
Member checks: Participants verified the interpretations directly after the interviews for content accuracy. The observational data were corroborated during the interviews.	Use of a reflective diary to enhance awareness and help retain the possibility of being surprised by the findings.	A clear description of the context where the participants worked and the research settings were provided.
On-going observation and triangulation of data (use of multiple sources of evidence - observation & interviews).	Independent audit: Experienced qualitative researcher during the analysis phase and through discussions with academic supervisors.	Clear audit trail maintained through the research process (Appendix 10).
Researcher's engagement in the field of study.	Guidance of an expert in case study design (Professor Robert Stake) in relation to data quality.	Field Notes/reflective accounts (Appendix 1).
Transcription - 30 interviews by the researcher.		A recognised framework for analysis.

Source adapted from Whittemore *et al.* (2001) and Jorgensen (2006)

4.10. Summary

This chapter has presented how this research was operationalised. The case selection, gaining and negotiating participant access, recruitment of participants, ethical approval and considerations, along with the observation and interview process have all been discussed.

The chapter has also made explicit the process of managing and analysing the data sets (interviews and observations). The research quality controls involved a combination of Whittemore *et al.'s* (2001) and Jorgensen's (2006) criteria; namely, credibility, authenticity, criticality, and integrity.

The next chapter describes the context of case study sites.

5. Chapter Five: Sites Involved, Demographics and PSI Training

5.1. Overview

This thesis has addressed issues associated with PSI-trained MHNs' experiences of using PSI in practice from their perspectives (Appendix 1, Part 2, Table 1, Field Note 17). The purpose of this chapter is to present the general description of the four sites involved in the study as a whole, as opposed to describing them individually. The reason for this approach is that care had to be taken to ensure anonymity of both the sites and the protection of the individual participants (Chapter 4, section 4.2.2.3). The four sites refer to the four cases supplying the study settings where the research was executed. This is followed by the demographics and details of the PSI training received by the participants.

5.2. Description of the Four Sites Involved

Chapter 1 presented an overview of the origins and evolution of Irish mental health care and services that provided a context for this study. This study has focused on four cases, all of which are based in the HSE and provide a range of services to adult mental health services, including community, inpatient and day hospitals. PSI-trained nurses worked in these various settings within MDTs. In particular, many of the nurses worked alone in the community setting when it came to supporting clients, which meant that there were regularly the main coordinators of care. In addition, many MHNs in the cases held senior positions, such as and ANPs, executed multifaceted roles in various contexts.

Similar to international policy, Irish health care policy has positioned mental health nursing within a recovery-orientated care approach (DoH&C 2006, Mental Health Commission Ireland 2007). As advocated in the 'A Vision for Change' policy document, the majority of inpatient beds are being depleted in Irish mental health services due to the development of the community services. Between 2007 and 2009, fifteen state psychiatric hospitals remained operational. Acute psychiatric units in general hospitals (DoH&C 2006) have superseded these. Recent evidence shows that, until the remaining psychiatric hospitals are closed, staff resources cannot be redeployed to community mental health teams (Mental Health Reform 2015, p. 23). This has implications for practice in that staff shortages persist within organisations. Yet, this gives some plausible explanations for some of the findings identified in this study in relation to the unhurried implementation of PSI in practice.

Mental health services are linked to a number of third level academic organisations responsible for undergraduate and postgraduate nursing education. A particular type of training is required to become a PSI nurse. After qualifying as a psychiatric nurse initially, the individual is required to register with the Nursing and Midwifery Board of Ireland (NMBI), formerly known as An Bord Altranais. They can then avail of further training at postgraduate level after a few years of practising as an MHN. Table 5.1 provides a summary description of the participants' demographics (n=40) across the four cases.

5.3. Demographics

Table 5.1: Demographics for Participating Mental Health Nurses (n=40)	
Characteristics	**n (%)**
Gender: n (%)	
Male	15 (38)
Female	25 (62)
Grade: n (%)	
Staff Nurse	13 (32)
Clinical Nurse Manager	10 (25)
Community Mental Health Nurse	1 (3)
Clinical Nurse Specialist	14 (35)
Advanced Nurse Practitioner	2 (5)
Age Range: n (%)	
22-25	2 (5)
26-30	5 (12)
31-35	9 (23)
36+	24 (60)
Number of years trained in PSI: n (%)	
1-5	17 (43)
6-10	10 (25)
11-15	4 (10)
16-20	4 (10)
20+	5 (12)
Location of work: n (%)	
Inpatient	6 (15)
Community	29 (73)
Across Community and Inpatient	5 (12)
Level of education: n (%)*	
Certificate in PSI	2 (6)
Diploma	3 (7)
Degree	3 (7)
Higher Diploma	3 (7)
Postgraduate Diploma	18 (45)
Master's Degree	11 (28)

* Table 5.2 (p. 103) outlines in more detail the PSI curriculum content for each of the programmes

In summary, Table 5.1 conveys that the majority of the sample was female (62%, n=25) and most of the participants were at clinical nurse specialist grade (35%, n=14). All age ranges were

represented, the majority of which were within the 36+ age range (60%, n =24). In addition, the total number of years that nurses were trained in PSI is represented in Table 5.1; the majority were 1-5 years trained (40, n=17). The community setting was the most prevalent location of work for participants (73%, n=29). The level of educational qualifications consisted of Certificate in PSI (6%, n= 2), Diploma (7%, n=3), Degree (7%, n=3), Higher Diploma (7%, n=3), Postgraduate Diploma (PGDip) (45%, n=18) and Master's Degrees (MSc) (28%, n=11).

5.4. PSI Training Received by Participants

Table 5.2 details the PSI training received by participants. This was identified in the demographic information and from many of the participant responses; this puts into context the types of PSI training and education that participants received during the course of their programmes.

Table 5.2: PSI Training Received by Participants																
PSYCHOSOCIAL SKILLS CHECKLIST			A	B	C	D	E	F	G	H	I	J	K	L	M	N
PROGRAMME TITLE & DURATION	Case	Participant														
*BASIC LEVEL			A	B	C	D	E	F	G	H	I	J	K	L	M	N
Degree: 4 years	1	25	√	√	√	√	√	√		√	√		√		√	
	1	37	√	√	√	√	√	√		√	√		√		√	
	3	11	√	√	√	√	√	√		√	√		√		√	
Certificate: CBT: 3 months	2	27	√	√	√	√	√	√								√
	2	2	√	√	√	√	√	√								√
Diploma: Nursing: 3 years	1	33	√			√										
Diploma: Counselling: 2 years	1	32	√	√		√	√		√							
Advanced Dip: Person-Centred Counselling: 1 year	3	8	√	√		√	√		√							
PGDip: Professional Nursing Studies: 1 year	1	24	√	√		√										
HDip: Gerontology: 1 year	4	7	√	√		√							√	√		

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			A	B	C	D	E	F	G	H	I	J	K	L	M	N
MSc: Nursing: 2 years	2	28	√	√		√										
	2	29	√	√		√										
	3	12	√	√		√										
	3	13	√	√		√										
	4	1	√	√		√										
	4	2	√	√		√										
**INTERMEDIATE LEVEL			A	B	C	D	E	F	G	H	I	J	K	L	M	N
PGDip: CBT: 18 months	1	23	√	√	√	√	√	√	√	√		√				√
	2	15	√	√	√	√	√	√	√	√		√				√
	2	26	√	√	√	√	√	√	√	√		√				√
	2	30	√	√	√	√	√	√	√	√		√				√
	3	14	√	√	√	√	√	√	√	√		√				√
PGDip: Acute & Inpatient care: 1 year	4	5	√	√	√	√	√	√	√	√	√	√	√	√	√	
	4	6	√	√	√	√	√	√	√	√	√	√	√	√	√	
	4	18	√	√	√	√	√	√	√	√	√	√	√	√	√	
	4	19	√	√	√	√	√	√	√	√	√	√	√	√	√	
	4	20	√	√	√	√	√	√	√	√	√	√	√	√	√	
	4	21	√	√	√	√	√	√	√	√	√	√	√	√	√	
PGDip: Acute Mental Illness: I year	1	39	√	√	√	√	√	√	√	√	√	√		√	√	√
Diploma in Mental Health: 1 year	1	35	√	√	√	√	√	√	√	√	√	√		√	√	
PGDip: Mental Health: 2 years	2	40	√	√	√	√	√	√	√	√	√		√	√	√	√

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			A	B	C	D	E	F	G	H	I	J	K	L	M	N
	4	17	√	√	√	√	√	√	√	√	√		√	√	√	√
PGDip: Community Mental Health Nursing: 18 Months	3	9		√	√	√	√	√	√	√	√	√	√	√	√	√
PGDip: Severe & Enduring Mental Illness: 1 year	1	34	√	√	√	√	√	√	√			√	√		√	√
PGDip: Cognitive Psychotherapy: 18 Months	1	36	√	√		√	√		√							
MSc: Psychotherapy: 2 years	4	3	√	√		√	√		√					√		√
MSc: Counselling & Psychotherapy: 2 Years	4	4	√	√		√	√		√					√		√
***ADVANCED LEVEL**			A	B	C	D	E	F	G	H	I	J	K	L	M	N
HDip: CBT: I year	3	10	√	√	√	√	√	√	√	√		√				√
MSc: Mental Health: 2 years	1	38	√	√	√	√	√	√	√	√	√	√	√	√	√	√
MSc: SFBT & CBT principles: 2 years	1	22	√	√	√	√	√	√	√	√	√	√	√	√	√	√
MSc: CBT: 18 months	2	16	√	√	√	√	√	√	√	√		√		√		√

Legend:

A	Assessment	B	Engagement	C	Stress-vulnerability
D	Problems list/goals	E	Formulation	F	CBT principles and/or CBT for psychosis
G	Family work	H	Relapse prevention	I	Recovery
J	Early warning signs	K	Concordance management	L	Case management
M	Social inclusion	N	Training in supervision skills		

*BASIC: T**his level indicates that participants gained basic theoretical knowledge and interpersonal awareness of PSI, but participants were not adequately prepared to apply PSI confidently in practice.
INTERMEDIATE: This level indicates that participants gained good theoretical knowledge, practical skills and interpersonal awareness of PSI, and had some preparation to deliver PSI in practice.
***ADVANCED**: This level indicates that participants had developed a rich understanding and knowledge of PSI theory, received training in supervision skills and were confident and well-prepared to deliver PSI in practice.

This information presented in Table 5.2 details the PSI training received by participants across 22 programmes that participants completed across the four cases. The table includes a PSI curriculum checklist derived from the participants' demographic details, interviews and the literature. This table also identifies module and programme-based courses, as well as third level diplomas and degrees. The information obtained suggests that there were differences in the length, content and types of programmes, suggesting that the education and training of the participants vary from case to case. These discrepancies may be accounted for by the fact that PSI training is not mandatory for MHNs in the Irish context. This goes against what the Bologna Declaration set out in 1999 (European Higher Education Area 1999), the intention of which report was to move all disciplines working in mental health towards a more comprehensive and compatible educational approach and a broader use of evidence-based practice. Nevertheless, it is evident from the list of the programmes that components of best practice in mental health nursing were included.

The training separates into 'basic', 'intermediate' and 'advanced' levels, as the programmes contained various taught components of PSI. The programmes ranged from three months' to four years' duration. The four-year degree comprised PSI content that was compiled into three mental health modules within the programmes. Most of the participants had completed a one-year programme (37% (n=8), while 18% (n=4) completed an 18-month programme, 28% (n=4) completed a two-year programme, 4% (n=1) completed a three-year programme, 4% (n=1) completed a four-year programme and 9% (n=2) completed a certificate in CBT. Furthermore, the content of some programmes was very broad in that they did not focus on PSI specifically; an average of two to three PSI-specific skill modules consisted of PSI theory and skills development.

As described in chapter 1, section 1.2, definitions of PSI vary, but usually acknowledge the stress-vulnerability model of psychosis (Zubin & Spring 1977) as a unifying component. Participants conveyed a good understanding of PSI, and all of the mental health and cognitive behavioural therapy (CBT) programmes incorporated the stress-vulnerability model, accounting for 13 programmes (26 participants), of which 19% (n=5) were taught at a basic level, 66% (n=17) at an intermediate level and 15% (n=4) at an advanced level. Assessment and engagement skills featured in all of the programmes; however, these particular components were taught generically across the non-specific mental health programmes. All the mental health-specific programmes included explicit teaching on problems/goals and formulating problems, while the non-specific mental health programmes contained generic content for

these components. This meant that all 40 participants received training on problems/goals: 40% (n=16) at a basic level; 50% (n=20) at an intermediate level; and 10% (n=4) at an advanced level. Conversely, 22% (n=7) of the participants received training in formulating problems at a basic level, 65% (n=20) at an intermediate level; and 13% (n=4) at an advanced level. Early warning skills were not featured in basic level training programmes, while 79% (n=15) were taught this component at an intermediate level and 21% (n=4) at an advanced level.

CBT for psychosis was included in 13 of the programmes, which meant that 26 participants were taught this component: 19% (n=5) were taught this at a basic level; 66% (n=17) at an intermediate level; and 15% (n=4) at an advanced level. Family work featured in all the mental health and CBT programmes: 8% (n=2) were taught this component at a basic level; the majority 77% (n=20) were taught at an intermediate level; and 15% (n=4) at an advanced level. Eleven of the programmes included relapse prevention, which totalled 23 participants: 13% (n=3) at a basic level; 70% (n=16) at an intermediate level; and 17% (n=4) at an advanced level. Recovery and social inclusion were also components that were taught in nine programmes: 18% (n=3) were taught at a basic level; 71% (n=12) at an intermediate level; and 11% (n=2) at an advanced level. Case management featured in 12 of the programmes; no participants reported being taught this component at a basic level, while 82% (n=14) were taught at an intermediate level and 18% (n=3) at an advanced level. The inclusion of concordance management (often referred to as medication management) appeared in only seven of the programmes: 22% (n=3) were delivered at a basic level; 64% (n=9) at an intermediate level; and 14% (n=2) at an advanced level. Training in supervision skills is the component least likely to be taught in programmes; overall, 11 programmes provided skills training in offering PSI supervision: 18% (n=2) incorporated this component at a basic level; 46% (n=11) at an intermediate level; and 36% (n=4) at an advanced level.

In summary, a summary description of the participants' demographics across the four cases (HSE sites) was presented, along with the details of the sites involved was discussed. Additionally, the particulars of the PSI training that was completed by the participants were discussed. The next section explores in detail the findings from this research.

6. Chapter Six: Findings from Interviews and Observations

6.1. Introduction

This chapter presents the study findings of both the interviews and observations across the four cases. The interview data that generated the largest amount of data are presented first, followed by the observational data. The analysis drew on interpretivism as the guiding paradigm for the study. Table 6.1 provides a summary of the data sources in this chapter.

Table 6.1: Data Sources	
Sources of data	**Identified by**
Interviews	case by case number and participant identifier (e.g. case 1, participant 22)
Observations	reference to observational data (observation notes by the researcher: excerpt)
Field Notes (accompanied observational data)	alphabetical letter (e.g. Field Note A, B, etc.)
Field Notes (Reflective notes during research process)	labelled (e.g. Field Notes 1, 2, 3, etc.)

6.2. Findings from Interviews

This section details the study's cross-case interview findings undertaken to meet objectives 1 and 5 for this research, namely:

Objective 1: Explore with PSI-trained MHNs their understanding and interpretation of PSI;
Objective 5: Present the similarities and differences between PSI-trained MHNs' experiences across all the cases in a cross-case analyses report.

As consistent with the multiple case study approach and in keeping with analysis framework (Ritchie & Spencer 1994) (Chapter 4, section 4.7), the researcher initially analysed the interview data from the four cases separately, as described by Yin (1994) as the within-case analysis stage. Following this, a cross-case analysis (Yin 1994) was completed, whereby separate sections in the findings chapter focused on cross-case issues, with data from

individual cases spread through the chapter (cf. Brinton 1938, Kaufman 1981, both cited in Yin 1994). In other words, the findings chapter in this thesis is presented by taking a cross-case format drawing on data from the amalgamated four cases. This process allowed three overarching themes to emerge from the interview data (Appendix 1, Part 1, Reflective entry 11). Each overarching theme also encompassed a number of sub-themes. Table 6.2 outlines the overarching themes and sub-themes. Interview excerpts are included in this section to illustrate some of the salient issues across the four cases (research sites where the MHNs worked).

Table 6.2: Overarching Themes and Sub-themes [Derived from within-case analyses]	
Overarching Themes	**Sub-themes**
1. PSI-Trained MHNs' Understanding and Use of PSI.	**1.** Formal and Individualised Application of PSI **2.** Informal, Unstructured and Individualised Use of PSI
2. Facilitating Factors Supporting the Use of PSI by PSI-Trained MHNs.	**1.** Supportive Culture and Working Environment **2.** Educational Needs and Training
3. Obstacles Limiting the Use of PSI by PSI-Trained MHNs.	**1.** Pressured and Constrained Working Environment **2.** Challenges with Engaging Unwell Service Users

Theme 1: PSI-Trained MHNs' Understanding and Use of PSI

This first overarching theme explores the nurses' understanding and interpretations of PSI, defined by the participants as interventions that include a range of formal and informal approaches delivered by MHNs trained in PSI (Appendix 1, Part 1, Reflective entry 13). The participants reported mixed understandings comprising positive and negative aspects in relation to using PSI in their daily work. It was clear from the demographics that the participants varied a lot in terms of experience, in that they operated in different work locations, and had undertaken different levels of PSI training (Chapter 5, section 5.3 & Table 5.2). Participants spoke of employing formal and informal types of PSI in a number of ways and on a number of levels in practice. The formal types as described by the participants mainly include CBT, recovery and family type interventions. The informal PSI approaches that were identified comprised medication concordance and monitoring, psychoeducation, relapse prevention interventions and educational type programmes. Within this overarching theme, two sub-themes could be identified:

1. Formal and Individualised Application of PSI

2. Informal, Unstructured and Individualised Use of PSI

1. *Formal and Individualised Application of PSI*

This sub-theme is defined by participants as including types of PSI that have a formality attached to them, in terms of structure and delivery. These types of interventions are usually utilised in daily practice on a one-to-one basis or in groups to clients. The MHNs had undertaken PSI-specialised training such as CBT and were well-experienced PSI-nurses with good levels of clinical skills that are required to implement the structure and planning attached to these formal types of interventions. However, an evidence-based method such as CBT is challenging to implement or apply directly in some practice settings, because of conditions such as severe mental health issues or, indeed, a lack of time to carry out the interventions to the full.

There were similarities and differences between participants' understandings and interpretations of formal and individualised PSI from an everyday clinical practice perspective. There was attention and reference made to CBT and some participants spoke in detail about their understanding of a formal structured CBT session and gave the impression of how CBT can be utilised with their client groups. CBT is by its nature structured in terms of the information gathered by MHNs, and in order to achieve this, it must sit within a structure as regards the session itself. CBT is also conducted in a collaborative way and therefore involves the client as much as is possible in all components and entails active engagement both in and outside the therapy sessions, as detailed by this participant:

> The session would be structured … at the beginning of the session and look at perhaps what the last session did, or a piece of homework that you had planned together … the task might have been, say the depressed client, an activity schedule. Therefore, they might come in with a few sheets of a couple of days that they charted. And what you might find is they are actually doing a little bit more than they thought, and they have increased their activity a little bit. In addition, that might then have an impact on their mood. Alternatively, what you might find is that they are sleeping quite a lot of the day, or something like that and that might be something that you decide to address with them… you would start maybe with reflections on homework or a piece of work or what was discussed at the last session. Then you would see what you want to do today, in today's session, so you might use that information. Or they might come with their own agenda and you might factor that in and start off with what they want, and maybe what you might think would be helpful. And the end of the session would then be sort of looking at what are they getting out of the session perhaps. What would they like to focus on between now and the next session? … setting a task; or homework as we would call it (case 3, participant 10).

These data show how the nurse works collaboratively in an individualised and structured way with the client taking into account his/her agenda. The purpose of agenda setting is primarily to be able to manage the time of the sessions in the most efficient way possible and to help the collaboration where both the MHN and client identify agenda items to be discussed within a therapy session. This excerpt also highlights that the MHN takes the lead from the client and, from this, the CBT components, such as reviewing the activity schedule or reflections on homework, will be determined. One could interpret from the excerpt that the MHN modifies the CBT strategies to suit the issues that the client presents in a planned session. When a client engages in CBT, they should know what to expect from the MHN and the CBT approach, and how many sessions will be on offer. In this way, clients are encouraged to take responsibility and focus on their needs. One could argue that the practical demands of clients are very immense when they engage in the formal types of PSI.

For some of the participants, it would also appear that engagement and normalising life events for a client are important from the onset of a CBT session. This allows the MHN and client to get to know each other and work together in identifying the concerns of the client. In this way, an individualised and structured way of working is possible, whereby the MHN can closely connect with the client in finding strategies and resources to cope with his/her condition as opposed to focusing on symptoms. This is evidenced in the excerpt below:

> … so I think that the engagement and the normalisation from the beginning, from the very beginning, is crucial. I think it is from that moment that we meet them and the respect that we show them … to normalise everything for them from that point…you would kind of be working with that person using the cognitive behavioural approach … so you would be zooming in to what's their thinking style, so if it was psychosis it would be maybe that the voices were annoying them, or hassling them, or giving out to them or whatever. So that's what would be going on in their thinking, so you would be looking at that, and the anxiety that creates, and trying to get them first of all to educate them as well about the condition itself, and to treat that as part of the condition as opposed to believe and give credit to the voice… (case 2, participant 36).

Those participants who had experience and knowledge offering CBT components described these interventions as being delivered within a rigid structure and based on evidence. However, this may not be always the case as the rigid form may not be suitable for some clients. In this situation, nurses need knowledge and experience of being able to dip into other approaches, depending on the needs of their clients, as illustrated by this participant,

> … I tried to stick rigidly to this sort of formulating the problem, as the CBT therapist … using the cognitive model … using the research-based methods … that worked in CBT ... over the years I

have realised that not everybody fulfils the model, or the illness model as I would like to see it, nothing is very clear-cut … (case 3, participant 14).

One could claim that this excerpt suggests that MHNs who utilise CBT may need to fade out various CBT components so as to meet individual needs; for example, a client experiencing a lot of mental distress may only be able to engage with some of the CBT components that an MHN offers, whereas a client with mild forms of distress such as anxiety may be capable of engaging with several CBT components, as the MHN therapist guides them. On the one hand, this means that MHNs have to be flexible, but one could also suggest that MHNs may lose specific skills if they are not practising them regularly. On the other hand, it would be important that MHNs with specific PSI skills are assigned appropriate referrals from the MDTs so that they can work within their defined PSI-trained roles.

Furthermore, another participant interpretation drew attention to the fact that PSI-nurses in therapy sessions rely on the use of various CBT strategies such as workbooks, coping cards, homework and diaries for individuals. These techniques can offer practical ways for participants to help understand their problems in keeping with the collaborative nature of this type of intervention.

> … we are starting to use workbooks now and they are really good if the person is able and not overwhelmed by them. But even like, coping cards; just little small cards and you write the stuff down. They go back to that stuff. Like, often people said, 'I took down the stuff and I went over it again'… they might come back just for one booster session where they go, so I think unless it is written down somewhere you are going to forget it … So we write a lot of stuff down, we give them the homework written down, they fill in the homework sheets … most people come with books or diaries and they keep all their stuff in that … (case 2, participant 16).

Many comments were frequently referred to as regards the recovery model, and there was a belief that this approach fits under the structured PSI remit. As some participants described, '… recovery would be a big thing within the services …' (case 1, participant 39) and '[recovery] is a big buzzword at the moment …' (case 1, participant 36). Some participants understood recovery in terms of using a blend of structured PSI to promote recovery of clients and their families. At the core of this approach is good structured individualised assessments in helping clients identify their goals. One participant explicitly commented,

> I would see PSI [as] a combination of a number of interventions that nurses would offer in order to promote the recovery of individuals and families … starting with a good generic biopsychosocial assessment that looks at the person across a holistic spectrum … in the assessment – a good care plan. So, good goals that the person would have set collaboratively; to move on … the interventions specific to the goals identified … always sitting side by side,

with the strengths of the individual that they can bring to attain these goals (case 4, participant 1).

The excerpt above highlights this participant's understanding in terms of a structured assessment and collaboratively working with individuals and their families in identifying goals and focusing on individual strengths.

Furthermore, the use of standardised PSI assessment tools in therapy sessions was also mentioned in the interview findings. As one participant commented, '… [MHNs] uses the rating scales, or do a risk assessment. We would use the CRAM [Clinical risk assessment and management] assessment …' (case 3, participant 8). Participants also remarked on the stress-vulnerability model underpinning PSI, which has been alluded to in Chapter 5. This participant stated, 'PSI [are] about drawing on the literature and using the stress-vulnerability model to inform practice and … normalising events for participants and using education' (case 4, participant 1). Similarly, other participants, especially those who base therapy sessions around the recovery model underpinned by the stress-vulnerability principles, shared a similar understanding of PSI. One participant reported,

> … sort of working on a recovery model … working towards with the strengths of the individual … is just giving us another way of describing it or another language to use it … the individual's hopes and direction … and different stress management techniques … and different approaches to cognitive behavioural-physiological stuff … the stress vulnerability, the stress bucket … (case 1, participant 36).

Another participant who came from a family-focused training background spoke about recovery in terms of embracing collaborative working in families, describing how '… I am family-focused, it is about involving the family … so that's kind of recovery-oriented … and my work involves meeting with families and bringing them in, bringing on board, hearing conversations, trying to link things, communicate, just enhancing that collaboration really …' (case 3, participant 13). Moreover, a participant who worked as community MHN described how FI comprise an educational component for the client and their family, as highlighted by the following data excerpt:

> … this can vary in terms of educational programmes and basically anything that involves any family members and enhances holism on behalf of the patient, and just equips them, making sure that they can actually deal with their illness in a lot more positive light … I like to look on medication and relapse prevention and concordance issues … work with families in terms of medication, and in terms of putting the patient in a better position where he can understand his medication, but not only the patient, also the family … (case 3, participant 9).

This excerpt describes how structured PSI are collaborative in nature through enhancing understanding and communication within families. The aim is to equip the client and their family with a structure around PSI strategies such as medication management and relapse prevention methods. The purpose is to facilitate the client to be in a better position to deal positively with their condition, as FI utilised by MHNs helps reduce the interference of the mental health difficulties that a client experiences in a family.

2. Informal, Unstructured and Individualised Use of PSI

This second sub-theme emerged describes MHNs' understandings and interpretations of informal types of PSI across the four cases. These PSI types appear to be delivered by MHNs in an unstructured fashion. Again, there is a wide variation in participant understandings of these types of PSI and their use in day-to-day practice. However, it is clear that their understanding under this sub-theme considers PSI as generally accepted to be much broader than the formal CBT or family work. According to some participants, these can even include from '… having a conversation with service users …' (case 3, participant 10), to daily activity monitoring, giving time, engagement, assessment, problem-solving, medication management and providing education, of which offer meaningful interventions to meet the needs of some client groups. One could argue that these variations of PSI would certainly include a higher proportion of clients who are not able to engage in the formal types of PSI. From the researcher's clinical experience, a person with memory or cognitive problems associated with mental health distress may find homework in the more structured CBT approaches difficult if they have no supports outside the therapy sessions.

However, it could be suggested that these strategies are things that all MHNs should be doing as part of their role and are not specific enough to come under the PSI umbrella. In contrast, one could argue that MHNs tend to use every strategy that would appear meaningful by including almost everything they do under the PSI remit. Perhaps, this could mean that there is less weight on the less structured PSI approaches, or indeed that MHNs may not have adequate training to provide the higher level of skills to their client groups. It is the usual practice that variations of PSI that may be required, realistically, are beyond the skill of the trainee, even on completion of training. This may be because the PSI training may not have been satisfactory to practise specific PSI skills. For example, one participant commented by explaining that informal types of PSI cover nearly everything that nurses do with clients, as is evident from the following excerpt:

> … we might use medication boxes and things like that, just to keep it very straightforward and
> as simple for them as we can. Everything [medications] would be filled out with them as much
> as we can do, depending on how well or unwell they are. But, you would always be explaining it
> to them and the family, what you are doing, all the time … they continue to get better they will
> take control of that back again, and they have a very good insight into their medication; what
> they are on, why they are on it … (case 4, participant 19).

Similarly, a participant described informal PSI types as '… interventions that are used within practice … to help someone with their mental health needs … used as a combination as well … of medication … the talking therapies, the simple things that we do …' (case 1, participant 38). Also, a participant who worked in an acute setting reported utilising unstructured PSI approaches with a client experiencing depression, and explained that PSI can involve MHNs attending to the daily living activities of clients, and facilitating the clients to take self-responsibility.

> … it depends on what is wrong with them … take somebody who is suffering from depression…
> if they are in the moderate to severe end you could be starting with very basic things. Like
> getting them to get up in the morning, encouraging them to keep maybe an activity log or
> something like that. When they get up, that they try to get up at a reasonable time in the day
> and that they are washed, dressed, eat. To even encourage them to eat regularly … if they are
> at home, encourage them to set themselves one or two small tasks; maybe sweep the floor, it
> could be make a phone call … make a dinner. Whatever it would be that they would start to
> take a bit of responsibility; but setting themselves small challenges that are achievable (case 3,
> participant 10).

Furthermore, one participant referred to unstructured types of PSI as 'looking at alternative coping mechanisms and what the [client] could do instead. Looking at things like safety plans … from a cognitive point of view, we [MHNs] looked at what else you could do instead of leading up to the crisis points, talk through some of the situations where she [the client] had reached crisis point before' … (case 1, participant 39). This participant concluded that unstructured PSI could be broad enough to allow clients to engage using a range of coping skills, especially equipping some individuals with useful skills such as drawing up advanced coping plans when they fear a crisis is looming in their lives. Therefore, clients are empowered to take on self-responsibility in determining their goals, in the likely event of something happening in their lives that could cause a relapse of their condition.

Discussion emanating from the interview findings in all the four cases also brought up the issue of time. Many participants described that an important intervention is to offer time to clients when they are in distress and facilitating them to problem solve as remarked by this participant, '…I think the biggest intervention is obviously offering the time … so it would be a lot of problem-solving at that stage…' (case 1, participant 24). However, in many responses in

this sub-theme, it was clear that PSI start when the MHN first meets the person. This involves fostering and building a therapeutic relationship with the client. As one participant stated, '… for me, the PSI starts when I meet the person … the fostering and the building of a therapeutic relationship are absolutely core …' (case 3, participant 8). Some participants also discussed that the MHN role is about the client and nurse working together; this involves setting clear goals with the client to work on, as commented by this participant, '… it is very important that you are on the same page as somebody, but we would always strive for clear goals with [clients]' (case 4, participant 19). While it is important to work collaboratively with clients, the issue of trust was also important for many participants. The reason is that, when trust is established within a therapeutic relationship, this offers the MHN the ability to engage with clients in a meaningful way, in relation to which, as one participant described, '… I think PSI are really interventions that are carried out that act on the best nature of the patient' (case 3, participant 9).

Similarly, another participant commented, '… a lot of it [PSI] really is establishing a good therapeutic rapport and then seeing what is up for the client at that time … this week … it [PSI] could be just planning how to do a weekly shop, it [PSI] could be someone with medication management…' (case 4, participant 3). This same participant further believed that informal PSI are '... counselling techniques … helping a client to find their resources … so ways of intervening, probing, questioning, supporting, educating, informing, assessment …' (case 4, participant 3). Data here raise the issue of how participants are perhaps not confident enough to talk about PSI use in their practice and therefore they emphasise elements of the generic client-centred approach. Alternatively, it could mean that MHNs are confusing the essential elements of the therapeutic relationship and its components with PSI. Nevertheless, the therapeutic relationship was identified as an influence on whether or not a client would be offered PSI.

There were also suggestions by some participants that medication strategies are important, but that they could be considered an easy option/intervention for MHNs, i.e. that medication are the only thing that will make a difference, rather than engaging with clients. This participant reported, '… people don't always see a value in knowing everything about people. Just get them in, give them their medication, get them better, and move them on. Sometimes that's handier …' (case 3, participant 13). However, there seems to be a contradiction here. Instead, the following participant believes that the best interventions are about the MHN

engaging purposefully with a client to encourage and help the person take responsibility for his/ her own life, and considers that medication is not the answer that will make a difference.

> … I do not think tablets are things that are going to make much of a difference to people … It is much, much more than that … because it is very easy I think for us, the easy route might be to just sort of go in and give the tablets and sort of say, 'Well, that's taken care of now'. What is probably harder is to give the person back their responsibility for their own lives and encourage them to take responsibility for it (case 1, participant 24).

This participant also believed that PSI are any informal interventions delivered by MHNs that help clients in times of distress, in conjunction with reassurance, as exemplified in the following interview excerpt: '… so the interventions are really about sort of slowing things down, reassuring people that things are okay…things are in hand, we have the skills to help …, we will be there' (case 1, participant 24).

Some participants also understood that the overall function of PSI are to assist individuals to function and live in society. A PSI-trained nurse who worked in a community setting reported '… any intervention [PSI] that improves function and that allows somebody to function socially and within their communities … that [clients] are able to participate in their society and within their communities … dealing with any concerns or issues that somebody might have' (case 2, participant 28). Another participant provided a more detailed account and described how PSI are about finding out what is actually happening in a person's life. This participant appeared to see PSI as a broad concept, yet they facilitate individuals to develop coping skills targeted for their needs.

> PSI I feel are about finding out what is actually going on for the person in their own life, and utilising that for them to develop their skills to solve problems and make changes in their life that benefit what is actually going on for them. And that might be all different types of PSI. It might be to do with housing for some people, very basic needs, food, warmth, and shelter, whereas for others it is about their problem-solving skills and how they have developed. And sometimes it is about coping mechanisms; the way that people learn to cope may be healthy or unhealthy, if they can understand better what is going on (case 2, participant 31).

This excerpt also suggests that a less structured approach may help to identify the essential needs that are required for some individuals. One could argue that if individuals' true needs are not identified and considered important, clients will more than likely have difficulty moving on towards focusing on other aspects of their lives.

Theme 1 Summary

This overarching theme of 'PSI-Trained MHNs' understanding and use of PSI describes their understanding and conception of PSI in their practice across the four cases. As mentioned earlier in chapter 1, section 1.5, PSI is a phrase that defies easy definition. This can create difficulties for MHNs offering PSI in clinical practice, and thus participants in this study reflected different variations and meanings of PSI. The MHNs who had undertaken specific PSI training programmes such as CBT were clearer in their understandings of PSI as they had good exposure to applying the types in their daily work. Additionally, many participants attributed PSI to recovery and understood that PSI are integral components to this development. One could claim that recovery is giving nurses another way of describing PSI or another language for using them. Furthermore, recovery could be considered as a salient aspect of justifying using PSI in the day-to-day practice of MHNs. In contrast, MHNs who had undertaken generic type training programmes whereby PSI were developed in many guises had varied meanings attached to PSI. These MHNs tended to put all care activities under the PSI umbrella. The topic of medication is undoubtedly also important and is often mentioned by the participants within the broader work of the MHN. This could be because this component is added to the general PSI training menu in programmes and is considered an important element of the MHNs' scope of practice.

Theme 2: Facilitating Factors Supporting Use of PSI by PSI-trained MHNs

This second overarching theme that emerged describes the facilitating factors that participants reported on that support PSI-trained nurses in the delivery and implementation of PSI methods in the context of their working environment. The faithful implementation of PSI in routine practice and clinical settings is dependent on a range of supports in MHN workplaces. These supports are described in this main theme through two sub-themes:

1. Supportive Culture and Working Environment
2. Educational Needs and Training

1. Supportive Culture and Working Environment

This sub-theme describes the need for MHNs to work in an environment in which there is a culture of supporting and developing nurses using PSI methods across the four cases. Participants frequently mentioned elements relating to 'support from managers, colleagues, and multidisciplinary teams', 'PSI guidelines', 'clinical supervision', 'confidence and autonomy

of nurses', 'role fulfilment' and 'time'. The reason being that this type of environment nurtures nurses' development and motivates nurses to utilise PSI in their day-to-day routine. One participant commented, '… a culture of developing staff … you have staff that has an interest in developing and staff that is interested in starting something new, or learning something new and being able to then go out and try it [PSI]' (case 1, participant 39).

In particular, participants in case 1 who worked in inpatient and community settings spoke strongly about the benefit of having local PSI guidelines in place in the workplace, as they facilitate nurses utilising the PSI in their day-to-day practice. There was an agreement that PSI guidelines can provide direction supported by evidence and a delivery pathway for the offering and delivery of different types of PSI. Some participants identified that these guidelines promote an expectation that every patient should have a one-to-one PSI daily. As this participant articulated,, '… the guidelines are written on the walls that each patient is due his one-to-one psychosocial intervention daily … we have guidelines of how to write it [PSI] into the nursing document … on how to deliver a one-to-one PSI session' (case 1, participant 22). This view was further supported by another participant in case 1 who described how '… it [PSI] is an expectation, but it is an expectation that everyone would embrace' (case 1, participant 24).

Many participants also expressed views about how managers in the services have a pivotal role in supporting and prioritising how PSI be delivered and implemented in the reality of practice. One MHN participant described how PSI should be safeguarded and prioritised, commenting that '[PSI] has to be ring-fenced and it has to be … there has to be an expectation rather than it being a luxury … so, on an adult inpatient unit, it should be that you will deliver at least these sorts of groups …' (case 4, participant 17). Data here highlight the need for a culture in which PSI are an integral part of MHN roles and not something 'added on' to roles. This also suggests that if PSI were given regular attention and used frequently by nurses, this would promote the offerings of PSI to clients. However, in order for PSI to be talked about and implemented, some participants commented on how management should demonstrate a proactive leadership whereby the working environment promotes a culture that PSI are offered to all clients, as emphasised by this participant, 'why did this [PSI] not happen?' (case 4, participant 17). These data illustrate the importance of an open culture whereby management encourage and promote PSI where MHNs work.

