Playing our Part

The work of graduate and registered mental health nurses

An independent review by the Foundation of Nursing Studies

Emeritus Professor Tony Butterworth CBE
Dr Theresa Shaw

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11-13 Cavendish Square, London W1G 0AN
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1. Foreword: the context within which this report is written

Playing our Part was completed early in 2017 just as the UK Prime Minister announced a call to action on mental health. The Foundation of Nursing Studies (FoNS) welcomes any renewed political focus on the mental health agenda. We believe graduate and registered mental health nurses are well placed to play a significant part in public mental health and wellbeing, and this report offers some proposals to optimise this role. It is important to note that the report focuses on the work of graduate and registered mental health nurses; in doing so and in suggesting ways of improvement, we are clear the beneficiaries must be people who experience mental illness.

This work did not set out to comment on health and social care funding or its impact on mental health frontline services, but debate and arguments on funding and poor service provision featured constantly during the course of the work.

There are significant moves to change health and social care through new workforce roles across the UK in response to mental health policies. The existing workforce must accommodate and adapt to these changes and work alongside those in the new roles. However, supervision requirements and new partnerships will need to be thought through with purpose. From the perspective of this report, it is important that workforce planners, employers and healthcare professionals do not focus on delivering numbers and creating 'new' workforce personnel without proper consideration of the deployment and redeployment of graduate and registered mental health nurses.

Meanwhile, the Nursing and Midwifery Council (NMC) is undertaking a wide-ranging consultation on nursing and midwifery competencies and standards. Graduate and registered mental health nurses are concerned this could lead to a single 'generic' nurse registration, meaning they will lose their specialist identity. This cannot occur without new legislation so the NMC's consultative work throughout 2017 will not change the different fields of registration. However, legislation will be needed to accommodate the new nursing associate role – now to be regulated by the NMC – so single registration could be brought forward at that point. A clear evidence base will be needed to support any move to 'absorb' mental health nursing in this way, 65 years after it was recognised as a specialist registration (Carr et al., 1980).

In this report the term 'we' is often used. To be clear, this shorthand indicates that FoNS is reporting the views of respondents and consultees with expertise in mental health services, education, research and clinical practice; the views are not necessarily those of the Foundation.

In undertaking this work, we have had to navigate the complexities of the health and social care system and professional regulation, but we hope we have cut through these to add clarity to the potential future role of graduate and registered mental health nurses. It is in this spirit of facilitating progress that FoNS is pleased to present this report.

Professor Tony Butterworth CBE, Chair
Dr Theresa Shaw, CEO
Foundation of Nursing Studies

2. Introduction: the need to play a part

Across the UK, nurses are being asked to respond to significant changes in mental health policy, get involved in professional strategies from their Chief Nurses and prepare for changes in professional competence from their professional registration body, the NMC. Plans for a reformed workforce are asking searching questions of nursing and other health professions, and the response can either be passive acceptance or more active engagement. We believe that the work reported here and supported by FoNS can be recognised as a credible response to demands for change, which demonstrates a willingness to play an active part.

Key message

We believe the work reported here and supported by FoNS should be recognised as evidence of an active response from graduate and registered mental health nurses to significant policy changes

Why FoNS?

The foundation was asked by senior nurses and trust executives to undertake a consultation on the work of graduate and registered mental health nurses and this report is the outcome. FoNS (fons.org) is an independent charity carrying a distinguished reputation for practice innovation and has previously supported graduate and registered mental health nurses to undertake successful practice development projects. FoNS was pleased to accept this challenge and, following a scoping meeting, accepted the following brief.

The brief

- Consult with graduate and registered mental health nurses on the work that they do now and might wish to do differently or better
- Give people who use services and other health professionals an opportunity to comment and suggest ideas for improvement and innovation
- Suggest necessary changes to the work of graduate and registered mental health nurses so they can best respond to demands from professional and health policy development

Why graduate and registered mental health nurses?

This focus is deliberate. Without being clear about the capacity and capability of the existing mental health nursing workforce, introducing new roles risks providing answers to questions on workforce shortages not yet properly defined nor understood. Graduate and registered mental health nursing is a considerable workforce, with up to 38,000 registrants shown in data for 2016. Numbers have fallen by 15% in the past six years (Campbell, 2016) and with workforce planners across the UK looking to grow the speciality, it is right that we focus on their existing capacity and capability to address mental health service delivery.

There have been two significant UK-wide reviews of mental health nursing in the past 23 years: *Working in Partnership* and *From Values to Action* (Department of Health, 1994; 2006). Professional obligations are now somewhat more country specific and often tied into broader mental health strategies. That is as it should be, but this report has drawn input from across the UK. Observations on graduate and registered mental health nurses reported here are built up not from government strategies but from the profession itself, people who use services and other health professionals. We believe that they carry a strong validity.

Key message

Graduate and registered mental health nursing has sufficient common elements and consistencies across the UK to allow some general observations

There have been suggestions that a single nurse registration is now desirable and would help address the deplorable fact that people living with mental illness are more likely to die earlier by 10 or more years (National Institute for Mental Health, 2015). We fundamentally disagree. A more sustainable strategy would be to ensure that continuing professional development (CPD) and undergraduate programmes in all branches of nursing attend to deficiencies in skilled assessment of mental and physical health so all nurses can be proficient and skilled in both. (*Note: the term 'mental health first aid' is occasionally used in this report to suggest the acquisition of mental health assessment skills. There are various ways of developing these skills.)**

Key message

A view that graduate mental health nurse registration should be discontinued and made part of a single generic registration has no support from people who use services or from the nurses themselves

Challenging developments in mental health and nursing policy are to be found across the UK. We take as a starting point that the practice of graduate and registered mental health nurses has sufficient common elements and consistencies to allow UK-wide observations. We found illustrative case examples of innovative and evidence-based practice; we are convinced that innovation and improvement led by graduate and registered mental health nurses makes a significant contribution to the delivery of high-quality services to those most in need of them. Where their work can flourish, outcomes are demonstrably positive (Research Excellence Framework, 2014).

