pna

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A New Era Begins! PNA Headquarters

Incorporating:
Psychiatric Nursing,
Intellectual Disability Nursing
& other Nursing Specialisms

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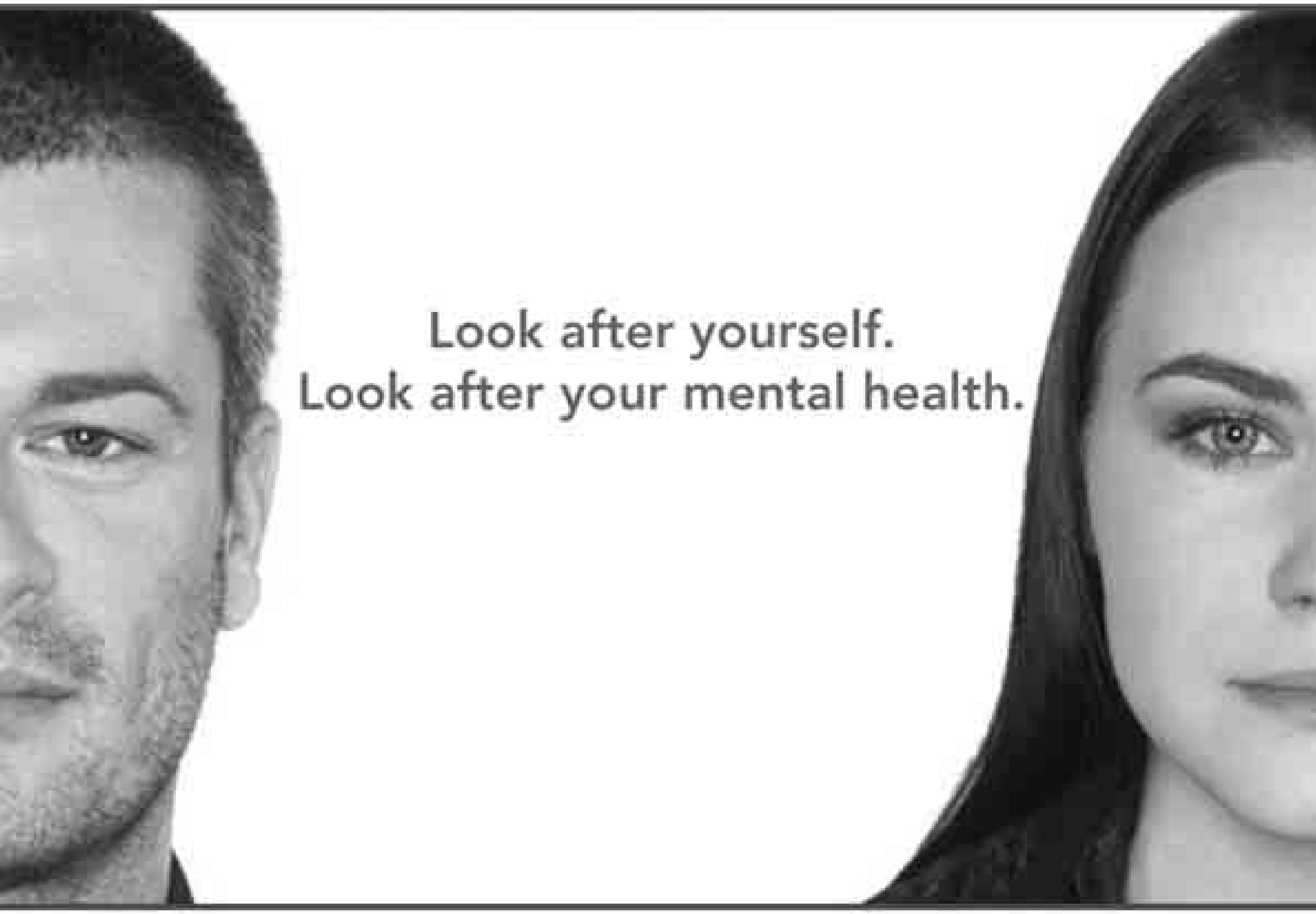

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editorial

How much more can Nurses take? A new Nurses and Midwives Bill that proposes to take away self regulation, abolishes the National Council, threatens Public Hearings of Fitness to Practice and increased retention fees for the privilege. A Benchmarking Report which dodged the issue leaving Nursing aspirations unrequited, and a Compensation Scheme which promises compensation for injuries Nurses are highly unlikely to experience and little or nothing for these injuries our members do experience. On top of all that a HSE in free fall, a Government failing their responsibilities to provide a decent health service for the people, and Nurses left to paper over the cracks with reduced staffing and disappearing resources.

Against this horrendous background the PNA & SIPTU are balloting for Industrial Action in pursuit of an adequate Compensation Scheme for Nurses injured by assault at work, to ensure the inclusion of real compensation for Psychological Trauma and to ensure the outstanding historical cases including the three nurses stabbed in Artane in 1993 are provided with a vehicle to provide them with Compensation.

Assaults on Nurses continue. Employers pay lip service to Training, Prevention and Risk Assessment. Staffing levels are being undermined creating greater risks to Nurses. Every Nurse realises that it is merely by the grace of god that they have avoided, so far, the horrendous stabbing experienced by the Consultant and Psychologist in the recent Limerick stabbing.

Minister Harney has walked away from her commitment to provide a scheme consistent with the PIAB. Her fat cat bureaucrats produced a cheapskate Insurance Scheme which is so appalling the term "yellow pack" would not do it justice.

We have no choice but to take this issue on once and for all and bring it to a reasonable conclusion. Let May 2008 be the definitive date for resolving the dispute, completing the campaign and providing our members with a scheme which is reasonable, responsive and respectful of the assaulted Nurse.

Des Kavanagh
General Secretary

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PNA SUBMISSION ON PROPOSED NEW LEGISLATION FOR THE REGULATION OF NURSES AND MIDWIVES BILL 2008

This document details the response of the Psychiatric Nurses' Association of Ireland to the call by the Minister for Health and Children, Mary Harney, T.D. to obtain the views of the public and key stakeholders on the draft new legislation. The response was compiled following consultation with the Union's membership and a series of consultation meetings with members of the PNA both former and present who sat on An Bord Altranais.

Size of the Board

An Bord Altranais is unique in so far as its elected members represent a uniquely large professional grouping spread across several disciplines and many specialisms.
Membership size of An Bord does not automatically equate to attendance at meetings.
The proposed reduction in the size of An Bord contributes to the reduction of representation from each discipline, and this is particularly noticeable in Psychiatry and Intellectual Disability.
The proposed reduction seems motivated by compliance with a generalised principle rather than reflecting the reality of a large diverse and multifunctional profession.

Membership of An Bord

Head 5 provides for the election of Nurses and Midwives to An Bord. It is noted that this provision reduces the elected membership from 17 to 9 a reduction of nearly 47%.
The Psychiatric Nursing reduction is 75%. This is most certainly disproportionate.
The Intellectual Disability reduction is 66% also disproportionate.
Head 5 (b) (ii) states that one person will be elected from Psychiatry and another from Intellectual Disability. It demands that one shall be from Clinical Practice but does not clarify how this can be assured.
The proposed Membership provides at 5b (vi) for the election of one person engaged in the care of older persons. Since there is not a separate register of Nurses of the Older Person who will constitute the electorate:

All Nurses
Those Nurses self declaring
Or will the electorate be confined to a single discipline
If Nurses self declare will that remove them from the other electoral rolls?

Or is it intended to provide representation for a Nurse from Private Nursing Homes as sought by their umbrella organisation.

Only one of the elected Nurses is guaranteed by designation to come from Clinical Practice. In the context of the business of Fitness to Practice this is hardly desirable.

Exclusions

Why are members of Local Authorities excluded from Membership of the Board? We believe Councillors, as servants of the democratic process have a lot to offer. Their presence is surely consistent with a drive for a "Public Board"

The reason given in the note re other amendments re increasing the autonomy of the Board and its independence from the Political Process sharply contrasts with some other provisions.