Furthermore, some participants highlighted how the newer managers are more encouraging of PSI, as there is recognition that they are having more autonomy. As one participant described, '… the newer generation of clinical nurse managers …[is] an awful lot more open … has definitely left a lot of autonomy … in terms of carrying through whatever psychosocial stuff that we like to do' … (case 3, participant 9). Another participant stated '… you will see the younger nurses, the degree nurses, coming out [to practice], they are more confident, they are more articulate' (case 1, participant 37). This could suggest that the newer nurses are more equipped with the necessary skills to prepare them for their roles, as the type of training they pursued was contemporary and in line with current literature and policy. It could also mean that they experienced positive role modelling during their training. The findings in this sub-theme also indicated that a manager who demonstrates good leadership and vision and who believes in what MHNs do is important, as reflected by this participant, '… he [the Manager] understands what we do and he believes that what we do is right … he sees mental health delivery as being a far bigger thing than just patients that need to be seen by the whole service … he had that vision from the beginning …' (case 2, participant 16). Overall, the data here further suggest that nurse leaders are key to advocating for the successful implementation of PSI.

Some participants also discussed how the support from work colleagues makes a real difference to providing support and encouraging trainees to use PSI post-training. One participant remarked how the support from a manager and specialist nurse can provide relevant knowledge and guidance for PSI-nurses, reporting '... we had a CNM2 and a CNS who did have a good knowledge base in relation to other interventions, not just medication. But they had trained within PSI … they would … teach us more principles of [PSI], it kind of gives us a little bit more focus on what we do as MHNs and gives the profession a focus in relation to what [PSI-nurses] should do as part of their role' (case 1, participant 38).

It was also apparent in the findings that some participants commented positively on the value of other informal supports within the workplaces. This can include peer support from colleagues in different sites and from clinical teams, as two participants described.

> There is definitely peer support, and I think the teams around here are very good teams, they are very close teams, tend to get on very well. So I think the dynamics within the teams here, and certainly, within our kind of community team, there is a very good one. We have three community nurses who all get on very well, link in and very much covers each other so there is very much a close working relationship there. We tend to have a monthly meeting amongst us as community nurses, but I think also with day hospitals, day centres, home care, there are

close links there. So from that point of view, I think there is a lot of informal support (case 1, participant 39).

The second participant spoke of how '… I could talk to my colleague, my CNM …, I could talk to other staff …, the assistant director of nursing is very approachable …' (case 2, participant 27). Another MHN discussed the value of being part of an MDT in supporting MHNs and commented, '… there is also good support … you are part of a team and its multidisciplinary so you can go even if you don't refer somebody on to the MDT for whatever reason, you always have them there to support you …' (case 4, participant 4). Specifically, there was a strong sense from some of the participant comments that, when PSI-trained nurses establishes a solid presence and voice within MDTs, this positively encourages MHNs to utilise the interventions. This participant remarked, 'it is important that nurses continue to establish their role on the MDT … but as well as that, you need nurses to have a strong voice because nurses really are the ones that advocate for clients on the teams' (case 4, participant 19). Overall, it is evident from these excerpts that various forms of support within the working environment for PSI-nurses are crucial. Related to this is the point that many of the participants in Case 1 made that PSI guidelines support professional nursing practice and provide the nurses with the guidance necessary for the implementation of PSI.

Moreover, it is evident from this sub-theme that across the four cases that many of the participants discussed clinical supervision. Of the 40 PSI-nurses, only nine received clinical supervision (six of whom were located in case 2). They spoke about clinical supervision as support from one another as it was beneficial in deliberating over clinical issues and clarifying concerns as regards clients on their caseloads. As reported by a participant, '… just cushions [clinical supervision] really, it [clinical supervision] just works. Because you need it [clinical supervision] working with people … you need it working with peoples' lives' (case 3, participant 11). Another participant remarked, '… survival … would probably be the first thing I'd say, at a personal level. I'm blessed that I have a lot of supervision …' (case 4, participant 1). Similarly, a participant also recognised that clinical supervision in workplaces provides a supportive mechanism for nurses to unload concerns about practice-related issues, reporting that 'clinical supervision helps to unburden in a way, and that they can say, "I do not think you are suitable to work with this client; there is not enough emotional space" … the things like counter-transference you pick up and you might get frustrated sometimes and clients do nothing to frustrate me, it's my own issues … just going in there and saying, "I'm really struggling" … "I'm never stuck" (case 4, participant 3). For this nurse, one could interpret that

clinical supervision offers the opportunity to learn and provides a sense of security to help with clinical practice issues that cause frustration and worry.

Another nurse further described clinical supervision as 'a great leveller and a grounder … it [clinical supervision] keeps very structured and it keeps it up to date … it's lifelong ... it [clinical supervision] is not a luxury, it is a necessity, and it [clinical supervision] certainly has enhanced and improved my practice immensely' (case 4, participant 1). For this nurse, this means that clinical supervision helps in maintaining support and balance within the work environment whereby MHNs gain confidence and skills in practice. However, there was fear among some participants about the funding for clinical supervision. Participants recognised that clinical supervision funding is necessary, as, without this, some nurses would not be able to do their job. One reason for having supervision was that MHNs have to deal with a lot of verbal abuse from clients in some workplaces. One participant highlights the fear if clinical supervision funding was to be withdrawn in their workplace:

> … if the funding for the clinical supervision was pulled, I wouldn't do my job, to be honest ..., it is quite intense; sessions that you would have with people …, It's abuse, it's alcoholism, it's drug addiction, it's abusive relationships … it's all those kind of things, loss, relationships … family difficulties. So, you have to have the clinical supervision … it is demanding, it is definitely demanding, but I have good clinical supervision … (case 1, participant 37).

There was also acknowledgement within this sub-theme 'supportive culture and working environment' that PSI-trained nurses need to believe in themselves when it comes to PSI compared to their other clinical counterparts, as they are an equal and valuable member of the MDTs. One participant commented that '… it's [PSI] not just something that a psychologist does, or whoever else does on the team, "I can actually do this" and I shouldn't have to be afraid to say it, or be nervous about it [PSI], and we should be on the same par as everybody else on the team' (case 4, participant 20). Additionally, a participant who works as a CNM in a community setting further identified, '… there is an expectation that you will go in there [team meeting], you will present your caseload and you will present what you have done, why you did it … and you have to be able to articulate it [PSI], … you have to act confident and you have to present yourself in a certain way, and people expect it' (case 1, participant 37). This excerpt reinforces the need for MHNs to be confident, as there is a sense of achievement in being able to stand up and be autonomous in their defined PSI roles.

Specifically, in case 4, a strong belief was expressed by some participants that MHNs can achieve role fulfilment and can work more independently when they gain sufficient confidence

and autonomy in delivering PSI. As one participant highlighted, 'this [PSI] is very satisfying … and there is never anybody looking over your shoulder and saying … "What are you at" … So, I have great autonomy …' (case 4, participant 4). Another participant's narrative was about PSI-nurses who work in inpatient units, and described the confidence gained, and the role satisfaction in MDT meetings when presenting clients whom they offered PSI, '… it [PSI] is great; it gives you great confidence at MDT meetings … to present your clients and the problems … you are confident that your assessment is good, or that your interventions are working well … you can make a good argument … at times when there is a difference in opinion …, you are just confident that you are able to make your point as well (case 4, participant 19). One could interpret from these excerpts that these participants were able to be innovative, despite some resistance to utilising PSI, by showing high levels of confidence in their day-to-day working.

Additionally, data in case 4 showed that nurses who work in community settings are not as constrained by time to conduct PSI compared with nurses in the inpatient settings. As one participant reported, '… you see your people by appointments … in the hospital setting you have to manage your time a bit better maybe, and set aside time to do your PSI' (case 4, participant 20). Another participant also highlighted, 'I think it is much easier in a community setting; you are much more able to allocate time to it [PSI], and the individual … It is not a captive audience, people actively come in, if it's a group coming to attend a group, or if you are doing individual stuff there is an expectation; this is what you are coming out to do …' (case 4, participant 17). This leads to '… the conclusion that when MHNs have time, this allows them the space to focus on using PSI, and also the clients know what to expect coming to PSI sessions' (case 1 participant 37). Overall, these data suggest that there should be an expectation that PSI is available for everyone and should not be dependent on the working environment in which nurses operate. However, it is evident from these excerpts in this sub-theme 'supportive culture and working environment' that it depends on the setting and the culture of the environment if PSI are offered or not. One could argue that this certainly can affect client outcomes in that some clients will have PSI offered, while other clients will not as they could be in environments where there is little scope for nurses to offer PSI on a consistent basis.

It was also evident from the findings that the majority of MHNs have extensive experience in practice; the following interview excerpt within this sub-theme describes the value of experience when working as a PSI liaison nurse between ED and an outpatient setting. One

participant, who has over 20 years of experience working in mental health nursing, believed that a patient assessment comes as 'second nature' to nurses. There was also an inherent sense in the participant remarks that previous nurse experience need not be underrated, as this is associated with being a confident nurse:

> I think it is because I'm doing this [PSI] for a long time now, it is just second nature to do it … it is very hard to pluck out exactly and say what I do … I'd say certainly the first minute you're in the room with somebody, if not the first thirty seconds, I know or have a good idea whether they are going to be admitted or not. And that's one of those things that are hard to say why but I just know it from experience so if I have the feeling that somebody is psychotic, say, for example, the way I will interact with them is going to be quite different from somebody who is manic, so just again from the experience of knowing if someone has mania I need something to calm them down, if somebody is psychotic you have to be very careful about how you are … that you're not stimulating them, you're not colluding with them … at the end of the day, it is the safety is the issue … so I would say my job sounds fancy, but at the end of the day it is whether I need to know whether you're going to kill yourself or somebody else (case 4, participant 1).

However, these data also illustrate how some nurses can rely solely on experience without considering the evidence base behind their practice. It is although PSI-nurses are employed in advanced positions, but still working from a low evidence base. This is despite the fact that some PSI-nurses are not fulfilling their defined role. Furthermore, two questions come to mind: 1. Why are there no regular monitoring or expectations of advanced roles? 2. How can nurses work without taking responsibility and ownership for ensuring evidence-based practice? One could argue that these particular nurses are not practising within their scope of practice. It appears that when some nurses are in their defined advanced positions, the day-to-day nature of their job takes precedence over the evidence underpinning their practice. Ideally, however, PSI-nurses should be able to demonstrate a strong link between the evidence and their practice in providing the appropriate interventions to their client groups. Yet the importance of recognising nurses' previous experience ensures nurses feel valued and supported. Arguably, it is more than likely that they would also be the same MHNs who would advocate for PSI, even though they are not fully fulfilling their defined roles.

2. Educational Needs and Training

The sub-theme 'educational needs and training' describes how postgraduate education and training can positively encourage and influence PSI-nurses. Many participants commented on the benefits of pursuing education and training and remarked that this facilitated using PSI in their daily work. One participant stated, '… the post-grad; it did develop us to a psychosocial approach and recovery. I suppose because that was the main concept of the course [PSI] so I think my training did change my perspective on where I am now, I am utilising PSI within

practice' (case 1, participant 38). Many other participants across the four cases also echoed similar views, which are exemplified in the following two interview excerpts:

> I do think the community mental health nursing post-grad that I did, the diploma that I had completed, it definitely did help me do this job because this is what I do. So I am lucky enough I am able to put some of that into practice... it definitely did … So I would have started doing basic counselling courses, group work, facilitations skills, then a post-grad just in mental health nursing and then the CBT … (case 2, participant 28).

> …when you are an undergrad, you hear all this stuff in lectures, but it doesn't really make sense until you are out in the clinical area and you get to really see, you get to really understand what the lecturers were telling you about. So, the post-grad is great because you have experience under your belt, and you have a much better understanding of what they are talking about, and what they are explaining to you ... further education after the degree is very important for nurses who are qualifying now (case 4, participant 19).

In contrast, other participants recommended that the current psychiatric undergraduate programmes in Irish third level institutions should consider teaching nursing students PSI from the start of the nurse training.

> [PSI] maybe from an undergraduate level from the very get go … and in relation to now is the time to really bring that into play with the undergrad review that is taking place, looking at the degree programme and the structure …, it is up to … the third level institutions to really look at what are the criteria that An Bord Altranais sets out in relation to their undergrad mental health nursing programmes, and really focusing on PSI (case 1, participant 38).

In response to this excerpt, some participants discussed and recommended the need to review current curriculums and the extent of PSI content. However, this view was reinforced by another participant who believed that PSI should be taught during the undergraduate programmes: 'I think that a lot could be done earlier on … [nurses] should learn about PSI before they learn how to do an injection … that would make more sense… have it as a theme going all the way through …' (case 1, participant 24). Conversely, participants highlighted that it was important that staff get time and support from their managers in the workplaces to partake in on-going PSI training courses. The following participant remarked, '… they are always trying to support and encourage you … we are lucky; we do get one or two days … we have a two-day refresher now in PSI … you get two days' motivational interviewing, brief solution, focus therapy, narrative therapy … Generally, I have not been stopped from doing anything' (case 3, participant 8).

There were other participant responses within this sub-theme around the need for PSI-nurses to keep skills refreshed and updated, particularly the nurses who have not undertaken training in recent years. As one participant stated:

> I think probably we all need to refresh our skills. We all need to personally develop our role as nurses. And just because you trained thirty years ago … I think you have to continuously develop your own practice by yourself … I think times have changed so much that I think what I learned I need to learn, or we need to learn an awful lot more. We need to keep abreast of things in order for us to move forwards as a professional body … (case 1, participant 32).

Nevertheless, another participant explained how, in order to access training, '… nurses really have to make an argument now to go on training or to be given time off or funding towards that [PSI] … not everybody understands the importance of nurses furthering their education or implementing things, like PSI' (case 4, participant 19). These data highlight that there is still an on-going need to pressure management to fund and support MHNs' protected time for refreshment/booster PSI training programmes. The findings also revealed that the clients must know that MHNs are credible and qualified to deliver a service. As this participant commented, 'I think people do take you more seriously and should take you more seriously … education … and assuming that somebody is qualified, they need to know that you are qualified. They need to know that you can back up what it is you are doing and that it is coming from a sound basis …' (case 3, participant 10).

Conversely, it was also evident from the findings that some MHN participants had concerns in relation to education and the knowledge base of nurses. One participant recalled that MHNs are not sufficiently educated, stating that '… the education requirement for staff is very, very low as well. We are not educated, we are more or less, we are carrying it through from our experience and what we have picked up maybe from consultants, from the small one day course that we might have had and we are not educated enough there' (case 3, participant 9). This same participant remarked that some doctors often do not delegate responsibility to nurses, which results in nurses having a decreased ability to challenge practice due to the medical dominance. As this participant explained, 'the medical model is still a huge dominance and there is still that lack of challenging ability. I think to challenge the medics … handing away that wee bit of power which they are quite reluctant to do' (case 3, participant 9). Furthermore, it was also evident in the findings that some nurses feel that doctors devalue them, as they appear not to have the appropriate psychopharmacological knowledge. As one participant highlighted, 'I think there is a lack of confidence there as regards to actually delivering it [PSI], there was a consensus amongst our medical professionals, that we haven't studied the relevant psychopharmacology, so there was no way that we could actually carry that forward' (case 3, participant 9). These data illustrate and reinforce the challenge that some PSI-nurses experience when they feel that are not equal to the doctors as regards their

knowledge base and how this can discourage nurses developing specialist skills such as PSI and being more at the forefront of practice.

However, some participants also referred to the decreased time that MHNs have for partaking in further education and training. It is often the case that nurses are not encouraged by management in this respect, as the needs of the working environment come first, thereby furthering reducing nurses' protected time for on-going practice updates. One participant reported, 'Barriers would probably be to do with time and the management … they probably should start encouraging us or letting us have protected time each week, where you would look at some literature, or start looking at evidence-based practice … I think that people would go for it if it was encouraged' (case 4, participant 19). This same participant argued that MHNs need to be proactive in seeking training and funding, and to obtain release from clinical work to undertake further training, as illustrated in this excerpt, '… nurses really have to make an argument … to go training or to be given time off, or funding towards that [PSI], not everybody understands the importance of nurses furthering their education or implementing things, like PSI …' (case 4 participant 19). One could suggest from this data that the discouragement shown by management from releasing MHNs for training and education strengthens the doctor's power and therefore, they have the ability to dominate care delivery.

Theme 2 Summary

Overall, within the overarching theme 2, a common feature of the four cases was the value of having managers who would support PSI-nurses and the need for them to be strong advocates for PSI. Participants also believed that access to clinical supervision was important, and that a confident and autonomous nurse who is knowledgeable and who has a strong presence in teams strongly influences PSI in practice settings. Specifically, participants in case 1 spoke about the support of PSI guidelines in the delivery of PSI in the working environment. In addition, it appears from the data that MHNs who work in community settings have more time to focus on PSI than MHNs working in inpatient settings, the reason being that community MHNs are better able to allocate time to PSI, as they do not have the same constraints as MHNs working in busy inpatient environments. Conversely, PSI education and training were rated highly important by participants. When MHNs gain adequate education and training, they are more equipped to use PSI skills in day-to-day work with clients, but this is not always the reality in practice, as some MHNs struggle at times getting release from practice to partake in booster training and education.

Participants also commented that PSI ought to be taught in the undergraduate training programmes to a greater level as this would give newly qualified MHNs the opportunity to show the psychiatric nursing students that PSI should be an integral part of MHN roles. Arguably, this would help introduce new nurses to the 'real world' of mental health nursing as the workplaces in which MHNs work are constantly changing and are often complex environments to work in.

Theme 3: Obstacles Limiting the Use of PSI by PSI-trained MHNs

The final overarching theme defines the obstacles that limit nurses practising PSI in their workplaces. Across the four cases, many of the participants identified a number of obstacles. Many of the obstacles noted are compounded when the local organisational culture is not supportive of PSI. Also, PSI skills do not translate easily into routine practice due to the complexity of clients' needs and the lack of skills and confidence that PSI-trained nurses have in using the taught PSI skills. These issues are described in this final main theme through two sub-themes:

1. Pressured and Constrained Working Environment
2. Challenges with Engaging Unwell Service Users

1. Pressured and Constrained Working Environment

Participants mentioned many obstacles that deter them from delivering PSI in their everyday work. Commonly reported obstacles include the busyness of work environments, workload and caseload pressures, waiting lists, space and resources, increased administration and paperwork, lack of support and policy constraints.

Across the four cases, the reality is that MHNs often face many obstacles due to increased pressures of staff shortages in both community and inpatient settings and the reduction of beds within the mental health services. Consequently, nurses multitask and there is an expectation that some PSI-nurses (mainly ward managers who are more senior) will manage acute units as well as coordinating a caseload of clients. As one participant stated, '[we are] exceptionally busy because we have had a reduction in beds. So, … our reduction in staff as well, things are a lot tighter on the ground. So you are multitasking, doing different things … and now I'm finding myself going in, trying to manage the ward, but also trying to manage a caseload' (case 3, participant 9). These phrases could make sense in a pressured work

environment, whereby MHNs have a responsibility to keep the environment safe where lives are at stake. They are also constrained by the routines that are required for regular observations and care activities. However, one could argue that PSI-nurse roles are at risk of becoming blurred in which everything they do could fall under the remit of PSI, or indeed PSI without meaning and attention is a sort of an oxymoron. In other words, if there is no position of strength and distinctiveness in relation to PSI, this specialisation will fade for PSI-nurses and be lost. Alternatively, task orientation, therefore, may be understood as a means of coping with the pressures and stressors of mental health nursing.

As for PSI-trained nurses who worked in busy inpatient units, there was an inherent sense in some participant responses that many nurses feel isolated and fearful, as the need to keep each other safe is important, despite the fact that nurses are always at the forefront of practice. This means that PSI will not be consistently offered to clients or indeed be considered, as the focus for the MHNs is to get through day-to-day practice, ensuring that the work environment is as safe as possible for staff and clients. One participant shared this fear in this way: '… we are at the front line of the war and we are just keeping ourselves safe and that is what we are doing …' (case 4, participant 2).

Arguably, the role of the PSI nurse is to engage therapeutically with clients, but this engagement is often interfered with by the routinised nature of care activities in the working environment. As one participant reported, '… the routine of the words, the medication, the breaks … would be severely interrupted if you were saying "well, I'm going off to see Mary for an hour"… So that's the barrier … that spending time with the patients properly; not sitting beside them in the day-room, but bringing them into a space, that is still not done' (case 2, participant 16). This comment could suggest that the routine running of the work environment takes precedence over the therapeutic relationship and consequently there is little scope in the offering of PSI being to clients.

Additionally, due to the unpredictability of the work environments, the heavy workload of nurses is often challenging in that the required time for delivering PSI takes them away from their primary purpose of engaging with clients. Consequently, nurse interactions are often limited to the meeting of basic needs and spending little time per client. Other participants specifically highlighted that distractions arise from doing PSI on the inpatient wards, in which context nurses frequently have to move around to other wards due to staff shortages. One could argue that MHNs in this type of environment have little scope to provide consistent care

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to clients, as they are not long enough on wards to follow through with any PSI, as described by this participant, '… you didn't start doing the CBT because you may not have been left on that ward for long enough periods. You might have been moved around; you might have been allocated, different patients …' (case 2, participant 16). This same participant also commented that another barrier to offering PSI could often be the negativity towards colleagues who appear to be spending time with clients, as this tends to interfere with the repetitive nature of the ward meaning that routine tasks are not completed. Based on this finding, therefore, it is reasonable to conclude that such routine tasks, therefore, can supersede the offering of PSI to clients. This further means that the completion of these tasks is dependent on PSI being offered or not to the clients.

As mentioned previously, many participants also believed that every nurse should be expected to offer PSI consistently to their client groups. Accordingly, the barrier to this happening is due to other allied health care disciplines leading what PSI-nurses are trained to do; this can cause role conflict in that it is not clear which disciplines are is responsible for delivering the types of PSIs. Theoretically, all allied disciplines have training in various psychological interventions like nurses. However, the point is that the training is aligned to each discipline and probably there are some shared skill components across disciplines. Nevertheless, PSI-nurses need to be clear about the PSI skills that are unique to their discipline and be able to articulate and demonstrate these to MDTs in a confident and convincing way to avoid the blurring of roles. At the same time, some participants expressed the view that, due to nurses' busy roles and the lack of resources in pressured working environments, less qualified health professionals are running PSI groups, as they appear to have the time, thus taking the ownership away for the PSI work that MHNs do. One participant explained this frustration:

> I think [PSI] should be an integral part - I think a lot of the allied health disciplines are stealing our clothes and this is the stuff that we should be doing. But again, the resources kind of are not allowing it and it is kind of… it is very frustrating to see people who are not half as trained as psychiatric nurses delivering these [PSI] groups because they have the time … to do it [PSI]. It is very frustrating … they end up owning them [PSI] "Oh, this is what I do" and inviting nurses in nearly sometimes, whereas it [PSI] should be nurse-led, nurse-run (case 4, participant 17).

Another prominent PSI obstacle recalled by some of the participants was that many PSI-nurses face concerns about large caseloads, particularly within the community settings. The demands of large caseloads mean that nurses have less time with clients as they have to stretch themselves thin. This often causes distress among nurses, as they have to prioritise whom they care for. One participant who worked in a community environment shared this concern,

reporting how '… you could quite easily have a thousand clients on your list if you had the time, that there are always more people that need your time … you are restricted in a sense that there are only a certain amount of people that you can see within that time frame, so you very much have to prioritise' (case 1, participant 39). Similarly, another comment also shared the frustration about the lack of time for PSI and heavy workloads:

> I have forty-nine {clients] on my caseload … but it is a heavy workload … we are busy all the time, and you are seeing twenty to twenty-five people every week and that's along with all your other clients "God, I should see this person in a fortnight", and you are not sure if you are going to get the space in the diary … I would call it a pressure, a pressure of time, a pressure of space, that you carry all the time (case 2, participant 26).

These comments illustrate the sheer frustration that MHNs experience in constantly grappling with large caseloads, and how the competing demands on time can lead to a reduction in nurses offering PSI to their clients. However, the question here is why PSI-nurses are not proactive in looking at measures in reducing their caseloads.

Another PSI obstacle in the findings was in relation to the increase in waiting lists for client assessments. This finding was particularly applicable to case 2. This means that many MHNs have to work extremely hard to see more clients, as they often are required to provide care and treatment to more clients than the capacity of their caseload. This is because clients report having prolonged delays in being assessed, which can have a negative effect on their progress. The consequences of long waiting lists can result in tragedies while clients are waiting assessment by a MHN. One participant shared the disappointment: 'I met someone … they were saying that their son committed suicide a couple of years ago, and he felt that his son was let down because of waiting lists; that he wasn't seen, he had gone to the GP and was waiting to be seen' (case 2, participant 30). This excerpt suggests that MHNs often take responsibility for clients becoming unwell, due to inadequate resources or support within the services. In turn, this puts more pressure on MHNs to see clients, despite the fact that they are working to their full capacity.

In contrast, another barrier that deters PSI being utilised is that some MHNs are experiencing tighter role restrictions due to organisational pressures. There was the belief that some MHNs do not have fully autonomy to manage their caseload, as the numbers of PSI sessions they deliver are being monitored by mental health organisations. This implies that MHNs are more vulnerable in that they are being asked to justify their PSI work to the services, which can put

more constraints on who to see or not see on their client caseloads. One participant remarked, '… you are only allowed to see people … for eight sessions or whatever …, how much time are you spending there? Why are you seeing that person? These sorts of questions in the last year or so are starting to pop up …' (case 2, participant 26). These data further highlight the increased pressure that PSI-nurses experience and the limited scope that they have when it comes to being autonomous in their role. However, arguably, this may well mean that MHNs want more therapeutic contact, indicating that MHNs have to deal with conflict between the caring and controlling functions of some organisations.

Moreover, there were strong views expressed in regards to the need for PSI-nurses to be a stronger profession and to be more explicit in what they do in pressured work environments. A participant stated, 'We are not good at standing up, are we? …we are not good at saying what we do or what we don't do' (case 2, participant 16). One could argue that the unassertive behaviour of nurses could arise from how, according to some participants, nurses' roles are often constrained by the medical hierarchy; consequently, they are kept back from taking a lead in care decisions in the workplaces. Furthermore, this may reduce the nurse's self-belief in being able to offer PSI.

Others recalled that MHNs continually encounter increases in administration and paperwork, which can affect the offering of PSI to clients. There was a sense from some participants that their time was taken up more with administration duties that distract them from doing what they should be doing – namely, PSI. These two interview excerpts below sum up this perspective: '… administration resources are scarce. So we would do a lot of our filing … a lot of clerical administration work we would have to do ourselves … secretarial supports I suppose as resources are the ones that we do not have in abundance …' (case 2, participant 26); and '… an awful lot of paperwork … we have no secretary at all. All the stuff has to come in here to be processed and typed. So you are often doing a lot of stuff … typing stuff yourself' (case 2, participant 16). However, one could dispute that it is MHNs' responsibility to record and report the care activities/interventions with their clients.

Additionally, another obstacle that discourages PSI utilisation according to some participants arose from how other allied health professionals with whom they work often have the privilege of ring-fencing time to conduct PSI sessions with clients away from the acute environments. However, this is not possible for many nurses, as they appear tasked with other responsibilities in such environments. As one participant stated, '…it is all about fire-fighting, it

is all about managing the situation … if you can do some PSI today with someone, fine, if you can't, okay, you just weren't able to … whereas all-in-all the other health professions saying "no, no …"' (case 4, participant 17). This same participant spoke strongly about the perceived luxury that other health care professionals have when they seem to be offering PSI compared to MHNs. As this participant commented, '… I am [psychologist] taking so and so away [patient] … and they have that time, no one is disturbing or shouting or causing a ruckus, or there is nothing else happening around them' (case 4, participant 17).

Similarly, another participant commented on the lack of space and remarked that it was difficult at times finding a suitable place to facilitate PSI sessions with clients. A participant who worked in a community setting described, 'Space is a problem, certainly; in the building where I work we have four offices. Two of them [offices] are in constant use by allied professionals … on any given day, maybe five or six of us trying to get into those two rooms. But sometimes it is about you have [sic] to prioritise your own patients, and we have to book the time in the room' (case 4, participant 19). This suggests that MHNs have to be aware and prepared before offering any protected PSI time with clients.

Many participants across the four cases also voiced concerns about the challenge in getting adequate time to document the PSI delivered. As one participant stated, 'there is nothing there [documentation], so we are not really providing the evidence there' (case 3, participant 9). One could argue that, when PSI are not evident in the client's records, nothing has been offered to clients. This puts little value on PSI. At the same time, there was a sense from some comments that PSI are happening in practice, but MHNs are not good at articulating what they do. Consequently, PSI are sometimes delivered in an *ad hoc* fashion with no structure or planning. This might mean that nurses have difficulty describing what they do with clients in the MDTs. In the following two interview excerpts, participants recalled their concerns and disappointment about this:

> The first thing is we are not valuing our interventions; we are not recording our interventions, we are not documenting them properly. So nobody knows if we are doing them or not [PSI]. I think it is disappointing … because we are doing it [PSI], but people do not know they are doing it and basically we are *ad hoc* (case 3, participant 9).
>
> I think … we are not good at documenting [PSI] things that we are doing properly … we are not good at describing [PSI] in the proper language …, more people are doing PSI than they realise. And sometimes it lets nurses down at meetings when they are describing what they are doing … (case 4, participant 19).

In the same way, another participant shared the sheer frustration of not documenting PSI, commenting on the challenges that MHNs encounter in articulating what they do, and the time it takes to record PSI.

> The nurses are doing a lot of family work; it is just that they are not documenting it [PSI]. They spend time with families … they do not write it [PSI] down and it's not seen. I know whenever the mental health commission come in and look at notes it doesn't actually marry up to the time that they spend [with clients] then the message we would be saying then, "if you speak to a family member well write it down in the family care section, refer to it [PSI] in your nurse's notes …" but it is how do you document that? … a lot of things can be said; writing can take a lot of time (case 3, participant 13).

These data highlight the implications for PSI-nurses; by not documenting and describing the work they do, this can diminish their roles, thus limiting the image of MHNs in their workplaces in a way that further leads to a reduced value or recognition of their positions and skills.

However, while some PSI-nurses spoke favourably of how clinical supervision facilitates PSI-nurses, there seems to be a contradiction in the data, as a number of participants commented on the absence of clinical supervision for their PSI roles in the workplaces. This is in spite of the fact that some nurses were trained in the past to take on clinical supervisor roles. This participant stated, '… we do not have official clinical supervision, it is something we are looking for … and there have been several of us trained up as clinical supervisors many moons ago, and we had offered a facility to supervise, unfortunately, that wasn't taken up … but I find the longer I am in this job the more I realise how much I need [clinical supervision], how much I want [clinical supervision]' (case 1, participant 36). One could claim that the absence of clinical supervision can mean that MHNs are at risk of being socialised according to the traditional regimes of working, which further hinders nurses utilising PSI in day-to-day practice.

A number of other participants commented on policy constraints and spoke about how 'A Vision for Change' is not a realistic policy in supporting MHNs in the workplace. There was a strong sense from listening to the participants that many felt that the Irish Government lacks commitment in providing adequate resources to support policy recommendations, as noted by this participant:

> … I think there aren't firm enough policies really, from a nursing perspective … but when it comes down to it, I mean every second person will quote "Oh, Vision for Change, and we are all aspiring to the ideals of Vision for Change", and it is the way forward and all of that. But I feel that resources have never been made available … "A Vision for Change" is out since 2006 or

something like that; which is nine years ago really … and these things aren't really up and running … (case 4, participant 4).

Another participant reported that 'if I was truthful about it I think most people are sceptical of [A Vision for Change] because there are not the resources … I think how many documents we have had coming out over the last while … nothing happened' (case 2, participant 40). One participant was also of this view, commenting, '… I find that there are so many policies and procedures … and many of [the policies] are in black and white … but as regards implementing stuff on a practical level; sometimes the policies aren't exactly helping' (case 4, participant 21). These data highlight how a lack of government policy guidance can hinder how mental health services progress in implementing practice led initiatives such as PSI.

2. Challenges with Engaging Unwell Service Users

This sub-theme describes the challenges for MHNs when offering PSI to service users who are unwell. In all four cases, the participants' narratives identified the difficulty engaging with unwell service users, and they referred to many obstacles that can prevent the offering of PSI. The obstacles include the nature and extent of the mental health problems, decreased engagement and rapport, lack of reciprocity in client relationships and the language terms used by MHNs.

MHNs face challenges of engaging in their day-to-day practice with a mixed population of service users with varying degrees of mental health problems. Specifically, in the context of inpatient settings, MHNs' observations and duties are significantly taken up by the legal status and admission circumstances of clients rather than the use of PSI in that, usually, clients will be detained and treated under the Irish Mental Health Act (2001). This, in turn, can frustrate and distress clients, as they often feel that they have lost their rights to freedom and choice in their psychiatric treatment. Additionally, some service users may disagree with their medical diagnosis, resist being detained and disagree with taking prescribed medications, or indeed wish to decline the offer of any kind of therapeutic interventions. Thus, trust plays a major part in forming the basis for a good working relationship with clients. When trust is present, MHNs are able to engage and use PSI with clients in a meaningful way. However, some participants describe how the absence of the nurse rapport can hinder service users from engaging. For example, if service users have difficulty gaining trust or the nurse rapport has deteriorated due to their mental health problems, this can negatively affect how they interact. As one participant commented:

> I feel that is definitely the number one because I think the minute the client feels that they do not trust you, or rapport is broken, you have definitely taken a step back. And if you do not have that rapport, I do not think you can make steps forward into kind of overcoming what is going on. I suppose they might not be quite as honest with you. They might not feel that it is a safe place … if there is no rapport; it is definitely the cornerstone [developing rapport] really I think (case 4, participant 21).

Another comment was that PSI offerings are not only dependent on a service user's frame of mind but also their age, as described by this participant: '… another thing is their age … their frame of mind is a huge thing, and of course, the trust and the relationship you would have with them. However, I just feel some of the older men would not entertain [PSI] at all …' (case 4, participant 18). These data highlight how MHNs can be constrained by the type of PSI that they plan with service users. As one participant mentioned, 'I think you cannot have a "one size fits all", you can have the fundamentals … but that does have to be tailored and adapted to the individual and their circumstances' (case 1, participant 39). This means that PSI-nurses need to be flexible and require a broad knowledge base, while being equipped with broad PSI skills so as to meet service users' individual needs. The more specific interventions such as CBT may not be suitable due to the rigid structure attached to it and cause more distress, and hence disengagement.

Some participants recalled how the inconsistent nature of clients' problems affects what PSI-nurses can offer. Clients often require continuous support from numerous professionals and voluntary services, along with support from family and friends. The lack of reciprocity in some client relationships, where their mental health problems are severe, can lead to increased demands on nurses. Consequently, clients often drop out of treatment with nurses and, accordingly, may relapse and then often fail to engage in the process. One participant described how

> … I have people on our caseload … with severe enduring mental illness; with continuous relapses … you work really hard with the relapse prevention planning … you do the work, unfortunately, I think a lot of the time with long-term medication treatments, and long-term damage of continued relapses and their ability to take it on and work with you is limited … you keep trying … (case 1, participant 36).

Furthermore, due to the nature of mental health conditions, clients often experience reduced cognitive abilities such as poor memory recall or memory decline, speech deficits due to long-term effects of medication and decreased motivation. Some participants voiced their concerns about the intense work required from nurses when clients are unwell, which also necessitates greater investments of time, as evidenced below:

> … a lot of people that I see on my caseload have kind of enduring mental health problems…that kind of negative symptoms of enduring mental health problems…lack of motivation, kind of the lack of energy … wishing to engage in something can be a barrier … maybe not motivated to buy into the idea; so, functioning at that social level … So, things do not always work out … it is not ideal, and it is kind of going against the grain of what you do (case 2, participant 28).

One could argue from this excerpt that MHNs face increasingly challenging conditions, which make high demands upon nurses. For example, clients with challenging behaviours associated with their mental health problems can be labour-intensive and takes several nurses to care for them.

Another participant described the frustration around the language terms that PSI-nurses often use. When nurses use technical PSI terminology, such as 'stress vulnerability 'or 'relapse prevention', service users may not always understand such terms. Additionally, there can be cultural barriers in relation to the language used. It can be a daunting experience for clients when they have difficulty admitting to nurses that they hear voices connected to their illness. Especially when an interpreter is involved, clients tend to be more guarded when it comes to talking about their problems; as one participant observed, '… with the PSI, some of my clients … there is an actual language barrier … I think that clients can be quite guarded sometimes about admitting to someone that they are hearing voices, not just to one person, but an interpreter as well' (case 1, participant 23). Furthermore, other participants shared views about the need for MHNs to use non-professional language when interacting with clients, in order to minimise the risk of clients not being able to comprehend the actions of the nurse. This concern is exemplified in the following interview excerpt, which clearly provides a number of reasons why nurses should use less technical language:

> … the clever bit is converting the technical speak into everyday language. Like, I remember talking to an eighteen-year-old lad who got very paranoid all the time and he used to hit people, he used to get himself into trouble. And he said to me … "Look, I suffer from paranoia", and I said, "Do you know what that is?", and he said, "well I kind of know what it is. I smoke pot before I get paranoid, I smoke pot" … so that when he becomes paranoid … he needed it to be explained to him in layman's terms about the fact that he is going to have to have a drink and then he is going to get paranoid, and then he is going to be hypersensitive to people, visuals, whatever is going on … auditory … he might start hearing things … he is just going to become more dangerous and riskier (case 3, participant 26).