**In this report we use the term 'mental health first aid'. Although developed in Australia (Kitchener, 2010; Tutchener, 2010), the term is now being used more widely and within broader definitions. In this report, we use the term to mean confidence in mental health assessment by nurses.*

Investment in collation and dissemination of good practice makes absolute sense. FoNS already offers a model platform that could be expanded to accommodate more work on mental health practice.

Of course, we would not suggest that all is well in terms of mental health service delivery. We often heard at our roundtable events that most, if not all, complaints from people who use services are to do with accessibility and funding rather than with health professionals, but this must be set against some complaints about staff attitudes in patient surveys in individual trusts and boards. There is no room for complacency and we would urge the profession to continue to be self-critical, as well as to innovate and change.

Service users, families, service designers and academics quite rightly stress the concept of the 'whole healthcare team' as critical, and say the needs of people who use services should drive any initiatives. We wholeheartedly agree and wish to contribute to that a clearer view of the capabilities and strengths of graduate and registered mental health nurses, thereby enhancing conversations about 'the team'.

What next?

Throughout our consultation process each social media conversation and all outputs from our roundtable events were placed on our blog site (mhnurses.wordpress.com). The data still rest there, and are available for use by others. What is presented in this report is a product of those data, informed also by the conversations and contacts we have had with policymakers and others with experience and expertise. We anticipate and hope that the debates described here and the step changes suggested will stimulate influential 'others' to further action; indeed, the onus to act on all our suggestions inevitably falls on them.

> ***Key message***
>
> *We wish to contribute a clearer view of the capabilities and strengths of graduate and registered mental health nurses to conversations about the whole healthcare team*

We considered various approaches to our first steps in consultation. It is often the case that to gain an 'expert' view, so-called thought leaders are extensively consulted, sometimes to the exclusion of others. Experience shows that this can result in an incomplete picture and opinions that go unchallenged, meaning the consultation process risks becoming overly comfortable. Advice to FoNS suggested that building an initial dataset gathered through an open social media platform would provide a more robust starting point.

Using social media

Our first step was to create the mhnurses.wordpress.com blog site, to which a series of three discussion papers was uploaded. The papers used a framework of primary, secondary and tertiary prevention – a public health model of psychiatry (Caplan, 1964). At the end of each paper, questions were posed about the work or potential work of graduate and registered mental health nurses in each area. Three social media events were created in May, June and July to discuss each of the blogs in collaboration with @WeMHNurses. Using the well-respected #WeCommunities social media platform (wecommunities.org), open Twitter debates were held on each of the subject areas (WeCommunities, 2016). It is estimated that there were some 600 direct contacts with individuals and a potential reach well beyond that among social media users.

All data from the Twitter events were preserved and collectively analysed after the events. Arising from this analysis, a paper was placed on the blog site for critical consultation. This paper formed the basis of a second stage of consultation – a series of roundtable events across the UK.

Key message

FoNS used an innovative approach to expert consultation. A combination of social media and more traditional roundtable events provided rich returns

Roundtable events

The six roundtable events were hosted either by healthcare organisations or by universities. Some basic ground rules were developed for the hosts and FoNS attended all events. For each event invitations were offered to up to 30 participants, including graduate and registered mental health nurses, users by experience, other health professionals, service managers and students. Each participant received a briefing in advance of the event. The ground rules and briefing are both available on the mhnurses blog.

A common agenda for each roundtable covered three starter questions:

- What do graduate and registered mental health nurses do now?
- What would you like them to do differently?
- What new things should graduate and registered mental health nurses do?

Participants shared sticky notes that captured key points, which were then ranked and ordered collectively by all participants.

A second session at the events discussed three areas developed from our social media data:

- The education of graduate and registered mental health nurses
- Employment and graduate and registered mental health nurses
- Graduate mental health nurse identity

Outputs were again rated by participants. A write-up from each event was posted on the blog site for open comment and criticism.

Other engagement activity

Alongside these organised activities, our work was presented to conferences and through email contact with key players and influencers. As before these outputs were placed on the mhnurses blog site and remain there as publicly available open data.

FoNS undertook to engage with students, experts by experience, key influencers and other health professionals. We have kept contact with the Chief Nurses, the NMC, the Council of Deans of Health, Health Education England, NHS England, Skills for Health, the RCN, the Royal College of General Practitioners, The Royal College of Psychiatrists and NHS Employers. There were conference presentations to directors of nursing of mental health trusts and to the *Nursing Times*/*Health Service Journal* Transforming Mental Health conference in December 2016; we also attended the annual conference of mental health undergraduate nursing students and spoke to some 200 participants. Our work was also presented to the Network for Psychiatric Nursing Research and Mental Health Nurse Academics UK. We established an expert group of mental health nurse educators, who provided important critical insights into undergraduate mental health nurse programmes.