Head 7 provides for the Appointment of:

A Preliminary Proceedings Committee
A Health Committee
The PNA welcomes the proposed Preliminary Appointment Committee. However we need to clarify its makeup and how it will operate as referred to in Heads 27 & 28.
Historically far too many cases went to full Fitness to Practice process causing trauma to the accused, excessive workload for the Committee, more business for the Lawyers and contributed little or nothing to the protection of the public. What is it about the Preliminary Proceedings Committee which will guarantee /ensure that those cases not requiring or appropriate to Fitness to Practice will be finalised before referral to that body? In the past a similar informal arrangement operated but it did not prevent some cases being referred to Fitness to Practice which should not have been sent there.

Head 7 (7) seems to provide for the establishment of Preliminary Proceedings Committees and Fitness to Practice Committees which will remain in place for the duration of the Board. How will this work? On previous occasions getting a quorum for a hearing often proved difficult with 29 people available to make up one Committee.
We believe each of their Committees should have a quorum of five.

Head, 7 (8) provides that up to two thirds of that Committee may be external nominees. Clarification is therefore required re:
The Role of that potential two thirds
The "class of persons" from whom such nominees will be made e.g. Will they all be Managers? What will qualify a person as a potential candidate?

Head 14 provides for the possible payment of Allowances to the President, Board Members and/or Committee members.

We would welcome clarification of your thinking in this matter
e.g. Why is this being proposed now?

Is the proposal driven by an identified need to reward external nominees?

In noting how Head 16 gives the Minister the right to give "general policy directions" to the Board we look forward to you outlining the relationship between the Minister and a Board whose existence and functions are funded by a Nursing Profession, and in particular how this sits with the declared aspiration to increase the autonomy of the Board and assure its independence from the Political Structure.

Head 18 Rules

We note these provisions which provide for the setting of rules relating to the establishment of Committees. Against a backdrop of poor forward planning for Nursing Manpower needs in the 1980's and 1990's we want to acknowledge the work and success of the Careers Centre in prioritising Nursing as a career.

Head 19 proposes changes from the existing Divisional structure in so far as it seems to abolish the current arrangement whereby Psychiatric, Intellectual Disability and Sick Children's Nurses are registered in separate divisions and will in future be included in a General Division.
The reasons for and implications of this change need clarification. Several attempts have been made in recent years to introduce Generalist Training. However experience, research and literature reviews have led to retention of the current systems of education, training and registration. We are therefore concerned at the emergence in this section of a General Division as a replacement for the separate divisions now in use. This needs to be explained.

Specialist Division / Specialist Register

References to Specialist Division and Specialist Register is confusing and creates the impression that they are different entities when they are not.

Head 23

This section refers to the right of a Nurse to seek to have his/her name removed from the Register. We are concerned that in the case of an accused Nurse accepting responsibility and offering to retire, withdraw from the workplace, have her registration rescinded that such provision is not available.

Instead s/he is forced through an expensive investigation which may cause distress not just to the accused but to witnesses including patients.

Head 24

Education and Training.
9 (A) (i) (ii) refers to bodies which may deliver programmes: "of basic, post registration and specialist Nursing... education and training"
Please clarify if the bodies referred to includes "Centre for Nurse Education" (CNE's)
Does the term "Post Registration" incorporate continuing education as well as Post Graduation higher qualifications?
We are concerned that in this Section there is no provision to ensure that those delivering courses or course content have clinical or nursing credibility.

While understanding the need to comply with E.U. Directives etc it is essential that An Bord is satisfied that Nurse training at basis and specialist level is safe. In this regard it is a fact that what is deemed acceptable in many European Countries would not be acceptable to An Bord Altranais.

Professional Competence

Head 25 deals with the issue of continuing Professional Competence. We have examined this section in the context of provisions effecting Doctors under Section 93 of the Medical Practitioners Act. In this regard we note that it is the absolute obligation of the Nurse to maintain competence over a 40+ year career and where it is deemed necessary to up skill and re-educate her/his self at her/his own cost. In the case of Medical Practitioners the H.S.E. or other Employer "shall facilitate the maintenance of Professional Competence by registered medical practitioners".

A number of other issues require clarification:
What will trigger An Bord to require a Nurse to demonstrate competence? Will it in all cases be a referral to Fitness to Practice or can the process be initiated outside the Fitness to Practice Committee.
Who will judge whether a Nurse "demonstrates her/his relevant competencies to the satisfaction of the board?"

Continued Professional Competence should be supported, financed and facilitated by the Employer.

Fitness to Practice
Head 26 Fitness to Practice Complaints.

At 26 (i) (b) poor professional performance is included. At one level this is an understandable inclusion but it is once again the Nurse who carries the full responsibility and cost for defending herself in cases where allegations can and do emerge because:

Managers overload the Nurse
Managers owners fail to properly resource the service
Managers/owners put in place structures which undermine professional practice.

In its present form this section may result in many minor issues/cases being referred to the Preliminary Proceedings Committee rather than serious or persistent poor professional performance. There must also be an onus on employers to provide support and training to any Nurse guilty of poor performance.

Section 27 identifies a particular role for non board members appointed to assist the Preliminary Proceedings Committee which seems to pertain to the exercise of taking and reporting evidence for the Committee. This requires further clarification.

Head 28

We note that the Committee will consider reports or affidavits but will not "hear" evidence.

We believe a Preliminary Proceedings Committee should include one Nurse in Clinical Practice from the area/speciality in which the accused nurse practices, though this will be nigh impossible under the current membership proposals.

Immediate Suspension

In Relation to Head 29 the PNA believes that in cases where An Bord decides to make applications to have a Nurse suspended from the Register where it believes "immediate suspension is necessary to protect the public" such application should be made within a specified time scale thus supporting by the principle of 'urgency' or 'immediacy' It is our understanding that in at least one precedental case the Court refused the Boards ex-parte application for removal because, inter alia, the time lapse between the original application for Inquiry and that later application to the Court was not demonstrable of immediate need.
We therefore suggest that this process should be time limited.

Heads 30, 31 and 36

These provisions provide a range of options either in dealing with a complaint. We believe these important options need to be underpinned by Rules and Regulations which will ensure their use.

Head 30 introduces a number of interesting innovations which are welcome and in some areas require further clarification
e.g. 30 (2)(a) the option to refer a complaint to another body or authority requires further clarification.

30 (2) (d) The option to refer the complaint for resolution by Mediation or other informal means is also welcome but requires further clarification as to the kind of complaint that might be subject to mediation and the kind of qualifications/experience which might be deemed appropriate in those who "may attempt to mediate or otherwise resolve a complaint"

Fitness to Practice – In Public

Head 34 raises very grave concerns in so far as it provides for the hearing of Fitness to Practice cases in public.

The PNA's principle concerns in this matter have to be for the reputation, health and welfare of the accused person who is innocent until proven guilty.
The PNA has built up extensive experience over more than 20 years representing Nurses at Fitness to Practice Hearings. We are absolutely satisfied that some Nurses later exonerated would never have recovered from the public humiliation of having unsubstantiated allegations broadcast for public consumption.
We are aware of Nurses who while under investigation and later were under the care of a Psychiatrist. We believe the publication of their cases would have "pushed them over the brink".
Reluctant Witnesses who were prevailed upon to appear before hearings held in private and/or were willing to be frank in criticising service managers or Nursing Home owners/managers may be even less willing to appear before a Public Hearing.
Persons who are considering making a complaint to the Fitness to Practice Committee may well be discouraged from doing so because of the fear of a public hearing.
While it might be pointed out that other Professionals face public enquiries it must be pointed out that rewards in medicine and other areas far exceed those available to Nurses. They can afford different and more substantial support.

Head 35 (3)(b) appears to provide for the giving of evidence by affidavit. This most certainly requires explanation as it seems to remove from the accused person the right to have a witness cross examined. We believe this may be unconstitutional.

