The Turku Declaration

Identifying the unique contribution of Psychiatric and Mental Health Nurses (PMHNs) to the care of people with mental health/illness challenges

Document Development

- The initial draft was initiated at the Horatio Board meeting in Turku, Finland, October 2010 and developed till February 2011
- The Board of Horatio ratified Draft One 19th February 2011
- Draft Two was a further development of Draft One based on feedback from Board of Horatio members and members of the European Expert Panel of Psychiatric Nursing, published on the Horatio web site 6th April 2011
- Document progress discussed at the Horatio Board meeting in Amsterdam, July 2011
- Draft Three was distributed to the full European and international sections of the Horatio Expert Panel of Psychiatric Nursing for their comments and uploaded to the Horatio website September 2011.
- All member states were asked to provide comments concerning Draft Three with individual members, non-members and technical experts canvassed for their opinions and feedback. Additionally, other European mental health organisations and NGOs were invited to provide comments.
- Feedback from Draft Three was discussed by the Board of Horatio at its meeting in Stockholm 15th/16th October 2011.
- Final edit (Draft Four) was undertaken October/November 2011.
- The completed document was published on the Horatio web site (November 2011)

Section A. Introduction

1. Nurses have contributed for decades to the improvement of health outcomes and cost effectiveness of care for people challenged by mental illness, cognitive deficits, addictions, emotional and psychological distress or trauma.

2. Psychiatric and mental health nursing (PMHN) represents the largest workforce group in mental health care, with the widest area of clinical roles and the most varied responsibilities. Their expertise in the workforce is consistently lost (in large numbers) through migration and/or redundancy.

3. It is Horatio's conviction that PMHN has certain fundamental clinical roles and responsibilities, which are distinct from other core mental health disciplines. These are described in Section C and supported by the other sections of this document.

4. If PMHN is absent from care these roles and responsibilities will not be provided for and this will negatively affect treatment outcomes. Therefore, these roles and responsibilities underscore what constitutes nursing in this field.

5. It may well be that some of these roles and responsibilities can be undertaken by other members of a unified mental health multi-disciplinary team, (e.g. where members of different core mental health disciplines work together, pooling their skills for the provision of individualized packages of care) but they invariably originate from *mental health nursing science* research and practice development and will have been adapted for use by other disciplines, to suit their own work experience and responsibilities.

6. *Mental health nursing science* is seen as methods, interventions, care management processes or evaluative activities developed specifically for the work PMHNs, usually through nurse-specific or interdisciplinary nurse-led research and/or adapted from other sources, i.e. medical, psychological, psychosocial interventions etc., using robust practice development studies. It is, however, recognised that PMHNs may also use these approaches in their original format without nursing adaptation.

7. There exists an absence of continuity between different member state European PMHNs concerning their core competencies, educational preparation, support, management and clinical practice that has never been fully addressed by either national representative organisations or the EU Commission. This lack of harmonisation has produced a 'have and have not' culture with some PMHNs able to provide high quality, sophisticated individualised care, whilst at the other end of the continuum others lack the resources to function independent of other professions and subsequently offer minimal care.

8. Amongst member states there are historical differences in the titles used to describe those with mental health problems, including: service users; residents (for those in long term care facilities), patients (in hospital of clinic settings), consumers (often attributed to community care), people with the lived experience of mental illness and survivors (those who have survived mental health institutions). We have taken advice from European partner organisations on the best choice for this document and the word 'patient' will be used throughout for the purpose of consistency.

9. PMHNs have different levels of qualification and responsibility.

10. The implicit (and even explicit) work of PMHN may often be underestimated by the wider health community.

11. Despite their wide level of specialisation and broad competencies they have the knowledge to become, with university education, Advanced Nurse Specialists with expanded responsibilities. These specifically differ from their medical colleagues because they have different roles, despite the fact that there may be overlap between the two disciplines.

12. This document is designed to redress the current situation by identifying the unique contribution that properly educated, resourced and managed PMHNs should be able to provide to those for whom they have professional responsibility.

13. It should act as a rubric for European-wide professional development in PMHN and thus improve the care options offered to those with mental health problems.

14. It is recognised that there is a substantial difference in wording and concepts between countries and whilst this document has attempted to use generic terminology where ever possible there may be instances where these are unclear to some PMHNs and will require further clarification in later reviews of the declaration.

15. The following does not represent solely those things that PMHNs do, but those things that other professional groups do not do, or do not do in the same way as PMHNs. These are also areas where appropriately trained PMHNs should take the professional and/or clinical lead whilst working either as part of a unified multi-disciplinary team or as independent, autonomous practitioners.

Section B. Educational Preparation – PMHNs should…

16. Horatio has identified the following 'principles' for education, practice research and professional development and supports these for all European PMHN.