Lessons learned from the consultation and engagement processes

We suggest elsewhere that our engagement processes represented a sound and innovative approach and we would recommend the use of social media in this respect. Our use of locally determined roundtable events was productive but we became aware of the need for a longer lead time in establishing them. Pre-event reading material was valued by participants. Inevitably, our ambition to capture as wide a view as possible has left us feeling we might have done more, but time and resources did not allow this. Despite those constraints, we believe the work we completed and present here is sufficiently broad based to be valid.

4. The nature and uniqueness of mental health nurses

Clarity around the nature and uniqueness of graduate mental health nursing is of great importance (Hart, 2016). At the roundtable events people grappled with offering a succinct definition and often reverted to all-embracing if somewhat vague descriptions. They were asked the 'lift conversation' question: imagine sharing a lift with the Secretary of State for Health who asks 'who are graduate and registered mental health nurses and what do they do?' You have only three floors in which to provide an answer! While participants wrestled with this, there was some agreement that mental health nurses offer person-centred and evidence-based therapeutic interventions, create safe places of positive asylum and give expert professional help to those in mental distress and their families. While a more succinct definition may be difficult, this would be a helpful description for those unfamiliar with the profession.

> **Key message**
> *Mental health nurses offer person-centred and evidence-based therapeutic interventions, create safe places of positive asylum and give expert professional help to those in mental distress and their families*

It remains true that all nursing is a complex set of interrelated activities and, in many circumstances, a 'safety-critical profession' (Leary, 2016). It is the mental health nurse who oversees and is responsible for the most constant contact time with inpatients, in the home treatment setting and, increasingly, in the community.

During our conversations and social media exchanges, it became clear that graduate and registered mental health nurses feel a growing anxiety about the primacy and focus of their day-to-day work. Psychiatrists, allied health professionals, clinical psychologists, IAPT workers and primary care graduate mental health workers work collaboratively with these nurses – indeed there has been much good work to describe commonly held competencies, such as the 10 Essential Shared Capabilities for Mental Health Practice (McGonagle, 2014). However, many of our respondents said they felt their previous sense of equity with other mental health professionals was being eroded.

Our work has confirmed that people who use mental health care services greatly value the sustained contact nurses offer. However, the rush to provide session-based psychological intervention services has placed this subtle but valued relationship under threat. There is ample evidence that nurses are more than equal to the task of medication management (Gray, 2004), providing high-quality behavioural or psychodynamic interventions (Devane, 1998) and taking responsibility for case management (Simpson, 2003). This vital supportive work by nurses often goes undescribed or is referred to somewhat disparagingly as low- or secondary-level activity.

Unfortunately, graduate and registered mental health nurses often take for granted their valuable ability to create safe asylum and protective places of care for those in distress. Nurses are skilled at building psychosocial support systems and should be more confident of their work in this area and be prepared to articulate it with greater clarity. The psychosocial and interpersonal skills used by mental health nurses are critical and central to the delivery of care. Working with people who can be withdrawn, depressed, uncommunicative and sometimes aggressive requires great skill – skill that mental health nurses have in abundance.

> **Key message**
> *Graduate and registered mental health nurses must be better able to describe their work in building psychosocial support systems; these skills are critical and central to the delivery of care*

Robust work by Bowers (2009) and others has described the importance of people who use inpatient care services and the ways in which nurses create safe and purposeful care – this now needs translation into evidence-based undergraduate programmes and CPD.

> **Key message**
> *Working with people who can be distressed, withdrawn, depressed, uncommunicative and sometimes aggressive is particularly skilled work; mental health nurses have these psychosocial and interpersonal skills in abundance*

Link between mental and physical health

The connection between physical and mental health is now well documented; statistics showing that the life of those with serious and enduring mental illness is shortened when they have poor physical health are familiar and lamentable (Blythe and White, 2012). The title 'nurse' would in itself suggest graduate and registered mental health nurses can assess the physical wellbeing of those in their care. Reports from current students we consulted suggest this ability is largely absent from undergraduate programmes or has a low profile and minimal content. Equally interesting is evidence from our educators group that general nursing students were offered little chance to develop mental health assessment skills or mental health first aid. All nurses should hold these skills and undergraduate programme providers must address this shortfall. All educators and health employers have a responsibility to ensure nurses are competent in physical and mental health assessment.

Key message

To play their part in the physical health of those with mental illness and the general mental health of the population, all registered and graduating nurses, regardless of registration route, should have physical and mental health assessment skills

Underused skills

Graduate and registered mental health nurses hold significant skills that appear to be underused. Extensive investment has been made in advanced prescribing courses for these nurses but we often heard these skills were not being used well and that advanced medication-management skills were not being used in practice. This appears wasteful. The concept of the 'approved and responsible clinician' defined under mental health legislation was also reported as being underused. The reasons for this are unclear and should be further explored. Dix (2014) showed that in 2014 there were only 32 non-medical approved/responsible clinicians in the UK, of which only 14 were graduate or registered mental health nurses (see also Veitch and Oates, 2016).

There is still work to do in other areas. We mention two here as they were often raised in the process of our work. There is emerging evidence (Brooker, 2016) that graduate and registered mental health nurses feel ill equipped to engage in routine assessments of sexual violence and abuse often experienced by those with mental ill health.

Support and training would give these nurses greater confidence in their assessments. They also repeatedly expressed a wish to work more with children and young adults but their lack of experience often makes them feel unable to move comfortably into these services. There are practical solutions to this.