Similarly, one participant recalled how the lack of privacy and confidentiality, particularly within acute environments, can be further obstacles to conducting PSI, as often many individuals who are in distress are not always comfortable sharing problems Consequently,

MHNs experience difficulty in engaging individuals in any meaningful way. This participant commented:

> … the barriers … would be privacy, confidentiality … the environment. The general hospital setting is not conducive to dealing with a lot of mental health disorders … if someone is agitated, confused … talking to someone about active command hallucinations in the middle of the ED department waiting room … they refuse to go into the cubicle because it is possessed by evil spirits or something like that, you are limited ... you have got people listening and watching, so that would be very difficult. So your approach is going to be reserved and is going to be blunted … in many respects. So, the working environment is not brilliant for chatting from a mental health perspective … (case 2, participant 29).

Conversely, other common responses from participants indicated that some MHNs are also still in favour of offering medications to clients, which means that PSI may not be given much attention. As one participant described, '… there is no other way except for medication [nurses see medication as the main treatment for clients], I feel that you would often be told that "Look, they're never going to change, and this is not going to change for them, and don't waste your time trying to figure out why they are doing it" …' (case 4, participant 20). Based on these findings, one could argue that some MHNs still rely on medication, but the motive could be that the care in the context of the nurse's work is directed to medication and consultant-led, as summed up by this participant: 'From working in both areas, in the inpatients and in the community setting … I could honestly say that I have not seen much PSI in the inpatient setting. Because it is very routine, it is very busy … there are patients, again, with different needs. I think it is all very medicated focused, very consultant focused …' (case 4, participant 18). One could interpret from these data that when a care environment is focused on medications and a medical approach of working, there will be less offering of PSI to clients, thus, there is a potential that clients will not be able to identify coping strategies for their condition. This could explain why some clients are more challenging than others are.

Theme 3 Summary

This main theme described those participants' narratives that identified multiple obstacles in relation to utilising PSI in day-to-day work, including MHNs not having sufficient time to conduct PSI with clients. This is also coupled with heavy workloads and large caseloads in ways that further impact on MHNs' roles and the job they are they are trained to do. MHNs often do not feel supported and valued. The findings showed that increased administration and paperwork can deter nurses from doing PSI; and that little time was focused on documenting what PSI-nurses do. In addition, participants spoke about how MHNs are often unable to offer PSI to unwell service users. This is due to a lack of engagement to the extent that service users

can drop out of treatment or experience long-term effects of medication and decreased motivation, all of which may be obstacles in the offering of PSI to client groups. This could suggest that a care environment that focuses on medication as the first line of treatment may not include the offering of PSI to client groups.

A summary of the findings in relation to similarities and differences across the four cases will now be discussed.

6.3. Interview Findings: Similarities and Differences

In order to meet objective 5 for this study (Chapter 1, section 1.5), the similarities and differences between PSI-trained MHNs' experiences across the four cases are summarised in Table 6.3.

Table 6.3: Interview Findings: Similarities and Differences Across Four Cases		
Themes	**Similarities**	**Differences**
Theme 1: **PSI-trained MHNs'** **understanding of** **the use of PSI.**	Similar understandings shared by participants of PSI in which many attributed PSI to Recovery. Overall, MHNs had good knowledge of the wider ranges of PSI. A distinction was made between formal and informal PSI.	
Theme 2: **Facilitating factors** **supporting the use** **of PSI by PSI-** **trained MHNs.**	Positive working culture and working environment; peer support, PSI role models and MDT support. Proactive leadership and supportive managers. PSI guidelines in practice environments. Access to clinical supervision. Postgraduate training and on-going education and booster training. Increased confidence and autonomy of MHNs.	**Case 1:** There was an expectation that all nurses use PSI as an integral part of their role. Local PSI guidelines are in place. Supportive management structure; a strong working culture that supports PSI in terms of training nurses in PSI. **Case 2:** Six participants who were clinical nurse specialists were offered regular clinical supervision; the reason being that they were all CBT therapists and clinical supervision is a mandatory requirement for all CBT therapists. **Case 4:** PSI needs to be ring-fenced and prioritised in services. MHNs working in community settings are not as constrained by time as inpatient settings. Role fulfilment – increases MHNs confidence and autonomy.
Theme 3: **Obstacles limiting** **the use of PSI by** **PSI-trained MHNs.**	Levels of training varied; no standardisation of training. Protected time for training and education was not always available by the organisations. Medical dominance curtailed practising PSI, particularly within inpatient settings. Busy working environments - competing pressured demands on time. PSI-nurses experience large caseloads and workloads. Challenging mental health problems of clients. Lack of clinical supervision. Poor PSI-nurses visibility - lack of confidence in 'speaking up'. Staff shortages and reduced resources. Policy constraints.	**Case 2:** Waiting lists were in place. A plausible explanation for this was that this case had the highest number of PSI specialists; therefore, the demand for the services was much higher. The majority of these CBT therapists worked from GP practices, which meant their caseload numbers and workloads were much higher. This was in addition to their taking referrals from psychiatrists from the mental health services.

The remainder of this chapter will detail the findings from the observational data across the four cases.

6.4. Findings from Observational Data

The cross-case observational data are detailed in this section, organised and presented as follows:

- Vignettes
- Field Notes
- Reflective commentaries

This organisation helps to illustrate the extent to which PSI-nurses utilise PSI in practice. In total, 19 hours, 20 minutes of non-participant observations across the four cases was conducted (Chapter 4, 4.2.1, Table 4.2), comprising one hour of observation with a MDT and seven observations of PSI-nurses during clinical encounters with clients. The MHNs sought permission from the clients prior to the researcher sitting in on their sessions. An observational guide (Appendix 7) directed the observed data. The eight observations for the study are presented in the next section.

6.4.1. Vignette: Observation One

Context: This observation excerpt was from a PSI-trained nurse who was a CNS and trained in MI. This observed episode took place at the MHN's office in a day hospital setting. An MI intervention provided the nurse with a toolkit of interpersonal skills to overcome resistance to behaviour change, giving personal choice and control to the client (Miller & Rollnick 1991).

Observation Notes by Researcher: Excerpt

Case 4, participant 3:

Space & Actor[8]: The MHN had a booked appointment with a client. I noticed that the MHN had the phone unhooked. In addition, there was a computer on the desk; a clock was on the wall, and a comfortable armchair for the client to sit on. The MHN sat on a high chair, which meant that eye contact between the client and the nurse was not equal; however, the client was sitting at a comfortable distance from the MHN. I sat on a chair, across from the MHN.

Behaviour & Goal: My first impressions were that the MHN showed great interest in the client. It was clear that the session followed on from previous sessions, as the client started talking about what she had written in the homework diary. The MHN facilitated the one-to-one session in an engaging manner. During the observation, I noticed the MHN was using good listening and reflective skills. In particular, the MHN picked up quickly that the client was coughing a lot during the session, which I felt hindered the flow of the conversation at times between the client and MHN. However, the MHN tried to establish more details about the cough. The client openly talked about smoking cigarettes. The MHN suggested that an appointment be made with the GP about the cough, and proceeded to educate the client about the harmful effects of cigarette smoking. I observed that the MHN was using the 'wheel of chain' framework, which is core to applying MI techniques such as encouraging, supporting, affirming and

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[8] The observational guide is displayed in Chapter 4, Figure 4.1 and appendix 7.

acknowledging strengths and abilities for individuals. This framework helped the MHN to establish more facts about the issues associated with the cough. The MHN established that the client has just recovered from a chest infection a few weeks previously. As a result, the client's mental health had deteriorated.

Time: The session was 90 minutes. The MHN planned the next appointment for a month's time, and reinforced at the end of the session that the client should contact the GP about the cough as soon as possible.

Feelings: The MHN provided an environment that was comfortable. I observed that this facilitated the client to talk with ease. I noticed that the MHN focused on a strength-based approach, as it was evident, the ability to affirm with the client the positive things that was going well.

Object: During the observational session, the MHN took notes. In addition, it was clear that the MI principles helped underpin the MHN's practice. The open questioning approach appeared to engage the client to talk more freely about her problems.

The researcher completed the Field Note below shortly after the observation, and just before the interview with the PSI-nurse.

Field Note D by the Researcher

Case 4, participant 3:

I felt rather uncomfortable initially at the start of the session, as I thought my presence might hinder the client talking. However, it was obvious that the client soon forgot about me as she progressed to talking about her problems. The MHN appeared very professional, well-dressed and demonstrated genuine care for the client. The environment was quiet and relaxed. During the observation, it was evident that a good therapeutic relationship between the client and the MHN was developed, and that the MHN was confident and autonomous. I did not think that the MHN was aware of sitting on the high chair, but I observed that this did not appear to affect his level of engagement with the client. Overall, the MHN conducted the session at ease, but structured and individualised; the client was treated with genuine respect. There was no judgement made about the client.

Reflective Commentary

This observation has indicated that the MHN was utilising the 'wheel of change' and MI to underpin practice as a way of facilitating engagement with the client. The MHN practised some formal components of MI to explore the issues in more depth with the client, but still flexibly enough to allow the client to feel at ease during the session. The good listening and empathic skills of the MHN aided the flow of conversation, which made the client feel relaxed and comfortable. The client's coughing during the session raised a concern for the MHN. It was difficult for the MHN to ascertain the client's expectations about smoking; the client appeared hesitant about the seriousness of the cough. However, the client acknowledged the need to contact the GP by the end of the session. Overall, this observation demonstrated that the MHN was knowledgeable and confident.

6.4.2. Vignette: Observation Two

Context: This observation was in a community context. The MHN was a staff nurse who had 1-5 years' experience practising PSI in practice. The MHN used anxiety management within a group setting.

Observation Notes by Researcher [Anxiety Management Group]: Excerpt

Case 3, participant 11:

Space & Actor: This observation took place in a Day Hospital. At the beginning, the MHN acknowledged and thanked all the clients for coming along. They were all living at home. A student nurse was facilitating the session with the MHN. The environment was very relaxed, candles were burning and comfortable armchairs were available. All the clients were sitting in a circle around a coffee table that was in the middle of the room. The clients relaxed by drinking tea and coffee just before the session.

Behaviour & Goal: This session was the third week of an eight-week anxiety management group. At the start of the session, the nurse asked the clients how they had managed over the past week, and how everyone was feeling. They all appeared very relaxed and forthcoming with information; both of the nurses listened carefully. The MHN used paraphrasing and reflective skills to clarify issues with the clients.

Time: The session was 180 minutes.

Feelings: During the observation, it was evident that the MHN was constantly consistently establishing a positive atmosphere and encouraging the clients throughout the session. Client's demonstrated engagement as the MHN emphasised to the group that it was important to concentrate on the things that work for them individually in managing their anxiety. I noticed that the MHN was constantly observing the clients' body language from a distance, and had the skill of re-focusing the clients to the present moment if they were drifting away from the core issue of anxiety.

Object: After everyone had shared their experiences, the MHN followed on by demonstrating diagrams and pictures on a flip chart to help the clients to understand anxiety and its components. Clients were prompted to visualise the 'stream' image that had been introduced the previous week: 'Let your thoughts go down the stream and let them float; let them pass you down the stream and do not pick up thoughts that will feed your anxiety.' Subsequently, the nurse drew a panic diagram, along with a picture of a crossroads that illustrated ways of viewing and managing anxiety. The strategy helped the clients visualise the consequences of taking one road versus the other road: one road helping escape from the panic attacks; the other road enabling the client to face up to the panic attacks. Emphasis was on the following mantra: 'Nothing will happen … I have done this before, and I can do it again.' The mantra helped clients to feel more positive and thus relaxed at the end of the session, and further focused the clients on anxiety management techniques to work on throughout the following week. The MHN reminded the clients to use their diaries in writing down feelings, challenges and struggles that they experienced over the week. A date was set for the next group session.

The following Field Note was written immediately after the observation, which particularly focused on the environment. It was evident that both MHN and the student nurse promoted a relaxed atmosphere for the clients.

Field Note A by the Researcher:

Case 3, participant 11:

My impressions from the observations were positive and enlightening, because they made me think back to when I was working in clinical practice. Anxiety management groups were an aspect of my work that I enjoyed. What excited me initially was the environment. The environment was very relaxed; the

scented candles generated a sense of relaxation; the armchairs created a sense of comfort for clients. The clients and facilitators [MHN and student nurse] sat in a circle together, which was engaging. I observed that the clients were motivated and interested during the group session, and felt very positive afterward.

Reflective Commentary

This observation indicated that the MHN was using a combination of informal and formal PSI skills in a group setting. The MHN was also confident and autonomous in managing the group. During the observations, it was obvious that the nurse and the student nurse had already developed strong therapeutic relationships with the clients from previous weeks. It was further evident that the clients benefitted from the session; they appeared immersed in the group as it progressed. The MHN continually showed support for the clients, which created a relaxed atmosphere that facilitated the clients in engaging with the group tasks. The observation demonstrated that the MHN was using therapeutic interventions such as engagement strategies, problem solving and goal setting. It was also apparent that the stress-vulnerability model was utilised to underpin the MHN's work; this helped a number of clients to identify stressors and vulnerabilities within their lives. Additionally, it was apparent during the observation that a focus was on early warning signs of getting unwell and discussed simple tips for reducing relapses of their illnesses. It is the researcher's experience that clients often express fears about the future and have worries about the recurrence of mental illness. This group facilitated the clients in further focusing on developing coping skills so that they would be more confident and empowered in taking control of their lives going forward, in keeping with the recovery ethos and PSI to care.

6.4.3. Vignette: Observation Three

Context: This observed data in a community setting, comprising a working day with an advanced nurse practitioner and had 11-15 years' experience in mental health nursing.

Observation Notes by the Researcher: Excerpt

Case 4, participant 2:

Space & Actor: When I arrived, the MHN was waiting in the office. It was apparent that the MHN was busy sorting out referrals from the psychiatrist on call during the night.
Behaviour& Goal: The MHN informed me that a client needed an assessment in the ED. The referral reported that the client was homeless and had a history of using drugs. The client has contact with a CPN every week. The referral for the client came from a chiropodist who was treating the client for foot problems. The referral stated that the client was expressing suicidal thoughts. The MHN rang to get a collateral history from the CPN, GP and drug service. The CPN found out that client was recently evicted from the hostel where he was staying due to a theft the previous weekend and was out on bail. According to the CPN, this client had been a patient in hospital a few months before. In addition, another referral for a client to Jigsaw [a young person's mental health service] was urgent as a client

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was due discharge from the general hospital. In between all this, the nurse was also answering the office phone to doctors and updating them about certain clients. The bleep and mobile phone were also constantly ringing.

Time: This observation lasted 360 minutes – a working day with the MHN in practice.

Feeling: The MHN appeared to be going from crisis to crisis, during which the mobile phone was constantly ringing [GPs, doctors, etc.]. Many other client referrals were coming from the ED. It was clear that the MHN had to write notes on scraps of paper so that she could record detailed notes at the end of the day. The MHN appeared exhausted at the end of the day and reported that this is what happens every day, thus curtailing the MHN from engaging in any formal PSI.

Object: The MHN established through skilful questioning that the client had no active suicidal ideation. The MHN prescribed an antihistamine medication as the client reported difficulty sleeping, taking into account the client's previous history of drug abuse. The MHN reported to me that there was no evidence of the client having a mental illness. I did not see any use of measuring/assessment tools used by the nurse. The nurse suggested to the client to register with a GP. The hostel staff were contacted by the MHN who agreed to take the client back. In the meantime, there was a further phone call from a senior house officer [SHO] in Oncology for advice on another client. The nurse suggested to the SHO to increase the medication that the client had been on in the past while a patient in the inpatient unit. Afterwards, the MHN completed a quick assessment and established that the client's son had died a year ago by suicide. A few days after the death, this client received a diagnosis of rectal cancer. Based on this information, the MHN suggested a referral to the oncology psychologist for bereavement counselling. At this point, the bleep went again (this must have been the sixth phone call with a few minutes apart)…

Field Note C by the Researcher:

Case 4, participant 2:

The MHN was busy, appeared very experienced clinically, and exhibited a good level of autonomy and confidence. The nurse worked well with her medical colleagues. I got the sense that these colleagues depended a lot on this nurse as regards decisions and treatment plans with particular clients. It was interesting that the nurse suggested an increase in medication, not the doctor. A lot of the MHN's time was on the phone liaising with voluntary organisations and ED staff as regards clients' circumstances. It was evident that the MHN utilised informal brief therapeutic interventions such as prescribing appropriate medication, patient education, supporting families and referring clients to appropriate services after assessments had been undertaken. The MHN appeared to cope with situations very well, even though the working climate was very busy and chaotic. It was also apparent that the MHN engaged 'well with clients and displayed a calming approach at all times in the various situations. It was not apparent that the MHN utilised any formal PSI.

Reflective Commentary

This observation demonstrated that the MHN had little time to focus on any formal PSI due to the busyness of the role and the chaotic working environment. The MHN utilised informal therapeutic PSI such as general assessments, educational strategies and management skills. It was clear that the nurse was autonomous and confident and was able to make astute decisions about client care in a professional manner. The nurse was also able to maintain a sense of calmness at all times. It was apparent that the nurse was highly respected by the doctors and the MDT, and that the focus was clearly on communicating nursing actions to the doctors and keeping everyone informed. The nurse demonstrated in her role the ability to carry out quick assessments with clients, which had to be done because of the extra demands

and time constraints of the busy working environment. This observation did note the continuing value of nurse interactions with clients, but also the effect of increasing workloads when trying to engage with clients. The busy environment and the constant flow of clients appeared to be obstacles in that there were no opportunities for the offering of any focused PSI. However, the skills and expertise of the nurse made it possible to manage the environment and still meet clients' needs in the short time while they were in the nurse's care.

6.4.4. Vignette: Observation Four

Context: The following observation was in a busy and demanding ED unit. The PSI-nurse was a clinical nurse specialist in a liaison position, with 1-5 years' experience practising PSI.

Observation Notes by the Researcher: Excerpt

Case 2, participant 29:

Space & Actor: When I arrived at the ED, the nurse was having a conversation with a client at the entrance of an ED cubicle. The nurse was expecting my arrival and came over to me within a few minutes. As we walked through the hospital corridor, the MHN entered a cubicle. The MHN introduced me to the client and permission was sought from the client to sit in on the session.
Behaviour & Goal: The MHN proceeded to talk to the client; it was obvious that this MHN had developed a good therapeutic relationship with the client. The MHN had already seen the client a few hours previously for a follow-up visit, as the client was being prepared for discharge. It was apparent that the MHN had prior knowledge that the client had taken an overdose the previous night. The nurse's approach was compassionate and kind. As we left the cubicle, I noticed the busyness of the ED: people going in all directions, the noise of trolleys and loud hoovers, the constant sound of doctors' pagers going off. The sliding door outside the cubicle was opening and closing continuously as people entered and exited the ED.
Time: This observation was 180 minutes.
Feelings: I did observe that the MHN appeared to be preoccupied. The phone rang approximately five times within a three to four minute span. I was very conscious of my presence and did not want the MHN to feel pressured because of this.
Object: Other nurses asked the MHN for more information about other clients; for example, the nurse had to complete a risk assessment for a client that had been done earlier in the day, which someone wanted within 5 minutes. The unpredictable nature of the nurse's busy role in this environment was obvious, involving the nurse having to multitask and having to remember a lot of detail about clients. In addition, the nurse kept paper records, though I did not notice anything documented in the care plans of clients during this observation. It was also not evident during this observation what the nurse's underpinning approach to care was, but it was difficult for the nurse to do any formal or structured interventions due to the busy working environment and the demands on their role. At the same time, this nurse was very experienced, appeared to have good levels of confidence and was autonomous.

The following is a short Field Note about the observations.

Field Note F by the Researcher:

Case 2, participant 29:

My impression from the observations was that the demands on this MHN's time were enormous. It was observed that this nurse was a central figure in this busy environment and that many other professionals needed advice and expertise about issues in relation to clients with mental health problems. It was evident that this nurse had a lot of important information and knowledge about

voluntary services in the community. The MHN reported to me that many referrals came from doctors and other mental health care professionals for people needing mental health assessments. This MHN was mainly utilising informal PSI approaches such as practical help, liaison, discharges and initiating referrals to appropriate agencies. This observation showed that this MHN had no time to reflect or conduct any formal PSI due to the busy working environment and the demands made on the MHNs role.

Reflective Commentary

This observation clearly demonstrated how the MHN was under pressure in a busy working environment like the ED. As a result, this hindered the MHN from using any formal PSI. The MHN did not appear to have time to fully engage with clients, as it was evident that the MHN was going from crisis to crisis and was in constant demand. However, the MHN was professional, calm and confident when interacting with clients. This observation highlighted the unseen background nature of some nurses' work. Additionally, the MHN was very confident and autonomous, despite the heavy workload, and it was evident that other health care professionals, especially doctors, respected this nurse. This indicated a supportive working environment; however, it was clear at times that the MHN experienced stress due to the extra demands of the role. It is not surprising from this observation that nurses who work in busy environments like the ED have difficulty in documenting their interventions, which can in turn greatly influence how MHNs articulate what they do in practice. There was insufficient time or space for any reflection about the work with clients. This could result in complacent and routine practice where prior experience and intuition is mainly used to base practice. Furthermore, the atmosphere of the environment curtailed this nurse's role; for example, the nurse did not have any control over the number of clients that had to be assessed. These challenges added extra pressures to the MHN's role, which in turn limited engagement with any specific PSI. It is fair to suggest that environments like the ED can curtail the occurrence of PSI, as a result of which PSI-nurses might experience disintegration of skills over time.

6.4.5. Vignette: Observation Five

Context: This observation was of a MDT meeting that took place in a day centre within a community setting. The four MHNs in attendance at the meeting had clients on their caseload for treatment review. The MHNs were located in different geographical sites in the mental health service. The clients presented in the meeting were living at home but were under the care of the consultant psychiatrist who was chairing the MDT meeting. This observation facilitated more clarity concerning how MHNs work on a day-to-day basis in their practice.

Multi-disciplinary Team [MDT] Observation Notes by the Researcher: Excerpt

Case 4

Space & Actor: I met with the DoN in an office before the MDT meeting started. The team comprised four MHNs [including the DoN], a consultant psychiatrist, a social worker and a psychologist. I obtained verbal agreement from all the members at the start to observe the meeting.

Behaviour & Goal: One of the first things that I noticed was how the psychiatrist sat beside a desk, writing notes on her knee while the MHNs sat in a circle around the psychiatrist. They were initially having conversations around mundane topics such as the weather. When the psychiatrist started the meeting, the MHNs appeared to talk about their clients in a relaxed and confident way. They gave reports of the clients, for example, one nurse stated:

'John's [a pseudonym] relationship with his mother is improving, but the reason for that is that his mental health is stabilising. He appears to be settling back well to his home environment after his discharge a month ago. He is compliant with his medications and this was confirmed by his mother. However, his mother has to remind him to take the prescribed medications. He has nothing to do during the day; he only watches TV and listens to music. His mother reported that he is always complaining of feeling tired all the time, but John denies this when he asked about his energy levels etc. His mother also reported that he could stay in bed until she comes home from work in the evenings. He stays alone a lot in his room and has no interest in socialising with friends…'

After this report, the psychiatrist suggested a decrease of the client's medication and a review of the treatment in the outpatient clinic in a few weeks. The psychiatrist appeared to be listening carefully to all the MHNs' suggestions. The psychiatrist's input clearly concerned the treatment for clients in relation to increasing or decreasing medications. The MHNs agreed with the decisions made by the psychiatrist, and did not appear to challenge these or comment upon them.

Time: The observation was 60 minutes.

Feeling: I observed that the MHNs were looking to the psychiatrist for direction, who appeared to dominate all elements of the team decisions as regards treatment options. I did not get a sense that any of the MHNs would disagree with the psychiatrist about any of the treatment decisions. It was noticeable that the MHNs were comfortable for the psychiatrist to make the clinical decisions that were mainly around medications.

Object: This observation indicated that the psychiatrist was fulfilling his/her professional role and that the MHNs recognised their responsibility to client care. It was evident that they were happy with the psychiatrist's direction - the 'doctor knows best' attitude. Neither the social worker nor the psychologist had much input into the meeting. Overall, it was apparent that there was less emphasis on the psychosocial aspects of caring for the clients. Although there was one occasion during the meeting when the team discussed some family issues, this was also in relation to medication issues.

Reflective Commentary

A notable feature of this observation was how all the MHNs were comfortable with the psychiatrist making decisions about the treatment approaches for clients. The core agenda for the team meeting was concerned with these approaches in relation to medications. The observation indicated that the MHNs had good knowledge about their clients; they appeared to put their focus and energy into the medications. I observed that the MHNs did not report if they had undertaken any formal PSI with clients, except in relation to medication management. This could well mean that they did not see that discussing PSI was of interest to the psychiatrist, or indeed relevant to the meeting, which could in turn be due to the existing biomedical culture in mental health services, as often this approach to care can oppress

nurses' confidence and autonomy in speaking at meetings. It would appear from this observation that the MHNs' work curtails individualised practice, where PSI-nurses work alone in an isolated and unreflective way with clients.

6.4.6. Vignette: Observation Six

Context: This observation was with a MHN who was the key worker for a client on an inpatient unit. This MHN had undertaken a postgraduate training programme that comprised two modules on PSI content. Training in supervision skills was not available during the programme of study, and the nurse was not in receipt of clinical supervision.

Observation Notes by the Researcher: Excerpt

Case 1, participant 32:

Space & Actor: When I arrived on the inpatient ward, I noticed that both staff and clients in the lounge were talking, while some clients were watching television, reading the newspaper or asleep on chairs. I did not observe any particular activities going on, but I noticed that the television was very loud. I imagined that this would make concentration difficult for clients and even staff, all of whom seemed oblivious to the noise. I also noticed a client listening to a radio. In addition, some nurses were doing paperwork in a lounge straight across from the nurse's office. The MHN whom I planned to observe was waiting for me in the nurse's office. I followed the nurse into a room that was booked for the session. The room was bright, furnished with comfortable armchairs and a desk in the corner.

Behaviour & Goal: Just as the MHN was to approach the client for the session, another client stopped and asked the nurse a few questions. The MHN had to go back to the office to get something that this client requested. As a result, the client whom the MHN had scheduled to see became very annoyed that the nurse was late. The MHN apologised and offered the client a coffee, which the client declined. However, the client relaxed and the session continued. The client knew that I was coming to observe the nurse and was very comfortable for me to be in the room. The MHN and the client sat on two armchairs directly opposite each other, while I sat in another corner of the room facing the MHN. The client started by telling the nurse a story about her life, during which it turned out that the client had had a miscarriage a year ago. This appeared to be a difficult time for the client as her boyfriend also left around the same time as the miscarriage happened. The client felt at the time that her mood was low, and as a result, it was difficult to attend college on a regular basis. At this point, the nurse was listening very carefully while maintaining good eye contact with the client, who was very tearful. As the session continued, the client reported that it was the first anniversary of the baby. The client wanted to go home and spend some time alone. At this point, the MHN asked more questions to clarify issues and proceeded to find more about the extent of the suicidal thoughts that the client had been reporting since admission. The client hesitated at this stage, remained silent, and became very restless. I noticed a concerned look on the MHN's face; it was clear that there were anxieties about the client leaving the ward. However, the MHN stayed very calm and was very observant of the client's moves and reactions to the questions. It was obvious that the nurse did not feel that the client was ready to leave the ward alone. The nurse informed the client that the psychiatrist was authorised to give permission for home leave. The nurse did not get the opportunity to finish the session as the client walked out. At this point, I felt it was appropriate to leave and thanked the MHN for letting me sit in on the session. I later conducted an interview with the nurse when the nurse had made safe arrangements for the client.

Time: This observation was 90 minutes.

Feelings: I observed that the MHN was rather surprised at the length of the conversation, and I noticed that the client had forgotten about me in the room. It was obvious that the MHN was continually assessing the client and was keeping good communication channels between them both during the conduct of the session.

Object: The MHN did use therapeutic skills such as listening, clarifying and showing genuine interest with this client. This observation emphasised to me the unpredictability and complex nature of client problems. It is not always appropriate to engage in any formal PSI with clients until they are ready to commit and work collaboratively with nurses.

The following is a short Field Note excerpt on this observation.

Field Note G by the Researcher:

Case 1, participant 32:

My impression from this observation was that the MHN appeared shocked by the client's reaction on finding out that the psychiatrist had to give permission for home leave. However, it was apparent that the MHN created a relaxed environment, which helped the client to tell their story. There were some silences in the session, but the nurse appeared to be very comfortable with these and continually engaged the client.

Reflective Commentary

This observation was a planned PSI session that the MHN had organised with a client. This MHN's interactions with the client were sensitively conducted, which highlights the challenges when engaging with distressed service users who are vulnerable. Overall, the observation indicated that the nurse showed good therapeutic engagement and created an informal relaxed atmosphere that enabled the client to feel and talk at ease. There was no formal PSI observed; however, due to the nature of the session, it was apparent that it was difficult, to move beyond the basic therapeutic skills such as empathic and listening skills.

6.4.7.   Vignette: Observation Seven

Context: This observation took place in a day hospital within a community setting. This MHN worked as a CBT therapist within a multidisciplinary team.

Observation Notes by the Researcher: Excerpt

Case 1, participant 23:

Space & Actor: A quiet environment was arranged to conduct the session. The MHN was expecting me and had arranged with the client for me to sit in on the session. The MHN had already negotiated a 10-week CBT programme with the client. This was the third scheduled session. The client had come back to the session with some homework done; this involved the completion of an exposure chart in relation to spiders.

Behaviour & Goal: Once the nurse had settled the client into the session, the client became less anxious. Initially, the client spoke slowly and in a low tone of voice, and did not maintain keep eye contact with the MHN. It became apparent that the client was questioning the treatment plan and was not so happy having been asked by the nurse to touch spiders. The nurse went through the exposure chart and offered the client a lot of praise and encouragement about the hard work in relation to touching the spiders and documenting their feelings. The nurse allowed the client time to talk and maintained good eye contact when appropriate. It was observed that the MHN was constantly checking during the session that the client understood all the information and the tasks. A considerable amount

of attention to the client's feelings in relation to the associated anxiety about the spiders was noticeable.

Time: The duration of the observation was 90 minutes.

Feelings: The MHN used structured CBT strategies. There was a constant focus on the strengths of the client and the MHN provided a lot of positive reinforcement throughout the session.

Object: The MHN suggested the continuation of the exposure chart and agreed another plan with the client. The MHN also introduced relaxation techniques with the client. The client was provided with a relaxation tape along with extra charts. The MHN and the client agreed a date and time for another session.

Reflective Commentary

This observation highlighted that the MHN was using formal CBT interventions with this client. The MHN was skilful in challenging the client to think about ways to overcome their fear of spiders. The purpose of the exposure chart was to guide the client to take control of their anxiety, and to become more aware of their fears. I observed that the MHN documented the interventions immediately after the session. This observation demonstrated that the MHN had good confidence and autonomy and was knowledgeable practising CBT strategies. This could be because this nurse had regular clinical supervision to guide and support practice.

6.4.8. Vignette: Observation Eight

Context: This observation was in an inpatient unit in a side room away from the nurse's station. The MHN was the nominated nurse for the client for the day. This MHN had undertaken a postgraduate diploma in mental health two years previously. The following is a brief Field Note while I was waiting to observe the MHN.

Field Note G by the Researcher: Excerpt

Case 3, participant 9:

The CNM invited me to wait in the office, as the MHN whom I had planned to interview was not ready to see me. I was more than happy to sit and wait. The entire experience brought me back to when I worked on a mental health ward as a MHN ['it was so busy']. As I sat in the office, it formed a useful reminder of the times when I was in charge of units in similar environments. What struck me was how medication was the main issue for nurses. MHNs were constantly in and out of the office looking for medication charts and ringing doctors to review medications for clients. I observed that they were not aware of my presence in the office, as they were all so busy. This observation highlighted for me again the stressful environments in which nurses' work. The effect of these busy environments no doubt influences how nurses interact and use PSI with clients. During this observation, it was noticeable that medications management was the focus.

Observation Notes by the Researcher: Excerpt

Case 3, participant 9:

Space & Actor: I noticed when I first arrived on the ward that the environment appeared very busy; some clients were pacing up and down the corridor of the ward. As I walked up the corridor, I saw a nurse talking to a client. Very similarly, to observation 6, I noticed staff and clients in the ward lounge.

Some clients were communicating with each other, others were reading newspapers/books and some clients were asleep. I did not notice any activities happening, nor did I notice the television on. The lounge environment was certainly quieter than before. The nurse was delayed [hence, the Field Note above]. However, the nurse had already prepared the client for a session. This client was 28 years old and had been admitted to the inpatient unit via a referral from the GP two days previously. This was the client's first presentation to a mental health service.

Behaviour & Goal: The challenge for the MHN was that the client spoke 'pidgin or 'broken' English. The nurse was trying to elicit information to complete the assessment. A translator was not available. It was obvious that the client was getting more distressed as the MHN was probing for more information. The client appeared timid and frightened, and it was obvious that the client had difficulty understanding the nurse. However, the MHN spoke with a warm, soft voice and appeared confident. It was evident that excellent listening and empathy skills were was being utilised. The MHN also documented the assessment on a consistent basis throughout the session.

Time: The observation was for 90 minutes.

Feelings: The nurse appeared uncomfortable at times when it was difficult to understand the client, but the client also looked frustrated due to the communication barrier. However, it was obvious that the nurse was very aware of the client's feelings and as a result attempted to engage therapeutically with the client.

Object: The MHN utilised a care plan to document and guide the assessment.

Field Note H by the Researcher:

Case 3, participant 9:

My impressions were that a translator might have helped the nurse to consolidate the assessment and thus make it easier for the client to talk and feel understood. The interview was probably a strange experience for the client. I noticed that the MHN was informally using therapeutic skills such assessment and engagement. The MHN found it challenging to progress with any specific PSI due to the communication barriers.

Reflective Commentary

This observation highlighted the many challenges that PSI-nurses experience as regards implementing PSI on inpatient units. The MHNs knowledge and awareness of the cultural issues that arose with this client were not clear. The MHN reported in the interview that clinical supervision was not available and there were limited opportunities for on-going education and training within their working context. The next section focuses on the key points from observational data.

6.5.   Key Points from Observational Data

The observed data met objective 2 for the study. This was as follows:

Objective 2: Observe PSI-trained MHNs use of PSI in practice.

In brief, across the four cases, the vignettes illustrate six observations from the community settings and two from inpatient settings (Chapter 4, Table 4.1). The observational data

highlight issues that the researcher might otherwise not have noticed (Chapter 6, 6.4.1 - 6.4.8). Five of the eight observations were similar in that PSI-nurses were engaging in either formal or informal PSI beyond the basic therapeutic interventions. During observation one, it was evident that MI was been delivered in conjunction with other therapeutic skills, such as communication, listening and engagement, while observation two showed that the MHN was delivering anxiety management and psychoeducational approaches in a group setting. However, observation three revealed that the MHN had little time to engage in any formal PSI due to increasing demands and pressures on their role, coupled with the busy clinical environment. Similarly, observation four conveyed that the MHN worked in a busy environment, which also meant that they had limited scope to engage in any formal PSI with clients. Yet, during observation five, it was evident that MHNs did not demonstrate delivering any formal PSI with clients within the multidisciplinary team meeting. Observation six showed similar findings in that no formal PSI were delivered to clients. However, a good therapeutic engagement was evident during the session, while the MHN created an informal relaxed atmosphere that enabled the client to talk at ease. During observation seven, it was evident that the MHN was delivering CBT in a structured way. Observation eight conveyed no evidence of delivering any formal PSI, but informal components of PSI such as assessment and engagement care activities were evident.

Overall, a similarity across the four cases showed that PSI-nurses encountered many obstacles that constrained them from offering or delivering of specific PSI. Many pressures in the working environments was apparent, such as the sheer busyness of the inpatient units meaning that the nurses' time was taken up doing other tasked-related activities that curtailed them in utilising any formal types of PSI with clients. However, the observations highlighted that PSI-nurses who work in community settings appeared to have more time to implement PSI compared to those who worked in the inpatient units. Clients within a hospital setting are likely to experience more acute mental illness symptoms and be on more medication; therefore, they are less able to commit to engaging fully in any specific PSI. Conversely, PSI-nurses who work in community settings had clients on their workload who were more likely to be coping and working towards recovery; thus, these clients were more able to commit to engaging in PSI. While these participants represent those who work in the community versus a hospital setting, the observational data suggested that MHNs were attempting to use PSI in their daily work.

In brief, the observational vignettes provide some insight into PSI-nurses' use of PSI. However, caution is necessary, as the eight observations were only a small snapshot of nurses' everyday practice. It was difficult to obtain a coherent sense of the PSI-nurses' remit during the observations. It is likely that MHNs use other PSI on other days, depending on the needs of clients and the practice environment in which they work.

6.6. Integration of Findings from Data Sets

6.6.1. Introduction

The purpose of this section is to draw together the two main sources of data collection methods that were utilised: semi-structured individual interviews with 40 PSI-trained MHNs and non-participant observation with seven of the 40 PSI-trained nurses. The cross-case analysis allowed similarities and differences among the four cases to emerge.

6.6.2. Outline of Integration of Findings from Data Sets

The integrated findings of both data sets are displayed in Table 6.4. This table is divided into three columns centred on the three main themes and associated sub-themes that were derived from the analysis.

Column one in the table identifies main themes, sub-themes and key findings from the interviews.

Column two in the table identifies the evidence from the observational data associated to the main themes and sub-themes.