In relation to 35(b) the facility to impose a fine of up to €5000 is again an interesting concept. However it is nothing short of extraordinary that the maximum fine for a Nurse is the same as for Medical Practitioners. Justice surely requires that such fines relate to income and ability to pay. A Fine of €5000 nett may represent 25% of Nurses annual earnings but 5% of a doctors or 2% of a Consultants annual earnings.

Head 36

Where the Preliminary Proceedings Committee forms a preliminary view relating to a complaint should this committee have the right to invite the Nurse or his/her representative to "consent to censure or remedial action etc" so avoiding an expensive Fitness to Practice Committee Hearing?

Fitness to Practice – General Comment.

The PNA believes the recent judgement in the Hugh Court Judicial Review Proceedings in the cases of Prenderville v Medical Council and Murphy v Medical Council may be relevant to any new Act pertaining to Fitness to Practice proceedings. We would welcome clarification re same.

The PNA believes the process should be geared towards establishing truth. Instead it is prosecutorial. The CEO of the Board is placed in the position of prosecutor – his legal advisors being his prosecution team. In this context exoneration of the Nurse can be seen as failure on the part of the CEO and his team. In reality we should all be pleased to see a Nurse exonerated since such a result is positive for the Nurse and for her service / employer.

In this regard we believe the whole area of witnesses needs to be reviewed. Witnesses for the prosecution are paid expenses and provided with meals by An Bord. Defence witnesses are treated as less important, or lesser mortals.

Prosecution witnesses are screened before hand and in the event one's evidence is perceived to be of benefit to the defence that witness is not called. Is this acceptable?

Head 40 provides at (d) for the possible "transfer of Nurses registration to another division of the Register" needs clarification. While we might postulate that this section provides for the removal of ANP status we would welcome clear and unambiguous clarification.

Leadership, Support and Guidance

Traditionally when Nurses phone An Bord Altranais for support and guidance re Professional and ethical issues they are advised to phone the PNA or other Unions.

Section 58 purports to provide for the leadership, support and guidance of Nurses but raises questions as to whether this support will be real or illusory, whether general or specific.
The issuing of policy statements is an easy but somewhat vacuous response to the needs of Nurses "on matters relating to clinical practice". Up to now when Nurses have submitted statements to managers re issues of concern as provided for in the Code of Conduct managers have regularly binned those statements often in full sight of the complaining Nurse.

What is it about Head 58 which might give meaning or relevance to the stated aim?

Finance

The proposed New Act is capable of being read as changing An Bord Altranais from a Nurses' Board to the Minister's Board. When introducing the retention fee it was frequently argued by the then Minister, Dept. Of Health and Children, and representatives of An Bord that Nurses would in effect be paying the cost of self regulation and that the Board containing 17 Nurses from 29 members would in fact be Nurse led.

We will now have the extraordinary position that the Minister's nominees and therefore by association the Minister will control An Bord Altranais and its Committees ; yet Nurses will pay the cost for the privilege of Ministerial Regulation and control. This is absurd. The proposed abolition of the National Council will add further costs to the Board and therefore increase the retention fee.

Cost of Fitness to Practice.

It is a safeguard to all concerned, especially the accused Nurse, that proceedings are in accordance with High Court Rules. In assuring the safeguarding of the process the Chairperson of Fitness to Practice is advised by Counsel. This is reasonable.

However the insistence by An Bord that it must be represented by Solicitors and Counsel creates an obligation for the accused Nurse to be similarly represented. This creates enormous costs for the Nurse, unless s/he is lucky enough to be a member of a Trade Union who will cover the cost. The enormous costs are then carried by the Union.

In some cases which have been heard in recent years the Nurse was not a member of a Union at the time of the complaint and subsequently sought assistance from a Trade Union in defending her practice. The Union in turn could not expend the monies of members in securing the assistance of Solicitors and Counsel. Instead the Nurse was represented by a Trade Union Official who was not trained in either cross examination or High Court Rules. S/he was then representing a Nurse against the C.E.O. who was prosecuting the case through Solicitors and Counsel. This raises issues of fairness.

When Fitness to Practice first emerged under the 1985 Act is was presented to Nurses as peer review. What has emerged is a legalistic and expensive monster. In future the peer review element will be removed and replaced by a type of judgement by community. Is it necessary that it be so legalistic and expensive?

The cost to a Nurse in defending a case at Fitness to Practice case is similar to a Doctor/Consultant defending a case before the Medical Counsel. Yet the earning power and therefore the resources of Nurses is far less than medical colleagues.

The expenses of witnesses for the prosecution are paid by An Bord. The Nurse (or her union) must personally pay the expenses of her witness.

We believe it is grossly unfair to expect Nurses to fund such cases. Indeed in many cases the Nurse is exonerated but has incurred huge costs in defending herself.

The Minister, while responsible for another portfolio introduced the PIAB to reduce legal costs for consumers and the insurance industry. Lawyers, hurt by the impact of PIAB, are seeking other "cash cows". Fitness to Practice should not be one of them.
It is the PNA view that:

The Senior Counsel Employed to advise the Committee should be the guarantor that High Court Rules are respected.
The CEO of the Board or his nominee should 'prosecute' the case on behalf of the Board.
Joint training should be provided to those personnel of the Board and those personnel of the Trade Unions who would thereafter be involved in prosecuting or defending a case at Fitness to Practice.
In this way the cost to the Board, the Union and Nurses would be reduced.
Should a Nurse insist on legal representation then the Board would also employ legal representation.

Neither Nurses nor their Unions have 'deep pockets' and should not be expected to bear the costs of a legalistic process when alternatives are available.

National Council for Nursing and Midwifery

Head 60 proposes the abolition of the National Council, which was out in place by Government following the recommendations of the Commission on Nursing. The Role of the Council will in future be subsumed within An Bord Altranais.

The Commission on Nursing must have had very good reasons for the establishment of a council independent of An Bord. The DOHC was party to these decisions. Why is it now being abolished? Is this another cutback? Will Nurses now be required to pay for the functions of the Council after it is positioned within An Bord?

To conclude the Psychiatric Nurses Association as a representative professional body with a unique focus on Psychiatric and Mental Handicap nursing has a central role to play in the determination of future roles. Nursing legislation and regulation must be enabling and empowering to the profession, equally the organisation will be absolute and deliberate in the pursuance of the necessary education, support and autonomy to ensure that nurses can transform and extend their roles in the interest of patient/ client treatment and care.
Evident throughout the consultation process was the passion and pride PNA members have for the profession we feel this is at the cornerstone of our relationship with the regulatory body An Bord Altranais .

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4th Programme

Nurse & Midwife Prescribing

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Report of the Public Service Benchmarking Body Nursing Grades

The following is an extract from Chapter 12 of the Report of the Public Service Benchmarking Body

In subsequent paragraphs the generic term nurse(s) is used for ease of reference. This term should be regarded as including both nurses and midwives.

Unlike any other group, two separate job evaluation exercises were conducted in relation to the nursing grades. At the time job evaluation exercises were conducted for the generality of public service grades, the Irish Nurses Organisation (INO) and the Psychiatric Nurses Association (PNA) had not agreed to process their claims through the benchmarking process and, accordingly, the job evaluation exercise in relation to the nursing grades was confined to those represented by IMPACT and SIPTU. Following the decision of the INO and PNA to participate in the benchmarking process, a further job evaluation exercise was carried out in relation to persons represented by those two unions.

Comparison with levels of remuneration in the private sector using the methodology described in Chapter 8 and the application of a discount, as described in Chapter 7, in regard to the value of public service pensions, produced results showing that the remuneration of some of the nursing grades was below private sector rates for jobs of comparable sizes.

The grades in question are:

- Clinical Nurse Manager III
- Assistant Director of Nursing (Non-Band 1 Hospitals)
- Director of Nursing Band 3 Hospitals
- Director of Nursing Band 1 Hospitals.

The salaries of the grades of Staff Nurse, Clinical Nurse Manager II and Public Health Nurse were not found to be below private sector rates on the basis referred to in the preceding paragraph.