17. Receive formal education, preferably at university level, using a curriculum that encompasses the fundamentals required to offer patients intervention, care and management options consistent with the most up-to-date research in the field of mental health, and specifically the work of PMHNs.

18. Register with their national governing bodies, where these exist, as PMHNs only if they have received a recognised training/education programme. Nurses without specific PMHN education but who work with mentally ill patients must be encouraged to undertake courses at university level specific to their patient group. This should be a basic requirement of all nurse registering and governing bodies throughout the EU.

19. Seek support from their local and national universities to develop and deliver PMHN programmes at either undergraduate or postgraduate level consistent with the core requirements to work as a PMHN and/or advanced nurse specialist. Universities should be encouraged share these programmes internationally.

20. Should not be forced to work in areas of mental health care without appropriate preparation and support.

21. Receive regular continuing professional development opportunities (life-long learning) once graduating to ensure care quality is based upon contemporary evidence and best practice.

22. Have the opportunity to progress academically through the higher degree structure at both Masters and Doctorate levels in subjects appropriate to PMHN with career structures that support this potential increase in skills and knowledge.

23. Receive mentorship (during educational preparation), preceptorship (specific supervision for a limited period on first qualifying) and clinical supervision (throughout their professional career). At the very least PMHNs should be given access to these support and professional development measures.

Section C. Clinical Practice – PMHNs should…

Part 1 Working with patients

24. Undertake good practice through the development of a working, therapeutic, relationship with each individual patient. This relationship is constructed using models that may be nursing in origin or adapted from other professions. They vary from those used by other disciplines in both their intensity and the degree to which they may become the medium through which therapeutic activities are undertaken. They require knowledge and skill to perform and cannot be undertaken therapeuti cally without preparation and training.

25. Recognise that all patient contact requires specific interventionist activities. Often the focus of the PMHN's work is to have a nursing presence with the patient facilitating the development of the therapeutic use of self, using that alone to reach patients in crisis, severely depressed or highly disturbed. Professional befriending may also be the method through which further PMHN functions are undertaken with the long term or chronic mentally ill person.

26. Undertake biopsychosocial observations of patients to underscore clinical assessment activities.

27. Establish nursing diagnoses i.e. the impact of clinical symptoms on the patient's ability to manage daily living activities independently. These reflect a more dynamic and ever changing process than medical diagnoses and, though possibly linked to them, therefore differ from them. A patient's medical diagnosis may remain static throughout their life, whilst their nursing diagnosis will alter according to the patient's ability to deal with its affects.

28. Develop care plans specific to the individual needs of each patient using a variety of intervention options but based upon the imperative of establishing a robust therapeutic relationship with that patient.

29. Engage with the patient in mutual, collaborative, care planning, treatment and clinical outcomes, where possible, to establish a level of concordance that allows the patient to have control over their own care.

30. Evaluate within a given or set time frame the effectiveness of the care plan, its interventions, the assessment conclusions made as a baseline and the impact on the patient and to negotiate this with the patient.

31. Design further care plans once objectives have been achieved, or modified, and to maintain the collaborative relationship with the patient to improve the possibility of further success and recovery. The primary purpose of this is to work towards patient independence from the PMHN and may therefore include disengagement activities where appropriate.

32. Be the front-line staff in all mental health care situations (be they in-patient, community, home treatments, specialist unit, out-patients or disasters) – specifically, they are the only mental health professionals with responsibility for 24/7 patient contact within any in-patient setting.

33. Provide frontline interventions during psychiatric emergencies such as self harming, aggression towards others, violent outbursts, absconding, suicidal attempts, (as opposed to crisis intervention which is best dealt with using multi-disciplinary teams that should include a PMHN) and be responsible for their successful resolution using recognised harm reduction models and approaches.

34. Contribute to crisis intervention, either as a key worker or as a member of a dedicated crisis team, offering input based upon nursing science evidence.

35. Through their observation, prevention and psychosocial intervention activity, prevent the development of further mental health symptoms and the reduction of existing ones, reducing, where appropriate, the potential of institutional (re)admission.

36. Implement harm reduction activities/processes/models within care programmes for individual patients, based on identified need and symptom severity.

37. Apply a wide range of medical, psychological and psychosocial interventions, adapted to suit the functions of the nursing therapeutic relationship and the individual requirements of each patient. Whilst other professional groups (such as occupational therapists) may in certain circumstances also adapt these to their own clinical activities it is PMHNs who mostly utilize any and all these because they will be confronted with the widest range of symptoms and conditions and the most extreme range of symptom severity.

38. Work within the patient's environment, whenever and wherever possible, not just clinical areas, in a variety of different roles and with differing responsibilities and agendas. This may be as a lead case manager within a patient's own home or, conversely, as a care partner at a venue designated by the patient - including his/her choice of meeting within an in-patient setting.