Column three in the table highlights the extent of the evidence across both data sets. The integration of data sets resulted in rating the evidence between the data sets across the sub-themes. The evidence to support these was given a rating on a scale of 0-3. For example, the evidence was strong if rated 3; moderate if rated 2; weak if rated 1; and unobserved evidence if rated 0. This template, with the rating scores, was adapted from the literature (Begley *et al.* 2010).

In relation to main theme 1, ('PSI-trained MHNs' understanding of the use of PSI'), the evidence was rated 2, which was moderate pertaining to sub-theme 1 ('Formal and Individualised Application of PSI'). There were fewer similarities in the observational data

compared to the interview data in support of sub-theme 1. A notable similarity was that CBT was the most popular structured intervention used by nurses and the observational data captured a nurse using CBT in a structured way.

In relation to sub-theme 2 ('Informal, unstructured and individualised use of PSI') that was associated to main theme 1, the evidence was a 3 rating, which was strong evidence. This evidence showed that similar data were found both in the interview and in the observational data. Many of the nurses reported using informal, unstructured and individualised approaches of PSI in the interviews and the observational data also identified many examples of informal, unstructured and individualised offerings of PSI.

Regarding main theme 2 ('Facilitating factors supporting the use of PSI by PSI-trained MHNs'), the evidence pertaining to sub-theme 1 ('Supportive culture and working environment') was rated at a 2, which was moderate; this evidence showed that there were facilitators supporting PSI reported in interview data. The observational data did not show as much evidence of the factors supporting PSI in the mental health care settings.

With regard to sub-theme 2 ('Educational needs and training') associated to main theme 2, the evidence received a 2 rating, i.e. moderate evidence. The interview data indicated that many participants found postgraduate education and on-going training was very beneficial in offering and delivering PSI in practice. The observational data showed some evidence that MHNs had knowledge about PSI and was able to show application of skills in practice but the evidence was not as strong as the reported interview data.

In relation to main theme 3 ('Obstacles limiting the use of PSI by PSI-trained MHNs'), the evidence was rated 2, which was moderate evidence pertaining to sub-theme 1 ('Pressured and constrained working environment'). The reported evidence in the interview data showed that there were many obstacles to implementing PSI, due to the stressful environments in which nurses' work. While the observational data also showed direct evidence of obstacles to implementing PSI, the evidence was more apparent in interview data.

As regards sub-theme 2 ('Challenges with engaging unwell service users') that was associated with main theme 3, the evidence received a 'weak' rating of 1. Here, the evidence was not as strong in the observational data compared to the interview data regarding the offering of PSI to service users with serious mental health problems.

Table 6.4: Integration of Findings Across Data Sets		
Interview findings	**Observation findings**	**Comparison of Findings & Evidence rating: 0 = no evidence; 1 = weak; 2 = moderate; 3 = strong**
Theme 1: PSI-trained MHNs understanding of the use of PSI.		
Sub-theme 1: Formal and Individualised Application of PSI PSI-nurses reported some examples of using formal and individualised forms of PSI. The main one used was CBT, where there was a structure and a plan for clients **(Chapter 6, 6.2)**.	Observation one, two & seven **(Chapter 6, 6.4.1; 6.4.2; 6.4.7)** showed similar evidence of formal PSI, anxiety management in a group, motivational interviewing and a CBT session was captured.	**2 - Moderate evidence:** This indicates that some similarities were noted in the observational data compared to the interview evidence in supporting the main theme 1.
Sub-theme 2: Informal, Unstructured and Individualised Use of PSI Many PSI-nurses reported using informal, unstructured and individualised PSI, such as daily activity monitoring, giving time, engagement, assessment, problem solving, medication management and providing education **(Chapter 6, 6.2)**.	Observations three, four, five, six & eight **(Chapter 6, 6.4.3; 6.4.4; 6.4.5; 6.4.6; 6.4.8)** showed similar evidence of informal, unstructured and individualised use of PSI. Examples included providing psychoeducation to clients in relation to their condition and medication issues, motivational interviewing skills, self-management strategies, risk assessment, medication management, engagement and assessment. There was also some evidence of client engagement in relation to goal and non-goal directed activities.	**3 - Strong evidence:** This indicates that there were stronger similarities of evidence in the interview data and the observational data in both data sets in supporting the main theme 1.
Theme 2: Facilitating factors supporting the use of PSI by PSI-trained MHNs		
Sub-theme 1: Supportive Culture and Working Environment Reported evidence indicated that support from managers, colleagues and multidisciplinary teams, PSI guidelines, clinical supervision, role fulfilment of nurses and time were all facilitators to supporting PSI in practice. Less busy environments and decreased workloads/caseloads also created a supportive culture for PSI implementation **(Chapter 6, 6.2)**.	Observations one, two & seven **(Chapter 6, 6.4.1; 6.4.2; 6.4.7)** showed some evidence of facilitators that support PSI use in practice environments, including access to clinical supervision and less busy working environments such as community settings. It was also evident that quiet and suitable environments were suitable for MHNs in the offering of PSI.	**2 - Moderate evidence:** This indicates that there were fewer similarities in the observational data compared to the interview evidence in supporting the main theme 2.
Reported evidence also indicated that the recognition of PSI-nurses' roles is important. Some nurses described the importance of having good confidence and autonomy. Nurses who worked in community settings had more flexibility and control over their workloads. Teamwork and respect for nurses, up-to-date knowledge and skills are important components in increasing autonomy and confidence of nurses.	Observations one, two, three, four & seven showed similar evidence of how the MHNs demonstrated confidence and autonomy using PSI **(Chapter 6, 6.4.1; 6.4.2; 6.4.3; 6.4.4; 6.4.7).**	**2 - Moderate evidence:** This indicates that the reported evidence in the interview data were more obvious than the observational data in supporting the main theme 2.
Sub-theme 2: Educational Needs and Training Reported evidence showed that participants found postgraduate PSI training and booster training and education were key in helping to apply PSI in practice **(Chapter 6, 6.2)**.	All seven observations indicated that MHNs had knowledge about PSI. Specifically, observations one, two and seven showed that MHNs have good knowledge and application of PSI skills **(Chapter 6, 6.4.1; 6.4.2; 6.4.7).**	**2 - Moderate evidence:** This indicates that the reported evidence in the interview data were more apparent than the observational data in supporting the main theme 2.
Theme 3: Obstacles limiting the use of PSI by PSI-trained MHNs		
Sub-theme 1: Pressured and Constrained Working Environment Reported evidence indicated that busy working environments, especially inpatient units, affected PSI-nurses partaking in PSI with service users. They had less time with service users; the busyness took over from	Observations three & four **(Chapter 6, 6.4.3; 6.4.4)** showed similar evidence of pressured and busy working environments, and that MHNs had little time to focus on PSI. In addition, it was evident that a lack of privacy and confidentiality in EDs and inpatient units reduced nurses' time for the use of	**2 - Moderate evidence**: This indicates that the reported evidence in interview data were more apparent than the observational data in supporting the main theme 3.

interacting with them. There was a quick turnaround of service users on the units, which meant that it was challenging to engage largely with service users. The busyness also detracted from documenting care; there was more emphasis on doing tasks. Excessive workloads, large caseload numbers, increasing complex and challenging mental health problems, competing demands on time and skills and increased demands on the mental health services were all obstacles that limited the implementation of these interventions. The inconsistency of staff numbers and poor leadership in the settings also restricted nurses offering PSI. Additionally, the reported evidence indicated that the increased demands on mental health services and reduced resources affected PSI-nurses' roles. Also, the limited access to clinical supervision meant that the nurses were not adequately supported. The decreased opportunities to get practice release for further education and booster training resulted in nurses not having up-to-date knowledge, which decreased MHNs' confidence in delivering PSI. Reported evidence showed that the many of the mental health services continue to have a biomedical focus to care. This influences how PSI-nurses deliver PSI; medical dominance leads to reduced autonomy and confidence of nurses [more evident in the inpatient setting]. Reported evidence indicated that nurses were weak at articulating their roles. Some MHNs are slow to challenge practice. Consequently, MHNs are less visible within the MDTs **(Chapter 6, 6.2)**.	PSI, and that the busyness of the working environment led MHNs to write notes on scraps of paper. Some observations also indicated that MHNs were involved in task-orientated care, which meant that many PSI delivered by MHNs were informal and non-directed. Not all MHNs had access to clinical supervision. Observation five **(Chapter 6, 6.4.5)** showed similar evidence for how psychiatrists can dominate an MDT and make all the decisions about treatment for clients. Medication was a core focus in the MDT discussions. The difference was that the observations showed that the MHNs had good levels of confidence. They also demonstrated a good knowledge about clients' needs.	
Sub-theme 2: Challenges with Engaging Unwell Service Users Reported evidence showed difficulty in engaging clients in formal PSI due to challenging and persistent mental health problems, which meant that MHNs were delivering low-level therapeutic skills. The cultural barriers, literacy problems and cognitive impairments of service users also affected the use of PSI. Also, the adverse effects of medications such as side effects of drowsiness affected how clients engage with the nurses **(Chapter 6, 6.2)**.	Observations two & three **(Chapter 6, 6.4.2 & 6.4.3)** indicated some similar challenges using PSI with unwell service users. One difference was that the observations did not indicate any challenges with service users engaging with the MHNs.	**1 - Weak evidence:** This indicates that there were fewer similarities in the observational data compared to the interview evidence in supporting the main theme 3.

Adapted from SCAPE study Begley *et al.* (2010)

7.   Chapter Seven: Discussion

7.1. Overview

This penultimate chapter presents a synthesised discussion of the findings, which are drawn from the semi-structured interviews and non-participant observations, and the literature reviewed in Chapter 2. This multiple case study set in an Irish context has aimed at exploring PSI-trained MHNs' experiences of using PSI in their care of persons with a mental health problem, underpinned by the interpretive paradigm. The overall findings are discussed through the lens of five research objectives addressed in this study.

1. Explore with PSI-trained MHNs their understanding and interpretation of PSI;

2. Observe PSI-trained MHNs' use of PSI in practice;

3. Explore with PSI-trained MHNs their perspectives on the knowledge and skills necessary for PSI to be used in practice;

4. Examine with PSI-trained MHNs the factors that help or hinder using PSI as an integral part of their role;

5. Present the similarities and differences between PSI-trained MHNs' experiences across all the cases in a cross-case analysis report.

The theoretical writings of Benner (1984) (knowledge and education), Lipsky (1980) (worker training in the public sector), Foucault (1977, 1980, 1988, 2008) (power and knowledge), Goffman (1959) (role performances), Graffam (1979) and Festinger (1957) (cognitive dissonance theory) all offer mechanisms for understanding some of the findings. The discussion informs the suggested recommendations for the study in Chapter 8.

It is evident that PSI are an accepted part of a modern, comprehensive mental health service and are recognised as the most important approach for people with severe mental health problems (SIGN 2005a, NICE 2002, 2004, 2009, 2014). Particularly in Ireland, attention is now focused more sharply than ever before on recovery, along with other contemporary frameworks such as human rights and trauma-informed care. Currently, developments are being pursued to advance recovery-orientated practice in many mental health services across the Republic of Ireland; for example, since 2013 an Advancing Recovery Ireland Project (ARI) has been piloted, supporting six mental health sites in implementing key recovery strategies

(HSE 2013). There is great potential for PSI-nurses going forward to develop a skill set of PSI in line with the recovery movement. To do so will require MHNs to be more proactive in balancing the biomedical model and working in support of those recovery-orientated practices where PSI are embraced and considered as an overarching paradigm within the recovery ethos. If this does not happen, the debate will need to consider the lack of education, knowledge or autonomy in unsupported working environments in which nurse's work. Alternatively, is it possible that MHNs are not fully engaging with the evolving recovery and PSI principles; hence, they are not able to find conduits to make their PSI-nursing roles more explicit within mental health services, according to some of the study findings as discussed below.

7.2. Study Findings

The findings will be critically discussed under the two main themes:

    i.   MHNs understanding of PSI - Knowledge and skills;

    ii. Factors that facilitate or hinder the use of PSI in practice.

These themes will be organised in line with the study's objectives (Section 7.1).

7.3. MHNs Understanding of PSI - Knowledge and Skills

One of the objectives was to explore with PSI-trained MHNs their understanding and perspectives on knowledge and skills for PSI in practice. These study findings have provided a good indication that the lack of PSI knowledge and practical skills can obstruct the offering and implementation of PSI in daily work environments. The findings showed that education and on-going booster training are necessary to increase understanding and developing MHNs' in the delivering PSI to their client groups. These issues are debated in the context of the literature reviewed, under the thematic headings 'PSI Knowledge, Training and Application' 'Practice Release' and 'Policy and PSI'.

7.3.1. PSI Knowledge, Training and Application

It was evident from the findings that most participants had a mixed knowledge and understanding of PSI. This depended on the type of PSI training undertaken by MHNs. In particular, the PSI-nurses with specialised skills in CBT working in community settings conveyed good knowledge levels of the different ranges of PSI. The explanation given by these

participants was that they experienced increased opportunities and exposure in practising the skills, compared to MHNs working in inpatient settings.

A salient finding in this research concerns the extent to which the education and training differ for PSI-nurses. It was clear that all participants had undertaken some form of training in PSI theory and skills (Chapter 5, Table 5.2) and a reasonable representation was interpreted through the study's demographics and from many of the participant responses. Thus, findings indicated that there were many differences in the type of PSI training and education across the four cases; for example, the training that some of the participants had undertaken ranged from basic to advanced types of PSI training (Chapter 5, Table 5.2). Many of the study participants who had undertaken postgraduate PSI-specific courses (Higher Diploma, Postgraduate Diploma, Master's) (n=32) delivered over an 18-month or two-year period, reported that they had gained increased understanding, improved knowledge and skills during the PSI training, which over time helped them to be more confident in applying some of the skills. This finding resonates with previous research that confidence and increased skills are important for the successful implementation and continuation of PSI (Repper 1998, Baker 2000, Bowles 2000, Cleary *et al.* 2005, Jones *et al.* 2005, O'Neill *et al.* 2008, Butler *et al.* 2013). In particular, Butler *et al.*'s (2013) study suggested that, following prolonged training over a year, MHNs were able to implement PSI skills confidently; however, they found that CBT and FI were the least used interventions after the PSI training, as these particular interventions could not always be implemented due to trainees being located in unsuitable work environments. This further supports a salient finding in the current study that also indicated that some of the PSI-nurses were working in unsupportive and unsuitable workplaces. Consequently, this in turn results in the possibility that those MHNs often hold back from using PSI due to the workplace not being conducive to allowing MHNs to implement their skills, with the further potential of MHNs losing such skills more quickly. This outcome compares similarly with a finding in Repper's (1998) research that the students who had completed 12-month postgraduate certificate PSI thorn programme did not always have the opportunities to use the skills taught, as their workplaces were not always suited to PSI-orientated skills.

However, one could argue that for some participants the shorter type courses that PSI-nurses had undertaken did not cover the content about the different types and ranges of PSI in adequate detail, and that there was a lack of in-depth practice of taught PSI skills and training in supervision skills. Consequently, the shorter type courses limit MHNs' use of PSI and suggest that the trainees are not fully equipped with the necessary knowledge and skills to use of PSI.

This was particularly evident in those programmes that did not focus on PSI-specific skills (Chapter 5, Table 5.2). This might further indicate that the implementation of PSI in practice is hardly attainable if the nurses are working from different platforms and with different training, skill sets and expertise.

7.3.2. Practice Release

The findings also convey that many MHNs had experienced difficulty obtaining work release from practice to undertake further booster training on PSI. Some participants reported that management does not often acknowledge the importance of PSI booster sessions; hence, many of the nurses reported that they do not get enough organisational support to do their job adequately. This can result in many of the participants having less confidence in practising the skills with their client groups. These findings are consistent with a recent Irish study conducted by Gaffey & Cooney (2014) that also found that staff had little support in terms of attending educational programmes for recovery. According to Benner (1984), when nurses gain increased knowledge and education, they are more capable of moving into higher levels of skill performance, which in turn results in a more holistic approach being taken in practice. Therefore, in keeping with Benner's (1984) theory, one could suggest that the PSI-nurses in this study who experienced limited opportunities to undertake further education and booster training sessions are more likely to be constrained from becoming experts with higher levels of skill performance in practice contexts. As such, one could infer that they might then be classified as less experienced nurses working from a basic level of knowledge and skills. Accordingly, the findings of this study suggest that the lack of mastery of PSI after shorter training opportunities, lack of organisational support and lack of opportunity to practise the skills, go hand in hand in a way that more than likely generates a vicious cycle for many PSI-nurses in that these repeating conditions discourages the implementation of PSI in the practice settings.

Therefore, one could suggest from the findings in this study that the reality is that the mental health nursing workforce may not be fully equipped for practice, as there are gaps in the provision of training and education to meet the needs of the services. A recent psychiatric/mental health nursing in Ireland (HSE 2012) document states 'that nurses should be confident using PSI and that these skills should be developed through education and skills training (Cusack & Killoury 2012, p. 100). However, one could question should nurses assume a greater responsibility for their own professional development, particularly in light of their demanding roles and responsibilities and policy directives. According to Owen & Fox (2009),

nurses should be accountable for their own educational development so that they are kept updated, thus having the capacity to influence change in practice settings.

7.3.3. Policy and PSI

Nationally and internationally, mental health policy development has been the foundation on which PSI training has been built. As the literature review suggested in the Irish context, it is well known that 'A Vision for Change' provides a blueprint for the modernisation of Irish mental health services. One recommendation of this policy emphasised that there should be a strong commitment to the concept of recovery. Yet, the gap between policy and recovery and its implementation in Ireland remains problematic. Nevertheless, while many of the study's participants welcomed PSI and their relevance to recovery, there is a question whether the participants were strongly committed to this principle, despite the study's demographics indicating that many of the PSI-nurses had trained within the current models of care delivery, i.e. recovery practice. Forty-three percent (n=17) had undertaken PSI training within the last five years. It is, therefore, possible to speculate that this cohort of nurses should be more prepared for the demands of contemporary PSI/recovery mental health nursing practice. One could also infer that the participants who has undertaken PSI training 20+ years ago (12%, n=5) may not be sufficiently equipped or prepared to practise specialised PSI skills as, over time, their skills may have slowly declined if they were not utilised on a regular basis. It is also highly possible that training in the past decades is not in line with current policy thinking and models of recovery-orientated practices.

7.4.   Factors that Facilitate or Hinder the Use of PSI in Practice

A further aim of this study was to examine the factors that facilitate or hinder PSI-trained nurses' use of PSI as an integral part of their role. These factors are discussed in the context of the literature reviewed, under the thematic headings: 'Clinical Supervision'; 'PSI Guidelines'; 'Effects of the Biomedical Paradigm'; 'Impact of Power and Knowledge'; 'Effects of Workload and Casework Demands'; 'Mental Health Issues and Workload'; 'Work Expectations'; 'Effects of the Working Environment'; and 'Challenges Reporting and Documenting PSI Activities'. While the nine theme headings are presented here separately, there is some overlap between them, which will also be explored.

7.4.1. Clinical Supervision

Most of the participants reported that clinical supervision was pivotal in supporting the success of PSI implementation. The findings convey that it was mainly nurses who work as cognitive behavioural therapists in community settings, who had access to on-going clinical supervision. A possible explanation is that there is a mandatory requirement for therapists to seek on-going clinical supervision post-CBT training. While, the inpatient nurses who had completed the generic PSI type training had no mandatory requirements for on-going supervision. The PSI-nurses who had regular clinical supervision believed that they had the ability to enhance their PSI skills; therefore, this led to an increase in their confidence in implementing PSI with their client groups. Other similar PSI studies found that mental health professionals' taught skills increase when they are in receipt of regular clinical supervision in their workplaces (Repper 1998, Milne *et al.* 2001, Bradshaw 2002, Sin & Scully 2008).

In this study, data also referred to the fact that there were clinical supervisors trained up in the services, but there was no recognition that they could provide clinical supervision to other staff. This suggests that potentially valuable expertise and resources are unused. This problem was also reported in Neil *et al.*'s (2010) study that evaluated the provision of supervision within an early intervention team. Neil's study found that participants had experience and skills in supervising others, many of whom were interested in providing PSI supervision, but that they were not allocated the time and training to provide this resource. It is recommended by Neil *et al.* (2010) that staff who are interested in supervising others could promote such supervision as part of their continuing professional development.

The findings in this current study also suggest that PSI-nurses who had undertaken PSI specialist training either within the community or inpatient settings experienced a lack of management support within their workplaces for clinical supervision. These findings lend support to existing research such as Brooker *et al.* (2003), Brooker & Brabban (2004) and Griffiths & Harris (2008) that all identified that clinical supervision was lacking for PSI-trained staff, which affected how PSI was implemented in practice. According to Bradshaw (2002), it is likely that such supervision stops when programmes finish, which can be a barrier to nurses implementing PSI in practice. Furthermore, Butler *et al.* (2013), who explored PSI in mental health nursing practice in Ireland, found similar results that indicated a decreased availability of clinical supervision in practice settings. This means that PSI-nurses have fewer opportunities in their workplaces to develop the skills learned in training. However, a positive step has already been taken in that a recent HSE clinical supervision framework has been published by

the Office of Nursing and Midwifery Service (ONMSD) (HSE 2015) in Ireland with the aim of providing a standardised structure to support mental health services in integrating clinical supervision as part of every nurse's professional role. Perhaps, then, some of the issues in relation to supervision reported in this present study can be addressed within the Irish mental health system on the basis of this HSE framework.

Nonetheless, the question remains; why is clinical supervision not available for all PSI-nurses and why there is such a variance in MHNs' receiving or not receiving clinical supervision? A plausible explanation for the lack and/or variability in quality of clinical supervision is that, as the findings in three cases (1, 3 & 4) reported, the majority of the participants had low managerial commitment and support, along with poor leadership and reduced resources, in driving PSI in those organisations in which nurses work. Other studies have consistently reported on poor leadership and low management support as being unhelpful in the offering of PSI in routine practice (McCann & Bowers 2005, Butler *et al.* 2013). According to Sandstrom *et al.* (2011), nurse managers can have a significant impact on how they influence the culture and context in which nurses work. By contrast, Lipsky (1980), who investigated training in the public sector in the USA, has commented, 'Worker training is less important for practice than the working conditions themselves. Without a supportive network of working peer relationships, training to improve the service capacity of workers is likely to wash out under the pressure of the work context' (p. 200). Thus, in the context of Lipsky's theory, this observation suggests that PSI are compromised not only by lack of supports, such as poor leadership, reduced resources and lack of clinical supervision, but also by pressures to conform to the expectations of the institution.

7.4.2. PSI Guidelines

This study's findings also extend the literature, as it is possible to conclude from the interview and observational data that local PSI guidelines in mental health services can support the implementation of PSI in practice settings. Specifically, in case 1, participants reported that they had PSI guidelines developed within both the inpatient and community settings. These guidelines provided an expectation in the services that all MHNs utilise PSI into routine daily practice with their clients. Routine use of PSI has also been recommended by Mullen (2009). However, participants in cases 2, 3 and 4 did not refer to any PSI guidelines. The participants in case 1 identified that they were provided with support and commitment from management to use PSI post-training for their client groups. This finding is contrary to what other evidence suggests, in that research derived from both Milne *et al.* (2001) and Sin & Scully (2008)

identified management support only during the undertaking of PSI training. Yet the evidence in these current study suggest that the development of PSI guidelines would provide nurses the backing in offering PSI in their daily work, which supports the NICE (2014) clinical guidelines. In 2011, the first national guidelines for PSI were developed by the Swedish National Board of Health and Welfare (NBHW) so that people with schizophrenia had equal access to high standards of care. Sandstrom *et al.* (2011) conducted a qualitative study of professionals' views of these 2011 NBHW guidelines and their implementation in practice. The findings from Sandstrom *et al*'s study showed that the participants had limited knowledge of their content, despite the fact that these guidelines had been in existence for twelve months. In relation to this current study, one could suggest that if guidelines are embedded locally, there is a better chance that nurses will use them to guide practice. However, in order to fully implement PSI guidelines, it would be important that the hierarchical structures are supportive of these within the mental health services.

7.4.3. Effects of the Biomedical Paradigm

Despite the increasing policy emphasis on the importance of recovery in developing Irish mental health services (DoH&C 2006, Mental Health Commission 2007), the findings of the present research conveyed that the mental health sites involved in the study seem to remain encapsulated by many aspects of the biomedical paradigm of care, thereby negatively affecting MHNs' implementation of PSI. Furthermore, what emerges from the participants' stories is that modern MHNs are challenged in that recovery and PSI principles do not fit well with the former medical model. The Irish mental health commission (MHC) survey (2007) support these findings, which highlighted that the medical model was still dominant and, thus, a barrier in promoting recovery-orientated practices. This is also consistent with a publication on behalf of psychiatric/mental health nursing in Ireland (HSE 2012) that stated that the medicalised approach to care is still very much apparent within Irish mental health services. One could claim that this HSE evidence indicates that policy and reality in practice are not the same in Ireland as in the UK and other countries, as what stubbornly persists in Ireland is the traditional 'medical model'. This also suggests that 'recovery' versus the 'biomedical' represent different models of care that have specific foci. In a sense, this can pose issues for the Irish mental health services in that care for services users is less unified, in that service users may have more than two clinicians who work in different directions. This also could mean that this may lead to poor communication and splitting of MHNs by service user groups.

It was also evident from this present study's interview and observational data that there is still a culture of over-reliance on medication prescribed by psychiatrists, particularly on the inpatient units, which further endorses the biomedical paradigm. This finding is comparable with existing literature that show that inpatient services can still be over-reliant on the medical approach to practice (Cutcliffe & Stephenson 2008, Marsh 2010). In addition, a more recent study conducted by Goulter e*t al.* (2015) found that medication activities ranked highest, with more time devoted to administering medications and a very small amount to providing medication-related psychoeducation. Therefore, arguably, the biomedical approach to care is not conducive to the promotion of PSI. Thus, one would speculate, if this biomedical approach remains in its current form, how can recent PSI developments such as the trauma-informed care framework and the recovery movement be visible in the reality of MHNs day-to-day practice.

7.4.4. Impact of Power and Knowledge

Some participants commented that there is a perception that psychiatrists are more knowledgeable than the nurses due to the power that is given to the former. Foucault (1977) stated that dominant discourses are continually forming and maintaining boundaries through the development of power and knowledge. Those working within the discourses of power and knowledge determine who has access to or is deprived of knowledge, and thus who sustains control, while dominated discourses remain at the margins (Foucault 1980). In the context of this study, many participants reported that psychiatrists still hold the control of the care and treatment for service users in clinical settings. Yet, this goes against the Foucauldian model implying that the psychiatrists do not have to 'strive' in this way. In other words, their 'organisation' is already being taken care of in advance by the institutional power. One interpretation might be that psychiatrists still strive to retain an authoritative position in that power constructs their position in advance, meaning that they can practise and work without being challenged (Appendix 1, Part 2, Field Note entry 24). Furthermore, once the belief that one is being observed is internalised, Foucault maintains, one becomes one's own observer, and thus a 'docile' subject willing to comply with disciplinary power (Foucault 1977). In a sense, this can mean that, from some of the participants' comments in this thesis; they are still positioning their practice within the protocols of biomedical approaches that remain rather compressed. This finding corroborates the way some participants reported how they felt, in stating that they did not have the confidence and autonomy to apply PSI skills when some psychiatrists were still dominating care delivery. One could question if MHNs perceive

themselves to have a duty to carry out doctors' orders due to the inherently powerful positions of psychiatrists that can place nurses in weaker positions.

In addition, Foucault (1980) claims that power comes from everywhere, being 'web-like' rather than linear, and permeating everyday life, whereby power and knowledge are combined, each supporting the other. Many dialogues may co-exist, generating 'different truths and different ways of speaking the truth' (Foucault 1988, p. 51). However, these truths are not always seen on the same terms or as having the same power, some having a higher worth than others (Foucault 1980). The dominant discourse may be seen to give an understanding of 'speaking the truth', while the non-dominant discourses generate a (sometimes) conflicting description of the truth. This results in an unequal power dynamic in which communications are centred on hidden struggles for power and claims for truth. As applied to this study, utilising Foucauldian thinking is generally helpful when trying to understand the way in which power is entangled within the mental health services in Ireland, and why some discourses such as those of psychiatrists still gain dominance over the MHNs as reported in these study findings, and how this dominance negatively affects the offering of PSI in the workplaces.

Many other researchers have also recognised that MHNs' knowledge is challenged by the psychiatric system of knowledge (Moncrieff 2008, Frances 2012). One forward-thinking Irish psychiatrist has claimed that disproportionate power to one profession leads to an imbalance that both precludes mutual understanding with other professions and other service users (Bracken 2012). In the context of this study, this inequality can leave nurses feeling less confident in the offering of PSI, in a way that further supports Foucault's (2008) work, who also wrote about psychiatry in terms of the teaching role in mental hospitals and the significance of the 'medical gaze', which he identified as involving an insensitive questioning of patients and the teaching of students in the 'grand round' or clinic as key to the formation of psychiatric power/knowledge. In turn, Foucault (2008) maintained that this 'grand round' teaching reinforces the medical standpoint, and supports the psychiatrist's belief in the validity of 'his or her' knowledge. Such knowledge is taken as 'truthful', and is accepted without question, because the institution of psychiatry speaks (p. 189). This can result in an unchallenged and oppressive culture, as the dominance of the medical model takes precedence over everything else, as explicitly spoken by some participants in this present study.

In an earlier statement in 1959, Goffman, in discussing role performances, recognised two types of behaviour, which he identified as 'reality' and 'contrivance':

> We tend to see real performances as something not purposely put together at all, being an unintentional product of individual's unselfconscious response to the facts in his situation. And contrived performances we tend to see as painstakingly pasted together, one false item on another, since there is no reality which the items of behaviour could be a direct response to (p. 70).

Following Goffman's thinking, this study's findings can relate that, as on the one hand, some PSI-nurses may embrace their role by performing well, thus displaying high levels of PSI skill and commitment. On the other hand, other nurses may just practise skills by imitating or guess work. Nevertheless, one could contend that the latter can be attributed to external or mitigating influences; for example, nurses might distance or disengage themselves from the PSI role they are expected to perform, merely because they do not have the required skill or competency or have lost the confidence to use PSI because of a time lapse between training and being given opportunities to apply the skills. Also, one could further interpret from the study findings that this is an explanation for why many PSI-nurses may not vocalise their expertise. Another notable factor that may impinge on how PSI-nurses' professional identities are perceived is the possibility that the resources driving PSI for service users have been deprioritised over the last decade in Irish mental health services (Mental Health Reform 2015), indicating that there is no mandatory requirement that nurses use PSI as integral to their roles. In relation to the findings, this may in turn reduce the pressure on nurses to be proactive in updating skills and knowledge, further decreasing their confidence within MDTs and wider mental health services.

7.4.5. *Effects of Workload and Caseload Demands*

A common pattern that similarly emerged in participants' comments across the four cases involved the effects of workloads in relation to extra responsibilities outside their PSI roles and high caseload numbers. Many of the participants expressed concern and appeared troubled about how workloads and high caseload numbers were deterrents to embracing PSI in many of the settings. Not unexpectedly, these findings reinforce earlier research that highlighted a low presence of PSI due to increased workloads/caseloads within mental health services, including acute inpatient units (Cleary *et al.* 1999, McCann & Bowers 2005, Butler *et al.* 2013). Additionally, subtle expressions in this study findings showed that MHNs were bound by busy routines particularly on in-patient units that were too focused on stressful task-orientated duties. Consequently, these busy routines tend to prevent PSI happening. This finding is also comparable with existing research (Sin & Scully 2008, Thibeault *et al.* 2010) that refers to acute in-patient units being busy, chaotic, and increasingly challenging in the context of acute psychiatric care. However, many PSI-nurses in this study appeared resigned to the situation

and did not offer any possible solutions as to how they could reduce workloads or numbers on their caseloads with a view to increasing the offerings of PSI. It is also reasonable to conclude that, if there were more pressure on one-to-one PSI sessions, this would reduce MHNs being too absorbed with the task-orientated activities.

On the one hand, however, it could suggest that such acceptance show feelings of powerlessness and helplessness due to extra working demands. This indicates that MHNs' roles are more focused on the task-based activities such as giving orders – from 'it's time for medication' or 'make the bed' to 'serving meals'. These could be considered activities outside the main functions of PSI-nurses, instead of key PSI skills that should be offered, such as working more effectively with service users facilitating self-management and recovery either in a one-to-one or in a group format. On the other hand, chronicity is commonly associated with seriously mentally ill clients (Gournay *et al*. 1997) and therefore this means that, over a period of time, mental health services will potentially accrue larger and larger caseloads as new service users are identified. Yet, the study's participants did not directly report this as an issue. Nevertheless, there is a question of whether forward planning by managers of the services is notably absent or instead MHNs may not be drawing enough attention to reducing workloads and caseloads. Arguably, if PSI skills were to be prioritised by nurses and given more consideration, this could help justify a reduction in client caseload numbers. Furthermore, if there were clearer expectations and consistency in guidelines across the mental health services that every client have PSI offered to them, caseloads could justifiably be considered and reduced to allow the offering of PSI to more client groups.

7.4.6. *Mental Health Issues and Workload*

Many of the participants who participated reported similar experiences in that the clients with multiple and complex mental health issues pose challenges to their workload and hinder the offering of PSI to client groups. Some of the clients can have lower cognitive abilities such as poor memory recall or memory decline, speech deficits, decreased motivation and energy, and be highly disturbed and experiencing side effects due to long-term medication use. Yet, it is also often the MHN's role to engage closely with clients who do not regard themselves as unwell and who need help in treatment. It is not surprising that nurses may be sparing in how much time they can give to PSI with service users who are volatile and acutely unwell. Therefore, it is reasonable to conclude that this client group would need higher-level skills such as CBT or FI. The findings did indicate that PSI-nurses were not always using higher-level skills with those of their clients experiencing severe mental health problems due to on-going

symptoms and associated illnesses, social and family difficulties. These issues further hinder how clients engage with PSI, as they often cannot commit to PSI or indeed attend PSI sessions that are offered by MHNs working in the community, due to financial constraints arising from travelling long distances.

Furthermore, a difference reported in case 2 compared to the other three cases (1, 3 & 4) was the frustration of having waiting lists for unwell clients, meaning that some clients experience a long delay from the initial referral to their appointment time. However, in case 2, the majority of the MHNs were trained cognitive behavioural therapists with high caseloads. The demand for this particular PSI is high within the service, which can explain the waiting lists. However, this issue also emerged from data of a previous study (Prytys *et al.* 2011) that reported long waiting lists for psychological therapy, in which participants described frustrations at the long wait after referral and the problem of clients' situations changing.

7.4.7. Work Expectations

This finding with unrealistic work expectations also offers insight into how some PSI-nurses struggle to meet the demands of their roles. For example, some of the participants reported often felt torn by their obligations toward their PSI responsibilities while being required to do other tasks in their workplace that sometimes involved working within a medical approach to care delivery, without clinical supervision, with limited organisational support and, increasingly, under time constraints. One could assert that this finding is understandable in light of the culture of psychiatry, as traditionally the mental health nursing profession has been subordinate to the power of psychiatry, and MHN training was constructed on the foundation of its association with the medical approach, as a result of which nursing students have been trained in relation to the identification of clinical symptomatology and medication approaches.

However, like the participants in this study, Butler *et al*'s (2013) study reported similar barriers to using PSI such as high caseload demands, decreased availability of clinical supervision and time constraints. In a sense, this could mean that the participants experience 'inner conflict' when their practice is not consistent with their values or level of experience. Cognitive dissonance theory (Festinger 1957) suggests that this 'inner conflict' can be experienced as highly unpleasant. According to De Vries (2009), cognitive dissonance theory can offer a way of understanding individuals' processes of inner conflict, change and resistance to change. In relation to this study, it would be important to put effort into reducing this inner conflict. For example, ideally this would be done by improving practice, in this case advocating for the

active use of PSI. However, the inner conflict can also be reduced in undesirable ways such as denial, trivialisation, shift one's attention away from the inner conflict or seek justifications or excuses. Thus, the application of cognitive dissonance may well provide a mechanism in disentangling MHNs' conflict with the new PSI-orientated practices and their association with traditional practices in the mental health services. In other words, MHNs could experience the inconsistency of practising PSI with other task demands and responsibilities (De Vries & Timmins 2016). Furthermore, De Vries & Timmins' (2016) application could also suggests that being unable to find a solution to both types of dissonance (PSI approaches versus the traditional medical approaches) at the same time would most probably mean that MHNs would experience on-going discomfort in practice.

Similarly, Graffam (1979) uses the term 'cognitive dissonance' to explain 'feeling torn', defined as the discomfort experienced by people trying to meet two or more conflicting demands simultaneously, or who are subject to demands to participate in activities in dispute with their beliefs, thus creating a discernment of incompatibility. When applied to this study, the issue of concern is what leads MHNs to experience a divide between the expectations of services and those of their clients. One could also claim that the study's findings indicate a degree of dissonance between two factors. For instance, some PSI-nurses convey a high commitment to their PSI roles, but, in reality, their PSI roles appear to reflect a different picture in that a custodial ethic is attached to their role rather than one that allows them to being seen as autonomous clinicians with specialised PSI skills. Consequently, the desire to reduce the dissonance results in bargaining with oneself to decrease discomfort or stress or resorting to other actions, such as avoidance of using PSI skills. Hence, MHNs experience dissonance when considering their responsibility in fulfilling their PSI roles, and the challenge that they have in continually managing the other competing workload functions in practice. According to Taylor & Bentley (2005), mental health practitioners often experience 'professional dissonance'. In a sense, this means that, for these findings, the MHNs can feel discomfort arising from the tension/conflict between professional values and expected tasks associated with their job, thus, further supporting De Vries & Timmins' (2016) application of cognitive dissonance theory in practice.