As indicated in Chapter 7 and in the report by Life Strategies, a lower discount could be considered in respect of the value of public service pensions in the case of a Staff Nurse. As stated in paragraph 7.21the Public Services Committee of ICTU took a strong position that a common figure should be used for the cost of public service pension terms for all the grades covered by the benchmarking process. However, even if a lower figure as indicated by Life Strategies were to be used for the three grades mentioned above it would not produce a basis for an increase in salary by reference to the comparison exercise conducted by the Body.

Recommendations

The Body recommends increases as shown below for the grades listed. Nursing grades make an employee contribution in respect of personal superannuation benefits and the recommended scales take account of that contribution. The salary scales recommended include the second phase (with effect from 1 June 2007) of the increases due under the public service pay agreement associated with Towards 2016.

Clinical Nurse Manager III
Existing Salary
€55,139 - €56,266 - €59,114 - €60,234 - €61,361 - €62,502
Recommended Salary % increase
€58,888 - €60,092 - €63,134 - €64,330 - €65,534 - €66,752 6.8%

Assistant Director of Nursing (Non-Band 1 Hospitals)
Existing Salary
€52,796 - €53,960 - €55,143 - €58,271 - €59,557 - €60,741 - €61,938 - €63,575
Recommended Salary % increase
€58,076 - €59,356 - €60,657 - €64,098 - €65,513 — €66,815 - €68,132 - €69,933 10%
Director of Nursing Band 3 Hospitals
Existing Salary
€64,726 - €66,176 - €67,629 - €69,082 - €70,530 — €71,989 - €73,436
Recommended Salary % increase
€71,199 - €72,794 - €74,392 - €75,990 - €77,583 — €79,188 - €80,780 10%
Director of Nursing Band 1 Hospitals
Existing Salary
€74,671 - €76,747 - €78,826 - €80,899 - €82,973 - €85,055 - €87,128
Recommended Salary % increase
€82,138 - €84,422 - €86,709 - €88,989 - €91,270 - €93,561 - €95,841 10%

Future Developments
A statement by the National Implementation Body (NIB) in May 2007 on the settlement of a dispute affecting nurses included the following:

''It remains open to the unions to put to the Benchmarking Body a case which reflects a very much expanded role for nurses and midwives in the context of enhanced duties, more cost effective and appropriate skill mixes and more efficient rosters, as have been proposed during discussions between the parties.

The NIB recommends that the Parties should confirm to the Benchmarking Body the scope and potential of such proposed changes and assist the Body by outlining the arrangements for verification and validation of such changes. These changes are consistent with the overall

Transformation Programme which is underway in the HSE and would deliver significant added value to the Health Service.''

The unions set out details of an expansion of the role of nurses from 2001 to date and referred to an increase in activity and complexity in all areas of the work of nurses. Such developments are part of the general evolution of the role of nurses and, in common with developments affecting other groups, have been taken into account in the job evaluation exercise conducted by the Body which assesses the current roles and job sizes of grades and thus reflects changes which have taken place since the last benchmarking exercise.

In relation to the statement by the NIB, the unions referred to willingness by nurses to embrace change and radically expand their role and contribution to productivity in the health service. However, no details were given of agreed proposals for specific changes. The employers referred in broad terms to the possibility of an expanded role and provided information on the provision for an education programme to allow a very small number of nurses to undertake prescribing duties. General statements were made by the employers also about possible future developments involving a broadening of the role of a staff nurse/midwife and an improved skills mix in response to emerging needs in the health service. Insofar as changes have already taken place in the role of nurses these would have been reflected in the job evaluation exercise carried out. In view of the statement by the NIB the Body would have expected that the submissions of the parties would comment in detail on proposed future changes in the role of nurses. This was not the case and neither of the parties gave significant emphasis to proposed changes. The supplementary submission by the employers contained a very brief ''Joint Statement on role expansion'' as follows:

Joint Statement on role expansion

It is recognised that the establishment of the National Council for the Professional Development of Nursing and Midwifery, Nursing and Midwifery Planning and Development Units, Centres for Nursing/Midwifery education, and the appointment of Nurse Practice Development Coordinators have delivered significant developments in the role of nurses and midwives. This is a continuing process, the benefits of which are yielding real improvements in patient care and service delivery. The objective of expanding activities for every nurse and midwife is to increase efficiency in the health service by developing higher levels of skills and competencies within the nursing resource. The health service's need for the efficient use of nursing and midwifery resources offers a unique opportunity to consider a significant reconfiguration of the role of the staff nurse/midwife. In the context of the current expansion of the role of the nurse and midwife significant additional value will be delivered to the Health Services for the benefit of patient care.

The joint statement is expressed in the most general terms. The desirability of expanding the role of nurses is referred to in an aspirational manner only and no examples are given of specific agreed changes. We noted that in a submission made as part of the oral hearing the representatives of the employers stated that it was accepted by management that the expansion of the role of nurse and midwife had the potential to bring significant added value to patient care. However, it was also stated that in many cases it remains for that potential to be realised and delivered.

The submissions made to the Body gave little emphasis to possible changes in the roles of nurses. Many of the other grades that made submissions to the Body referred to possible development of roles in the future. As a general principle the Body's recommendations must be based on the jobs of public service grades as they now exist and it would not be appropriate to recommend increases on the basis of possible future changes. In the case of nurses the statement by the NIB referred to proposals for an expanded role for nurses and midwives in the context of enhanced duties, more cost effective and appropriate skill mixes and more efficient rosters but these were not significant features of the submissions to the Body. The Body would make the general point that if there are to be defined developments of the kinds mentioned in the case of nurses; these could have an impact on the overall role and job size of nurses and would be reflected in a future evaluation of their jobs. In this regard, the Body notes the statement in the submission on behalf of the HSE – Employers Agency (HSE-EA) that expanding the role of the nurse/midwife ''will require service analysis to determine need, investment in educational preparation and skill development, integration of new work practices with the multidisciplinary team, development of appropriate clinical governance arrangements and evaluation of the expansion in terms of patient and service benefit.''

Other issues relating to nursing grades

A number of other claims on behalf of the nursing grades are discussed in the following paragraphs.

Third Party Recommendations concerning Benchmarking

The terms of reference of the PSBB provide that ''The Body should also consider any issues arising from any third party recommendations concerning benchmarking and any group on List A since the Body's first report, including specifically Labour Court Recommendations Nos. 17526 and 17805''. The Labour Court Recommendations referred to concern the nursing grades. In addition, subsequent to the preparation of the terms of reference, the Labour Court issued Recommendation No. 18763, dated 9 November 2006 in relation to the nursing grades.

The extent to which issues relating to nurses are discussed in this report may seem somewhat disproportionate by reference to other public service grades. However, as a result of its terms of reference and the subsequent Labour Court Recommendation referred to, the Body is required to consider specific issues which concern the nursing grades. To this extent the Body is asked to consider a wider range of issues relating to nurses than in the case of other groups.

The unions representing nurses and the HSE-EA addressed the specific issues affecting the nursing grades in their written and oral submissions.

The Body sets out below the matters arising from the Labour Court Recommendations, a summary of the submissions advanced and the Body's conclusions on the issues.

The two Labour Court Recommendations referred to in the terms of reference concerned the following claims:

- an increase for nursing grades working in the Intellectual Disability Sector to restore a previous pay differential relative to social care workers;
- the introduction of a 35 hour week;
- a revised system of payment for shift working; and
- a Dublin weighting allowance.

The subsequent Labour Court Recommendation No. 18763 concerned the above claims but the claim by reference to social care workers was expressed as a claim for an increase of 10.6% for all nursing grades. In addition, Labour Court Recommendation No. 18763 related to further claims which the Labour Court considered should be pursued through the benchmarking process. These further claims were as follows:

- a claim for parity with therapeutic grades; and
- the payment of a preceptorship allowance.