Rotational two-year contracts on graduation and a better theoretical and practical exposure to the needs of children and young adults during undergraduate programmes would make a huge experiential difference (Gamble, 2016). It should not be impossible to offer short 'experience' contracts to existing employees to make them feel more confident and skilled in this area. It is easy to be glib or tokenistic when highlighting the need to work with and for people who use services and their families. However, this was an important target of our work from the outset. People who use services become 'experts by their own experience' and know better than anyone else the day-to-day realities of living with mental illness. We heard continuously of a strong alliance between people who use services and graduate and registered mental health nurses; this relationship needs to be valued, nurtured and developed, particularly at a national level.

5. Summary of our key findings with suggested step changes

This work has identified several broad outcomes, which we have used to develop a series of necessary step changes that we hope will add a greater purpose to the work and result in better engagement of graduate and registered mental health nurses. Each is supported by content to be found further on in this report and should be read within that more informed context. We wish to preface this list by saying that there is a great deal to celebrate about the work of graduate and registered mental health nurses. They are a critical part of service delivery and have shown the willingness and the ability to innovate in their practice.

There is room to go further, however, and we would like to see these nurses play a more active part in policy development and be more confident and vocal about their significant contribution to caring for those with mental illness. We would urge graduate and registered mental health nurses, employers, senior nurses and educators to look again at this profession and its place in mental health care. We would hope a more active approach will lead to action to address the questions raised by outcomes of this work.

Key message

Graduate and registered mental health nurses want to play a more active part in policy development, be more vocal about their significant contribution to caring for those with mental illness and look again at their profession and its place in mental health care

The nature and uniqueness of graduate and registered mental health nurses: securing professional identity

At our roundtable conferences, it became clear that the professional identity of the nurses causes them concern. Mental health nursing has a long history and its progression to graduate status has been hard won. The title 'mental health nurse' is important and carries both status and professional obligations. Trades unions and the RCN, while helpful for employment purposes, are perceived to be insufficiently active in defending and developing the work of graduate and registered mental health nurses. There were calls from contributors for an alliance or a college of mental health nursing; the RCN made a welcome first step by holding a 'summit meeting' in this area in December 2016, but there is still much work to do.

We would urge the Chief Nurses in each of the four countries to endorse the good work of graduate and registered mental health nurses more regularly and publicly.

Key findings with step changes

A renewed alliance with people who need services and with experts by experience

We found continuous evidence of a strong alliance between people who use services and graduate and registered mental health nurses. We heard justified criticisms of service funding and delivery but this sustained relationship is viewed very positively. Service models that offer session-based interventions and better access are welcome but limited, in that supportive continuity can sometimes be lost in a drive to introduce performance measures that are often poorly implemented. Experts by experience have criticisms of service funding and access, and it is important that mental health nurses work in partnership with them to tackle this.

Step change 1

To take the next step in forming a more meaningful national alliance with those who use services and work together on matters of common concern.

Key people: Mental health charities, and graduate and registered mental health nurses, via a common national forum.

A new focus for education in mental health nursing

The undergraduate mental health nurse curriculum needs a fresh focus and a relevant evidence base. It is almost impossible to find a common specialist thread that produces graduate and registered mental health nurses and gives them professional identity; in some university curricula the evidence base appears to stem from academic personal preference. As well as a resolute response to NMC proposals on professional competencies in 2017, a consensus on an evidence-based spine to the undergraduate curriculum will be vital.

Step change 2

To continue a focused dialogue with key players about the establishment of an alliance or a college of graduate mental health nursing.

Key people: Chief Nurses; RCN; National Forum of Mental Health and Learning Disability Nurse Directors and Leads; Mental Health Nurse Academics UK; other influential professional leaders.

Step change 3

The creation of a standing conference of graduate nurse educators is imperative. It should be drawn from mental health academics and employers. Eventually, this might form part of a new institute/alliance.

Key people: mental health nurse academics; RCN; Council of Deans for Health.

An employment strategy for graduate and registered mental health nurses

Our evidence suggests graduate and registered mental health nurses are being underused by service providers and that employers could be less risk averse in using graduate nurses to their full potential. Failure to take advantage of prescribing skills, status as responsible clinicians and potential to benefit primary care amounts to underuse of an experienced workforce. While the secondary care nurse workforce is vital, unless mental health nurses can play their part more fully in primary care and prevention, opportunities will be missed.

Step change 4

A strategic examination of the employment of the mental health nurse workforce by senior professional leads and employers to determine areas of greatest impact for primary, secondary and tertiary services, and any necessary changes. This should include developing a clinical career pathway.

Key people: national workforce leads, NHS Employers.

Research activity and graduate mental health nursing

We were repeatedly told that clinical career prospects for graduate and registered mental health nurses are muddled to say the least, particularly in the development of clinical academic careers. We found considerable evidence supporting the research productivity of these nurses, and opportunities to develop clinical academic careers should be increased and widened.

Step change 5

Ensure 15 clinical academic scholarships, with five at postdoctoral level, are obtained by graduate and registered mental health nurses within the next five years.

Key people: Mental Health Nurse Academics UK; Council of Deans for Health; Association of UK University Hospitals.

Practice development and leadership

The gradual loss of well-found CPD for graduate and registered mental health nurses is lamentable. Despite the importance of sustaining and developing this workforce, little funding is available to support them. New CPD opportunities can be found through distance-learning programmes but these require different motivational skills (Futurelearn, 2017). The requirements of revalidation have rightly taken centre stage and there is an obligation to provide evidence of CPD. Programmes to develop nurses for new roles and new ways of working should not be abandoned, but funding for CPD is becoming hard to find. Credentialing may offer new opportunities for career development (RCN, 2016). A robust response to the competencies being developed by the Nursing and Midwifery Council is important. The NMC must be urged to consider capability to undertake clinical supervision, a key competence for all nurses.