7.4.8. Effects of the Working Environment

One Irish study has referred to mental health settings as being very restrictive in that their climate and culture reflects that of a 'mini-institution' in which only a few therapies or activities were offered (Tedstone Doherty *et al.* 2008, p. 8). This echoes the findings in this

study, in which some MHNs conveyed that they were often obstructed in delivering PSI due to the pressured and constrained working environments in which they worked, and the constant interruptions while working. This was a particular concern for those MHNs working in inpatient environments, which are often subject to on-going change. For example, it is common for these clinical environments to experience nurse shortages, meaning that there is often a quick turnover of nurses and an extra burden on MHNs that often curtail the offering of PSI. These findings of the present study are consistent with the recent mental health reform (2015) report that drew attention to the decrease in nursing staff and commented how this negatively affects the provision of services.

7.4.8.1. Changing of and Articulating Roles

Many participants reported similar findings across the cases that many PSI-nurses are perceived as having 'multi-changing roles' that appear ambiguous within the working environment. These roles can range from that of a generalist nurse who takes on many different roles from key worker to case manager to (the) manager. This continual changing of roles 'shifts [MHNs'] professional identity', which means that their role does not specifically include specialised PSI skills such as CBT or FI, which in turn 'limits their scope to practice' (Figure 7.1) due to the perceived variations connected to these different roles.

Figure 7.1: Multi-changing Roles
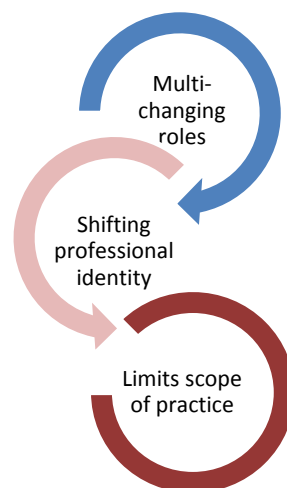
Arguably, if MHNs acknowledge that PSI is integral to their roles, it would be less difficult for them to use PSI. However, this involves a good degree of independence, which needs to be visible among colleagues and the MDTs. As indicated previously, data in this study reveal that many of the PSI-nurses were constrained by the medical approach of working in the

environments in which they work. According to Coffey & Hannigan (2013), it is not clear how nurses can provide care in relation to different ways of thinking and working if they are submerged by the medical approach in their working environments. Hence, if PSI-nurses continue to practise within the prevailing medical model in the absence of alternative models, this model will be the one to which they will resort in explaining their work and providing care, which might restrict how care is delivered (McAllister & Moyle 2008). As a result, this may diminish a MHN's professional identity among other healthcare professionals and MDTs (McAllister & Moyle 2008).

Furthermore, the findings also suggest that some PSI-nurses have difficulty articulating and defining their role due to the wide-ranging definitions of PSI and their wider responsibilities. A possible recommendation is that some PSI-nurses may need to work towards 'letting go' of their existing multi-roles, such as task-orientated work and administrative duties. In other words, their focus should involve a shift away from the task-based way of working to more specialist PSI and recovery-orientated practices. As far back as 1995, Gijbels describes this as nurses becoming 'jacks of all trades'. This suggests that MHNs have generic roles and the focus is on the 'doing' with clients, where 'doing' means using the skills that they have been trained to use. If MHNs focus on the 'doing' (PSI), this will help them to move towards 'taking up' PSI-dedicated specialist roles, and to focus on 'adapting' to their new specialist roles that involve the type of clearer expectations that are transparent among other healthcare professionals and the MDTs. Figure 7.2 illustrates how MHNs can work towards re-defining their role identities.

Figure 7.2: Refining Role Identities
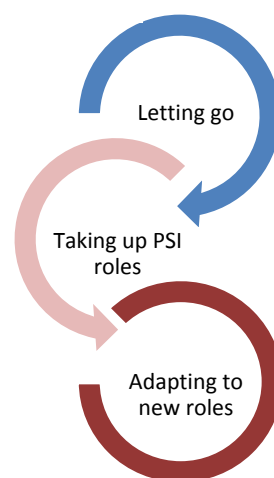
On the one hand, for some of these nurses, an extension of their PSI role might be an impossible undertaking if there is not the adequate organisational support, education and booster training, which leads to further implications for PSI implementation. On the other hand, if MHNs were able to retain and refine their PSI specialist skills in the context of working with other members of the MDT, it is more possible that they would be able to provide higher quality PSI. In a sense, they will not have the wider task-orientated responsibilities, and hence, furthering opportunities to keep up-to-date with recent developments in their field.

7.4.9. Challenges Reporting and Documenting PSI Activities

This study has also yielded valuable insights into the challenges with documentation and their relevance to PSI. It was clear from many of the participants' comments that different variations of care plan documentation are being used across Irish mental health services. The most surprising finding and one that extends the knowledge suggests MHNs are not conscientious in reporting PSI in care plans, meaning that there is an under-reporting of these care activities and further suggesting that little time is being devoted to documenting PSI in service users records. On the one hand, this finding contradicts data in Doyle e*t al.'s* (2007) study that discovered an overall increase in the number of PSI documented in nursing care plans and acknowledged that the PSI training that nurses received had a direct influence on improvement in practice. On the other hand, other research has found that the psychosocial aspect of a nurse's role is difficult to express in nursing records (Hyde *et al.* 2006). Similarly, a mixed-method systematic review by Wang *et al.* (2011) of the quality of nursing documentation suggested that there is a lack of visibility of nurses' work in records. Comparable findings also suggest that recording nursing care is difficult for nurses and that they tend to use their own notes (sometimes on scraps of paper) as a record of care (Hardey *et al.* 2000). When applied to this research, observational data (cf. Observations three, four & seven, Chapter 6) showed that MHNs had difficulty recording PSI due to time constraints. Ireland's Mental Health Reform (2015) report states that care plans are often completed due to their being a mandatory aspect of the nurse's role; however, there is still often a lack of communication between service users and staff.

One could question whether the complex nature of documenting PSI obstructs the MHNs in recording the PSI activities. This leads to the possibility that the therapeutic work done by these nurses is not always communicated and the information is hence not transferred to MDTs, thus further diminishing the credibility of PSI-nurses. Existing research shows that changes in client status are often observed by the nurse first, suggesting that nurses need to

put a strong emphasis on communication and conveying information (Deacon & Fairhurst 2008, Chang *et al.* 2011). Of obvious importance is the fact that nurses are accountable within their scope of practice for documenting interventions carried out and for the impact of interventions on client outcomes (NMBI 2014, Mental Health Reform 2015). In particular, the code for Nursing and Midwives in Ireland (NMBI 2014) explicitly states that nurses need to recognise that effective and consistent documentation is an integral part of their practice and a reflection of the standard of an individual's professional practice. This requires nurses to acquire the knowledge and skill to be able to document the interventions.

Additionally, many participants appeared to accept these weaknesses in terms of reporting PSI and spoke unreservedly about a number of motives for the shortfall in their locations. Their hectic workload was believed to be an obstacle in that their roles were very busy, but this was also be due to the broad nature of PSI and, specifically, what to report. This could mean that many PSI activities that MHNs engage in with service users may not be documented, as they may not acknowledge them as care interventions; for instance, taking a client for a walk or shopping. This is consistent with previous research that found that MHNs have difficulty in defining what they actually do with clients (Barker *et al.* 1999, Happell 2011, Brown *et al.* 2012). Furthermore, the work carried out by Happell (2011) maintains that by MHNs not defining what they do can be seen as an impediment to professional identity and recognition. The invisibility of the nurse's work, according to Pearson (2003), is due to the long tradition of nursing avoiding the written word and an over-reliance on handing down both information and knowledge by word-of-mouth. This can occur during handover rituals, where records and care plans are often not referenced and informal notes are used in verbal reporting to each other. Thus, in this researcher's experience, PSI sometimes occurs in opportunistic ways in that nurses do not often set out to do any formal PSI, but opportunities to do so happen in the clinical area. This often arises when nurses overlook the documenting of the interventions. This begs the question: is a hectic workload or busyness in the working environments an acceptable excuse for not communicating or documenting effectively?

The findings of this study have also confirmed what other researchers have noted: that the burden of paperwork takes MHNs away from direct client care, so that participants have less dedicated time to focus on PSI (Cleary 2014). In a sense, this means that time with service users should have a therapeutic focus, such as PSI. Research has also shown that there is a perception among clients on inpatient wards that nurses appear to be too busy to devote time to them; this, in turn, may lead to clients avoiding therapeutic contact with nurses (Stenhouse

2011, Wyder *et al.* 2015). As applied to this study, this perception can have practice implications in that this further reinforces that MHNs may in turn focus more on the task-orientated care as clients may make fewer demands on them, hence, further reducing the need to report and document care activities.

Yet, in this study's findings, new knowledge also describes why MHNs are not documenting some care. It was evident from some of the participants' comments that unclear language is often used in exchanges between the nurses and psychiatrists. For example, some participants indicated that it is counter-intuitive for the nurse to use a different frame of reference from psychiatrists. Due to such uncertainty, nurses may resist documenting interventions. This may well explain the difficulty that some of the participants in this study experienced in explaining why documentation is overlooked. According to Christensen (2003), nursing language is important for nurses to make sense of their practice and enables effective communication between professionals (Meerabeau *et al.* 1997). Nonetheless, one could claim that recovery is giving nurses another way of describing PSI or another language for using them.

Some of the participants in this present study also understood PSI as something that they would use with service users if they had the time in the working environment. One could argue that nurses may attempt PSI without any structure or focus and when it suits them. This would support Blackburn and Twaddle's worry (1996, p. 253). They stated that, when the therapist is without structure, it is 'like a traveller without a map, or an explorer with no destination, going round in circles and perpetually distracted by immediate objects of potential interest'. As applied to this research, this goes against PSI principles and, according to these findings, arguably, PSI are seen as a supplementary activity (O'Neill *et al.* 2008) and, hence, 'extra work', in that PSI are not viewed as an integral part of the MHN role and responsibilities. Undoubtedly, this can lead to many implications for nurses, particularly if they are practising according to the recovery philosophy, which requires a range of MHNs to be trained and skilled in a repertoire of PSI.

Furthermore, according to this study's findings, nurses also need continued updating of knowledge and skills such as PSI booster training sessions so that they can describe and report PSI interactions adequately. Repper (1998) suggests that PSI training on its own is not good enough. This poses many implications for practice in that nurses' roles will continue to be questioned by other health care disciplines within the MDTs, as there could be ambiguity about their expertise and skills. Most importantly, they will not be truly adhering to their

nurses' scope of practice (NMBI 2014). However, an explanation for this ambiguity could be the fact that many of the participants noted situations where there were different expectations in the mental health services in relation to nurses using PSI. As applied to these research findings, only one case site (case 1) where MHNs worked had clear PSI guidelines and where there was an expectation that nurses were working from a PSI-orientated approach. In contrast, the other three case sites (cases 2, 3 & 4) had no supporting structures on which to base practice; in the absence of support from managers, the nurses used PSI inconsistently and often not at all. In a sense, this suggests that there is no disciplinary requirement for PSI to be offered to service users in these three cases.

7.5. Concluding Remarks

This discussion has thus demonstrated where the findings presented in the thesis have resonated with the PSI literature and the contribution to new knowledge that will assist in informing the recommendations for this research. In making a key contribution to new knowledge, this dissertation is the first study to critique PSI-trained nurses' voiced experiences of using PSI in mental health services in Ireland since the current policy document, 'A Vision for Change'.

The findings do suggest that the PSI-nurses had mixed experiences of using PSI in their day-to-day practice. The overall message in this multiple case study is that there are still problems within an Irish context in the implementing of PSI in practice. There was also a sense of discontent with the lack of updating and supplementary training, which may not be forthcoming. In addition, while study participants were often critical of the barriers to utilising PSI, participants were generally positive and supportive of the need to use PSI with their client groups. The challenge ahead is how to continue supporting PSI-nurses after training to positively influence practice in a recovery-orientated approach or indeed how best to prepare trainees to be PSI-orientated lynchpins in systems of care, as the findings have indicated that the dominance of the biomedical discourse in contemporary mental health care is still featuring in the participants' experiences. One could argue that PSI training for staff can play a pivotal role in transitioning services from a traditional model to a recovery approach to service delivery.

However, despite the numerous strategies and attempts to provide solutions to implementing PSI, there is still a persistent PSI vacuum. It is reasonable to suggest from these findings that a more proactive image of the PSI nurse is needed. Thus, these study findings have contributed

new knowledge from an Irish context, in that one of the most distinctive features of this study is the recommendation of PSI guidelines that offers MHNs support and confidence in implementing PSI with their client groups. The other specific contribution to new knowledge in the findings concerns the issue that some PSI-nurses recognised the under-reporting of their interventions, and indeed sometimes not documenting them at all. Interestingly, PSI-nurses spoke unreservedly about the issue of not documenting PSI, but offered no solutions to improving this important aspect of mental health nursing practice. These study findings help to provide further clarity to clinicians, researchers and policymakers about MHNs' delivery of PSI within an Irish context, with a view to enhancing client experiences and PSI recovery outcomes.

7.6. Study Limitations

There are a number of limitations that should be considered. This section gives careful attention to some of the limitations imposed by the research design of this study. A review of the study's rigour has been presented in chapter four and the methodological approaches have been examined in chapter three.

7.6.1. Methodological Issues

The reason for choosing multiple case study research to address the study's aim and objectives was that it offered greater insight into the environments in four different research sites. However, since it is of partial value outside these environments, one could argue that these study findings are only applicable to the population studied and therefore may not be generalisable. Despite this limitation, it is important to take into account that the study participants worked in a range of mental health settings over large geographical sites and thus it is highly possible that the findings have common application across other mental health care settings. Though, arguably, unless a particularly unusual practice was chosen, there will be relevance for PSI-nurses and those involved with delivering PSI in similar practices. This researcher's personal experience includes working in and visiting many environments with a similar desire for PSI. In addition, the study followed a rigorous methodology (Chapter three) with a large sample.

7.6.2. Method Issues

Multiple case study methodology made it possible to use multiple sources of data that also helped in obtaining deeper and richer data. Yet, the findings could have been strengthened by interviewing service users, as this would have given a greater insight into the issues from their

perspective. Nonetheless, it was not the purpose of this research to seek service users' insights. The concordance between the interview and observation data strengthens confidence in the findings, together with the representativeness of the sample in terms of geographic spread and speciality, which goes a good way to decreasing some of these limitations.

There was also the potential for interviewer bias in the study's interviews. For example, as often happens in PhD studies, the researcher carried out the interviews alone. This meant that strategies needed to be in place from the onset to ensure that the study was conducted transparently. The interview schedule ensured that each MHN had the opportunity to tell their story in the same way, while all nurses were invited to add anything they wished at the end of the interview (Appendix 6). Every effort was made to minimise the potential drawbacks of interviewing, including telephone numbers being given to all the participants, who were advised to contact the researcher if issues arose for them after the interview. Also, following interviews, participants were asked to confirm findings, an experienced researcher was asked to review the extent to which themes were representative of the data.

It was also possible that the observations as a method of data collection could have had a bearing on the MHNs during the clinical encounter with the clients (the Hawthorne effect), in that the participants may have responded in a way to please the researcher. This drawback was avoided (Carr 1994) by informing the participants about the study details in advance, who were given assurances about the guiding ethical principles, such as anonymity and confidentiality (Polit & Beck 2012). Again, every attempt was made to reduce this by not distracting the MHNs during the observations. Additionally, the MHNs and the clients were well informed in advance about the study. The use of reflectivity (Appendix 1) was helpful in maintaining continuous awareness of the research and how it may affect the findings. It can also be acknowledged that illuminating the PSI-nurses' roles can downplay the importance of teamwork and collaborative care. Nevertheless, one could contend that knowledge of the frequency of PSI-nurses' visibility in the literature regarding their skills and expertise within any MDT is fundamental to any proper planning of mental health nursing to meet future healthcare needs.

7.6.3. Validity and Reliability Issues

To ensure that data analysis was not biased, care was taken to fully understand data and allow ideas to emerge during data analysis. NVivo allowed the handling of large amounts of data in a

well-organised and transparent manner. The researcher also worked closely with the supervisors and a qualitative researcher in the development of the coding template that substantiated the data analysis. As in any study, the researcher's former clinical experience and subjectivity could have influenced the data collection and analysis. However, the researcher constantly strove to minimise subjectivity through regular discussions of the analysis journey with academic supervisors and the qualitative advisor. Additionally, reliability was preserved throughout the study by maintaining an audit trail (Appendix 10).

The next and final chapter focuses on the study's contribution to new knowledge and offers recommendations for future research, prior to the conclusion of the thesis.

8.   Chapter Eight: Contribution to New Knowledge & Recommendations

8.1. Introduction

The previous chapter has presented the findings of this research in support of the literature. This final chapter details the contribution of this dissertation to new knowledge, in which recommendations will be offered to meet research objective 6, namely to inform the development of specific recommendations for mental health nursing practice, policy, nursing education and research.

8.2. Contribution to New Knowledge

This dissertation has contributed to new knowledge in a number of ways as summarised below:

8.2.1 First Qualitative Study of PSI-Nurses' Experiences of PSI in a Range of Mental Health Care Settings in Ireland

The most significant contribution of this study is that this research is the first qualitative study that provides an original contribution to the existing literature and knowledge on the voiced experiences of PSI-trained nurses in the Republic of Ireland on utilising PSI in their daily work since the current policy document, 'A Vision for Change'. The other valuable contribution to knowledge is that MHNs were interviewed and observed across inpatient and community care settings. In particular, the interview data gave the perspective of MHNs' insight into the struggle for progress that nurses had in offering PSI in these Irish care settings. The study has also contributed by adding the insight of MHNs' observations of the way that they work with their clients in demanding situations and environments and the challenges in delivering PSI to their client groups. Specifically, this study has contributed to new knowledge by integrating both data sets (interviews and observations) in Chapter 6, section 6.6. The evidence to support these was given a rating. The rating scores were adapted from a template developed by Begley *et al.* 2010.

Thus, the emergent findings have highlighted multifaceted issues in using PSI in Irish mental health services, and the challenges associated with their implementation. As such, this is an original and unique contribution to nursing knowledge. It also adds weight to the empirical evidence (Maruthu *et al.* 2013, Butler *et al.* 2013), using qualitative data in Irish mental health

services, and giving the spectrum of the facilitating factors supporting PSI and the obstacles limiting their use.

8.2.2 First Multiple Case Study on Topic

The work presented in Chapter 3, the methodology chapter, has added to the emerging research base, in regards to which this study is the first that provides an exemplar of executing multiple case study research within an Irish context to explore MHNs' experiences of using PSI. Additionally, an exploration of this topic that utilises multi-method data collection methods in the different settings, across four research sites (cases), has not previously been reported in the literature internationally. Thus, this particular multiple case study methodology helped the researcher to immerse in four different research sites and explored real-life contexts in which PSI happens and has provided an increased understanding of these contexts in which PSI-nurses work in Ireland.

Furthermore, this multiple case study also helps to provide a number of contextual factors likely to influence the effectiveness of PSI in the reality of mental health nursing practice that were not likely to have been obtained from quantitative methods alone. The study presents findings from the four 'subunits of analysis' embedded within the four cases that refer to the PSI and the way in which MHNs offer PSI (Chapter 3, Figure 3.1), triangulated to validate and complement each other to provide an in-depth understanding and interpretation of the study's objectives. Thus, the cross-case analysis of all four cases provided meticulous knowledge about the topic and the extensive analysis identified the similarities and differences between the four cases (Chapter 6, section 6.3), which further helped in answering the study's objectives. So, through this methodology, MHNs knowledge can benefit from a better understanding of the 'how' and 'why' of numerous phenomena [PSI] that have implications for mental health nursing practice and ultimately improve client outcomes. Thus, one could argue that this study has brought multiple case study research to the forefront of mental health nursing research.

8.2.3 First Study in Ireland to Produce Type and Levels of PSI Skills Training

This study is the first to detail the content of PSI curricula across twenty-two programmes, including a PSI curriculum checklist that was separated into the different types and levels of training that PSI-nurses had undertaken in an Irish context (Chapter 5, Table 5.2).

8.2.4 Other Original Contributions

This study reiterated and reinforced a number of previous findings from the literature, which promotes the credibility of the study and suggests that there is transferability of the findings to MHNs and other mental healthcare providers in other jurisdictions with the potential to influence and guide the development of future research. However, and crucially, the findings do appear to have added further depth to some of the reported findings with the literature. This in-depth insight of MHNs' perspectives will also have meaning for PSI-trained nurses internationally.

The findings further suggest that local PSI guidelines can make a difference in helping MHNs employ PSI in practice across both inpatient and community settings. The findings also conveyed that PSI-nurses are not always documenting PSI in care plans, meaning that there is an under-reporting of their PSI activities, which has implications for mental health nursing practice.

Furthermore, another contribution of the present study is through the utilisation of a consistent explanatory trail of the participants' experiences. Hence, the value of this research lies not only in the findings, but also in the involvement of collaborating with PSI-nurses within four research sites that provided an opportunity for the nurses to openly voice their experiences.

8.3. Recommendations

Based on the findings presented in Chapter 6, a set of recommendations to build on the work of PSI within a recovery ethos in the Irish context is made below in relation to management, education, policy and research.

8.3.1. The Role of Managers in Supporting PSI-trained Nurses

It is recommended that:

In order to support PSI-nurses in their role, it is important that management of mental health services commit in a demonstrably meaningful way to the supports that will foster the implementation of PSI, particularly in light of the recovery-orientated practice that is emerging in Ireland.

Explanation

Mental health nurse managers leading the development of PSI are regarded as an important component in supporting PSI-trained nurses. This will require a stronger 'buy-in' from management to support every PSI nurse. Workshops for managers in workplaces should be made more available to explore ways in which students on PSI programmes can develop their roles after training. These workshops could focus on organisational changes such as the provision of a more robust infrastructure that promotes role development and clinical support in the form of on-going clinical supervision. Furthermore, implementation plans and training strategies should be developed so that PSI are placed high on everyone's agendas.

Support in the study

The supports for this in the study suggest managers need to play a more active role in supporting PSI-trained nurses utilising PIS in practice.

8.3.2. Continuing Education

It is recommended that:

MHNs need on-going education and booster training to enhance the implementation of PSI in daily practice.

Explanation

There is a need for increased work release to allow MHNs to attend relevant PSI training courses. Consideration should be given to having regular booster/refresher sessions facilitated by expert PSI trainers that are undertaken on a rotational basis, where every PSI nurse is required to be updated in relevant and appropriate skills that match their caseload and workplace at least every two years. This should start with older trained PSI-nurses, in the first instance, in the different work settings. Moreover, there is a need for protected time out from practice to attend study days and keep up to date with current developments in practice, so that PSI- nurses' knowledge and skills are in line with contemporary PSI/recovery-orientated practice.

Supports in the study

The supports for this in the study suggest that continuing education and training in the form of booster PSI sessions is important for PSI-nurses to help implement PSI in practice.

8.3.3. Content of undergraduate educational programmes

It is recommended that:

Nursing schools should be more proactive in developing undergraduate curriculums that have a focus on PSI and recovery, so that future MHNs is equipped with the necessary PSI skills and knowledge for the practice settings.

Explanation

According to the findings, PSI skills and knowledge should be a core part of the undergraduate curriculum. Where taught universal PSI modules are delivered, they should comprise the same depth of skills and knowledge across curricula so that graduates can implement PSI in an open, confident and competent fashion. This will further help reduce the huge clinical variance in skills and expertise. This also means that nurse educators should review their teaching methods to ensure that MHNs are given educational opportunities to develop higher-level skills in order to meet the needs of clients with complex needs. In addition, contact with mental health service users who have received PSI and who have recovered could be part of the undergraduate training of all undergraduate students.

Supports in the study

The supports for this in the study suggest that the content of undergraduate educational programmes be more PSI focused.

8.3.4. National Guidelines

It is recommended that:

A review of current policies and processes needs to be undertaken with the aim of developing standardised PSI guidelines for MHNs.

Explanation

Local and national guidelines would help a consistent implementation of PSI in practice. In other words, if there were a disciplinary requirement for one-to-one PSI for every service user, this would promote the offering of PSI.

Supports in the study

The supports for this in the study suggest a development of national PSI guidelines to support MHNs implementing PSI in their daily work.

8.3.5. Documenting and Recording

It is recommended that:

Better ways of documenting and recording PSI care activities are warranted.

Explanation

Participants alluded that there is an under-reporting of PSI activities as there was little time devoted to documenting PSI in service user's records. Their hectic workload was believed to be an obstacle in that their roles were very busy, but also the broad nature of PSI and, specifically, what to report.

Supports in the study

The supports for this in the study suggest that PSI-nurses need to be more proactive in documenting PSI activities. This is consistent with their scope of practice.

8.3.6. Policy Development

It is recommended that:

Policies in practice be reviewed that take into account the protection of time for PSI-nurses to update and practise core PSI skills. Mental health job descriptions should specify requirements for PSI-trained nurses with key skills and knowledge in evidence-based interventions, particularly in new clinical areas.

Explanation

The lack of policy direction can be an obstacle in practice for MHNs in that they will not have the support that is warranted to be consistent in using PSI with their client groups.

Supports in the study

The supports for this in the study suggest that MHNs' need more time for on-going education and booster PSI training for MHNs, and the need for policies in support of their work.

8.3.7. Research Developments

It is recommended that:

More focused research needs to be directed to explore service user perspectives on the impact of PSI delivered by nurses. Additionally, it would be good practice for PSI to be audited within Irish mental health services.

Explanation

This study has exposed the need for further research into the service user perspective, particularly from an Irish perspective. This would add to and complement the MHNs' perspective, thus contributing to the knowledge base and help measure service user outcomes.

Supports in the study

The supports for this in the study suggest an exploration of the service user perspectives on the offering of PSI delivered by nurses, and auditing of PSI in providing evidence of the extent of PSI implementation, and their sustainability in practice settings.

8.4. Future Research Directions

To conclude the chapter and thesis, the following is suggested as directions for further research.

The therapeutic role of MHNs is of increasing importance in regard the quality of care for people with serious and on-going mental health problems. However, the success of implementing PSI in the mental health services will need careful consideration of many factors; for example, how PSI-nurses are trained and supported post-training will be a challenge in the future. Thus, it is hoped that these findings can serve to stimulate action around the urgent need for regular on-going booster/refresher skills updates post-PSI training for nurses, in conjunction with regular clinical supervision for all MHNs. According to Travelbee (1971, p. 19), psychiatric nurses need to work with an 'educated heart and an educated mind'. Thus, to nurture the heart of practice, nurses must engage in more dialogue around their expertise and the specialist skills that they use in practice. This can only be achieved if managers are proactive in leading and developing training strategies and implementation plans so that PSI are placed high on everyone's agendas in the mental health services, as stipulated in the recommendations. The researcher will, therefore, undertake a further study to gather a more in-depth perspective on some of the obstacles identified in these study findings.

Selecting this topic for a Ph.D. study has helped the researcher to work more closely with key stakeholders in the mental health field. As a result, this researcher will help progress towards a closer link between research and practice, with a view to facilitating MHNs, stakeholders, educational institutions and policy planners to formalise and regularise PSI in line with the

recovery agenda. A study investigating the impact of PSI from the perspective of service users should be undertaken so that research that is more comprehensive can be obtained to improve service users' outcomes in Ireland.

It is important to return to the question of whether or not the overall thesis has fulfilled its aim, namely, exploring PSI-trained MHNs' experiences of using PSI. This study has clearly met all the study's objectives pertaining to the overall aim so that the overall aim is fulfilled. The original contribution has been detailed that this thesis makes to new knowledge. This is the first piece of research in which MHNs have been asked to share their experiences of using PSI in practice employing a multiple case methodology.

The research does not pretend to be definite; by its very nature it needs to be constantly updated. Thus, this research could be seen as a testimony of a beginning rather than an end. A review of the international literature indicates that the issues highlighted in this study are not limited to the Irish context and that nurses globally encounter similar challenges in their working contexts. This has to be considered in light of the fact that on-going care still has to be organised and delivered for the duration of the person's lifetime.

Though inherently challenging, it is hoped that this multiple case study has yielded adequate insights and contributed to new knowledge of what it is like to be a trained PSI nurse on a day-to-day basis in practice. This researcher hopes that this multiple case study and the related thesis make a difference to the work of MHNs and their clients that they compassionately care for. This real difference can be referred to as 'praxis', according to Lather (1991). This author suggests that:

> We consciously use our research to help participants understand and change their situations (p. 57). (Appendix 1, Part 1, Reflective entry 15).

The Irish Mental Health Reform and Mental Health Ireland have expressed interest in taking this work further, in line with developing regulations around psychological therapies within Ireland. From this perspective, the researcher completes this thesis by advocating that mental health care services takes the responsibility for implementing PSI, in the hope that MHN clinicians and researchers will take up this challenge.

9. References

Abma T.A. & Stake R.E. (2014) Science of the particular: An advocacy of naturalistic case study in health research. *Qualitative Health Research* **24**(8), 1150-1161.

Adler PA & Adler P. (1987) *Membership roles in field research.* Sage, Newbury Park, CA.

Adler P.A. & Adler P. (1998) *Observational Techniques. In Collecting and Interpreting Qualitative Materials*. (Denzin N.K. & Lincoln Y.S., eds), Sage, London, 79-110.

Agee J. (2009) Developing qualitative research questions: a reflective process. *International Journal of Qualitative Studies in Education* **22**(4), 431–447.

An Bord Altranais (1994) *The future of nurse education and training*. An Bord Altranais, Dublin.

An Bord Altranais (2007) *The Guidance to Nurses and Midwives Regarding Ethical Conduct of Nursing and Midwifery Research*. An Bord Altranais, Dublin.

Anderson C.M., Hogarthy G. & Reiss D.J. (1980) Family management of adult schizophrenic patients: A psychoeducational approach. *Schizophrenia Bulletin* **6**, 490-505.

Anthony S. & Jack S. (2009) Qualitative case study methodology in nursing research: An integrative review. *Journal of Advanced Nursing* **65**(6), 1171-1181.

Argyle M. & Kendon A. (1967) The experimental analysis of social behaviour. In L. Berkowitz (Ed) *Advances in Experimental Social Psychology*, Volume 3, Academic Press, New York.

Aveyard H. (2007) *Doing a Literature Review in Health and Social Care – A Practical Guide*, (1st edn). Open University Press, Milton Keynes Berkshire, UK.

Azeem M., Aujla A., Rammerth M., Binsfeld G. & Jones R.B. (2011) Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing* **24**(1), 11-15.

Bailey R., Burbach F.R. & Lea S.L. (2003) The ability of staff trained in family interventions to implement the approach in routine clinical practice. *Journal of Mental Health* **12**(2), 131-141.

Baker J.A. (2000) Developing psychosocial care for acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing* **7**(2), 95-100.

Barker P., Jackson S. & Stevenson C. (1999) The need for psychiatric nursing: towards a multidimensional theory of caring. *Nursing Inquiry* **6**(2), 103-111.

Barker P. & Buchanan-Barker P. (2005) *The tidal model: A guide to mental health professionals*. Brunner-Routledge, Taylor & Francis Group, Hove, New York.

Barks C. (1997) *The essential Rumi: Translations by Coleman Barks with John Moyne.* Castle Books, Edison, New Jersey.

Barnett J.E. & Neel M.L. (2000) Must all psychologists study psychopharmacology*? Professional Psychology, Research and Practice* **31,** 619-27.

Bates J., Boote J. & Beverly C. (2004) Psychosocial interventions for people with milder dementing illness: a systematic review. *Journal of Advanced Nursing* **45**(6), 644-658.

Bateson G. (1980) *Mind and nature: A necessary unity*. Bantam Books, Toronto.

Bazeley P. & Jackson K. (2013) *Qualitative Data Analysis with NVivo*. Sage, London.

Bazeley P. (2007) *Qualitative Data Analysis with NVivo.* Sage, Los Angeles.

Beck A.T., Rush A.J., Shaw B. & Emory G. (1979) *Cognitive Therapy for Depression*, Guildford Press, New York.

Becker H.S. & Geer B. (1970) Participant Observation and Interviewing: A comparison. In *Qualitative Methodology: First hand Involvement with the Social World*. (Filstead W.J. ed), Chicago, Markham, 133-142.

Begley C., Murphy K., Higgins A., Elliott N., Lalor J., Sheerin F., Coyne I., Comiskey C., Normand C., Casey C., Dowling M., Devane D., Cooney A., Farrelly F., Brennan M., Meskell P. & MacNeela P. (2010) *Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner Roles in Ireland (SCAPE) Final Report.* National Council for the Professional Development of Nursing and Midwifery in Ireland, Dublin.

Benner P.A. (1984) *From novice to expert: Excellence and power in clinical nursing practice*. Addison-Wesley, Menlo Park.

Birchwood M. (1983) *Family coping behaviour and the course of schizophrenia*. Dissertation University of Birmingham.

Birchwood M., Smith J. & Cochrane R, (1990) The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *British Journal of Psychiatry* **157**, 853-859.

Birchwood M. & Tarrier N. (1994) *Psychological management of schizophrenia.* Wiley, London.

Blackburn I.M. & Twaddle V. (1996) *Cognitive Therapy in Action*. Souvenir Press, London.

Bloom B.S. (1956) *Taxonomy of Educational Objectives. Handbook I: The Cognitive Domain*. David McKay CoInc, New York.

Boblin S.L., Ireland S., Kirkpatrick H. & Robertson K. (2013) Using Stake's qualitative case study approach to explore implementation of evidence-based practice. *Qualitative Health Research* **23**(9), 1267-1275.

Bond G.R. & Campbell K. (2008) Evidence-based practices for individuals with severe mental illness. *Journal of Rehabilitation* **74**(2), 33-44.

Booth J. (2015) Observation. In *The Research Process in Nursing*, 7th edn. (Gerrish K & Lathlean J. eds), John Wiley & Sons, Ltd, Chichester, West Sussex, UK, 427-439.

Borckardt J.J., Madan A., Grubaugh A.L., Danielson C.K., Pelic C.G., Hardesty S.J., Hanson R., Herbert J., Cooney H., Benson A. & Frueh B.C. (2011) Systematic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital. *Psychiatric Services* **62**(5), 477–483.

Bowen G.A. (2008) Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research* **8**(1), 137-152.

Bowers L., Simpson A. & Alexander J. (2005b) Real world application of an intervention to reduce absconding. *Journal of Psychiatric and Mental Health Nursing* **12** (2), 598-602.

Bowles A. (2000) Therapeutic nursing care in acute psychiatric wards: engagement over control. *Journal of Psychiatric and Mental Health Nursing* **7**(2), 179-184.

Bracken P. (2012) Psychiatric power: A personal view. *Irish Journal of Psychological Medicine* **29**(1), 55-58.

Bradshaw T. (2002) Training and Clinical Supervision. In Harris N., Williams S. Bradshaw T. (Eds) *Psychosocial Interventions for People with Schizophrenia: A practical guide for mental health workers*. Palgrave MacMillan, Basingstoke.

Bradshaw T., Butterworth A. & Mairs H. (2007) Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric and Mental Health Nursing* **14**(1), 4-12.

Brennan D. (2014) *Irish Insanity 1800:2000,* Routledge, Oxon*:* UK and New York: USA & Canada.

Bringer J.D., Johnston L.H. & Brackenridge C.H. (2004) Maximising transparency in a doctoral thesis 1: The complexities of writing about the use of QSR*NVivo within a Grounded Theory study. *Qualitative Research* **4**(2), 247-265.

Brooker C. & Brabban A. (2004) *Measured Success: A Scoping Review of Evaluated Psychosocial Interventions Training for Work with People with Serious Mental Health Problems.* National Institute of Mental Health. Trent, UK.

Brooker C. & Butterworth A. (1991) Working with families caring for a relative with Schizophrenia, the evolving role of the psychiatric nurse. *International Journal of Nursing Studies* **28**(2), 189-200.

Brooker C. & Butterworth A. (1993) Training in psychosocial intervention: the impact on the role of community psychiatric nurses. *Journal of Advanced Nursing* **18**(4), 583-590.

Brooker C. & Repper J. (1998) *Serious Mental Health Problems in the Community, Policy, Practice and Research*. Bailliere Tindall, London.

Brooker C. (2002) A decade of evidence-based training for work with people with serious mental health problems: progress in the development of psychosocial interventions. *Journal of Mental Health* **10**(1), 17-31.

Brooker C., Tarrier N., Barrowclough C., Butterworth A. & Goldberg D. (1992) Training community psychiatric nurses for psychosocial intervention. Report of pilot study. *British Journal of Psychiatry* **160**, 836-844.

Brooker C., Falloon I., Butterworth B., Goldberg D., Graham-Hole V. & Hillier V. (1994) The outcome of training community psychiatric nurses to deliver psychosocial intervention. *British Journal of Psychiatry* **165**(2), 222-230.

Brooker C., Molyneux P., Deverill M. & Repper J. (1997) An audit of outcome and costs in the Tameside rehabilitation team: report of a pilot study. *Journal of Mental Health* **6**(5), 491-502.

Brooker C., Saul C., Robinson J., King J. & Dudley M. (2003) Is training in psychosocial interventions worthwhile? Report of a psychosocial intervention trainee follow-up study. *International Journal of Nursing Studies* **40**(7), 731-747.

Brown G.W., Birley J.L. & Wing J.K. (1972) Influence of family life on the course of schizophrenia disorders: a replication. *British Journal of Psychiatry* **121**(562), 241-258.

Browne G., Cashin A. & Graham I. (2012) The therapeutic relationship and mental health nursing: it is time to articulate what we do. *Journal of Psychiatric and Mental Health Nursing* **19**(9), 839-843.