The claim concerning the introduction of a 35 hour week is being addressed through a separate process but the other issues fall to be dealt with by the PSBB.

Claim for parity of pay between the basic Staff Nurse/Midwife grade and the basic therapeutic grade

The claim sought parity of pay between the basic Staff Nurse grade and the basic therapeutic grades (Speech and Language Therapist, Occupational Therapist, Chiropodist etc.). The claim also sought consequential upward adjustments by reference to Therapy Grade Manager for the Clinical Nurse Manager II and Therapy Grade-in-Charge for the Clinical Nurse Manager III.

In support of the claim, the nursing unions referred to the educational requirements of both groups, the value of the contribution that both make in terms of patient care and the delivery of a better health service as well as changes affecting nurses. As regards educational qualifications, reference was made to the current position that new entrants to nursing, as a minimum requirement to register with An Bord Altranais, must pass an honours bachelor's degree which is accredited under the system of the Higher Education and Training Awards Council (HETAC) as Level 8. The unions also referred to the high proportion of nurses who attain honours level in the degree course.

The Body was also invited to have regard to the pay determination system ''Agenda for Change'' in the UK under which a job evaluation exercise found a Staff Nurse to be at the same level as the therapeutic grades. Reliance was also placed on cross-sectoral relativities. It was argued that, as graduates, nurses belonged to an identifiable group and should be paid the same rate as various other categories of graduates.

It was also suggested to the Body that regardless of the outcome of comparison with the private sector, the criterion of internal relativity required that nurses be paid at the same level as the therapeutic grades.

The employers contended that the claim based on comparison with the therapeutic grades was in conflict with the Body's terms of reference which require the Body to undertake a ''coherent and broadly based comparison with jobs and pay rates across the economy.'' It was argued that it was the function of the Body to evaluate the role of nurses (and associated grades) and then to compare them with jobs of a similar size in the private sector and not to compare one particular grade with another particular grade in the health sector. The employers expressed the view that it was imperative that the same process used to examine other grades was applied to the nursing grades also. The employers expressed the view that qualifications alone are not sufficient to justify an increased pay rate and it was argued that any increase would have to be based on job size encompassing all the relevant components of this.

The only therapeutic grades within the remit of the PSBB were the three grades of Speech and Language Therapist.
Conclusions
Having considered the submissions made, the Body concluded as follows:

(i) the claim by nurses for parity with the therapeutic grades generally is beyond the terms of reference of the Body which are confined to the grades determined by the parties to the benchmarking process (i.e. the grades on List A). In the case of the therapeutic grades only the speech and language therapy grades were evaluated by the Body;

(ii) the claim for parity (simpliciter) with speech and language therapy grades is not consistent with the approach dictated by the terms of reference for determining the remuneration of public service grades;

(iii) the principle of internal relativities is not sufficient justification in itself for determining the remuneration of nurses solely on the basis of the pay structures applicable to the speech and language therapy grades;

(iv) the Body must rely on its own job evaluation system devised to meet the requirements of the benchmarking exercise and cannot adopt methodologies and principles designed for the ''Agenda for Change'' system in the UK;

(v) the fact that newly registered Irish nurses are now graduates does not justify pay parity between nurses/midwives and graduate recruits in other disciplines without reference to an assessment of the job size in a manner consistent with the Body's terms of reference; and

(vi) the claim on behalf of nurses has to be determined in accordance with the terms of reference which require an evaluation of the job size of individual posts followed by comparison with the pay and other benefits applicable to jobs of a similar size in the private sector.

The Body wishes to comment specifically on the suggestion that regardless of the outcome of comparison with the private sector, the criterion of internal relativity required that nurses be paid at the same level as the therapeutic grades. The Body does not accept that its terms of reference allow internal relativities to overrule completely comparison with the private sector. Adoption of such a principle could mean that where two public service grades with different pay rates are found to have jobs of a similar size, the pay of the lower paid grade would have to be increased to the level of the other grade regardless of how the salaries compare to the private sector.

On this occasion the Body was required to examine the jobs of the nursing grades and the speech and language therapy grades following the methodology set out elsewhere in this report. As a general principle jobs which are rated equally under the job evaluation system should attract the same level of pay.

If two jobs which are rated equally are paid differently at present, the outcome of the comparison exercise with private sector jobs of similar weight should bring about parity of remuneration unless one or both of the jobs is paid above private sector levels. As explained above, in such a case we would not regard it as being consistent with our terms of reference to recommend increases beyond what is justified by reference to the private sector simply to create parity between two public service grades.

It follows from the position set out in the previous paragraph, that if jobs are not rated as being equal under the job evaluation system, the outcome of comparison with private sector jobs will produce different levels of remuneration.

Our conclusion based on the outcome of the examination and the other factors referred to in our terms of reference was that we should not recommend that there be parity of pay between the grade of Staff Nurse and the grade of Speech and Language Therapist. Furthermore, in the job evaluation exercise conducted on our behalf the grade of Speech and Language Therapist achieved a higher points score than the grade of Staff Nurse. Developments of the kind referred to previously might bring about a change in that position in a future benchmarking type exercise.

Claim for an increase of 10.6% for all nursing and midwifery grades to restore a previous pay differential relative to Social Care workers

The nursing unions gave considerable emphasis to this claim. At present the salary of the grade of Social Care Worker is higher than the salary of a Staff Nurse. The difference at the long service increment points for both grades is small and the salary of the grade of Social Care Worker is ahead by a little over 1%. It was indicated by the unions that a situation where the salary of social care workers is higher than that of nurses arose from increases of 19% to 27% in 2001 to the former grade of assistant house parent (now social care worker) in the childcare sector. They indicated that this had the effect of reversing a pay situation which had previously existed and which acknowledged that a registered nurse was a higher grade than an assistant house parent. The unions stated that the increase for the former assistant house parent was based solely on the professionalisation of the grade to diploma level and coincided with a change in the title of the grade to Social Care Worker.

The unions pointed out that in 2002 the increases referred to were applied to social care workers (former assistant house parents) in the intellectual disability sector and that this was provided for in a memorandum of understanding which was made available to the first Benchmarking Body. Paragraph 9.7 of the report of the PSBB in 2002 stated ''the Body recommends that the agreement between the HSEA and IMPACT regarding house parents/childcare workers which involve increases ranging from 19% to 27% at the top of the respective scales, should be extended to house parents/childcare workers working in the intellectual disability sector.''

The unions contended that the present pay position constituted an unsustainable anomaly particularly as in the relevant sectors nurses are the registered publicly accountable carers and often the supervisors of social care workers. The unions also stated that, in terms of the accreditation structure of the Higher Education and Training Awards Council (HETAC), the educational standard required for a nurse is Level 8 (regarded as the equivalent of an honours bachelor's degree) while that required of a social care worker is Level 6.

The unions stated that prior to the application of the 19% to 27% increases in 2001, the salary of a nurse and midwife was ahead of the assistant house parent by 9.25%. It was argued that the salary of nurses would have to be adjusted by 10.6% in order to restore the former pay position.

It was contended that there was no justification for allowing a situation whereby a nurse was paid less than a social care worker in child and adolescent psychiatry or the intellectual disability sectors being allowed to continue beyond the present benchmarking exercise. Furthermore, it was contended, that in terms of the basis on which the award was given in the first place there should be no question of those nurses working in child and adolescent psychiatry or the intellectual disability sector, whether side by side, supervisor, or as the accountable professional unit of care, being paid less. On this basis, it was suggested that the

Benchmarking Body should direct that in the case of the intellectual disability sector, an adjustment in salary should be applied retrospectively.