As new workforce roles emerge, regular, high-quality clinical supervision is likely to be essential for patient safety, as well as for staff oversight, development and wellbeing. Its importance in everyday practice was raised repeatedly in our work. Graduate and registered mental health nurses cannot offer others good supervision without receiving it themselves. The Care Quality Commission has set out obligations for clinical supervision in England (CQC, 2013).

Step change 6

Examine alternative opportunities for CPD and scholarship awards. Make a commitment to the implementation of clinical supervision by all employers.

Key people: NHS Employers; National Forum of Mental Health and Learning Disability Nurse Directors and Leads; NMC.

6. A renewed alliance with people who need services and with experts by experience

Last year, the Picker Institute issued its extensive CQC-commissioned survey on community mental health, reporting that the areas of greatest concern to the respondents were service access, and a lack of time given to their needs and treatments (CQC, 2016). Equally, shared decision making was poor and care agreements were insufficiently personalised. These survey results show no real changes from 2015 or 2014. Similar issues were raised continuously with us during our work with graduate and registered mental health nurses. There is clear agreement between health professionals and people who use services of the need to work together on these common concerns.

We heard that graduate and registered mental health nurses have concerns about diminishing opportunities to sustain long-term supportive relationships with people with acute or recovering mental illness. Service models that offer session-based interventions and better access do bring benefits but these can be at the expense of the supportive continuity valued by nurses and by those using services. There is sound evidence to support the use of peer support, care planning and coordination (Simpson, 2016). Where there is collaboration and input from clinicians, relationships are seen as being more therapeutic, and where treatment options are more varied, services are rated as more recovery focused.

Key message

Mental health nurses have concerns about diminishing opportunities to sustain long-term supportive relationships with people with acute or recovering mental illness

There are areas in which graduate and registered mental health nurses fear they are having limited impact. Concerns around the mental health of children and young adults are currently high on the national agenda but we are not preparing graduating students to work confidently in these specialist community and inpatient services. While local relationships with schools and services may be developing well, there is little or no evidence of engagement with young peoples' mental health charities at a national level. It is here that the failure of national policy to build graduate and registered mental health nurses' capacity and capability to engage with people who use or need services is most evident.

After the last two major government reviews of mental health nursing (Department of Health, 2010; 2014) recommended that we should 'Work in Partnership' or take our 'Values into Action' much work remains to be undertaken to realise these ambitions. We would urge the profession to work more strategically with national mental health charities to bring about a step change in partnership and co-production.

7. Undergraduate education and the curriculum

This section considers entry into the profession as well as the undergraduate and continuing educational needs of qualified mental health nurses. It covers the existing workforce and the workforce of tomorrow.

Future entry into the profession

At the time of writing, the countries of the UK are beginning to differentiate their approaches to accessing nursing education. Scotland has declared no change, Wales will continue to offer educational bursaries but with obligations for employment after graduation, and England will withdraw bursary support in 2017. We will not dwell on the effects of these perturbations on recruitment and education, rather it is important to look at the different characteristics of those entering mental health nursing. They are likely to be older, in their late twenties or early thirties, and may already have financial responsibilities and family obligations. They will often already hold a degree and can thus receive accreditation of prior learning. Such entrants are unlikely to expose themselves to significant student debt and so the proposed apprenticeship degree route in England may appeal. Even if recruitment by self-funding holds up in some fields, it is particularly important to monitor applications into mental health nursing in the immediate future as it might become 'situation critical'. In England, the new nursing associates may, on successful completion of their trainee period, be able to enter pre-registration training if they wish to, with the support of their employer.

Key message
It is particularly important to monitor applications for entry into mental health nursing educational programmes – it may become 'situation critical'

Curriculum content

We consulted with a specially convened group of mental health nurse educators and met many others during our roundtable events, including practice educators and placement facilitators. There was agreement that mental health nursing is a particular discipline and that while there are common competencies, it can be clearly differentiated from general nursing.

We also heard that it is possible to offer a sound evidence-based curriculum; it makes sense to capture and use evidence from mental health nursing history, professional development, research, social and behavioural sciences, interpersonal and experiential processes, the latest outputs from biomedical sciences and management in the caring environment. Surrounding this with good mentorship and clinical supervision during placement experience makes it safer and more authentic. Conversations with students and with educators suggest experiences vary widely between universities. This cannot be right and we would urge the creation of a standing conference of mental health nurse educators so that an agreed curriculum spine can be established.

> **Key message**
> *We would urge the creation of a standing conference of graduate and registered mental health nurse educators*

If undergraduate and registered mental health nurses continue to be educated without preparation for the professional environment, we will be doing them and the healthcare system a grave disservice. Equally, our respondents spoke of moves to 'genericise' the curriculum; if this continues, the specific needs of people with poor mental health, and those of their families, will be badly served. The advanced and special skills of mental health nurses cannot be shoehorned into a generic programme; proper attention to developing such skills is vital. Experience working across the full age range, but particularly in children and young adults, is vital from a theoretical perspective and in terms of placements. We recognise this will be difficult to realise but it will be well worth the effort.

> **Key message**
> *Working with children and young adults is vital from a theoretical perspective as well in terms of placement experience*

Graduating students who become registered mental health nurses must be able to offer person-centred and evidence-based therapeutic interventions, create places of safe positive asylum and give expert professional help to those in mental distress across all age groups. Curriculum content and structure must provide the necessary theoretical and practical knowledge.

Educators, teaching and mentorship.