Bryman A. & Cassell C. (2006) The researcher interview: a reflective perspective. *Qualitative Research in Organisations and Management* **1**(1), 41-55.

Butler M.P., Begley M., Parahoo K. & Finn S. (2013) Getting psychosocial interventions into mental health nursing practice: a survey of skill use and perceived benefits to service users. *Journal of Advanced Nursing* **70**(4), 866-877.

Callaghan P. (2009) Introduction: mental nursing past, present, and future. In *Mental Health Nursing Skills.* (Callaghan P. & Cooper L. eds), Oxford University Press. Oxford. Chapter 1, 2-7.

Carolan C.M., Forbat L. & Smith A (2016) Developing the DESCARTE Model: The design of case study research in health care. *Qualitative Health Research* **26**(5), 626-639.

Carpenter J., Milne D., Lombardo C. & Dickinson C. (2007) Process and outcomes of training in psychosocial interventions in mental health: A stepwise approach to evaluation. *Journal of Mental Health* **16**(4), 505-520.

Carr L.T. (1994) The strengths and weaknesses of quantitative and qualitative research: what method for nursing? *Journal of Advanced Nursing* **20,** 716-721.

Casey D. (2004) Challenges of collecting data in the clinical setting. *Nursing Times Research* **9**, 131-141.

Casey D. & Houghton C. (2010) Clarifying case study research: examples from practice. *Nurse Researcher* **17(**3), 41-51.

Chang C.W., Huang H.C., Chiang C.Y., Hsu C.P. & Chang C.C (2011) Social capital and knowledge sharing: effects on patient safety. *Journal of Advanced Nursing* **68**(6), 1793-1803.

Charmaz K. (2006) *Constructing Grounded Theory*. Sage, London.

Christensen J. (2003) An introduction to nursing language. In *Naming Nursing: ACENDIO Ireland/UK Conference.* (Clark J. ed), Verlag Hans Huber, Swansea, 57-70.

Clarke D. (2009) Using qualitative observational methods in rehabilitation research: Part one. *International Journal of Therapy and Rehabilitation* **16**(7), 362-369.

Clarke C., Reed J. & Keyes (2015) Case Study Research. In: Gerrish K. & Lacey A. *The Research Process in Nursing.* 7th edn. Wiley Blackwell, London, 279-290.

Cleary M., Edwards C. & Meehan T. (1999) Factors influencing nurse-patient interaction in the acute psychiatric setting: an exploratory investigation. *Australian and New Zealand Journal of Mental Health Nursing* **8**(3), 109-116.

Cleary M., Freeman A., Hunt G.E. & Walter G. (2005) What patients and carers want to know: an exploration of information and resource needs in adult mental health services *Australian and New Zealand Journal of Psychiatry* **39**(6), 507-513.

Cleary M. (2014) The 'buzz' about evidence-based practice in psychiatric-mental health nursing. *Journal of Psychosocial Nursing and Mental Health Services* **52**(3), 3-4.

Coffey M. & Hannigan B. (2013) New roles for nurses as approved mental health professionals in England and Wales. *International Journal of Nursing Studies* **50**(10), 1423-1430.

Cohen L., Manion L. & Morrison K. (2011) *Research Methods in Education*, 6th edn. Routledge/Falmer, London.

Corbetta P. (2003) *Social Research: Theory, Methods and Techniques*. Sage, London.

Corrigan P., McCracken S., Edwards M., Brunner K., Backs A., Rashid F. & Farmer R.D. (2001) Organisational correlates to staff attitude about behavioural programs. *Behaviour Change* **18(2)**, 114-123.

Corrigan P., Kwartarini W. & Pramanan W. (1992) Staff perceptions of barriers to behaviour therapy at a psychiatric hospital. *Behaviour Modification* **16**, 132-144.

Cowman S., Farrelly M. & Gilheaney P. (2001) An examination of the role and function of the psychiatric nurse in clinical practice in Ireland. *Journal of Advanced Nursing* **34**(6), 745-753.

Creswell J.W. (1998) *Qualitative Inquiry and Research Design: Choosing Among the Five Traditions.* Sage, Thousand Oaks, CA.

Creswell J.W. (2003) *Research design: Qualitative, quantitative, and mixed methods approaches.* 2nd edn. Sage, London.

Creswell J.W. (2007) *Qualitative inquiry and research design: Choosing among five approaches.* 3rd edn. Sage, Thousand Oaks, CA.

Criminal Lunatics (Ireland) Act (1838-1867) Retrieved from https://en.wikipedia.org/wiki/Criminal_Lunatics_(Ireland)_Act_1838 on 9th January 2016.

Cronin C. (2014) Using case study research as a rigorous form of inquiry. *Nurse Researcher* **21**(5), 19-27.

Cronin P., Ryan F. & Coughlan M. (2007) Undertaking a literature review: a step-by-step approach. *British Journal of Nursing* **17**(1), 38-43.

Crotty M. (2003) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Sage, London.

Crowe M., Whitehead L., Wilson L., Carlyle D., O'Brien A., Inder M. & Joyce P. (2010) Disorder-specific psychosocial interventions for bipolar disorder: a systematic review of the evidence for mental health nursing practice. *International Journal of Nursing Studies* **47**(7), 896-908.

Crowe S., Creswell K., Roberson A., Huby G., Avery A. & Sheikh A. (2011) The case study approach. *BMC Medical Research Methodology* **11**(100), 1-9.

Curran J. & Brooker C. (2007) Systematic review of interventions delivered by UK mental health nurses. *International Journal of Nursing Studies* **44**(3), 479-509.

Cusack E. & Killoury F. (2012) *A Vision for Psychiatric/Mental Health Nursing – A Shared Journey for mental health care in Ireland.* Office of the Nursing & Midwifery Services Director, Health Services Executive, Dublin.

Cutcliffe J. & Stevenson C. (2008) Never the twain? Reconciling national suicide prevention strategies with the practice, educational, and policy needs of mental health nurses (Part one). *International Journal of Mental Health Nursing* **17**(5), 341-350.

Dash N.K. (2005) Selection of the research paradigms and methodology. Retrieved from https://www.celt.mmu.ac.uk/researchmethods/Modules/Selection_of_methodology/ on 6th May 2016.

Davis J., Rawana J. & Capponi D. (1989) Acceptability of behavioural staff management techniques. *Behaviour Research & Therapy* **4**, 23-44.

Deacon M. & Fairhurst E. (2008) The real-life practice of acute inpatient mental health nurses: an analysis of 'eight interrelated bundles of activity'. *Nursing Inquiry* **15**(4), 330-340.

Deady R. (2005) Psychiatric Nursing in Ireland: A phenomenological study on the attitudes, values, and beliefs of Irish trained psychiatric nurses. *Archives of Psychiatric Nursing* **19**(5), 210-216.

Denzin N.K. & Lincoln Y.S. (1998) *Strategies of Qualitative Inquiry (Volume 2 of The Handbook of Qualitative Research)*. Sage, London.

Denzin N.K. & Lincoln Y.S. (2003) *Strategies of qualitative inquiry.* 2nd edn. Sage, London.

Denzin N.K. & Lincoln Y S. (2011) Part II: Paradigms and perspectives in contention. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., 91-227). Sage, Thousand Oaks, CA.

Department of Health & Children (DoH&C) (1984) *The Psychiatric Services – Planning for the future.* Stationery Office, Dublin.

Department of Health & Children (DoH&C) (1992) *Patients' Charter.* Stationery Office, Dublin.

Department of Health & Children (DoH&C) (1995) White Paper; A New Mental Health Act. 5-11.

Department of Health & Children (DoH&C) (2001) *Mental Health Act 2001*, Stationery Office, Dublin.

Department of Health & Children (DoH&C) (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy.* Stationery Office, Dublin.

Department of Health (Ireland) (DoH) (1945) *Mental Treatment Act*. Stationery Office, Dublin.

Department of Health (DoH) (2001) *Treatment Choice in Psychological Therapies and Counselling*. Department of Health, United Kingdom.

Department of Health (DoH) (2004) *Organising and delivering psychological therapies*. Department of Health, United Kingdom.

Department of Health (DoH) (2006a) *From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing*. HMSO, London.

Department of Health (DoH) (2014) Department for International Development How to note. Retrieved from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/291982/HTN-strength-evidence-march2014.pdf on 20th April 2014.

Devane S., Haddock J., Lancashire S., Bagguley I., Butterworth C., Tarrier N., James A. & Molyneux P. (1998) The clinical skills of community psychiatric nurses working with patients who have severe and enduring mental health problems (an empirical analysis). *Journal of Advanced Nursing* **27**(2), 253-260.

De Vries J.M.A. (2009) The 'Cognitive Dissonance Meme' and Psychotherapy. *Inside Out,* Issue 57, Spring edn.

De Vries J.M.A & Timmins F. (2016) Care erosion in hospitals: Problems in reflective nursing practice and the role of cognitive dissonance. *Nurse Education today* **38**, 5-8.

Doyle M., Kelly D., Clarke S. & Braynion P. (2007) Burnout: The impact of psychosocial interventions training. *Mental Health Practice* **10**(7), 16-19.

Drake P., Shanks G. & Broadbent M. (1998) Successfully completing case study research: combining rigour, relevance and pragmatism. *Information Systems Journal* **8**(4), 273–289.

Drury V., Birchwood M. & Cochrane R. (1996) Cognitive therapy and recovery from acute psychosis: A controlled trail 1: Impact on psychotic symptoms. *British Journal of Psychiatry* **169**(5), 593-601.

Edvardsson D. & Street A. (2007) Sense or no-sense: the nurse as embodied ethnographer. *International Journal of Nursing Practice* **13**(1), 24-32.

Eisenhardt K.M. (1989) Building theories from case study research. Academy of Management Review **14**(4), 532-550.

Eisenhardt K.M. & Graebner M.E. (2007) Theory building from cases: Opportunities and challenges. *Academy of Management Journal* **50** (1), 25-32.

Ekers D.M., Lovell K. & Playle J.F. (2006) The use of CBT based, brief, facilitated self-help interventions in primary care mental health service provision: Evaluation of a 10-day training programme. *Clinical Effectiveness in Nursing* **9**(1), 88-96.

England M. (2007) Efficacy of cognitive nursing intervention for voice hearing. *Perspectives in Psychiatric Care* **43**(2), 69-76.

Ericsson K.A. & Simon H.A. (1993) *Protocol analysis: Verbal Reports as Data*. MIT Press, Cambridge.

European Higher Education Area (Bologna Declaration) (1999), *Joint Declaration of the European Ministers of Education*, *Bolog*na, 19 June 1999. Retrieved from: http://www.tandfonline.com/doi/pdf/10.1080/03797720802522627?needAccess=true on 23rd April 2014.

Everitt J. (1999) *The Psychosocial Intervention Skills List. University of Manchester.* Manchester. Unpublished.

Ewers P., Bradshaw T. & McGovern J. (2002) Does training in psychosocial interventions reduce burnout rates in forensic nursing? *Journal of Advanced Nursing* **37**(5), 470-476.

Fadden G. (1997) Implementation of family interventions in routine clinical practice following staff training programs: a major cause for concern. *Journal of Mental Health* **6**(6), 599-612.

Fadden G. (1998a) Family Interventions in Psychosis. *Journal of Mental Health* **7**(2), 115-122.

Fadden G., Brooker C. & Repper J., (eds.) (1998) *Community Mental Health Services for People with Serious Mental Health Problems: Policy, Practice and Research*. Bailliere Tindall, London.

Fadden G. & Heelis R. (2011) The Meriden family programme: Lessons learned over 10 years. *Journal of Mental Health* **20**(1), 79-88.

Falloon I., Boyd J.L., McGill C.W., Razani J., Moss H.B. & Gilderman A.M. (1982) Family management in the prevention of exacerbation of schizophrenia: A controlled study. *New England Journal of Medicine* **306**(24), 1437-1440.

Farhell J. & Cotton S. (2002) Implementing psychological treatment for psychosis in an area mental health service: the response of patients, therapists and managers. *Journal of Mental Health* **11**(5), 511-22.

Fennell P. (1996) *Treatment Without Consent; Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*. Routledge, 148-167.

Festinger L. (1957) *A Theory of Cognitive Dissonance*. Harper & Row, New York.

Fielding N.G. & Lee R.M. (1998) *Computer Analysis and Qualitative Research.* Sage, London.

Fisher J.E. (2014) The use of psychological therapies by mental health nurses in Australia. *Journal of Psychiatric and Mental Health Nursing* **21**(3), 264-270.

Fleet M. (2004) Assertive Community Treatment with People with Experiencing Serious Mental Illness. *In Mental Health Nursing – Competencies for Practice*. (Kirby S.D., Hart D.A., Cross D. & Mitchell G., (eds), Palgrave MacMillan, Great Britain, p, 335.

Flyvbjerg B. (2006) Five misunderstandings about case-study research *Qualitative Inquiry* **12**(2), 219-245.

Fontana A. & Frey J (1994) Interviewing, the art of science. In: Denzin N. Lincoln Y. (eds) *The Handbook of Qualitative Research*, Sage. Thousand Oaks, CA.

Forrest S. & Masters H. (2004) Evaluating the impact of training in psychological interventions: a stakeholder approach to evaluation – Part 1. *Journal of Psychiatric and Mental Health Nursing* **11**(2), 194-201.

Forrest S., Masters H. & Milne V. (2004) Evaluating the impact of training in psychological interventions: a stakeholder approach to evaluation – Part one 11. *Journal of Psychiatric and Mental Health Nursing* **11**(2), 202-212.

Foucault M. (1977) *Discipline and Punish, The Birth of the Prison*. Penguin, Harmondsworth.

Foucault M. (1980) *Power / Knowledge: Selected Interviews and Other Writings* 1072-1977. Pantheon Books, New York.

Foucault M. (1988) *Politics, philosophy, culture: interviews and other writings,* 1977-1984. Routledge, London.

Foucault M. (2008) *Psychiatric Power: Lectures at the Collège de France, 1973-1974*. Palgrave Macmillan, Basingstoke.

Fowler D., Garety P. & Kuipers E. (1995) *Cognitive behaviour therapy for people with psychosis*. Wiley, East Sussex.

Frances A.J. (2012) *Diagnostic Over inflation: Does Everyone Have a Mental Illness, Mental Health Matters at Centre for Addiction and Mental Health*. Retrieved from https://www.youtube.com/watch?v=yuCwVnzSjWA on 12th March 2015.

Gadamer H.G. (1975) *Truth and Method*. The Seabury Press, New York.

Gadamer H.G. (1996) *Truth and method*. 2nd edn. Sheed & Ward Ltd, London.

Gaffey K.A. & Cooney A. (2014) Knowledge and attitudes of Irish Mental Health Professionals working on Community Mental Health Teams and Acute Admissions Units to the Concept of Recovery from Mental Illness – five year later. *Unpublished Master Thesis.*

Gamble C. & Brennan G. (2006) *Working with Serious Mental Illness – A manual for clinical practice,* 2nd edn. Elesvier, Edinburgh.

Gamble C., Midence K. & Leff J. (1994) The effects of family work training on mental health users' attitude to and knowledge of schizophrenia. *Journal of Advanced Nursing* **19**(5), 893-896.

Gerring J. (2007) *Case Study Research. Principles and Practice*. Cambridge University Press, New York.

Gerrish k. & Lathlean J. (2015) *The Research Process In Nursing*. 1st edn. John Wiley and Sons Ltd, UK.

Gijbels H. (1995) Mental health nursing skills in an acute admission environment: perspectives of nurses and other mental health professionals. *Journal of Advanced Nursing* **21**(3), 460-465.

Gilliam T. (2002) Schizophrenia: care for the 21st century. *Nursing Times* **98**, 36-37.

Gilligan C. (2011) *Joining the Resistance*. Polity Press, Cambridge.

Glaser B.G. & Strauss A. (1967) *Discovery of Grounded Theory: Strategies for Qualitative Research.* Aldine de Gruyter, New York.

Glaser B.G. (1978) *Theoretical Sensitivity*. Sociology Press, California.

Goffman E. (1959) *The Presentation of Self in Everyday Life*. Anchor Books, New York.

Gold R. (1969) Roles in sociological field observation. In McCall G. & Simmons J., (eds.) *Issues in Participant Observation: A text and reader.* Addison Wesley, London.

Goulter N., Kavanagh D.J. & Gardner G. (2015) What keeps nurses busy in the mental health setting?: A work sampling study. *Journal of Psychiatric and Mental Health Nursing* **22**(6), 449-456.

Gournay K. (1995) Mental health nurses working purposefully with people with serious and enduring mental illness – an international perspective. *International Journal of Nursing Studies* **32**(4), 341-352.

Gournay K. (2000) Nurses as therapists (1972-2000) *Behavioural and Cognitive Psychotherapy* **28**(4), 369-377.

Gournay K. (2009) Psychosocial interventions, In R. Newell and K. Gournay (eds) Mental Health Nursing: *An Evidence-based Approach.* 2nd edn. Churchill Livingstone, London.

Gournay K., Sandford T., Johnson S. & Thornicroft G. (1997) Dual diagnosis of severe mental health problems and substance abuse/dependence: a major priority for mental health nursing. *Journal of Psychiatric and Mental Health Nursing* **4**(2), 89-95.

Government of Ireland (1998) *Report on the Commission on Nursing: A Blueprint for the Future.* The Stationery Office, Dublin.

Government of Ireland (2003) *Data Protection Amendment Act.* Government of Ireland, Dublin.

Government of Ireland (2006) *A vision for change report of the expert group on mental health policy.* The Stationery Office, Dublin.

Graffam S. (1979) Nurses responses to patients in pain. *Nursing Leadership* **149**(13), 17-22.

Gray R., Wykes T., Parr A.M., Harls E. & Goumay K. (2001) The use of outcome measures to evaluate the efficacy and tolerability of antipsychotic medication: a comparison of thorn graduate and CPN practice. *Journal of Psychiatric and Mental Health Nursing* **8**, 191-196.

Gray R., Wykes T. & Gournay K. (2003) The effect of medication management training on community mental health nurses clinical skills. *International Journal of Nursing Studies* **40**(2), 163-169.

Grey S.J. (2002) If psychological therapies make such good sense why isn't everybody doing it? *Journal of Mental Health* **11**(5), 465-468.

Griffiths R. & Harris N. (2008) The compatibility of psychosocial interventions (PSI) and assertive outreach: a survey of managers and PSI-trained staff working in UK assertive outreach teams. *Journal of Psychiatric and Mental Health Nursing* **15**(6), 479-483.

Guba E.G. *(1990) The paradigm dialog.* Sage, *Newbury Park, CA.*

Guba E.G. & Lincoln Y.S. (1989) *Fourth generation evaluation*. Sage, Newbury Park, CA.

Guba E.G. & Lincoln Y.S. (1994) Competing Paradigms in Qualitative Research. In Denzin, N. K. & Lincoln, Y. S. (eds.), *Handbook Of Qualitative Research,* 1st edn. Sage, Thousand Oaks, CA, 105-117.

Guba E.G. & Lincoln Y.S. (1998) Competing Paradigms in Qualitative Research. In Denzin, N.K. & Lincoln, Y. S. (eds.), *The Landscape of Qualitative Research. Theories and Issues*. Sage, Thousand Oaks, CA.

Guba E.G. & Lincoln Y.S. (2005) Paradigmatic controversies, contradictions, and emerging confluences. In N.K Denzin & Y.S. Lincoln (eds.) *The Sage handbook of qualitative research,* 3rd edn. Sage, Thousand Oaks, CA, 191-215.

Guba E.G. (1990) *The alternative paradigm dialogue.* In: Guba, E.G. (eds), *The Paradigm Dialogue*. Sage, Newbury Park.

Guest G., Bunce A. & Johnson L. (2006) How many interviews are enough? An experiment with data saturation and variability. *Field Methods* **18**(1), 59-82.

Halter M.J. & Varcarolis E.M. (2014) *Varcarolis' foundations of psychiatric mental health nursing: A clinical approach.* 7th edn. Elsevier, USA,

Hamilton L. & Corbett-Whitter C. (2013) *Using Case Study in Education Research*. Sage Publication. UK.

Hammersley M. & Atkinson P. (2007) *Ethnography: Principles in Practice.* 3rd edn. Routledge, London.

Happell B. (2011) Mental health nursing: what it is or what it does? Editorial, *International Journal of Mental Health Nursing* **20(**1), 1.

Happell B., Hoey W. & Gaskin C.J. (2012) Community mental health nurses, caseloads and practices: a literature review. *International Journal of Mental Health Nursing* **21**(2), 131-137.

Hardey M., Payne S. & Coleman P. (2000) 'Scraps': hidden nursing information and its influence on the delivery of care. *Journal of Advanced Nursing* **32**(1), 208-214.

Health Service Executive (HSE) (2012) *A Vision for Psychiatric/Mental Health Nursing, A shared journey for mental health care in Ireland.* Office of the Nursing and Midwifery Services Director, Dublin.

Health Service Executive (HSE) (2013) Advancing recovery in Ireland (ARI) http://www.hse.ie/eng/services/list/4/Mental_Health_Services/advancingrecoveryireland/ on 24th May 2017.

Health Service Executive (HSE) (2015) *Office of the Nursing & Midwifery Services Director 2015 Annual Report.* Office of the Nursing and Midwifery Services Director, Dublin.

Health Service Executive (HSE) (2015) *Clinical Supervision Framework For Nurses Working in Mental Health Services.* Office of the Nursing & Midwifery Services Director (ONMSD), Dublin.

Healy H., Reader D., Midence K., Gamble C. & Brennan G., (eds.) (2006) *Working with Serious Mental Illness – A manual for clinical practice.* 2nd edn. Elesvier, Edinburgh, Chapter 5, 55-70.

Henry M. & Deady R. (2001) Mental Health Nursing in Ireland. Red Lion Press. Kilkenny.

Hentz P. (2012) Case study: the method. In *Nursing Research: A qualitative perspective,* 5th edn. (Munhall P.L., ed), Jones and Bartlett Learning, Sudbury, MA, 359-379.

Higgins A. (2008) *A Recovery Approach within the Irish Mental Health Services, A Framework for Development.* Stationary Office, Dublin.

Higgins A. & McBennett P. (2007) Mental health. The petals of recovery in a mental health context. *British Journal of Nursing* **16**(14), 852-856.

Himadi B., Osteen F., Kaiser A.J. & Daniel K. (1991) Assessment of delusional beliefs during the modification of delusional verbalisations. *Behaviour Residual Treatment* **6**, 356-366.

Holloway 1. & Todres L. (2010) Grounded Theory. In Gerrish k. & Lacey A. (eds) *The Research Process In Nursing.* 6th edn. Blackwell Publishing, Oxford.

Holloway I. & Wheeler S. (2010) *Qualitative Research in Nursing and Healthcare,* 3rd edn. Wiley-Blackwell, Oxford.

Holloway I. & Galvin K. (2017) *Qualitative Research in Nursing and Healthcare,* 4th edn. Wiley-Blackwell, UK.

Hovorka D.S. & Lee A.S (2010) *Reframing Interpretivism and Positivism as Understanding and Explanation: Consequences for information systems research.* International Conference on Information Systems (ICIS) Paper 188.

Hyde A., Treacy M.P., Scott PA., MacNeela P., Butler M., Drennan J., Irving K. & Byrne A. (2006) Social regulation, medicalisation and the nurse's role: insights from an analysis of nursing documentation. *International Journal of Nursing Studies* **43**(6), 735-744.

Jackson S. & Stevenson C. (2000) What do people need psychiatric and mental health nurses for? *Journal of Advanced Nursing* **31**(2), 378-388.

Jolley S., Onwumere J., Kuipers E., Craig T., Moriarty A. Garety P. (2012) Increasing access to psychological therapies for people with psychosis: Predictors of successful training. *Behaviour Research and Therapy* **50**(7-8), 457-462.

Jones M., Lancashire S. & Bennett J. (2005) Supporting the application of psychosocial interventions in adult inpatient services. *Mental Health practice* **9**(2), 42-45.

Jorgensen R. (2006) A phenomenological study of fatigue in patients with primary biliary cirrhosis. *Journal of Advanced Nursing* **55** (6), 689-697.

Kavanagh D.J. (1992) Recent developments in expressed emotion and schizophrenia. *British Journal of Psychiatry* **160**(5), 601-620.

Kavanagh D.J., Pistkowska O., Clarke D., O'Halloran P., Manicavasagar V., Rosen A. & Tennant C. (1993) Application of cognitive-behavioural family interventions for schizophrenia in multidisciplinary teams. What can the matter be? *Australian Psychologist* **28**(3), 181-188.

Kelly B.D. (2008) Mental Health Law in Ireland, 1821 to 1902: Dealing with the Increase of Insanity in Ireland. *Medico-Legal Journal* **76**(1), 26.

Kelly B.D. (2008) The Mental Treatment Act 1945 in Ireland: an historical inquiry*. History of Psychiatry* **19**(1), 47-55.

Kingdon D. & Turkington D. (1994) *Cognitive Behavioural Therapy of Schizophrenia*. Lawrence Ehrlbaum, London.

Kirkpatrick D.L. (1967) Evaluation of training. In *Craig R.L. & Bittel L.R. (eds), Training and development handbook.* McGraw-Hill, New York.

Koufogiannakis D, Booth A, & Brettle A (2006) *ReLIANT: Reader's Guide to the Literature on Interventions Addressing the Need for Education and Training.* Retrieved from: http://eprints.rclis.org/8082/1/RELIANT__final_.pdf on 4th February 2009.

Krawiecka M., Goldberg D. & Vaughan M. (1977) A standardized psychiatric assessment scale for rating chronic psychotic patients. *Acta Psychiatrica Scandinavica* **55**(4), 299-308.

Kuhn T.S. (1962) *The Structure of Scientific Revolutions*. University of Chicago Press, Chicago.

Kuhn T.S. (1970) *The structure of scientific revolutions* 2nd edn. University of Chicago Press, Chicago.

Kuipers E. (2011) Cognitive behavioural therapy and family intervention for psychosis-evidence-based but unavailable? The next steps. *Psychoanalytic Psychotherapy* **25**(1), 69-74.

Kuipers E., Garety P., Fowler D., Dunn G., Bebbington P. Freeman D. & Hadley C. (1997a) London-East Anglia randomised controlled trail of cognitive-behavioural therapy for psychosis. I: Effects of the treatment phase. *British Journal of Psychiatry* **171**(4), 319-327.

Kuipers E., Garety P., Fowler D., Dunn G., Bebbington P., Freeman D. & Hadley C. (1997b) London-East Anglia randomised controlled trial of cognitive-behavioural therapy for psychosis. I: Effects of the treatment phase. *The British Journal of Psychiatry* **171**(4), 319-327.

Kvale S. (1996) *Interviews: An introduction to qualitative research*. Sage, Thousand Oaks, CA.

Lam D. (1991) Psychosocial interventions: a review of empirical studies. *Psychological Medicine* **21**(2), 423-441.

Lam D., Kuipers L. & Leff J.P. (1993) Family work with patients suffering from schizophrenia: The impact of training on psychiatric nurses' attitude and knowledge. *Journal of Advanced Nursing* **18**(2), 233-237.

Lancashire S., Haddock G., Tarrier N., Bagguley I., Butterworth C. & Brooker C. (1997) Effects of training in psycho-social interventions on community psychiatric nurses in England. *Psychiatric Services* **48**(1), 39-41.

Large S., Macleod A., Cunningham G. & Kitson A. (2005) *A Multiple-case Study Evaluation of the RCN Clinical Leadership Programme in England*. Royal College of Nursing, London.

Lather P. (1991) *Getting smart: Feminist research and pedagogy with/in the postmodern.* Routledge, New York.

Le Fevre P. (2001) Cognitive behavioural therapy: a survey of the training, practice and views of Scottish consultant psychiatrists. The Royal College of Psychiatrists. *The Psychiatrist* **25**, 425-428.

Leff J., Kuipers L., Berkowitz R. & Sturgen D. (1985) A controlled trail of social intervention in the families of schizophrenia: two year follow up. *British Journal of Psychiatry* **146**(6), 594-600.

Lincoln Y.S. & Guba EG. (1985) *Naturalistic Inquiry*. Sage, Newbury Park, CA.

Lipsky M. (1980) *Street Level Bureaucracy*, Russell Sage Foundation. New York.

Luck L., Jackson D. & Usher K. (2006) Case study: A bridge across the paradigms. *Nursing Inquiry* **13**(2), 103-109.

Lunacy Asylums (Ireland) Act (1821-1826) Retrieved from: http://www.irishstatutebook.ie/eli/1821/act/33/enacted/en/print.html on 10th January 2016.

Macleod S.H., Elliott L. & Brown R. (2011) What support can community mental health nurses deliver to carers of people diagnosed with schizophrenia? Findings from a review of the literature. *International Journal of Nursing Studies* **48**(1), 100-120.

MacMillan K. & Koenig T. (2004) The wow factor: preconceptions and expectations for data analysis software in qualitative research. *Social Science Computer Review* **22**(2), 179-186.

MacNeela P., Clinton G., Place C., Scott A., Treacy P, Hyde A. & Dowd H. (2010) Psychosocial care in mental health nursing: a think aloud study. *Journal of Advanced Nursing* **66**(6), 1297-1307.

Magliano L., Fiorillo A., Malangone C., De Rosa C. & Maj M. (2006) Implementing psychoeducational interventions in Italy for patients with schizophrenia and their families. *Psychiatric Services* **57**(2), 266-269.

Mairs H. & Arkle N. (2008) Accredited training in psychosocial interventions for psychosis: A national survey. *Journal of Mental Health Training, Education and Practice* **3**(2), 4-11.

Malterud K. (2001) Qualitative research: Standards, challenges and guidelines. *The Lancet* **358**(9280), 483-488.

Marsh I. (2010) *Suicide: Foucault, History and Truth*. Cambridge University Press, Cambridge.

Maruthu R., Mac Liam F. & Carroll G. (2013) *Report: Training and Evaluation of Psycho Social Interventions Dublin South East Mental Health Services*. Clonskeagh Hospital, Dublin 6. Retrieved from: http://www.lenus.ie/hse/bitstream/10147/311109/1/Training%20and%20Evaluation%20on%20PSI.pdf on 21st April 2015.

Maslach C., Jackson S.E. & Leiter M.P. (1996) *Maslachs Burnout Inventory Manual. Consulting Psychologists Press*, Palo Alto, CA.

Mason J.K. & Laurie G.T. (2011) Law ad medical ethics. 8th edn. Oxford University Press, Oxford.

Mays N. & Pope C. (1995) Qualitative research: rigour and qualitative research. *British Medical Journal* **311**(6997), 109-112.

Mays N. & Pope C. (2000) Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal* **320**(7226), 50-52.

McAllister M. & Moyle W. (2008) An exploration of mental health nursing models of care in a Queensland psychiatric hospital. *International Journal of Mental Health Nursing* **17**(1), 18-26.

McCann E. & Bowers L. (2005) Training in cognitive behavioural interventions on acute psychiatric inpatient wards. *Journal of Psychiatric and Mental Health Nursing* **12**(2), 215-222.

McCardle J., Parahoo K. & Mckenna H. (2007) A national survey of community psychiatric nurses and their client care activities in Ireland. *Journal of Psychiatric and Mental Health Nursing* **14**(2), 179-188.

McConnell-Henry T., Chapman Y. & Francis K. (2009) Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice* **15**(1), 7-15.

McFarlane W.R. (2000) Psychoeducation multi-family groups: adaptations and outcomes. In *Psychosis. Psychological Approaches and their Effectiveness*. (Martindale B., Bateman A., Crowe M. & Margison F., eds), Gaskell, London, 68-95.

McFarlane W.R., Lukens E., Link B., Dushay R., Deakins S.A., Newmark M., Dunne E., Horen B. & Torah J. (1995) Multiple-family groups psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry* **52**(8), 679-687.

McGorry P., Curry C. & Elkins K. (1997) Psychosocial interventions in mental health disorders: Developing evidence-based practice. *Current Opinion in Psychiatry* **10**(2), 173-177.

Meerabeau L., Casey A. & Old S. (1997) Language for research and practice: the English experience. *Nursing Times Research* **2**(5), 345-353.

Mental Health Act (MHA) (1945) Section 3 No 16, The Stationery Office, Dublin.

Mental Health Act (MHA) (2001) The Stationary Office, Dublin.

Mental Health Act (MHA) (2006) (Approved Centre) Regulations 2006. The Stationary Office, Dublin.

Mental Health Commission (MHC) (2005) Quality in Mental Health – Your views. Mental Health Commission, Dublin.

Mental Health Commission (MHC) (2007) *Quality Framework – Mental Health Services in Ireland*, Mental Health Commission, Dublin.

Mental Health Commission (MHC) (2012) Guidance Document on Individual Care Planning Mental Health Services. Mental Health Commission, Dublin.

Mental Health Commission (MHC) (2015) *Mental Health Commission Annual Report 2014 Including Report of the Inspector of Mental Health Services*. Mental Health Commission, Dublin.

Mental Health Reform (2015) *A Vision for Change Nine Years On*: *A coalition analysis of progress.* Stationary Office, Dublin.

Miles M.B. & Huberman A.M. (1994) *Qualitative Data Analysis. An expanded sourcebook*. 2nd edn. Sage, Thousand Oaks, CA.

Miller W.R. & Rollnick S. (1991) *Motivational interviewing: Preparing People to Change Addictive Behaviours.* Guilford Press, New York.

Milne D.L,. Keegan D., Westerman C. & Dudley M. (2000) Systematic process and outcome evaluation of brief staff training in psychosocial interventions for severe mental illness. *Journal of Behaviour Therapy and Experimental Psychiatry* **31**(2), 87-101.

Milne D.L., James I., Keegan D. & Dudley M. (2000b) *Teacher's PETS: a new observational measure of experiential training interactions.* MS under editorial review. Available from D. Milne, Centre for Applied Psychology, Ridley Building, University of Newcastle upon Tyne, England.

Milne D.L., Dudley M., Repper R. & Milne J. (2001) Managers' perceived contribution to the transfer of psychosocial interventions training. *Psychiatric Rehabilitation Skills* **5**(3), 387-402.

Milne D.L., Woodward K., Hanner S., Iceton J., Fitzsimmons A. & Rochester J. (2003) An illustration of delivering evidence-based practice through staff training: multi-dimensional process, outcome and organisational evaluation. *Behavioural and Cognitive Psychotherapy* **31**(1), 85-98.

Moher D., Liberati A., Tetzlaff J. & Altman D.G. (2009) Preferred reporting items for systematic reviews and meta-analysis: the PRISMA Statement. *Annals of Internal Medicine* **151,** 264-269.

Monaghan M., Doyle L. & Keogh B. (2008) Psychosocial Interventions. In *Psychiatric/Mental Health Nursing, An Irish Perspective.* (Morrissey J., Keogh B. & Doyle L., eds), Gill and MacMillan, Dublin, 139-155.

Moncrieff J. (2008) *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatmen.* Palgrave Macmillan*,* Houndmills.

Moore L. & Savage J. (2002) Participant observation, informed consent and ethical approval. *Nurse Researcher* **9**(4), 58-69.

Morrison M. & Moir J. (1998) The role of computer software in the analysis of qualitative data: efficient clerk, research assistant or Trojan horse: *Journal of Advanced Nursing* **28**(1), 106-116.

Morrissey J., Keogh B. & Doyle L. (2008) *Psychiatric/Mental Health Nursing, An Irish Perspective.* Gill and MacMillan, Dublin.

Morse J.M., Barrett M., Mayan M., Olson K. & Spiers J. (2002) Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods* **1**(2), 13-22.

Mulhall P.L. (2003) In the field: notes on observation in qualitative research. *Journal of Advanced Nursing* **41**(3), 306-313.

Mullen A. (2009) Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing* **18**(2), 83-90.

Munhall P.L. (2007) Ethical considerations in qualitative research. *Western Journal of Nursing Research* **10**(2), 150-162.

Myles P. & Milne D. (1997) *Self-rating of CBT Practice. Department of Psychological Therapies & Research.* Northumberland Mental Health NHS Trust.

Myles P. & Milne D. (2001) *The development of two new instruments for the evaluation of foundation level training in cognitive behavioural therapy*. Annual Conference for the British Association of Behavioural and Cognitive Psychotherapy. Strathclyde University, Glasgow.

National Council for the Professional Development of Nursing and Midwifery (2004) *Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts,* 2nd edn. National Council for the Professional Development of Nursing and Midwifery, Dublin.

National Institute for Health and Clinical Excellence (NICE) (2002) *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. NICE, London. [online] Available at: http://www.fundacion-salto.org/documentos/Esquizofrenia%20guideline%20NICE.pdf on 1st February 2014.

National Institute for Clinical Excellence (NICE) (2004) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care. Clinical Guideline 1.* National Institute for Clinical Excellence, London.

National Institute for Clinical Excellence (NICE) (2009) Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (Update). NICE, London. [online] Available at:

http://www.dualdiagnosis.co.uk/uploads/documents/originals/Schizophrenia%20%20Core%20Interventions%20NICE%20Guidance.pdf on 19th February 2016.

National Institute for Clinical Excellence (NICE) (2009) *Depression: management of depression in primary and secondary care.* CG90. National Institute for Clinical Excellence, London.

National Institute for Health and Care Excellence (NICE) (2014) *Psychosis and Schizophrenia in adults. The NICE guideline on treatment and management.* CG178. National Institute for Health and Care Excellence, London.

Neil S., Nothard S., Glentworth D. & Stewart E. (2010) A study to evaluate the provision of psychosocial supervision within an Early Intervention team. *The Cognitive Behaviour Therapist* *3*(2), 58-70.

Nolan P. (1993) *A History of Mental Health Nursing.* Chapman & Hall, London.

Nursing & Midwifery Board of Ireland (NMBI) (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.* Nursing and Midwifery Board of Ireland, Dublin.