The employers stated that initially, the unions' concerns about the relative pay positions of nurses and social care workers appeared to be confined to holders of the Registered Nurse of the Mentally Handicapped (RNMH) qualification who worked in the intellectual disability sector but that subsequently, the dissatisfaction extended to all nurses working in the intellectual disability sector. It was stated that the claim was now wider again in its application and that a pay increase of 10.6% was sought for all nurses, irrespective of where they might work or their relationship with social care workers — a point noted by the Labour Court in Recommendation No. 18763. The employers made the following points:

- there has never been any established pay relationship or pay relativity between the Staff Nurse Grade and the Assistant House Parent/Social Care Worker grade and the relative pay positions had fluctuated over the last decade;
- management had proposed that where Staff Nurses were required to supervise social care workers as part of their daily work, those Staff Nurse posts would be upgraded to Clinical Nurse Manager I level. Approximately 50 instances had been identified in which Staff Nurses were required to supervise social care workers and a claim for an increase for all nurses based on the position in 50 cases is not justified; and
- the qualification required for students in social care work is now a three-year degree qualification (previously a National Diploma) with an option for students to complete a fourth year to attain an honours degree.

Conclusions on the claim to restore a previous pay differential relative to Social Care Workers

The conclusions of the Body on this claim are broadly similar to the ones reached on the claim for parity with the therapy grades. The Body considers that a claim based on restoration of a previous relative pay position with another public service grade is not consistent with the benchmarking process. As already indicated, comparison with jobs of similar size in the private sector is the primary consideration taken into account by the Body in determining its recommendations. The terms of reference specifically provide that ''the existence of any traditional or historic relativities should not prevent the Body from recommending what it considers are the appropriate rates of pay for any particular job.''

In this case it was not suggested by the unions that a fixed relativity existed between the grades of Staff Nurse and Social Care Worker. Instead, what was sought was restoration of a relative pay position which existed at a particular time in the past. Apart from any other consideration, it would not be reasonable for the Body to recommend that a previous position be restored when it is not feasible to make an assessment now as to whether that previous position was an accurate reflection of the relative demands of the jobs in the past. However, for the reasons already explained it would not be appropriate in any event for the Body to approach the determination of the remuneration of nurses in this way and to confine the evaluation of nurses to comparison with another public service grade.

As previously stated, the Body's recommendations in relation to nurses have been mainly influenced by a comparison with the remuneration of jobs of a similar size in the private sector. As already explained this provided a basis for increases for some senior nursing grades but not for the grade of Staff Nurse. The Body does not consider, therefore, that an increase for nurses is justified purely by reference to comparison with another public service grade.

The Body acknowledges that there are difficulties in situations where nurses act as supervisors or otherwise work alongside social care workers. The employers have proposed that where Staff Nurses were required to supervise social care workers as part of their daily work, those Staff Nurse posts would be upgraded to Clinical Nurse Manager I level. The employers suggested that approximately 50 instances had been identified in which Staff Nurses were required to supervise social care workers. The number of instances referred to by the employers was disputed by the unions but they did not consider this approach as a satisfactory resolution of the issue.

The Body considers that the general approach suggested by the employers is reasonable.

The Body considers that upgrading to Clinical Nurse Manager I level should be applied to Staff Nurses working in the intellectual disability sector who, as part of their daily work, supervise social care workers or otherwise work alongside them in the same location. The Body notes that there is disagreement between the parties on the number of instances in which this arises. The Body is not in a position to adjudicate on this issue but considers that it should be a reasonably straightforward matter to identify where Staff Nurses in the intellectual disability sector, as part of their daily work, supervise or work alongside social care workers in the same location and urges the parties to enter into discussions and reach an agreement on this issue.

Claim for a Dublin weighting allowance

In support of their claim for a Dublin weighting allowance, the unions stated that payments of this kind usually arise where a location has become extremely costly to live in and where employers, as a consequence, find it difficult to recruit or retain staff. It was suggested that the twin elements of a costly location and difficulties with regard to recruitment and retention exist in the Dublin nursing market. Information was provided on the costs affecting nurses in Dublin and the turnover of nurses in hospitals in the Dublin area. It was stated that a variety of non-pay initiatives had been used, adapted and applied but that the turnover rate remains high.

The unions also referred to the London Weighting Allowance and large city weighting allowances payable in the UK. Reference was also made to payment of a Dublin allowance by an employer in the private sector in Ireland. In the oral hearing it was confirmed that the unions envisaged that the allowance sought would apply to persons working in Dublin regardless of whether they lived in Dublin or not.

The unions argued that it did not follow that concession of a Dublin allowance to nurses would result in extension of the allowance to other groups. It was argued that the experience of the decentralisation programme demonstrated that the issue in the civil service related to a reluctance by staff to leave Dublin. It was suggested that it would be difficult, therefore, to justify an extension to other groups of an allowance tailored specifically to the market conditions which relate to nurses, unless those same conditions applied to the other groups also.

The employers argued that there was no evidence that an allowance of the kind sought would improve turnover and that the rate of staff turnover in Dublin hospitals had improved recently.
It was suggested that there were reasons unrelated to cost for employees wishing to leave Dublin such as domestic considerations, a wish to travel etc. It was stated that the high number of training places in the Eastern region attracts a younger and more mobile workforce and that it would be expected that the turnover would be higher than in other regions.

The employers also stated that turnover of the kind described by the unions was not unique to nurses as it was a feature of private sector employment also. The employers stated that while a Dublin allowance had been introduced by one private sector employer, this practice had not been followed by other employers. The employers disagreed strongly with the view of the unions that concession of the allowance to nurses would not result in its extension to other groups and stated that if the allowance were applied to nurses there would, inevitably, be widespread repercussions affecting other groups.

Conclusions on the claim for a Dublin weighting allowance

The introduction of a Dublin weighting allowance for any group would be a major change in public service pay policy. The claim for such an allowance is based on the position of nurses and has not been a feature of submissions received on behalf of other public service grades.

The case put forward by the nursing unions for a Dublin allowance focussed largely on turnover in Dublin hospitals and the cost of living in Dublin. We have been provided with information which supports the unions' submission that turnover is higher in Dublin than in other areas of the country. However, we consider that there is validity in the argument advanced by the employers that there are reasons other than costs which may account for higher turnover in Dublin. We accept also that there are indications of some recent decline in turnover.

We acknowledge that living costs in Dublin are higher than elsewhere but arguments relating to costs cannot be confined to nurses and apply to other groups also. We consider that the arguments advanced by the unions in relation to costs in Dublin are somewhat weakened by the suggestion that a Dublin allowance should apply to persons working in Dublin, regardless of whether they live in Dublin or not.

We formed the view also that it is unrealistic to expect that the introduction of a Dublin allowance could be confined to nurses and that this would not spread to other public service groups.

Our overall conclusion was that the introduction of a Dublin allowance would be a radical departure from existing pay policy in the public service and would be at variance with normal practice in the private sector also. We are not satisfied that there is sufficient evidence that would justify the allowance sought by the nursing unions and we do not recommend its introduction.

Claim for a revised system of payment for working unsocial hours

Most staff nurses are required to work systems covering 24 hours a day, 365 days per year.
Payments additional to salary are made for actual unsocial hours worked and each of the payments is part of an integrated reward system for working unsocial hours. The payments are as follows:
Hours between 6 p.m. and 8 p.m. : Time plus one sixth
Hours between 8 p.m. and 8 a.m. : Time plus one quarter
Saturdays: Time plus payment of €15.02
Sundays and public holidays: Time plus 100%
The employers suggest that a nurse working continuous shifts would, on average, earn 23% over and above basic earnings.

The nursing unions argued that the payments to nurses for shift working were less favourable than those applying to other shift workers in the public and private sectors. It was suggested that shift workers outside the health service who are employed on rotating shifts are normally paid a consistent shift premium based on the type of shift worked and that a premium of 33.33% would normally be paid where twenty four hour coverage over seven days is provided. It was also argued that the present system of payment to nurses was inefficient as it gave an incentive to working at night and on Sundays while discouraging work on Saturdays. The unions proposed that a standard premium be introduced for all shift working by nurses.

The employers' submissions did not comment on this claim to any significant extent. However, in the oral hearing they opposed the claim and indicated that concession would be extremely costly. They also questioned whether the claim was consistent with the Body's terms of reference.