The location of undergraduate nursing education in the university sector has provided great advantages but questions are often raised about the importance accorded to teaching when set against a university's ambition to demonstrate research success. Some of our respondents felt undergraduate teaching has become a somewhat second-order activity. That said, universities are now more sensitive to the 'student experience' and the key experience for students is their degree programme. Most continue to support further joint appointments between employers and universities, more teaching in the clinical setting and better mentorship of students. Interesting views were raised about the potential for better linking of NHS trust-based educational facilities and universities. This would aim to enhance the educational enterprise not to replace it.

The Teaching Excellence Framework in Higher Education (*Times Higher Education*, 2015) is designed to offer a balance between teaching and research; it could be used to better advantage in graduate nurse education.

Changing the 'workforce footprint' of mental health nurses

The 'workforce footprint' of mental health nurses may need to change if they are to enhance further their contribution to the delivery of mental health services. Figures 1 and 2 below depict the current employment locations of mental health nurses and the shift that might have to take place in the future. This will prove challenging; workforce shortages are already critical across the UK as employers struggle to appoint experienced nurses. We are uncertain as to how this shift might be achieved but its importance is clear enough.

Figure 1: Current graduate mental health nurse workforce footprint

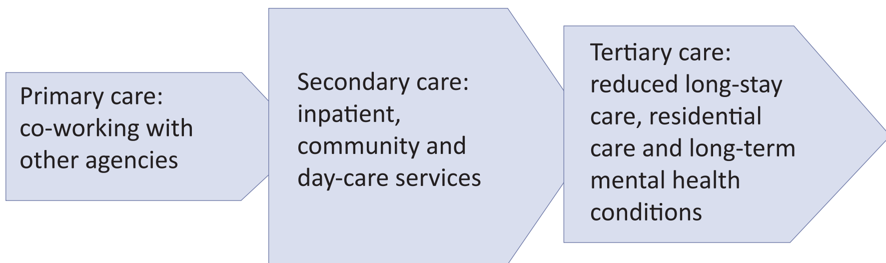
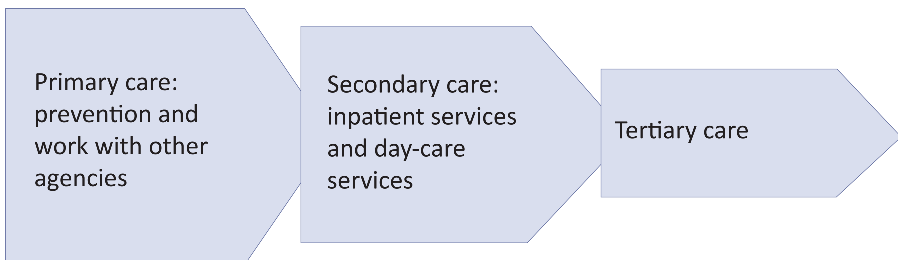


Figure 2: Necessary workforce footprint to achieve a change of focus



A public health model of preventive psychiatry

Adopting a public health model of care and prevention (Caplan, 1964) allows a focus on three significant elements of psychiatry: primary prevention (stop it happening); secondary prevention (early detection and treatment); and tertiary prevention (mitigating the ongoing or residual effects of mental ill health). Continuity of care across the three allows a more systemic view of the mental health/illness journey but this is still not a common experience for people receiving services.

Mental health policies in the UK are focusing on prevention. In England, the *Five Year Forward View for Mental Health* (NHS England, 2016) makes a case for greater investment in prevention,

helping to sustain the NHS and reduce health inequalities. This approach has implications for the mental health workforce and for those working across health and social care: first, for the workforce beyond mental health services, which makes a significant contribution to managing mental ill health, thus helping to reduce demand on inpatient services; and second, for the roles and skills with which mental health services support prevention and recovery and reduce mental health inequalities. Mental health nurses are equipped to enable and support the reduction of such inequalities, especially in communities with the worst health outcomes. They can impact on factors that create demand and instigate early intervention, better access and recovery.

Work in primary care and prevention

In primary care and prevention the ambition is to provide services that sustain health, strengthen capabilities, particularly with children and young adults.

> ***Key message***
> *To nurture an enthusiastic graduating mental health nurse workforce would appear to be important but no specific strategies are in place to facilitate their future employment in primary care*

Programmes already developed by the Institute for Health Visiting (2017) and for district nurses (Haddad, 2005) are particularly welcome in supporting mental health care in primary care across the whole of the workforce (Hardy and Kingsworth, 2015). The role of the mental health nurse in primary care is more varied. Community mental health nurses are well established but their work is evolving in very different directions. Their future is a little unclear and concerns were raised with us about demands to work on time-limited behavioural interventions to the exclusion of prevention or other long-term support. More work should be undertaken to look at their future role.

> ***Key message***
> *Work should be undertaken to look at the future and developing role of community mental health nurses*

There is a constant and growing concern that children and young adults are at increasing risk of suicide and self-harm (Young Minds, 2013/14). This growing number of young people who have self-harmed, tried to end their life or are experiencing other mental health problems deserve much better. This is not necessarily about extra funding; just as important is effective workforce deployment. Mental health nurses could make a much-valued addition to the primary

care workforce and to suicide-prevention initiatives, but so far few have found their way into such vital roles. Our conversations with undergraduate students indicated they are enthusiastic to gain early experiences in primary care and in children's and young people's mental health services on graduation.

> **Key message**
> *Undergraduate students indicate that they are enthusiastic to gain early experience in primary care and in children and young people's mental health services on graduation*

To nurture this enthusiastic workforce is important, but no specific strategies are in place to facilitate their future employment in primary care.