39. Engage in patient-education that promotes mental health and wellbeing as well as psychoeducational activities related to illness, disorders and recovery.

40. Focus patient expectations on the hope of recovery using existing and developing models of rehabilitation and recovery. Attempting a meaningful return to society, or where this is not possible, to encapsulate social inclusion to the patient's optimum level of independence should be the primary objective of all PMHN best practice within in-patient settings. For PMHN working within community settings or with specialist patient groups, e.g. disturbed children, long term care, elderly residential settings, addictions or refugee mental health, the same principle of attempting to reach optimal social inclusion applies at all times.

41. Attempt to use the least restrictive or coercive approaches to achieve clinical success for patient satisfaction.

42. Intervene in all areas of the biopsychosocial matrix.

Part 2 Working on behalf of patients

43. Undertake a variety of multi-professional assessments, including those specifically developed for nurses.

44. Share comprehensive assessment information with other mental health disciplines within both multi-disciplinary and multi-agency settings.

45. Use intuitive expert skills to assess and react effectively to any situation and on the spur of the moment. PMHN is highly situational, perhaps more so than any other discipline working within mental health care.

46. Provide continuity of care for all patients (specifically within in-patient settings but in many community settings as the care coordinator). Whilst the role of community care coordinator can be undertaken by any of the core mental health disciplines it is invariably the PMHN who undertakes this role with patients who have mental health or psychiatric problems. Other disciplines tend to focus care coordination around other related problems, i.e. social needs, where these are the main identified impact on the patient.

47. Monitor the effects of medication and therapy on patient progress and convey information back to other members of the clinical team.

48. Support patients in all stages of any psychiatric episode or health state, often referring on to other PMHN colleagues who may undertake different clinical roles as the patient passes through different stages and their needs change.

49. Always take into consideration the patients' perception of their experience of their current mental health status and previous contact with mental health services. This must be carried out prior to initiating any further interventions.

50. See all patients as partners in their own care process.

51. Have a legal responsibility for the safety of patients and the general society. This will vary according the national mental health legislation but at all times PMHN must provide safe and effective care to the patients for whom they have clinical responsibility.

52. Reduce caregiver burden and strengthen their coping skills specifically within the area of clinical liaison, personal intervention strategies and psychopharmacological education.

53. Always take into consideration when developing or delivering care the caregivers' perception of both its impact on them and any specific implications for their ability to cope.

54. Use clinical advocacy – acting as a translator between patients/caregivers and other disciplines, specifically medical colleagues, communicating about the whole care process.

55. Lead on identifying and addressing barriers to medication adherence to maximize the benefits of medications and reduce the likelihood of relapse.

56. Contribute to harm and stigma reduction through patient advocacy and provide support with stigma management to individual patients.

57. Apply local, national and international social policy initiatives and/or legislation to PMHN, management, support and interventions.

58. Follow and apply mental health law and social policy actions in support of patient safety, harm reduction and formal admissions to care. In certain states there may be legislation, which outlines specific roles for PMHNs, and these must be carried out scrupulously. Where such legislation does not exist PMHN must adapt their practice to ensure patient rights are protected.

59. Manage human resources for the benefit of the patient whilst acknowledging that there may well be limitations in terms of manpower, skills and expertise. PMHN should never offer something to patients that it cannot, or does not have the resources, or responsibility, to deliver.

60. Advocate for best-practice, (that which is supported by evidence, has been proven to have the desired outcomes for a particular problem and does not place the patient at risk) both in PMHN and mental health care generally, at all times.

Section D. Research and Practice Development – PMHNs should…

61. Undertake PMHN research in disciplinary and interdisciplinary fields and research groups.

62. Provide other disciplines with research generated models of care, intervention or developments that can then be adapted for use within the host discipline's area of responsibility.

63. Undertake the application of mental health nursing science research to PMHN clinical practice. This also applies to translating existing knowledge to the improvement of PMHN efficacy using robust models of practice development.

64. Apply nursing science to most mental health care activities, differentiating their work from that of other mental health disciplines who may also be undertaking similar roles and responsibilities.

65. Identify areas of their work, roles, responsibilities or interventions that require either audit or clinical governance. Once this has been undertaken and a baseline of clinical or professional need has been established best practice alternative/developments should be identified to modify the situation. These should be implemented and evaluated for their efficacy using robust practice development models. Where there is no existing best practice alternative it is PMHN responsibility to develop one (See item 61).

66. Engage in practice development that blends the person-centred culture of PMHN, through positive relationships between individuals and teams, personal qualities and creative imagination, with practice skills and practice wisdom. The outcome of such activity should be embedded in the corporate structure of employing authorities thus ensuring that PMHN is an essential component of any organisations core functions.

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