Conclusions on the claim for a revised system of payment for working unsocial hours

Shift working is not a requirement for most public service grades. In the case of grades being examined by the PSBB (those on List A) the main groups which work shifts are nurses, members of certain ranks of the Garda Siochana and prison officers. Fire-fighters also work shifts but are not on List A.

The system of payment for working unsocial hours which applies to nurses is consistent with the systems which apply to the other public service groups mentioned. This system differs, however, from the general methods of payment in the private sector but there are a variety of arrangements which apply in the private sector.

We did not consider that a compelling case has been made for a change in the present system. As previously indicated in paragraph 12.65, each of the payments made to nurses for working at night, weekends and public holidays is part of an integrated reward system for working unsocial hours. We consider that there is a reasonable argument to be made that the system of payment which applies in the health sector and the other sectors mentioned was negotiated and agreed to suit the particular work patterns of those sectors and should be seen as one component of the overall remuneration structure. For the foregoing reasons, we do not recommend any change in the present system.

Claim for the application of the preceptorship allowance to nurses and midwives who hold that responsibility

A preceptor is an instructor. The nursing unions stated that in the health service a number of grades are required to act as preceptor for undergraduate or postgraduate clinical placements within their area of expertise. They indicated that public health nurses have always carried out the role of preceptor for student public health nurses but that in recent years the preceptorship role has grown as responsibility was assumed for undergraduate nurse preceptorship.

It was argued that the degree requirement has led to a growing requirement for preceptorship from amongst all nursing grades. The unions stated that a preceptor is required to establish the competency or otherwise of the practitioner including, for example, student nurses in training, care assistants in training or overseas nurses prior to registration with An Bord Altranais. The unions also referred to payment of preceptorship-type allowances to therapeutic grades and medical scientists. However, no proposals were made as to the extent of the preceptorship duties in duration and frequency that would be required to qualify for an allowance. No proposals were made either on the basis for determining the amount of the allowance although it appears from Labour Court Recommendation No. 18763 that the claim was based on an amount (referred to in paragraph below) recommended for therapist grades by an Expert Group.

Employers' position

Following an oral hearing the Body received correspondence from the unions and employers concerning the claim for a preceptorship allowance. The employers took the view that there is a professional responsibility on every nurse to provide students with support, guidance and coaching and that this was mandatory. They argued strongly that this had always been regarded as part of the duties of Staff Nurses. They referred to the Code of Professional Conduct for nurses and midwives issued by An Bord Altranais which refers to the responsibility of nurses to junior colleagues to transmit acquired professional knowledge, skills and attitudes.

The employers also referred to a report of the Nursing Education Forum in 2000. The Forum had the task of preparing a strategy for moving pre-registration nursing education from the three year diploma programme to the four year degree programme. The Forum recommended that each student should be assigned a named preceptor during clinical practice placement. The Forum commented that a fundamental component of the role of every nurse is the teaching of nursing students in the practice area.

As regards payments made to other grades, the employers said that the Expert Group on Various Health Professions had recommended an allowance of approximately \3,200 (in present terms) for persons involved in clinical placement of students and not for preceptorship. Furthermore, it was subsequently agreed in negotiations that the proposed allowance would be treated instead as a payment for professional/educational development and would be spread over all members of the grade. On this basis it was agreed that each member of the therapeutic grades would be entitled to an annual allowance of €250 to be used for professional/educational development.

The Expert Group on Medical Laboratory Technicians also recommended an allowance for staff responsible for overseeing and co-ordinating the rotation and training programmes of student medical scientists. In that case the HSE attempted to reach agreement to have it implemented in the same manner as applied to the therapeutic grades i.e. a small amount for all members of the grade. The union wished to have the full allowance applied as an allowance for Student Training Co-ordinators payable only to those who perform the duty. The Labour Court supported the union's position and an allowance of €3,200 approximately is now paid to certain medical scientists.

The employers argued, however, that the position in nursing is quite different to that applying to the therapy and medical scientist grades. They said that unlike the other areas a promotional grade of Clinical Placement Co-ordinator was created at Clinical Nurse Manager II level with the specificfunction of guiding and supporting student nurses and ensuring that there are clinical placements to meet the requirements of the education programme.

The employers suggested that the role of acting as a preceptor would be captured in the job evaluation of the role of nurses and questioned whether the payment of a separate allowance could be regarded as being covered by the terms of reference.

Unions' response

The unions' response to the points made by the employers suggested that there was an attempt to confuse the concepts of preceptorship and mentoring. It was argued that mentoring is an accepted part of the duties of all professional grades including nurses but that preceptorship involves specifically trained professionals who are required to sign off on the competencies and milestones for students. The unions referred to a statement in the report of the Nurse Education Forum which quoted a recommendation by An Bord Altranais that during clinical placement a student should be supported by a preceptor defined as a registered nurse who has been specifically prepared to guide and direct student learning.

The unions denied that preceptorship was mandatory for nurses and claimed that it could only be carried out by those who agreed to be trained in the process. They also said that the role of the Clinical Placement Co-ordinator was different to that of a preceptor and referred to a statement in the report of the Nursing Forum which distinguished between clinical placement and preceptorship. In this regard it might be noted that the employers did not say that the role of the Clinical Placement Coordinator was the same as that of a preceptor. They advanced the argument that the Expert Group on Various Health Professions recommended the allowance for therapeutic grades involved in clinical placement of students rather than preceptorship and that a somewhat similar situation applied to Medical Scientists.

Conclusions on the claim for the application of the preceptorship allowance

There is a clear conflict in the positions of the parties. The employers argued in very strong terms that preceptorship has always been part of the job of nurses and is mandatory. The unions take a different position. As regards the recommendations of the Expert Groups for the payment of an allowance to therapeutic grades and medical scientists it seems to the Body that the intention was to relate the payment to the kind of functions performed in the nursing area by Clinical Placement Coordinators rather than the kind of preceptorship envisaged by the unions. However, this was implemented in a different way by agreement in the case of the therapeutic grades resulting in a nominal payment to all members of the grade. The payments to the other groups do not seem to the Body to give strong support to the nurses'claim as the payments do not appear to relate to preceptorship-type duties precisely.

Following consideration of this claim, the Body formed the view that, on balance, a convincing case has not been made for the introduction of the allowance claimed.

BACKGROUND TO P.N.A DEMAND FOR THE INTRODUCTION OF A COMPENSATION SCHEME FOR NURSES

1. Assaults of varying degrees have been a fact of life for Psychiatric Nurses for a long number of years.
2. The stabbing of three of our colleagues in Artane in 1993 created a new and urgent impetuous to put in place preventative measures to minimize assaults, to cover for loss of pay, to ensure payment of medical costs etc and to secure introduction of a Compensation Scheme.
3. Following intensive negotiations over the next year a special scheme for nurses injured as a result of an assault at work, The Nurses Indemnity Scheme (5/6th Scheme) was implemented but the Dept of Health refused to countenance the introduction of a compensation scheme.
4. The PNA carried out research in 2002 into the level of assaults on Psychiatric Nurses in 2001 and found that 857 nurses had been injured by assault following which the PNA wrote to the Minister for Health Mr Michael Martin TD.
5. In our letter of February 20th 2002 we set out inter alia:

- The frequency of the incidents of assault in psychiatric services, can in most instances, be attributed to the mental health of the patient/client. Quite often the perpetrator of the "assault" is suffering from an illness such that if charged with a serious criminal offence, there would be a finding of insanity, or a finding of diminished responsibility.
- The failure by Dept of Health to recognise the fact of the increase in the incidents of assault is probably the main reason why there has been no adequate research done to identify and determine the cause or causes of this increase.
- In this letter we also set out our demands in relation to Prevention, Risk Assessment, Training and Provision of a Compensation Scheme.