In the space between primary care and admission to specialist mental health services lie growing demands to work with the prison service, the police, and with ambulance and accident and emergency services. Evaluated attachments by graduate and registered mental health nurses are starting to be found in all these. The usefulness of such innovative work is now commonly understood and it could be much more widely implemented (Freshwater, 2007; Dimbi, 2016).

In Wales we were alerted to the Mental Health Measure (Mental Health Wales, 2010), through which people are legally obliged to be offered better access and support to services and advocacy, as well as a greater say in their own care; this continues after discharge. A review suggested that it offers welcome support but evaluations of its value for money are ongoing. (National Assembly for Wales, 2015). At face value, it appears a useful and sensitive piece of legislation that supports the work of mental health nurses and draws on their particular skills.

Work in secondary care and prevention

Secondary care and prevention aim to detect illness earlier and offer treatment quickly. There is a significant presence of mental health nurses in this area. Their work in acute inpatients often goes unsung and under-reported. We were very much encouraged by what we heard about their innovative and dedicated work in these settings. There is growing literature on the creation of safe and productive environments.

Evaluations of initiatives such as The Productive Ward (Mumvuri, 2010) Safe Wards (Bowers, 2014) and Star Wards (Janner, 2007) provide ample evidence of how to enhance inpatient care. Although the idea of a therapeutic environment is always the aim in this setting, a safe and beneficial organisational climate is an important first ambition (McAndrew, 2014). Acquisition of the core skills that create such care environments must be part of the curriculum 'spine' in undergraduate mental health nursing education.

Work in tertiary care and prevention

Sadly, considerable numbers of people who have active mental illnesses or who are recovering are to be found within the homeless and prison populations. Recovery-based services are making some inroads but there is much left to do. The work of Recovery Colleges (Perkins et al., 2012), in which nurses play an active part in delivering courses alongside people with lived experience of mental health problems is encouraging, particularly in Northern Ireland (ImROC, 2014). As an integral part of a mental health system that has a recovery approach at its heart, Recovery Colleges offer educational approaches to equip people to sustain their lives while living with or recovering from mental illness. As part of their offering, the colleges may ask staff to also join in and experience educational approaches to working with people with mental illness. This is a clear step towards acculturating mental health nurses to the recovery approach in tertiary care. It is unclear from our work whether undergraduate students are being offered experience of these programmes but this would appear to represent a valuable experiential opportunity and could be incorporated into their undergraduate programmes.

Key message

Working in Recovery Colleges would appear to represent a valuable experiential opportunity for undergraduate students

Admiral Nursing: working across ‘boundaries’ in dementia care

The distinctions we have made using a public health model can of course be challenged, and we wished to make special reference to and commend the work of Admiral Nurses in dementia care, which crosses those divisions. Admiral Nurses, provided by the charity DementiaUK (dementiauk.org), have created a viable co-produced model of working, in which they offer early detection, supportive work with families and carers, and structured and evidence-based interventions. Surrounded by clinical supervision and continuing education, this offers a powerful way of working with carers and families.

9. Research involving graduate and registered mental health nurses

There are two elements to this section. The first considers the capacity and capability of mental health nurses to be competent researchers and develop a research or clinical academic career. The second discusses research-based work being produced that is informing practice and helping to shape service delivery.

Developing the research capability of mental health nurses

We heard some confidence that all nurse undergraduates will have been exposed to a critical understanding of the process of research and the importance of evidence-based practice. The recent nursing framework for England *Leading Change, Adding Value* (NHS England, 2016) highlights the importance of evidence in closing the care and quality gap by 'practising in ways which provide safe evidence-based care which maximises choice for people who use services' (p 11). Scotland's strategic aims talk of building the research capacity of nurses through undergraduate and postgraduate education (Scottish Government, 2014); In Wales, the *Key Priorities 2016-2021* talk of 'supporting the development of the evidence base for effective nursing & midwifery care' (White, 2016, p 2); Northern Ireland wants nurses and midwives to 'utilise practice development, research and benchmarking to integrate evidence based care' (2010).

For those wishing to pursue a research career on graduation as mental health nurses, the picture is less clear. A robust clinical academic career pathway for all health professionals is now in place in England (Health Education England) and is supported by extensive scholarship awards but it does appear that graduate and registered mental health nurses and their professoriate are not being particularly successful in securing funding to advance clinical academic scholarship. Data from the National Institute for Health Research personal awards scheme show the following picture for those wishing to work in mental health research (Table 1). Data for awards do not discriminate between the professional registration of applicants and so all nurses are included in that category.

Table 1: Applications to NIHR postgraduate scholarship schemes 2006-2016

Profession	*Predoctoral*	*Doctoral*	*Postdoctoral*	*N/A*	*TOTAL*
AHP	0	86	58	2	146
Midwife	0	10	1	2	13
Nurse	0	52	27	3	82
Medically qualified	28	145	158	2	333
Dentist	0	11	7	0	18

Of the applicants:

- Total nurses applying in the area of mental health: 56
- Total nurses awarded in the area: 16; 13 at doctoral and three at postdoctoral level

Application data do not allow the identification of mental health nurses as either applicants or supervisors but suggest only minimal success for applications to well-funded and prestigious schemes. This could be attributed to several things, including the relatively unsuccessful performance of all nursing in this awards scheme and the limited capability of supporting institutions in mental health. Steps are in place to address some of the shortcomings and the Association of UK University Hospitals (2016) has published new guidance on its website to make the necessary collaborations between the health service and universities much stronger.