O'Carroll M. & Young N. (2004) Education and training in psychosocial interventions: a survey of Thorn Initiative course leaders. *Journal of Psychiatric and Mental Health Nursing* **11**(5), 602-607.

O'Hagan M., Reynolds P. & Smith C. (2012) Recovery in New Zealand: An evolving concept? *International Review of Psychiatry* **24**(1), 56-63.

O'Neill M., Moore K. & Ryan A. (2008) Exploring the role and perspectives of mental health nurse practitioners following psychosocial interventions training. *Journal of Psychiatric and Mental Health Nursing* **15**(7), 582-587.

OED (2004) Oxford English Dictionary. Retrieved from: http://dictionary.oed.com/ on 10th December 2010.

Onken S., Craig C., Ridgway P., Ralph R. & Cook J. (2007) An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal* **31**(1), 9-22.

Overall J.E. & Gorham D R. (1962) The brief psychiatric rating scale. *Psychological Medicine* **10**, 799-812.

Owen S. & Fox C. (2009) Personal and professional development. In *Mental Health Nursing Skills*, 1st edn. (Callaghan P., Playle J. & Cooper L., eds), Oxford University Press, Oxford, Chapter 21, pp. 225-229.

Parahoo K. (2006) *Nursing Research. Principles, Process and Issues.* 2nd edn. Palgrave Mac Millan, Hampshire, UK.

Parahoo K. (2014) Nursing Research. Principles, Process and Issues. 3rd edn. Palgrave Mac Millan, Hampshire, UK.

Patton M.Q. (1990) *Qualitative Research and Evaluation Methods,* 2nd edn. Sage, London.

Patton M.Q. (2002) *Qualitative Research and Evaluation Methods*. 3rd edn. Thousand Oaks, Sage, CA.

Pearson A. (2003) The role of documentation in making nursing work visible. *International Journal of Nursing Practice* **9**(5), 271.

Perry J.C. (2009) A combined social action, mixed methods approach to vocational guidance efficacy research. *International Journal for Educational and Vocational Guidance* **9**(2), 111-123.

Pettigrew M. & Roberts H. (2006) *Systematic Reviews in Social Sciences: a practical guide.* Blackwell, Oxford.

Polit D.F. & Beck C.T. (2004) *Nursing research principles and methods,* 7th edn. Lippincott Williams and Wilkins, Philadelphia.

Polit D.F. & Beck C.T. (2012) *Nursing research: Generating and assessing evidence for nursing practice,* 9th edn. J.B. Lippincott, New York.

Poole J. & Grant A. (2005) Stepping out of the box: Broadening the dialogue around the organizational implementation of cognitive behavioural psychotherapy. *Journal of Psychiatric and Mental Health Nursing* **12**(4), 456-463.

Power Z., Campbell M. & Kilcoyne P. (2010) The hyperemesis impact of symptoms questionnaire: development and validation of a clinical tool. *International Journal of Nursing Studies* **47**(1), 67-77.

Prytys M., Garety P.A., Jolley S., Onwumere J. Craig T. (2011) Implementing the NICE guidelines for schizophrenia recommendations for psychological therapies: A qualitative analysis of the attitudes of CMHT staff. *Clinical Psychology & Psychotherapy* **18**(1), 48-59.

Randolph E.T., Eth S., Glynn S.M., Paz G.G., Leong G.B., Shaner A.L., Strachan A., Van Vort W., Escobar J.I. & Liberman R.P. (1994) Behavioural family management in schizophrenia: outcome of a clinic-based intervention. *British Journal of Psychiatry* **164**(4), 501-506.

Redhead K., Bradshaw T., Braynion P. & Doyle M. (2011) An evaluation of the outcomes of psychosocial intervention training for qualified and unqualified nursing staff working in a low-secure mental health unit. *Journal of Psychiatric and Mental Health Nursing* **18**(1), 59-66.

Repper J. (1998) Using single case experimental design to evaluate the clinical effect of a multidisciplinary training in psychosocial interventions for people with serious mental health problems. *Nursing Times Research* **3**(5), 374-385.

Repper J. (2000) Adjusting the focus of mental health nursing: incorporating service users' experiences of recovery. *Journal of Mental Health* **9**(6), 575-587.

Repper J. (2000) *Translating Policy into Practice. An evaluation of a multidisciplinary training in psychosocial interventions for working with people who have serious mental health problems.* PhD Thesis: awarded by the University of Manchester.

Repper J. & Perkins R. (2003) *Social inclusion and Recovery*. Bailliere Tindall, Edinburgh.

Richards D. & Everitt J. (1999) *The Attitude to Psychosocial Intervention Scale*. University of Manchester, Manchester. Unpublished.

Richards L. & Richards T. (1994) From filing cabinet to computer, In Alan Bryman & Robert G. Burgess (Eds), *Analysing Qualitative Data* (pp. 146-172). Routledge, London.

Ridenour C.S. & Newman L. (2009) *Mixed methods research: Exploring the interactive continuum*. Southern Illinois University Press, Carbondale, IL.

Ritchie J. & Lewis. J. (2003) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. Sage Publications, London.

Ritchie J. & Spencer L. (1994) Qualitative data analysis for applied policy research" by Jane Ritchie and Liz Spencer in A. Bryman and R. G. Burgess [eds.] *"Analyzing qualitative data",* 173-194.

Roberts M. (2008) Facilitating recovery by making sense of suffering: a Nietzschean perspective. *Journal of Psychiatric & Mental Health Nursing* **15**(9), 743-748.

Robson C. (1993) *Real World Research: A Resource for Social Scientists and Practitioners-Researchers.* Blackwell, Oxford.

Robson C. (2002) *Real World Research. A Resource for Social Scientists and Practitioners-Researchers*. 2nd edn. Blackwell, Oxford.

Rollinson R., Smith B., Steel C., Jolley S., Onwumere J. & Garety P. A., (2008). Measuring adherence in CBT for psychosis: a psychometric analysis of an adherence scale. *Behavioural and Cognitive Psychotherapy* **36**, 163-178.

Rollnick S. & Miller W.R. (1995) What is motivational interviewing? *Behavioural and Cognitive Psychotherapy* **23**(4), 325-334.

Royal College of Nursing (RCN) 2011) *Informed consent in health and social care research, RCN guidance for nurses*. 2nd edn. Royal College of Nursing, London.

Rubin H.J. & Rubin I.S. (1995) *Qualitative Interviewing. The art of Hearing Data*. Sage Publications, Thousand Oaks, CA.

Ruddy R. & House A. (2005) Psychosocial interventions for conversion disorder, *Cochrane Database of Systematic Reviews*, 4. Art. No: CD005331.

Ryan F., Coughlan M. & Cronin P. (2009) Interviewing in qualitative research: the one-one-interview. *International Journal of Therapy and Rehabilitation* **16**(6), 309-314.

Sackett D., Rosenberg W., Muir Gray J., Haynes R.B. & Richardson W.S. (1996) Evidence based medicine: what it is and what it isn't. *British Medical Journal* **312**(7023), 71-72.

Sackett D., Richardson W.S., Rosenburg W. & Haynes R.B. (1997) *How to Practice and Teach Evidence Based Medicine.* 2nd edn. Churchill Livingstone, Edinburgh.

Sandstrom B., Borglin G., Nilsson R., & Willman A. (2011) Promoting the implementation of evidence-based practice: A literature review focusing on the role of nursing leadership. *Worldviews on Evidence-Based Nursing* **8**(4), 212-223.

Schizophrenia Ireland (2006) *Talking about choice – Developing the dialogue for individual recovery and partnership*. Schizophrenia Ireland, Dublin.

Schwandt T.A., Denzin N.K. & Lincoln Y.S., (eds.) (2000) *Handbook of Qualitative Research*, 2nd edn. Sage, London.

Scott J., Jennings T. & Standard S. (1999) The impact of training in problem-based interviewing on the detection and management of psychological problems presenting in primary care. *British Journal of General Practice* **49**(443), 441-445.

Scottish Intercollectiage Guideline Network (SIGN) (2005a) *Bipolar Affective Disorder, SIGN publication N0 82* www.sign.ac.uk/pdf/sign82/pdf on 29th April 2010, severe mental disorders (Cochrane Review). Oxford.

Sheridan A.J. (2000) Psychiatric nursing. In *Nursing and Midwifery in Ireland in the Twentieth Century.* (Robins J., ed), An Bord Altranais, Dublin, 141-160.

Shorter E. (1998) A History of Psychiatry: From the Era of the Asylum to the Age of Prozac 48-65; Edward Shorter, A Historical Dictionary of Psychiatry (Oxford University Press 2005) 5; Edward Hare - schizophrenia as a Recent Disease (1988) *British Journal of Psychiatry* **153**, 521.

Silverman D. (2010) *Doing Qualitative Research.* 3rd edn. Sage, London.

Sin J. & Scully E. (2008) An evaluation of education and implementation of psychosocial interventions within one UK mental healthcare trust. *Journal of Psychiatric and Mental Health Nursing* **15**(2), 161-169.

Sin J., Livingstone S., Griffiths M. & Gamble C. (2013) Family intervention for psychosis: Impact of training on clinicians' attitudes, knowledge and behaviour. *Psychosis* **6**(2), 128-142.

Singleton R.A. & Straits B.C. (1999) *Approaches to Social Research*. Oxford University Press, New York.

Smith J.A., Flowers P. & Larkin M. (2009) *Interpretive Phenomenological Analysis: Theory, Method and Research.* Sage, London.

Spradley J.P. (1980) *Participant Observation.* Harcourt Brace Jovanovich College Publishers, London.

Stake R.E (1995) *The art of case study research.* Sage, London.

Stake R.E. (2005) Qualitative case studies. In Denzin, N. & Lincoln, Y.S. (eds) *The Sage Handbook of Qualitative Research.* 3rd edn. Sage, California, 443-466.

Stake R.E. (2006) *Multiple Case Study Analysis*. Guildford Press, New York.

Stenhouse R. (2011) 'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric and Mental Health Nursing* **18**(1), 74-80.

Stevenson C., Jackson S. & Barker P. (2003) Finding solutions through empowerment: A preliminary study of a solution oriented approach to nursing in acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing* **10**(2), 688-696.

Stickley T. & Wright N. (2011b) The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part Two: a review of the grey literature including book chapters and policy documents. *Journal of Psychiatric and Mental Health Nursing* **18**(4), 297-307.

Strauss A. & Corbin J. (1998) *Basics of qualitative research: Techniques and procedures for developing grounded theory*. 2nd edn. Sage, Thousand Oaks, CA.

Streubert H.J. & Carpenter D.R. (eds.) (1999) *Qualitative research in nursing. Advancing the humanistic imperative*. 2nd edn. Lippincott, Philadelphia.

Sullivan G., Bienroth M., Jones M., Millar H., Ratna L. & Taylor D. (2007) Practical prescribing with aripiprazole in schizophrenia: consensus recommendations of a UK multidisciplinary panel. *Current Medical Research and Opinion* **23**(7), 1733-1744.

Tarrier N. & Barrowclough C. (1995) Family interventions in schizophrenia and their long-term outcomes. *International Journal of Mental Health* **24**(3), 38-53.

Taylor M.G. & Bentley K.J. (2005) Professional Dissonance: Colliding values and job tasks in mental health practice. *Community Mental Health Journal* **41**(4), 469-480.

Tedstone Doherty D., Moran R. & Kartalova-O'Doherty Y. (2008) *Psychological distress, mental health problems and use of health services in Ireland*. HRB Research Series 5. Health Research Board, Dublin.

Thibeault C., Trudeau K., d'Entremount M. & Brown T. (2010) Understanding the Milieu Experiences of Patients on an Acute Inpatient Psychiatric Unit. *Archives of Psychiatric Nursing* **24**(4), 216-226.

Thorne S., Reimer Kirkham S. & MacDonald-Emes J. (1997) Interpretive description: a non-categorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health* **20**(2), 169-177.

Thurmond V.A. (2001) The Point of Triangulation. *Journal of Nursing Scholarship* **33**(3), 253-258.

Travelbee J. (1971) *Interpersonal aspects of nursing*. 2nd edn. F.A. Davis Company, Philadelphia.

Tse S., Cheung E., Kan A., Ng R. & Yau S. (2012) Recovery in Hong Kong: service user participation in mental health services', *International Review of Psychiatry* **24**(1), 40-47.

Turkington D., Kingdon D., Rathod S., Hammond K., Pelton J. & Mehta R. (2006) Outcomes of an effectiveness trail of cognitive-behavioural intervention by mental health nurses in schizophrenia. *British Journal of Psychiatry* **189**(1), 36–40.

Turton W. (2015) An Introduction to psychosocial interventions. In *Psychosocial Interventions in Mental Health Nursing*. (Walker S. ed). Sage, Los Angeles.

Tutty L.M., Rothery M. & Grinnell R.M. (1996) *Qualitative Research for Social Workers*. Allyn and Bacon. Boston.

Vallis T.M., Shaw B.F. & Dobson K.S. (1986) The cognitive therapy scale: psychometric properties. *Journal of Consulting and Clinical Psychology* **54**(3), 381-385.

Waddington D. (1994) Participant observation. In *Qualitative Methodology in Organisational Research: a Practical Guide* (Cassell C. & Symon G. eds), Sage, London, 107-122.

Walker S. (2015) *Psychosocial interventions in mental health nursing. Learning Matters*, Sage, Thousand Oaks, CA, London.

Wang N., Hailey D. & Yu P. (2011) Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review. *Journal of Advanced Nursing* **67**(9), 1858-1875.

Weaver K. & Olson J.K. (2006) Understanding paradigms used in nursing research. *Journal of Advanced Nursing* **53**(4), 459-469.

Weber R. (2004) The rhetoric of positivism versus interpretivism: a personal view. *Management Information Systems Quarterly* **28**(1), 3-7.

Whiting L.S. (2008) Semi-structured interviews: guidance for novice researchers. *Nursing Standard* **22**(23), 35-40.

Whittemore R., Chase S.K. & Mandle C.L. (2001) Validity in qualitative research. *Qualitative Health Research* **11**(4), 522-537.

Williams C. & Garland A. (2002) A cognitive-behavioural therapy assessment model for use in everyday clinical practice. *Advances in Psychiatric Treatment* **8**(3), 172-179.

Wilson L. & White K. (2007) Development of attitudes towards complementary therapies scale for psychologists. *Clinical Psychologist* **11**(2), 37-44.

World Medical Organisation (1964) *World Health Association Declaration of Helsinki*. World Health Organisation.

Wyder M., Bland R., Blythe A., Matarasso B. & Crompton D. (2015) Therapeutic relationships and involuntary treatment orders: Service users' interactions with health-care professionals on the ward. *International Journal of Mental Health Nursing* **24**(2), 181-189.

Yin R.K. (1994) *Case study research: design and methods*, 2nd edn. Sage, Thousand Oaks, CA.

Yin R.K. (2003a) *Case study research design and methods,* 3rd edn. Sage, London.

Yin R.K. (2009) Case *study research, design and method,* 4th edn. Sage, London.

Yin R.K. (2014) *Case study research: Design and methods,* 5th edn. Sage, Thousand Oaks, CA.

Young J. & Beck A.T. (1980) *Cognitive therapy scale*, Centre for Cognitive Therapy, University of Pennsylvania.

Zubin J. & Spring B. (1977) Vulnerability; a new view of schizophrenia. *Journal of Abnormal Psychology* **86**(2), 260-266.

10.   Appendix 1: Examples of Reflective and Field Note Accounts

This section comprises 2 parts. Part 1 captures examples of reflective diary entries and part 2 illustrates examples of the Field Notes throughout this research process. Spradley's (1980) framework was utilised to manage the Field Notes (Part 2, Table 1).

This description of reflexivity helped to keep me focused. Polit & Beck (2012) described reflexivity as reflecting critically on the self, and analysing and recording personal values that could upset data collection and interpretation. In addition, reflective diary entries and the Field Notes were used to support the study, as they helped capture meaning for many of the findings, in keeping with the multiple case study approach.

The use of a reflective diary helped to record and make sense of my emerging thoughts and ideas about the topic throughout the research process. I have learnt that qualitative research is challenging and complex due to the rigorous nature of this approach. I am inclined to think that this is partly because one is using oneself as a person, and so one has to be a mature, well-developed, sensitive person who is reflective and has developed personally and professionally. I am also convinced that qualitative researchers have to spend a lot of time developing themselves as people and professional researchers. The craft of qualitative research has to be learned, which is one of the reasons that I absorbed myself in this study. This involved a lot of learning and brought me to be a deeper reflector, which has helped me along the way as a researcher.

The Field Notes consisted of short notes, key words and phrases, all of which were recorded in a notebook during and shortly after the observations, to be expanded on the following day and later typed up for help with the data analysis. The Field Notes were also anonymised and revised to help legibility. Additionally, it was a matter of training the memory concerning the key items to record. This helped foster my efficiency in doing so, especially as the research progressed and became clearer.

Part 1

This section outlines examples of excerpts from reflective diary entries during the process of the study.

Chapter 1, section 1.4
Reflective entry 1 - The beginning
My research idea began when I returned to Ireland from the UK. As I worked in practice as an MHN, I felt a constant uneasiness and discontent with the growing emphasis on evidence-based practice (EBP). I spent some time thinking about what it was that was frustrating me. I was aware that there were problems with how it worked, but I needed to think about this much more. Over a period, a colleague and I began to have a dialogue about my ideas and concerns. We had many talks about the nature, value and inherent components of the ranges of the research paradigms and their value in creating a range of evidence that could be used to support professional practice. This was when the question of PSI came to mind, as I had undertaken PSI training in the UK. Many of the nurses appeared to be delivering care through the medical approach, which appeared to curtail their autonomy and confidence in everyday practice. Having been in receipt of clinical supervision in the UK, it was frustrating at the time that I had no access to this support in Ireland. I had nowhere to bring my clinical issues, which limited my scope to develop my practice personally and professionally. There were times when I felt I was delivering routine care that was absent of reflection; thus, I was not able to utilise my skills and expertise to my full capacity.

I posed myself many questions over a few months:

What does mean for me if I am an MHN who wants to continue developing the use of evidence-based practice?
How is this going to affect me when I am continuing to work in the field of mental health nursing?
Why am I not hearing from other nurses any questioning of practice?
How I am going to transform my role and relationships while I am endeavouring to explore evidence-based practice and its relationship to PSI?

On reflection, my thoughts and ideas needed to turn into actions if I want to be the MHN who could have an impact on mental health nursing and its close connections to patient care. I have always been a person-centred individual, whereby my practice is rich and fulfilling …

Chapter 3, section 3.4
Reflective entry 3 - Making sense
I clearly remember meeting Professor Robert Stake, who is one of the most influential researchers in case study research. This was an exciting and rich moment during the journey of the Ph.D. One of the conversations concerned his views of the case study methodology, and his experience justifying this methodology that he has written about for years. It was obvious that he was very passionate about case study research, and he was very confident of the fact that many more researchers from various disciplines are now using this approach. Thus, I was positive about its use in many different discipline areas.

> **Chapter 4, section 4.2.2**
> *Reflective entry 5 - Ethical process*
> Submitting the ethical applications was a nervous time for me. All the applications that had to be completed for the four research sites overwhelmed me initially. It took 11 months to obtain all the approvals, which meant that starting the data collection began later than anticipated. However, all ended well; I got approval for all the research sites (Appendix 3). The key learning for me was the fact that it was important not to lose interest for the research during the process.

> **Chapter 4, section 4.8.2**
> *Reflective entry 10 - News of difference*
>
> 'There is only one thing more dangerous than learning from experience and that is not learning from experience' (Archibald MacLeish)[9]
>
> When entering into the data analysis phase of the research, what struck me was the issue of time in relation to this stage. It was a challenging phase, but for the most part enjoyable, particularly when I was in the depth of reading the participant accounts. This is where the quotation above became significant, as qualitative research takes as its starting point that knowledge is constructed through the social reality of human interactions. This interaction involves interpretation, which can generate new knowledge. According to Bateson (1980, p. 4), new knowledge is 'news of difference', knowledge external to a person's existing frameworks and ways of understanding. If the researcher cannot step out of the shoes of knowledge frameworks, how can s/he produce news of difference? Again, this is where the quotation became meaningful, as the analysis phase moved me beyond my vision where I was able to produce news of difference!

> **Chapter 6, section 6.2**
> *Reflective entry 11 - Being woven*
>
> 'When ink joins with a pen, then the blank paper can say something.
> Rushes and reeds must be woven to be useful as a mat.
> If they weren't interlaced,
> the wind would blow them away.
> Of being woven.'
>
> Rumi (Barks 1997)
>
> I came across this quotation and quickly tuned into it. It made sense in relation to the research findings and the research process overall. This narrative was influential in my decisions about structuring the research findings, but, to ensure that my decisions were woven into the aim and objectives for the study, I had to become immersed in the participant stories and also cognisant of the context surrounding them. (As the quotation states, 'Rushes and reeds must be woven'.) Drawing on reflectivity helped me keep the research process alive and in the moment. I felt a privileged researcher many times while reading the stories and the interlacing accounts that many of the participants shared. The stories (interview data) were authentic in their own right; it was my responsibility to be true to the data lest the wind blew them away.

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[9] Source from Columbia Books of Quotations 1996.
http://www.goodreads.com/author/show/11154.Archibald_MacLeish

> *Chapter 6, section 6.2*
> *Reflective entry 13 - Knowledge versus practice*
> During the course of this Ph.D. study, I worked as a university lecturer in mental health. I regularly visited the clinical areas to support the undergraduate mental health students. One winter's day, I was teaching a skills session on CBT principles to fourth year mental health student nurses. It was clear that the students had a mixed understanding of CBT and the skills involved. They had all developed good communication skills, but had difficulty linking some of the CBT skills for the use with clients. This session altered and reinforced the need for real scenarios for students. In addition, my previous working experience was useful in helping the students link the knowledge to the practicalities of using the skills when working with different patient groups…

> **Chapter 8, section 8.4**
> *Reflection Entry 15 – Final thoughts*
> This epistemological journey has offered me many new experiences, new knowledge and practical wisdom as a former MHN and mental health lecturer. The process of reflective thinking helped me grapple with the issues that PSI-nurses face on a daily basis. The qualitative nature of this research has also contributed to understanding the practices of qualitative research even better. It has helped me to forget the moments that I was feeling panicked about the process of study. The interpretive aspect of this study has given me an understanding of the phenomenon which has been transformed, and in which I as the researcher have also been transformed. I was aware throughout the process that I needed to be real and to 'think' but also 'feel' within this qualitative study, as it was important to be thorough in my explorations of the topic.
>
> *Positioning oneself in the study*:
>
> I view and consider qualitative research as a set of interactive elements, not always a linear process. This research focuses on rigorous data collection and analysis. It is an approach to research that has a philosophical foundation. I found that I made decisions based on the views of the participants. It is my responsibility in this case study research to open up the inquiry to understand and gain meaning about the complexity of the phenomenon (PSI in practice). It is also my responsibility to ask open questions, analyse words and images and place emphasises on individual meanings, context, and self-reflexivity. I had to be flexible and true to the data, keeping an open mind at all times. At the same time, I had to work using a step-by-step process…

The next section presents examples of Field Notes during the process of the research, as outlined in Table 1.

Part 2

Table 1: Field Notes			
Chapter No.	**Condensed Accounts (Brief condensed accounts)**	**Expanded Accounts (Field Notes)**	**Field Notes and reflective accounts**
Chapter 1: Introduction & background	Literature, what literature? What key words will I use? what is my study about and its focus? Context!	PSI is such a broad term, which means so many things to so many MHNs due to the lack of clarity in the literature. I need to explore a wide scope of the literature, particularly looking at the Irish literature so as to make a justification for my study. Ethical approval has to be obtained from all of the HSE areas. I will be relieved when ethics has been approved to conduct the study from TCD.	**Field Note 3:** The writing of this chapter has been interesting, as it has helped me focus on the studies pertaining to PSI literature in more depth. **Field Note 4:** The ethical approval is such a long process; it has taken 11 months to get approval from all the research sites. How frustrating!
Chapter 2: Literature review	Sections: definition, developments of PSI, theoretical underpinnings, PSI training, types of PSI, barriers to and facilitating factors of PSI.	A good range of literature was located. This was interesting, I read abstracts and conference proceedings and other grey literature to get a handle on the different sources of literature. Now I need to get a referencing system in order to keep my references and articles managed.	**Field Note 5:** My search strategy has helped focus the appropriate literature relevant to the study, i.e. mental health field. **Field Note 6:** This chapter has taken me a long time, sickness and family bereavements has distracted me from focusing on the study. This work does not seem a priority at the minute. I hope that I can get back soon to working again on the study.
Chapter 3: Methodology	'What would the best approach to take to answer my aim and objectives?' Data collection and data analysis Framework for analysis?	My focus has changed since the proposal due to feedback from supervision and from my readings. Ensuring that the data collection methods stay aligned with research aim and objectives and the design of the study will be paramount.	**Field Note 10:** I am getting more and more confused: the more I read, the more things are not making sense to me. Paradigms, approaches, etc. are all used interchangeably in the literature. I have to get my head around these concepts in relation to my research! Questions for myself - *'What would the best approach to take to answer my aim and objectives? Is this a qualitative stance/lens that I use?'* **Field Note 11:** Happy with data collection methods, the methods blend well with case study research. **Field Note 12:** The analysis: This process was tedious and very time-consuming. I was drafting and redrafting the analysis 12 months later. Supervisors reviewed a draft; their feedback has helped me progress and see things differently.
Chapter 4: Conducting the research	Exciting but also challenging at times, especially gaining access to the research areas. This was a long tedious process. Meeting the MHNs was good. It was always worth travelling the long distances to listen to their stories.	Gaining access proved to go well, despite long negotiations with the DONs in the HSE areas and other gatekeepers. I am aware that successful Field Notes are to push thinking. I need to be asking questions such as 'what am I learning?' 'How does this case differ from the last? Context very important - big variations between sites as regards the implementation of PSI.	**Field Note 13:** On reflection, one concern was the perceptions of me as not only a lecturer but also an experienced MHN and a researcher. I was conscious that participants may view me as an authority figure. I did anticipate that some participants may have had difficulty in talking about issues around PSI; however as time moved on, surprisingly my relationship with the participants 'normalised' in that we saw each other as colleagues who

			were interested in getting a better understanding of the topic. My experience was that I needed to establish a degree of familiarity and a sense of collegiality with the participants to allow them to see that I had a researcher's hat on. However, the extent to which I was able to accomplish sufficient detachment to allow objective observation and analysis will be determined by the reader's perception of the description of the study. Moreover, it was important to develop broad links between the research settings so that the participants accepted my presence in the areas as a colleague, as an MHN and as a lecturer with a particular interest in PSI.
			Field Note 14: Overall, access to the research sites went well. I believe being a former MHN and the interesting topic that people could relate to were positive factors in gaining access. Data collection took a long time. I travelled many roads in the ice and rain early mornings so that I could reach the destination in plenty of time. It was important to remember that context was very important in particular to case study research. Some MHNs are expected to work in a psychosocial way. Are there any guidelines on how they should be done and documented? Must check this out.
			Field Note 15: What surprised me after 6 interviews was that many MHNs were not very confident using PSI in practice, despite them having training. Some suggested that they need to name what they do. PSI can allow us to do that and give credibility to their roles. Other allied professionals are well able to articulate what they do and are seen as more confident in team meetings. Some nurses mentioned using diluted forms of PSI, e.g. in interactions. The specialist professionals/nurses such as CBT therapists make good attempts in using different rating scales and outcome measures as part of their role. The clinical programmes should have an impact on the MHN's role, especially in the area of first-time psychosis.
			Field Note 16: What has struck me now from doing many interviews (17 to date) is how some of the participants are feeling more empowered because they value the experiences and how their work contributes and values the service user, but also how they contribute to the teamwork

			within the organisation. However, some nurses believed that, as they are 'pigeon holed', they could only do certain things, for example, anxiety management. On the other hand, there appear to be many 'issues' for the MHNs. The different expertise and skill mix, implications of this for role development and for professional development. Cutbacks, staff shortages, lack of leadership and moving around in practice, no consistency across the cases so far! Moreover, I am actually finding writing Field Notes getting more challenging and difficult as I continue the data collection. At the beginning of the data collection, I had a lot of notes and typed them up. Now I jot them down in my notebook; I guess emotionally I'm getting more immersed in the data. I'm also getting tired of PSI (not good).
Chapter 5: Context description	Four research sites equal the four case study sites.	Many MHNs were frustrated by the lack of support from management and how the government are not ring-fencing enough monies for mental health services. The variations across the cases are startling! Some of the services in some areas are better developed that others. No equality in terms of the funding allocation for services.	**Field Note 17:** The current recession in Ireland has negatively impacted on mental health services. It appears to have curtailed training and education for most nurses. It also impacts on the organisations in terms of developing many community services. There are numerous nursing staff shortages; this means that nurses do not have enough time to concentrate on PSI, particularly in inpatient units where the working environment is chaotic. Nursing staff are constantly trying to keep the environment safe due to the unpredictable nature of client illnesses. Clinical supervision is not available for inpatient nurses; however, some MHNs have this support, particularly if they are CBT therapists, as this is an essential requirement for CBTs to practise.
Chapter 6: Findings	Interview 10: Participant not focused, not a lot of experience, vague, much more probing to obtain good data. Was pleasant and was very relaxed during the interview. It was a difficult interview as the participants kept going off track. I had to concentrate on keeping the participant focused. Interview 14: good interview - focused, appeared confident, was aware of what PSI were about, and described them well. Stress-vulnerability, assertive outreach, medication management, autonomy and caseload, training and education.	This participant was not as focused as the previous interviewees, however, it was a few days since the last interview - didn't feel I got good data but the interviewer was rather unsure of things – interesting, a young nurse with a few years' experience. Good interview – focused as an interviewee, appeared confident MHN. Had a fair understanding of PSI – reported that they should be an integral part of the MHN's role. Skill mix – different experiences – Support, team support and caseload support. Nurse-led interventions as much as possible – very open to PSI - assertive outreach, anxiety management, medication management, crisis work, family involvement. This participant had good working links between the acute setting and community.	**Field Note 18 - Interviews 1-14:** So far, what has struck me most I think in the interviews to date was that many of the participants had problems verbalising exactly what PSI were and most found it easier to give examples of instances in which they were applied. The majority seemed very happy with their peer support and many reported the absence of clinical supervision. Depends on where the participants are working, the acute areas have no structured support or clinical supervision; this should be integral to the MHN's role and function. In addition, many reported that managers do not often encourage nurses using PSI, thus the support is absent. Having confident roles were important in using PSI in practice. The lack of time was a recurring theme and the lack

Interview 2: busy role, stress-vulnerability model, autonomy, caseload and credibility.	The practice was based on the stress-vulnerability model; Integral part of the MHN's role had autonomy with caseload, and has control of the referral system. Therapist or Nurse – credibility! Training and education should be on-going and should be part of UG training.	of resources, which was due to budgetary issues. In addition, there were wide variations across the areas in how PSI were perceived and delivered. All participants believed that different approaches/skills are used with the less severe mental illness than with clients who have more severe mental health problems. The more severe the clients' problems, the harder it is to engage due to cognitive abilities etc. The nurses often practise diluted forms of PSI. Not all MHNs involve families in their work. Usually, referrals were sent to a family therapist if one was available in the services. Some MHNs take direct referrals from GPs; this does have a positive impact for some clients as they never have to be referred to a psychiatrist! No proper databases are available in most of the services. Moreover, the availability of further education and training is not consistent. In-house training can be provided, but it is not always possible to get the time out from the units to attend. The medical dominance is still alive in the services and some MHNs still practise within this framework. It is fair to comment that contemporary mental health service provision continues to be driven by psychiatric illness and disorder focus across the services. New graduate nurses must learn a new language - PSI as a scientific language is important.
Day hospital setting. Open policy, responsible for a wide range of clients. No clinical supervision. Professional language, caseload.	CNM2 in day hospital - very supportive of the staff and believes that the nursing staff are autonomous in their role and supportive consultants, nurse-led and nurses can have their say. Not sure, what clinical supervision is but a fair idea is that it is about support. Made a guess what PSI is all about, was not sure. Not using the professional language. The day can very be busy as there are no restrictions on the number of clients who attend on a daily basis.	
Interview 34: Motivated, expectation, psychiatric nurse training, responsibility, culture, integral role, PSI, documentation.	This participant works as a staff nurse in day hospital. The expectation that nurses work in a PSI way. Supportive and autonomous in their role. Support from manager and CMN2. Initial psychiatric nurse training has sown the seeds for PSI, it led the way to utilising PSI, however, it is the nurse's responsibility to endorse PSI and get the training. Enthusiastic and motivated and if a culture is set that PSI is developed it will happen. The nurse puts a lot of time into the planning and organisation in the sessions has printer etc. into the sessions: gives clients handouts etc., this is very important as part of the CBT interventions. PSI as an integral part of the MHN's role. Staff shortages always a problem, and not enough time. MHNs are not always consistent in the PSI documentation.	Interview 30: by this interview, I had a number of observations and hunches - the study is allowing the MHNs to provide an analysis of their role, therefore in the transformation of practice. Helps them evaluate their roles and skills they utilise. Real life context – what is real in practice as regards delivering PSI? After Interview 40, on a more personal level, I have found that the data collection had an emotional effect on me … I could relate closely to what most of the participants felt and reacted to situations in practice. The MHNs' encounters with the service users brought me back to when I was an MHN in practice. I got a sense that nothing much had changed but I had experienced glimpses of hope in that my research should have an impact in practice.
Interview 4: Day hospital setting, appeared confident about practice, however, no access to clinical supervision. This participant had undertaken a week's course on PSI and had support from management but the medical model is still dominant. No electronic notes, all nursing notes are done manually.	This nurse believes that PSI are alternatives to medication. Has experience in running anxiety management courses. No access to clinical supervision: was offered it initially when commenced the role as MHN. Regrets it now, does believe that it is important to see another perspective. Undertook PSI training for a week; this comprised of the use of different assessment scales and techniques. It was delivered by a PSI trainer from London. Has a good supportive management structure. The medical model still has power in some of the mental health services. It is the belief of this participant that	

| | | there should be a standardised way of working across the services as regards working in a PSI-orientated way. Day hospital is busy and sometimes not able to be focused due to the open policy of the day hospital. Nursing staff have to deal with a lot of demands and crisis in the working environment. Documents care generally and compiling the stats of the groups etc., no time! Has a computer in the setting; makes life easier but notes are all in a paper format. The notes follow the client but a lot of time is wasted at times looking for notes, if electronic, a press of the button, access to the information would be more efficient. | |
| **Chapter 7: Discussion** | Relationships and theoretical associations between cases, differences, similarities, variances, and client care activities. | As well as their age and geographical location being somewhat dissimilar, the case study sites vary in their ethos, organisational structures and client care activities. | **Field Note 24** - Overall, across the 40 interviews, there was a particular assertion that the use of different PSI with clients depended on the severity of the mental health problems. MHNs tend to use lower level nonspecific PSIs; for example, practical support, coping strategies, case management, medication monitoring, liaison or assertive outreach when clients who have complex mental health problems. The skills used mainly involve engagement and assessment. The reasons for the use of lower level interventions are cognitive problems such as poor memory recall or memory decline. Other problems include speech deficits, long-term effects from medication, decreased motivation and energy. The process is slow; MHNs do not often see a quick response to using these interventions. In contrast, the clients who present with discrete mental health problems tend to be offered higher-level specific PSIs such as CBT or family interventions. The skills are holistic, ranging from engagement, assessment and problem formulation to interventions.

There were other issues such as organisational and personal factors within the cases that hinder or facilitate the MHNs' use of PSIs. In particular, some MHNs have shared the view that large caseloads can be a barrier; the lack of time and support means that MHNs do not have enough time with clients, particularly within the inpatient setting. There is decreased staff morale and decreased autonomy and confidence within the MHNs' role. There are not many |

			opportunities to go on further training. There was evidence of a power imbalance where the doctor makes the final decisions about patient care. Power was something that was important for the psychiatrists. There was a lack of support from management and not enough resources to drive the implementation of PSI. As regards facilitating factors, they include lower caseload numbers, increased autonomy and confidence, particularly within the community setting. Participants who had access to clinical supervision and support from management were positive. There was the assertion that clinical supervision enabled MHNs to use a broader range of higher-level skills. However, the implication can be that caseloads can increase when MHNs are seen to be very skilled in their role. They tend to get a lot more referrals from the multidisciplinary teams. MHNs that have the necessary training and have autonomy and confidence are more likely to use PSIs that are tailored to client needs and have access to clinical supervision. MHNs that are in advanced positions such as a CNS or ANP execute multifaceted roles and provide care to individuals in various contexts.
Conclusion	Emotions, future practice, Reflective diary helpful.	Implications for practice – implementing PSI across the services. PSI should be integral to an MHN's role. Reflection - added quality, enhanced understanding. Signposting the reader! Practical skills to overcome difficulties. Challenging but rewarding.	**Field Note 25** - The reflection during the completion of the audit was a real means of reviewing the study to improve and inform future clinical practice. In addition, the diary was helpful in reviewing the development of me as a researcher, my critical and analytical skills, but also it helped with recognising my thoughts, feelings and emotions and how they are integral to the research process. It was important to be self-disciplined in noting important reflections. It highlighted to me that keeping a research diary does not disregard that the qualitative researcher is the main mechanism for data collecting, but provides a space for a conscious form of self-monitoring that identifies how connections among researcher, data and process can impact on the final research report. **Field Note 26** - I believe that the reflective entries in the form of a diary added increased quality and texture to the study in an attempt to highlight a holistic picture of the research process. This may be what Gadamer (1975)

			intended by 'signposting the reader' to what transpired in the research. **Field Note 30** – During the process, I the researcher was aware of the times that seemed more challenging than others. Reflection on these components, for example, the transfer interview and acquiring ethical approval or during participant recruitment. It was a matter of developing the practical skills to overcome difficulties. It is hoped in the future that personal coping skills have been developed for facing with similar challenges with similar sources of uncertainty. Overall, the thesis was challenging, but a rewarding experience.

Source adopted from Spradley (1980)

11. Appendix 2: Summary of Studies

	Authors and Year	Research Design	Population Studied	Type(s) of PSI Delivered	Setting	Results – Post PSI Training (most cited)	CASP & ReLIANT: Quality
1	Brooker & Butterworth 1991	Quasi-experiment	CPNs	FI	Community	Facilitators Increased knowledge and improved attitudes Positive benefits for families Positive client outcomes Barriers Workload pressures Little management support No reduction in caseloads	Medium
2	Brooker & Butterworth 1993	Quasi-experiment	CPNs	FI	Community	Facilitators Increased knowledge and improved attitudes Positive benefits for families Adequate training More time spent with families Psychiatrist support Barriers No reduction in caseloads Little management support	Medium
3	Gamble *et al.* 1994	Pre-test/Post-test	MHNs	FI	Community & Inpatient	Facilitators Increased knowledge and improved attitudes Positive client outcomes Barriers Lack of on-going recognition, support, and enthusiasm from not only their peers but managers and	Medium

						health authorities	
4	Lam *et al.* 1993	Pre-test/Post-test	MHNs	FI	Community & Inpatient	Facilitators Increased knowledge and improved attitudes Weekly group supervision/ roleplaying/ experiential learning Trainees worked in pairs	Medium
5	Kavanagh *et al.* 1993	Survey	Mental health professionals	FI	Service based setting unclear	Facilitators Increased knowledge and improved attitudes Increased client outcomes Barriers Insufficient training and low staff levels Lack management support Demanding caseloads Over-reliance - medications	Medium
6	Lancashire *et al.* 1997	Pre-test/Post-test	CPNs	Generic PSI	Community	Facilitators Increased knowledge and improved attitudes Weekly clinical supervision Positive client outcomes Audiotape recordings of all clinical sessions with clients - increased confidence Barriers Limited resources	Medium
7	Milne *et al.* 2000	Quasi-experiment	MHNs & Mental health professionals	Generic PSI	Residential & Community	Facilitators Enhanced knowledge and improved attitudes Increased confidence Supervision groups PSI steering group	Medium

						Team meetings Client benefits	
8	Baker J.A. 2000	Experimental: course evaluations	MHNs & ward staff	Generic PSI	Inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes MDT philosophy of working <u>Barriers</u> Resource pressures Time constraints	low
9	Gray *et al.* 2003	Pre-test/Post-test	Community MHNs	Medication Management	Community	<u>Facilitators</u> Increased knowledge and improved attitudes Weekly clinical supervision Videotaped, role-played skills based scenarios PSI course curriculum developed by MDT, clinicians, academics and service users – provided the training Relevant to clinical practice Positive client outcomes	High
10	Brooker *et al.* 2003	Survey	MHNs & Mental health professionals	CBT, FI & Generic PSI	Community & Inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes Smaller caseloads Management support PSI strategy for training and implementation <u>Barriers</u> Insufficient training and lack of understanding from other staff Time constraints Difficulty finding suitable families Insufficient clinical supervision	Medium

11	Jones *et al.* 2005	Quasi-experiment	MHNs & Mental health professionals	Generic PSI	Inpatient	**Facilitators** Increased knowledge and improved attitudes Clinical supervision Continuing professional development.	Medium
12	Magliano *et al.* 2006	Quasi-experiment	MHNs & Mental health professionals	Psycho-education	Mental health centres	**Facilitators** Increased knowledge and improved attitudes Implementation plan and training strategy post training Regular clinical supervision Positive family and client outcomes **Barriers** Workload/time constraints No staff incentives Lack of management support - enthusiasm of staff decreased	Medium
13	Carpenter *et al.* 2007	Observational & self-reports	CPNs	FI, CBT & generic PSI	Community	**Facilitators** Increased knowledge and improved attitudes Clinical supervision Service user involvement during training Lecturers with specialist knowledge contributed to the training delivery A range of teaching methods, e.g. direct observations - video recording of the training	Medium
14	Ewers *et al.* 2002	Pre-test/Post-test	MHNs & Mental health professionals	Generic PSI	Inpatient	**Facilitators** Increased knowledge and improved attitudes MHNs experienced reduced frustration and hopelessness	Medium

						Reduced levels of clinical burnout in staff Barriers Lack of resources Organisational constraints	
15	Ekers *et al.* 2006	Pre-test/Post-test	Mental health nurses & Social workers	CBT	Primary health care settings	Facilitators Increased knowledge and improved attitudes Improved workload management Decreased waiting lists Variety of learning methods to reinforce learning Clinical supervision Increased confidence Barriers Lack of resources Organisational and institutional constraints - insufficient trained staff	Medium
16	Repper 2000	Single case study	MHNs, Psychiatrist & Mental health professionals	Generic PSI	Community, Residential & School of Nursing	Facilitators Increased knowledge and improved attitudes Clinically relevant – service users involved Increased confidence Barriers Unsuitable working environment Difficulty accessing suitable clients	High
17	Doyle *et al.* 2007	Pre-test/Post-test	Mental health Professionals	Generic PSI	Inpatient forensic unit	Facilitators Increased knowledge and improved attitudes Access to clinical supervision Influenced clinical practice Reduced levels of clinical burnout in staff	Medium

						Barriers	
						Inadequate training to apply the skills	
18	Forrest & Masters 2004	Interviews & course evaluations	MHNs & Mental health professionals	Generic PSI	Community & Inpatient	Facilitators Increased knowledge and improved attitudes Barriers Inadequate training Time constraints	Medium
19	Redhead *et al.* 2011	Pre-test/Post-test	MHNs & unqualified staff	Generic PSI	Inpatient	Facilitators Increased knowledge and improved attitudes Improved confidence Improved care plans and documentation of PSI activities Model of supervision	Medium
20	Sin *et al.* 2013	Survey	MHNs & Mental health professionals	FI	Community & Inpatient	Facilitators Increased knowledge and improved attitudes Increased confidence Training clinically relevant and interesting Barriers Unsupportive working environment Lack of management support in the prioritising of family work Lack of on-going clinical supervision	Medium
21	Mullen 2009	Review	MHNs	Generic PSI	Inpatient	Facilitators Increased knowledge and improved attitudes Improved client outcomes Adequate training Clinical supervision Increased professional credibility and	Medium

						job satisfaction Barriers Inadequate training Reliance on medication Custodial approach to care giving Role confusion Challenging mental health conditions Perceived time pressure/Workload demands	
22	Fadden 1997	Survey	CPNs & Mental health professionals	FI	Community & Inpatient	Facilitators Increased knowledge and improved attitudes Increased client outcomes Barriers Different work locations Difficulty finding suitable families Lack of clinical supervision Lack management support Demanding caseloads	Medium
23	Devane *et al.* 1998	Survey	MHNs	CBT	Community	Facilitators Increased knowledge and improved attitudes Barriers Insufficient training Lack management support Demanding caseloads Workload demands/Time constraints Insufficient clinical supervision	Medium
24	Bailey *et al.* 2003	Survey & focus groups	MHNs & Mental health professionals	FI	Community & Inpatient	Facilitators Co-working with MDT Flexible working Barriers Insufficient training & negative attitudes	Medium

						Lack management support Demanding caseloads Time constraints Insufficient clinical supervision	
25	Milne *et al.* 2001	Polit study: Survey	MHNs & Mental health clinicians	Generic PSI	Community & Inpatient	<u>Facilitators</u> Clinical supervision Peer support Management support Adequate training – transfer of skills <u>Barriers</u> Organisational constraints - lack of resources Time constraints	Low
26	Milne *et al.* 2003	Quasi-experiment	MHNs & Mental health care staff	Behavioural Analysis & Intervention training	Psychiatric hospital	<u>Facilitators</u> Supportive working environment – excellent support PSI manual for trainees Clinical supervision Peer support Adequate training – transfer of skills <u>Barriers</u> Time constraints	Medium
27	McCann & Bowers 2005	Survey & programme evaluations	Qualified Psychiatric nurses & unqualified Mental health staff	CBT & FI	Inpatient	<u>Facilitators</u> Trained cohorts of trainees from same areas Good leadership and management styles Sufficient training <u>Barriers</u> Challenges in releasing staff Inconsistency of staff in delivery of PSI Staff shortages Workload demands/Time constraints	Medium

						Insufficient clinical supervision	
28	Fadden 1997	Survey	MHNs & Mental health clinicians	FI	Community & Inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes Improved client outcomes Clinical supervision Increased confidence <u>Barriers</u> Staff shortages Workload demands/Time constraints Staff stress and burnout Difficulty finding suitable families Organisational culture	Medium
29	Bowers *et al.* 2005b	Pre-test/Post-test	MHNs & Mental health professionals	Generic PSI	Inpatient	<u>Facilitators</u> Supportive working environment Well- defined protocols for PSI delivery Sufficient training Positive client outcomes <u>Barriers</u> Lack of management support Time constraints	Medium
30	Sin & Scully 2008	Survey	MHNs	CBT & FI	Mental health care trust - (specific setting(s) not clear)	<u>Facilitators</u> Supportive working environment Access to clinical supervision Relevant policies in place Obtain additional funding for releasing staff <u>Barriers</u> Time constraints Staff stress and burnout	Medium
31	Griffiths & Harris 2008	Survey - telephone	Managers & PSI-trained staff	Assertive community outreach	Community	<u>Facilitators</u> Supportive working environment Management support	Medium

						Implementation plan and training strategy post training Barriers Insufficient clinical supervision Work demands/Time constraints	
32	Crowe *et al.* 2010	Systematic review	MHNs	Psychoeducation, FI & CBT	Unclear	Facilitators Well- defined protocols for PSI delivery Barriers Lack of management support Time constraints	Medium
33	Prytys *et al.* 2011	Audit & interviews	Community Mental health teams	FI & CBT	Community	Facilitators NICE guidelines Barriers Limited access to therapies Workload demands/Pressure on time High caseloads Lack of specialist staff Staff stress and burnout Lack of resources Organisational constraints Negative attitudes towards the clients with psychosis	High
34	Jolley *et al.* 2012	Pilot study: Survey/evaluation	MHNs & Mental health staff	CBT	Unclear	Facilitators Established CBT training in collaboration with the local NHS training department Programme trainers – worked as therapists Clinical supervision Training relevant: trainees worked with people with psychosis in local services for at least two days/week during the training	Medium

						Positive client experiences Barriers Workload demands/Time constraints No protected time Lack of management support Over stretched and under-resourced services following training	
35	Fisher 2014	On-line survey	MHNs	General Psychological therapies	Community & Inpatient	Facilitators Improved client outcomes Positive attitudes towards PSI Barriers In adequate management support Problematic leadership styles Low confidence/morale/self-esteem of staff Low training opportunities Overemphasis on biomedical treatments Workload demands/Time constraints/High staff-patient ratios Staff shortages/High staff turnover Unsuitable clients	Medium

Key: CPNs=Community Psychiatric Nurses; FI=Family Interventions; MHNs=Mental Health Nurses; CBT=Cognitive Behavioural Therapy.

Summary of Irish Studies

	Authors & Year	Research Design	Population Studied	Type of PSI Delivered	Setting	Results – Post PSI Training	CASP & ReLIANT: Quality
36	Jackson & Stevenson 2000	Qualitative: Focus groups	MHNs	Generic Nursing Activities	Mental Health Services - (specific settings not clear)	<u>Facilitators</u> Increased therapeutic relationships with clients <u>Barriers</u> Unsupportive working environment Workload demands/Time constraints Staff shortages Authoritative way of working	Medium
37	Cowman et al. 2001	Qualitative : Non-participant observation, activity log & documentary data	Psychiatric nurses	Generic Nursing Activities	Community & Inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes Increased autonomy and confidence <u>Barriers</u> Workload demands/Time constraints	Medium
38	Deady 2005	Qualitative: One-to-one interviews	Psychiatric nurses	Generic Nursing Activities	Community & Inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes <u>Barriers</u> Medical model dominant Little management support Lacked autonomy Over-reliance on medications	Medium
39	McCardle et al. 2007	Survey	CPNs	Generic Nursing Activities	Community	<u>Facilitators</u> Increased knowledge and improved attitudes Increased confidence <u>Barriers</u> No supporting working environment	Medium

						Large caseloads	
40	O'Neill *et al.* 2008	Qualitative: Focus groups	MHNs	Generic PSI	Mental Health Trust - (specific settings not clear)	<u>Facilitators</u> Increased knowledge and improved attitudes Increased autonomy and confidence <u>Barriers</u> Time constraints	Medium
41	MacNeela *et al.* 2010	Qualitative: 'think aloud' task performance approach	MHNs	Generic PSI	Community	<u>Facilitators</u> Increased knowledge and improved attitudes Increased autonomy and confidence <u>Barriers</u> Authoritative way of working	Medium
42	Butler *et al.* 2013	Survey	MHNs	Generic PSI, FI & CBT	Community & inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes Increased autonomy and confidence Goode nursing leadership <u>Barriers</u> Staff stress and burnout Lack of clinical supervision High caseloads/Time constraints	High
43	Maruthu *et al.* 2013	Survey	MHNs	Generic PSI	Community & inpatient	<u>Facilitators</u> Increased knowledge and improved attitudes Increased autonomy and confidence <u>Barriers</u> No access to booster training Time constraints	High

12.   Appendix 3: Letters of Ethical Approval

To maintain confidentiality and anonymity, all identifying features (e.g. name of HSE site, signature of the chair of the ethics committees) have been blocked out.

Dámh na nEolaíochtaí Sláinte,
An Chéad Urlar, Foirgneamh na Ceimice (an sineadh)
Colaiste na Tríonóide,
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Faculty of Health Sciences,
1st Floor, Chemistry Building
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Ms. Siobhan Smyth
School of Nursing and Midwifery,
24 D'Olier Street,
Trinity College,
Dublin

16 August 2012

Study: Psychosocial Interventions in Irish Mental Health Care Settings.

Dear Applicant(s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in May 2012, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely,

Dr. Ruth Pilkington
Chairperson
Faculty Research Ethics Committee

Supervisors:

Dr. Edward McCann
Dr. Jan De Vries

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
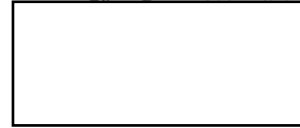
Ms. Siobhan Smyth
School of Nursing and Midwifery
NUI Galway
Galway

June 19th 2012

Re. Research Ethics Application

Dear Ms Smyth,

The Research Ethics Committee (REC) at ▮▮▮▮▮▮▮▮ Hospital has received your submission for ethical review of the study "*Psychosocial Interventions in Irish Mental Health Care Settings*".

The study underwent expedited review and the REC Chairman has given a **favourable ethical opinion** for the study.

Documents reviewed:
- Application form
- Protocol
- Invitation letter
- Information sheet
- Consent form
- Questionnaire
- Interview Schedule
- Insurance Cert
- Recruitment Flyer
- Access permission letter
- PI CV

The REC requires that approved studies submit an annual report to the REC. The annual report for the above study is due on July 18th 2013.

Yours sincerely

![HSE logo]

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

21st June, 2012.

Ms. Siobhan Smyth
Lecturer
School of Nursing & Midwifery
National University of Ireland
Galway.

Ref: C.A. 726 - Psychosocial Interventions in Irish Mental Health Care Settings

Dear Ms. Smyth,

I have considered the above project, and I wish to grant Chairman's approval to proceed.

Yours sincerely,

Chairman Clinical Research Ethics Committee.
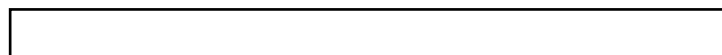
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

31 July 2012

Siobhán Smyth
School of Nursing and Midwifery
NUI Galway
University Road
Galway

Re: Research project:
Psychosocial Interventions in Irish Mental Health Care Settings.

Dear Siobhán,

Thank you for your letter and documentation explaining your PhD research project. I understand you have received confirmation from [   ] Acting Director of Nursing, in support of your study. Having examined your proposals and the ethic committee approvals attached, I am happy to confirm that I also support your work in this regard and interventions with the nursing staff within this service.

Yours sincerely,

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

11th July 2012

Ms. Siobhan Smyth
Programme Director
School of Nursing & Midwifery
NUI
Galway

Re: Psychosocial interventions in Irish Mental Health Care Settings
==

Dear Ms. Smyth,

The research proposal referred to above was reviewed by members of the ☐ Research Ethics Committee.

Your request for Ethics approval has been considered and I am happy on behalf of ☐ General Hospital Ethics Committee to grant Chairman's approval.

However, the committee have requested that particular emphasis be adhered to in relation to patient confidentiality and ensuring patient consent during the observation study. The committee also requested that you link in with Director of Nursing in Mental Health Services.

Can I wish you well with your proposed study.

Kind Regards.

Yours sincerely

Reply Reply All Forward ▼ ▼ ▦ ▼ ⌂ 🖨 🖺 ✕ 🖹 ▼ ⬆ ⬇

Re: Hello

Smyth, Siobhan

To: Colm

Dear Colm - thank you! Much appreciated. Siobhan

Siobhán Smyth

On 18 Jan 2013, at 11:10, "Colm   wrote:

Siobhan, May thanks for sending on the information and Brendan has kept me updated so no worries. The best of luck with the study and let me know if you need anything. Thanks Colum

Director of Nursing

From: Smyth, Siobhan [mailto:siobhan.smyth@nuigalway.ie]
Sent: 17 January 2013 11:40
To:
Subject: Hello

Dear Colm – I am aware that Brendan   been in touch with you as regards the study that I am doing. I should have been in touch with you before now. I am emailing to thank you for our support with this and to check if you require anything else from me. I am attaching the ethical approval from Trinity; I think Brendan may have sent this to you already. Brendan is so helpful. Thanks again. Siobhan

<div align="center">

Siobhan Smyth
Programme Director (PGD/Masters in Education) School of Nursing & Midwifery
+ 353-91-49 2832   siobhan.smyth@nuigalway.ie
www.nuigalway.ie/nursing.midwifery

</div>

13. Appendix 4: Research Information for Study

Letter Seeking Permission to Access Research Sites

Siobhán Smyth
School of Nursing and Midwifery
NUI, Galway
Date

Name/Address

Dear (Director of Nursing)

I would be very grateful for your assistance. I am a Ph.D. student, in Trinity College, Dublin seeking to explore Mental Health Nurses' (MHNs) experiences on the use of Psychosocial Interventions in Ireland. I am currently working at NUI, Galway as a lecturer in mental health nursing and a former mental health nurse.

The evidence highlights that the research is scant on how MHNs are using PSI in the Irish context. This study is timely in light of the current developments in the mental health services.

The study will employ a multiple case study design, as it appears the most appropriate to answer the research aim and objectives. The data collection methods will be semi-structured interviews and non-participant observations. The sample will be got from four HSE sites. It is intended to interview approx. 40 MHNs (10 in each site), and of these 40, I propose to observe two MHNs from each of the sites followed by an interview. It will be important that I will be able to shadow the MHNs once they get permission from the client. This is already acceptable practice in mental health as student nurses are constantly shadowing MHNs as they work with their clients. The length of the interviews should be approx. 60 minutes. The MHNs can stop and end the interview at any time and if they agree to be observed, the same applies, they can decide to stop or withdraw at any time. I will obtain written consent from the MHNs who agree to participate and verbal consent will be obtained from the clients. Information will be available about the study in the clinical areas.

The inclusion criteria for including the nurses are as follows: *MHNs who have undertaken PSI training and who currently uses PSI in practice.* I will gladly do a presentation of my ideas about this study to your team at any time. This can give everyone an opportunity to ask questions about the research and help to clarity any concerns that people may have. I believe that this study is an exciting endeavour that will provide an in-depth picture of PSI in Irish the mental health care settings. It is envisaged that the outcomes would be used to inform future policymaking and contribute to offering improved psychiatric/mental health nursing care. The name of the organisation or the MHNs' names will not be identified when the findings of this study is reported and finalised.

I hope that you are interested in the focus of my research and its possible outcomes. I would be grateful if you would kindly agree to let me gain access to your clinical area, and inform the nurses know about my research. You can ask them to contact me at the number or email below if they are interested in participating in the study. If you have any further queries or concerns, please do not hesitate to contact me on ---------- or email me at xxxxx.

Yours Sincerely,

Siobhán Smyth.

Covering Letter to Participants

Date

Dear

I would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it involves. As part of my higher degree in Nursing, I am very interested in hearing from mental health nurses about their experiences of using psychosocial interventions in their practice. I got permission from your Director of Nursing to conduct the research, who would have informed you about the study, and who would have asked you to contact me.

Please find attached an information sheet and consent form. If you are interested in taking part in the observations and/or interviews, please phone me on ---------------. Then we will arrange an interview and/or observation time. The interview and observations will take place at a location most convenient for you. You can forward the consent form back to me at the forwarding address or I can collect it before commencing the interview or observations.

In the meantime, if you have any further questions do not hesitate to call me at this number xxxxx.

Yours truly,

X _____
Siobhan Smyth
researcher

Siobhán Smyth

Information Sheet

PLEASE READ THIS INFORMATION SHEET CAREFULLY. IF YOU ARE WILLING TO BE OBSERVED AND/OR INTERVIEWED, YOU SHOULD SIGN THE CONSENT FORM ATTACHED. YOU SHOULD NOT SIGN THE FORM UNTIL YOU HAVE READ AND ARE SATISFIED THAT YOU UNDERSTAND ALL THAT IS CONTAINED IN THE INFORMATION SHEET.

What is the purpose of the study?

The overall purpose of the proposed study is to explore psychosocial interventions trained mental health nurses' (MHNs') experiences of using psychosocial interventions (PSI) with people with a mental health issue. I have a keen interest in this area as part of my higher degree in Nursing. I obtained permission from your Director of Nursing to conduct the research whom would have informed you about the study, and who would have asked you to contact me.

Who is conducting the study?

I will be conducting the research as part of my studies, and registered for the study at Trinity College, Dublin. I work as a lecturer in the National University of Ireland Galway.

Why is this study important?

I am about to conduct a study seeking to explore MHN' experiences of using PSI. There is evidence stating that PSI are not finding their way into routine practice. By focusing on the PSI-trained nurse's perspective, it is hoped that this study will contribute to knowledge and evidence in many forms. The need for nurses to maintain and develop their competence on an on-going basis has never being greater as the evolving landscape in the mental health services is challenging MHNs. It is recommended that a recovery perspective be adopted going forward within the mental health services in Ireland. The fact that there is limited evidence on how these interventions can assist MHNs in their work and improve client outcomes from an Irish perspective makes this study timely in light of the evolving developments in mental health organisations.

What do I have to do?

You will be asked to take part in an interview and be observed. If you agree, you will be asked to give your consent by signing a consent form to be interviewed and/or observed. If you agree to be observed, it is intended to observe you while facilitating a session with a client, and by the end of the observation; you will be interviewed by me. The interview will last approximately 60 minutes. If you give your consent to be interviewed, you will be free to end the interview at any time. As regards the observations, the degree of participation is directed by the nature of the clinical setting, that is if you work in a community or inpatient setting. The observations could be between 10 and 60 minutes. The ultimate objective of the observation and interviews is to arrive at a comprehensive understanding of the topic. I will be using non-participant observation. This means that I will just be sitting in a room observing you having a session with your client; I will be taking some notes as I observe with your consent.

Who will interview me?

I will be doing the interview; I am an experienced MHN and an experienced researcher.

What will happen when I am being interviewed and observed?

The interview will take place in a location of your choice, and the information that you provide will be confidential to you and the interviewer. The interview will be free flowing and open so that you can feel free to talk about your experiences. With your permission, a digital recorder will be utilised in order to ensure that your recollections are accurately recorded. The observations times will also be agreed with you and done at a time that is convenient for you. You will have the opportunity to feedback and review what was recorded and written at the end of the interview. You can stop and end the interview at any time and if you agree to be observed, the same applies, you can decide to stop or withdraw at any time.

What are the possible risks to me of being interviewed or observed?

There are no immediate risks to you of being interviewed or observed.

What are the possible benefits to others?
Research studies show that evidence-based practice leads to higher quality care, improved patient outcomes and greater nurse satisfaction.

Will my taking part in the study be confidential?
The information that you provide during the course of the interview and during the observations will be confidential to the researcher and will be used solely to provide material for this research. Your name or the health service will *not* be identified when the findings of this study are reported and finalised. The information that is gathered during the course of the interview and observation will be stored securely by the researcher.

What will happen after the study is completed?
The researcher will prepare written transcripts of the digital recorded interviews. The transcripts will be used to build a written account of your experiences.

Permission:
This study has Research Ethical Committee approval from the Faculty of Health Sciences Ethics Committee, Trinity College Dublin and the HSE.

Further information:
You can get more information or answers to your questions about the study and your participation in the study from me. My details for contact are as follows--------------------

The information that is gathered during the course of the interview/observations will be stored securely by the researcher in a password-protected computer and as a paper version in a locked cupboard in a locked office in the School of Nursing and Midwifery at NUIG. Your name will not be identified when the findings of the study are reported.

Thank you for your time.

Consent Form

Participant Identification Number:

Study Title: Mental Health Nurses' Experiences of the Use of Psychosocial Interventions in Ireland.

Name of Researcher:

Phone details: xxxxxx

I _____ confirm that I have read the information sheet for the above study.

I hereby consent to be interviewed by _____ regarding my experiences.

I hereby consent to be observed _____ regarding psychosocial interventions in practice.

DECLARATION: (Please read and tick if you agree)
I understand:

This interview/observation will be audiotaped and that the tape will be destroyed when the results are complied. ☐

In writing of the report or any subsequent publications that may arise from the study my identity will be protected absolutely, i.e. my name will ***not*** be identified when the findings of the study are reported. ☐

I am free to withdraw at any time during this interview and observations. ☐

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction. ☐

The information that I provide during the course of the interview and the observations will be confidential to the researcher and will be used solely for the purpose stated in the accompanying information sheet. ☐

The information that is gathered during the course of the interview and observations will be stored securely by the researcher and will be password-protected on a computer. A paper version of all transcripts will be kept in a locked filing cabinet in a locked office in the School of Nursing and Midwifery at NUIG. ☐

I have received a copy of this agreement and I understand that the results of this study may be published. ☐

I have read the attached information sheet, I understand the purpose of the interview/observations, and I hereby give my consent to:

Participate in the interview

PARTICIPANT'S NAME (Block Capitals):

……………………………………………..

CONTACT DETAILS: ………………………………………….

PARTICIPANT'S SIGNATURE:

Date ……………..

Participate in the observations

PARTICIPANT'S NAME (Block Capitals):

……………………………………………..

CONTACT DETAILS: ………………………………………….

PARTICIPANT'S SIGNATURE:

Date ……………..

Statement of investigator's responsibility: I have explained the nature and purpose of this study to the persons named above, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the person named above understood my explanation and has freely given informed consent.

RESEARCHER'S SIGNATURE……………………………………………

Date……………….

14. Appendix 5: Information Poster

Information Poster

PLEASE READ

I am currently conducting a study exploring mental health nurses' experiences on the use of psychosocial interventions in Ireland. I believe that this study is an exciting endeavour which will provide nurses with more evidence in supporting clients whom they work with.

It has been recommended that a recovery perspective be adopted within mental health services in Ireland. The fact that there is limited evidence about mental health nurses' work from an Irish perspective makes this study timely in light of the current developments in the mental health services.

This study will contribute by providing more substantial research, and it is envisaged that the outcomes would be used to inform future policymaking and contribute towards a greater understanding that will offer improved psychiatric/mental health nursing care.

I will be present in the vicinity during the study period on the (date) and I will be more than happy to answer any questions that you may have.

If you have any further queries or concerns, please do not hesitate to contact me on xxxxxx. Thank you for your co-operation.
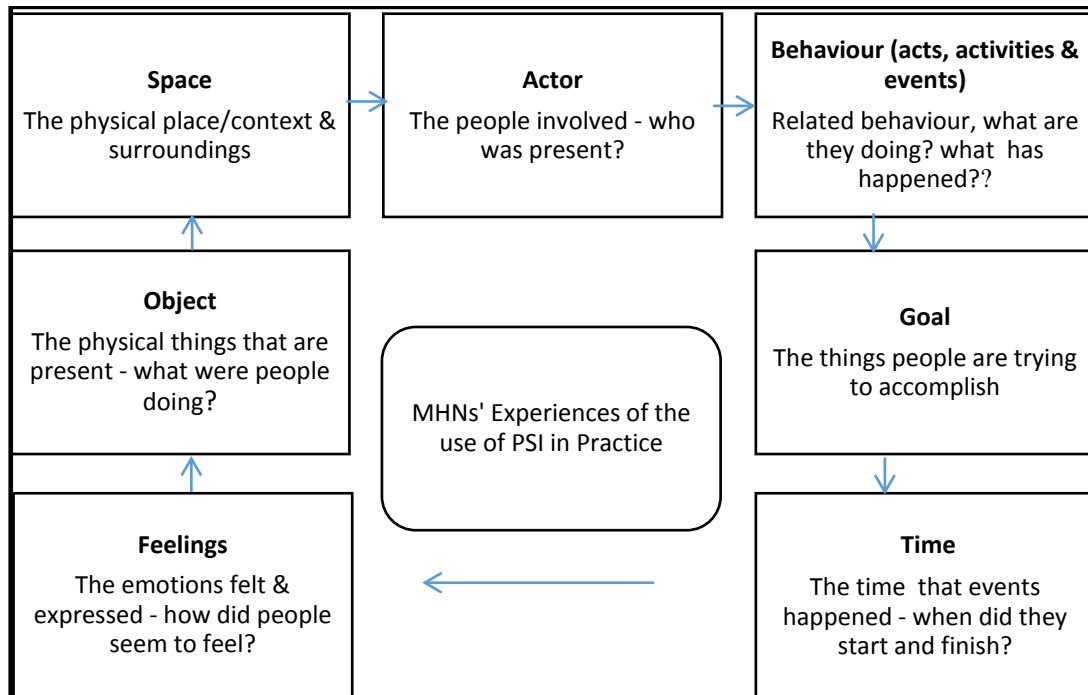
Yours Sincerely,

Siobhán Smyth
Researcher

15. Appendix 6: Interview Guide

Prompt Questions	Possible Probes
Could you tell me what your understanding and conception of PSI are all about? *(Objective 1)*	How would you describe your understanding of PSI? Could you tell me more about this please?
Could you tell me what knowledge and skills do you think are necessary for PSI implementation? *(Objective 3)*	Could you tell about your knowledge and skills that are necessary for using PSI? Could you tell me what your understanding and conception of what PSI are all about? Could you tell me what knowledge and skills do you think are necessary for PSI implementation? Could you tell me your experiences of using PSI to your work? Could you tell me about the factors that help or hinder you in using PSI in your work? Can you tell me if you think that different severities and types of mental health problems determine the type of PSI you use? Can you tell me more about this please? Anything else?
Could you tell me your experiences of using PSI to your work? *(Objective 5)*	What have been the most satisfying aspects of using PSI? What are or have been the most unsatisfying aspects? What supports are offered to you, for example, would clinical supervision be available to you? What other supports would assist you? Can you tell me how, why, if any? Could you tell me more about this please?
Could you tell me about the factors that help or hinder you using PSI in your work? *(Objectives 4, 6)*	Are there any changes occurring in your practice environment that help or hinder you using PSI in your work? If changes have been or are occurring, what has been the impact of these on your role as a PSI-trained nurse? What about on-going training and education? Are there any pressures on you to be involved in delivering PSI to your clients? Can you tell me how/why? Policy influences? Support? Could you tell me more about this please?
Is there anything else that you would like to say about PSI from your experience in your practice?	Could you tell me more about this please?

16.   Appendix 7: Observation Guide

Space The physical place/context & surroundings	**Actor** The people involved - who was present?	**Behaviour (acts, activities & events)** Related behaviour, what are they doing? what has happened??
Object The physical things that are present - what were people doing?	MHNs' Experiences of the use of PSI in Practice	**Goal** The things people are trying to accomplish
Feelings The emotions felt & expressed - how did people seem to feel?		**Time** The time that events happened - when did they start and finish?

Source adopted from Spradley (1980)

17.   Appendix 8: Demographic Questionnaire

Demographic Questionnaire

Code Number ☐

(Please tick box as appropriate)

Gender: Male ☐   Female ☐

Age: 17-21 ☐ 22-25 ☐ 26-30 ☐ 31-35 ☐ 36 + ☐

Ethnicity: White ☐   Asian ☐   African ☐   Afro Caribbean ☐   Other ☐

Grade: Clinical Nurse Manger ☐   Director of Nursing ☐   Staff Nurse ☐   Clinical Nurse Specialist ☐   Advanced Nurse Practitioner ☐   Other ☐

Years of Experience in Current Specialism: 1-5 ☐   6-10 ☐   11-15 ☐   16-20 ☐   20 + ☐

Professional Qualifications: RPN ☐ RGN ☐ RMHN ☐ RM ☐ Other ☐

Location of Work: Day Hospital/Centre ☐ Inpatient Setting ☐ Community Health Centre ☐ Other ☐

How many years have you been training using PSI (Please tick box as appropriate)

1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20 + ☐

Highest Level of Education Attained (Please tick box as appropriate)

Third Level Diploma   ☐   Third Level –Degree   ☐

Please Specify: _____   Please Specify: _____

Postgraduate Qualification   ☐   Other   ☐

Please Specify: _____   Please Specify: _____

Do you use a range of PSI in your practice?

     Yes ☐   No ☐

Please comment:

Thank you.

18.   Appendix 9: Confidentiality Agreement

Confidentiality Agreement

Transcription and/or Translation Services

I, **xxx**, transcriptionist and/or translator do hereby agree to maintain full confidentiality in regards to any and all audiotapes, videotapes, and oral or written documentation received from Siobhán Smyth related to her research study titled 'Mental Health Nurses' Experiences of the Use of Psychosocial Interventions in Ireland'.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audiotaped or live oral interviews, or in any associated documents;
2. To not disclose any information received for profit, gain, or otherwise;
3. To not make copies of any audiotapes, videotapes, or computerised files of the transcribed interview texts, unless specifically requested to do so by Siobhán Smyth;
4. To store all study-related audiotapes, videotapes and materials in a safe, secure location as long as they are in my possession;
5. To return all audiotapes, videotapes and study-related documents to Siobhán Smyth in a complete and timely manner;
6. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes, videotapes and/or paper files to which I will have access.

Transcriber/Translator's name:

_____

Transcriber/Translator's address:

_____

_____

Transcriber/Translator's signature

_____

Date_____

19. Appendix 10: Audit Trail

Audit Trail

An audit trail is a transparent description of the research process taken from the start of a research study to the development and reporting of findings. These findings are documented records that are saved regarding on what was done in a study. Malterud (2001) highlights the need to provide a detailed report of the analytical steps taken in a study:

> Declaring that qualitative analysis was done, or stating that categories emerged when the material had been read by one or more persons, is not sufficient to explain how and why patterns were noticed ... the reader needs to know the principles and choices underlying pattern recognition and category foundation (p. 486)

In this study, an audit trail was maintained throughout the research by adapting Lincoln & Guba's (1985) framework as a way to help structure the content of the audit trail, which helped the researcher to challenge and confirm interpretation of data.

Audit Trail For Thesis	
Category	**Audit Trail Examples**
Raw data	Proposal stage; all preparatory documentation, including discussion and correspondence about the proposal, correspondence with ethical committees, approval of notifications and meetings with supervisors were recorded and maintained in a diary. All documentation related to recruitment of participants (letters of invitation, information for the study, consent forms) are provided in **Appendix 4**. Examples of raw data were extracts from interviews and observations that are offered within the chapters of this thesis are in **Chapter 6.** The researcher's paper reflective diary also included dates for interviews, directions to research sites, thoughts and thinking processes before and after interviewing and ideas and thoughts about data and the emerging themes. In addition, the memoing during the analysis stage (**Chapter 4, Figure 4.5.1**) helped to keep the researcher focused on the aim and objectives for the study. Moreover, the memoing helped to gain a better in-depth understanding of the data and the context.
Data reduction & analysis products	Every step of the analysis is presented in **Chapter 4, Table 4.4** in a clear and transparent way. These steps were accounted for with diagrams, memoing and text during the various cycles of the analysis. The data analysis followed an iterative process in order to gain a full understanding of the topic, moving between data sets in an attempt to make meaning in answering the aim and objectives for this study.
Data reconstruction & synthesis products	Throughout the process, all the data sets (interviews & observations) and Field Notes informed the emergent categories and themes (**Chapter 6**). Data were examined with reference to the relevant empirical and theoretical literature (**Chapter 7**). Examining and interpreting the themes through the lens of mental health nursing supported by the interpretive approach provided a means of understanding the findings that emerged from this study and informed the contribution that this thesis makes to new knowledge. It also offered recommendations to improve mental health services for all involved (**Chapter 8, section 8.3**).
Process notes	Reflective entries and Field Notes are recorded throughout the thesis; entries that are more comprehensive are in **Chapter 6, 6.4.1 - 6.4.8** & **Appendix 1**. My documented thoughts and ideas during data collection helped in the development of the final overarching themes and sub-themes (**Chapter 6, section 6.2, Table 6.2**).
Materials relating to intentions	Short reflective and Field Note entries are offered throughout the text and extracts from the researcher's reflective diaries and entries are provided in **Appendix 1**. These reflections and Field Notes were all very valuable for the audit trail for this research.
Instrument development information	All forms and guides used in the study are included in the appendices.

Source adopted from Lincoln & Guba (1985), p. 319