Universities that actively engage in preparing research involving mental health nurses might do better to collaborate rather than compete in this area. The universities of Lincoln and Nottingham's research awards schemes offer a good case study in collaboration for early researchers (Mental Health, Health and Social Care research group).

> *Key message*
> *Universities that actively engage preparing graduate and registered mental health nurses to be researchers would be better to collaborate rather than compete for limited research training scholarships*

Research outputs

Evidence that nurse academics are capable and strong researchers is well described and has been thoroughly measured though a series of university research assessment exercises. The research of clinical academic nurses is often at the cutting edge, and highly relevant to service delivery and to people who use services. It can be seen in the provision of treatments and in the innovative delivery of services. While the nursing profession performs relatively well, teasing out the performance of mental health nurse academics from the 2014 Research Evaluation Exercise data is difficult. However, there is considerable evidence to show that evidence-based research contributes to the quality of service design and delivery (Research Excellence Framework, 2014).

> *Key message*
> *The research of clinical academic nurses is often at the cutting edge, and highly relevant to service delivery and to people who use services*

10. Developing mental health practice

It is natural that a report produced by FoNS would pay attention to practice development and, interlinked with this, professional development. FoNS' mission is to 'inspire and enable a culture across health and social care that values people, where services are the best they can be and staff feel appreciated and supported'. Our respondents frequently cited the paucity of practice and professional development opportunities and the variability of clinical supervision.

During the past 40 years, mental health nurses have led innovations in community-based care and behavioural approaches, and been active in developing courses in alcohol-dependency nursing services as well as in child psychiatry. These vanguard initiatives were supported by well-found education programmes and practice development opportunities, often under the auspices of a National Board of Clinical Studies. The changing nature of CPD means that long, experiential post-qualifying educational courses are no longer available. Other ways to gain experience and develop a stronger CV are now required for nurses wishing to advance their work and benefit service delivery. Our respondents reported that opportunities are now limited, funding almost non-existent and 'time out' for clinicians even for one-day conferences unlikely to be sanctioned.

Computer-based CPD is now more commonplace and professional development is likely to be tied directly to service need. While this is helpful, we note elsewhere in this report that even when nurses have undertaken programmes to become approved clinicians or expert in medication management, their employers often do not give them the opportunity to use this expertise. Postgraduate degrees address important matters such as research competence but are less likely to attend to practice development. The increasing number of applications to charitable funding sources for educational support such as the RCN Foundation (rcnfoundation.org.uk), suggests that employer funding support continues to deteriorate.

'Credentialing' as a means of continued professional validation and advanced practice appears to be gaining ground. The RCN (2016) has established criteria for a credentialing process, which include: a relevant masters qualification; an NMC recordable prescribing qualification; active NMC membership; and a job plan that shows a typical week and reflects the four pillars of advanced practice: clinical practice, leadership, education and research. The Australian College of Mental Health Nursing has a credentialing system in place, which allows recognition of advanced practice (ACMHN, 2017). Graduate and registered mental health nurses must grasp this agenda to further their professional credibility and positively safeguard the public.

Clinical supervision

We were concerned at how often we were told about uneven opportunities for clinical supervision. As new workforce roles in mental health and nursing begin to emerge, good practice would suggest these new staff will require purposeful clinical supervision; indeed, the importance of supervision in everyday work was repeatedly raised in our work. The needs of the existing workforce must not be sidelined amid the dash for a quick 'workforce fix'. Such new roles place additional demands on graduate and registered mental health nurses in terms of teaching, supervision and support. Respondents reported that these obligations have not been properly thought through.

A recent editorial in the *Journal of Advanced Nursing Studies* (White 2016) commented on the 'invisibility' of clinical supervision within policy agendas. We agree with this view and hope that the ongoing work of the NMC (2014) in developing nursing competence will attend to clinical supervision as a vital, active competence for the profession.

> **Key message**
> *Without properly found clinical supervision, staff wellbeing, the safety of people who use services and professional development all suffer needlessly*

There are obligations for clinical supervision laid out in the requirements of the CQC in England (CQC, 2013). Graduate and registered mental health nurses would do well to be familiar with these requirements and be bold in making sure they are respected.

Conclusions

Throughout this work, we were constantly struck by the enthusiasm of our respondents, be they nurses, people with lived experience or other health professionals. The upheaval of repeated service reorganisations have been borne with fortitude by both service users and NHS professionals.

Support for the work of graduate and registered mental health nurses is widespread, although there are significant challenges ahead for nurses, managers and policymakers. Delivery of the ambitious mental health policies across the UK will require health professionals to adapt their ways of working significantly. Bolder work at a national level with experts by experience should be more actively pursued, while educational programmes must also keep pace and deliver evidence-based, relevant undergraduate programmes.

Workforce planners, employers and professionals appear locked into delivering numbers and 'new' workforce personnel without proper consideration of the deployment and redeployment of the existing mental health nursing workforce. This could be a lost opportunity on their part. Nationally, professional leadership for mental health nursing is thin or absent – the workforce deserves better but waiting for someone to take the initiative on its behalf is likely to be futile.

As a largely graduate profession, nurses must be more resolute when it comes to shaping their own future through active engagement in policy. Nursing in general is undergoing seismic changes and therefore needs to take control of the agenda rather than sit back and allow 'others' to determine the direction of the profession. Mental health nurses, in particular, need to take the opportunity offered by the renewed focus on mental health policy across the UK to play a greater part in developing services that best support the people who use them.

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