6. There was no response from the Minister and the PNA balloted its members for industrial action. On the eve of this action the Minister intervened and set up a Task Force on assaults on Psychiatric Nurses. The Minister gave an assurance in writing that the findings and recommendations of the Task Force would be accepted and progressed within an agreed timeframe.
7. The Task Force reported in April 2003. The Task Force Report contained a recommendation for the establishment of a "no fault", non statutory compensation scheme for nurses working in mental health services who suffer serious injury as a result of an assault. This scheme was to be in addition to the Serious Physical Assault Scheme (5/6th Scheme).
8. It defined injury as any serious impairment of a person's physical or mental condition. It provided for retrospective compensation for nurses previously injured by assault. The PNA accepted the Recommendations of the Task Force but despite several demands from PNA there was no sign of the scheme being implemented.
9. Minister Martin met the PNA in March 2004 and informed the P.N.A that a draft memorandum had been circulated to all Government Departments and that very serious concerns had been expressed about aspects of the proposals contained in the Task Force report. In particular he mentioned that there were serious legal and financial issues highlighted in the responses from the Attorney General and Department of Finance and as a consequence would require further Government Consideration.
10. The Government considered the matter at its Cabinet meeting on 13/07/05 and the Tánaiste and then Minister for Health Mary Harney met the PNA that evening and stated that despite the Governments previous undertakings the Government had decided not to implement the scheme. She stated that she was asking the State Claims Agency to look at the introduction of a Fixed Redress Scheme along the lines of the P.I.A.B Scheme but it would expressly prohibit any Compensation for Psychological Trauma and would not cover any injuries prior to the introduction of the scheme. This was completely contrary to the recommendations of the Task Force and contrary to the undertakings of the previous Minister, Mr Martin. The PNA saw this as a breach of promise and further was a breach of Sustaining Progress and again balloted our membership for Industrial Action on the basis of this breach. The issue then became the subject of several conciliation conferences at the Labour Relations Commission.
11. This resulted in the Dept. of Health being forced to brief the PNA and S.I.P.T.U on 29/09/06 under the auspices of the LRC on the content of the scheme. This issued from the L.R.C in a formal document. It stated:

- There is agreement in principle at Government Department level and by the HSE to the introduction of an insurance based compensation scheme.
- The precise details of the administration of the scheme have yet to be finalised, however, it is envisaged that the scheme will be administered by an independent third party.
- The compensation amounts will be based on schedule of payments and will be relative to the injuries specified. Psychological injury/stress will not be included in the specified list of injuries.
- Any scheme introduced will be effective only from the date of commencement and will not have any retrospective effect. Any proceedings instituted prior to the commencement date will not be eligible for

consideration under the scheme. This does not affect and individual's statutory rights.
- Injury will be defined.
- The briefing document stated that no firm proposals can issue on the scheme until the matter has been considered and approved by Government. A lot of the official level consultation, required for this process, has now been completed. Proposals for consideration by Government are being finalised. Subject to Government approval, the intention is to have a scheme ready for implementation in the first quarter of 2007.

12. The P.N.A were adamant that Psychological Trauma and Retrospection must be part of any scheme, however decided that it would be prudent to allow the Government approve the scheme. At least the principle of no fault compensation would be established. The Government subsequently approved the scheme at its cabinet meeting on 17/01/07.
13. The PNA immediately referred the matter to the Labour Court and sourced legal and medical expert opinion for the case and Prof. Patricia Casey from the Mater Hospital and UCD attended the hearing. The Labour Court in its Recommendation upheld the PNA claim. It stated:

- The Court accordingly recommends that an insurance-based scheme be put in place to take effect from the date of this Recommendation, which should include an element of compensation for psychological trauma, where relevant, and where it arises directly from the effects of an assault on a nurse while at work.
- The Court's understanding is that there are approximately 40 such claims already lodged in the system. In the case of these claims and no other, the Court recommends that the terms of the proposed new scheme be extended to embrace those claimants on a once-off basis.
- The recommendation of the Court issued on 29th March '07.

14. Following on the recommendation from the Court, the Department went back to all Government Departments particularly Finance and Attorney General.
15. Following repeated requests to the Department of Health, H.S.E and H.S.E-E.A we were informed that the Department of Health had completed "its consultations" early this year and that a revised scheme to incorporate the findings of the Labour Court was presented to Minister Harney on 03/01/08.
16. The scheme was published by circular letter 04/'08 and the Union received a briefing on the circular on 25th January, which was a stormy affair.
17. The P.N.A issued a Press Release describing the Scheme as "Yellow pack in the extreme".

The Scheme provides as follows:

Major Injuries	Benefit
Death	€25,000
Quadriplegia	€100,000
Paraplegia	€100,000
Loss of Two Limbs/eyes	€100,00
Permanent Loss of Leg	€75,000
Loss of Hearing in an ear	€30,000
Loss of a Kidney	€20,000
Permanent loss or loss of use of a thumb	€20,000

* hairline fractures are not included

18. The National Executive has determined that an all out campaign must now be undertaken to achieve what was promised by Government 6 years ago.

European Festival of Psychiatric Nursing - *the age of dialogue*

Des Kavanagh Outlines How All Roads Lead to Malta in 2008 Planning is at an advanced stage for the first Horatio International Psychiatric Nursing Festival to be held in beautiful Malta from 5th to 9th November 2008.1 have just returned from the Horatio Board meeting which in many ways resembled a 'mini' dry run for the main event next year.

The Board Meeting was held in the Corinthia San Gorg Hotel, in Georges Bay about 20 minutes outside Valetta and 15 minutes from the Airport during the first week in November. The Hotel carries a well earned '5 Star' rating, is positioned between the Radisson SAS Hotel on one side and its sister hotel the Corinthia Marina on the other and is beautifully positioned on a promontory surrounded by blue seas. The San Gorg will provide the main facilities for next year's Horatio Festival. The wonderful facilities available at the Hotel include a spacious Conference room and European Festival of Psychiatric Nursing - the age of dialogue lots of breakout rooms.

For those who wish to relax and for partners and family who accompany Conference participants the hotel offers 5 outdoor swimming pools, an indoor pool and Spa, a wonderful restaurant, the Fra Martina, and several alternative restaurants on the extended complex including an American styled Bar and Grill, Fregatina fish restaurant, Vinotheque Parisian style Bistro/Bar, Da Marina Pizza and Pasta Bar, Corsairs Snack Bar and Grill and much more. A few hundred yards down the town many more restaurants are available and a fantastic night life. For Irish Nurses this venue provides a wonderful opportunity to get some autumn sunshine lounging by the pool, touring the many 'Open Air Museums' reflective of the country's Arabian, Italian, English and other European and African influences. The cost of getting there is minimal, especially for those who book early and the cost of food and beverages well below Irish prices.
The San Gorg boasts not just wonderful facilities, attractive decor, nice music and relaxing milieu its success is undoubtedly enhanced by its very friendly staff who seek out every opportunity to make you feel welcome. They do this in a variety of ways from sharing the latest good news on the weather front or even cautioning if one of their very quick storms is on the way , to reassuring you that once the storm passes the weather will be even warmer. Since November is the off season we wondered if it might be cool but in fact temperatures ranged between 20 and 28 degrees during the week. The week reminded me of a very good week in an Irish summer.

The Hotel has 450 rooms all of which have a balcony looking out over the sea. The rooms are spacious and very comfortable. The spacious foyer provides many meeting points where people can meet for latte or teas and later in the evening for a night cap or two.
During the week we had the opportunity to enjoy meals at a number of venues. The choice is great with varied cuisine and prices to suit everyone. In fact food in many of the restaurants is much cheaper than in Ireland while beverages are significantly cheaper

The Horatio Festival 2008 promises to be a huge success with psychiatric nurses attending from all over the World. Already enquiries have been received from Australia, Canada, U.S. and China. The First Call for Papers issued recently. I hope to see many Irish psychiatric nurses submitting papers for consideration by the Expert Panel. There are so many examples of best practice innovations throughout the country it would be a pity if our nurses were not to seek the opportunity to demonstrate our successes on the European and world stage.

I am looking forward to the dynamic experience that will be presented to participants in meeting colleagues from all over the world, the buzz of conversation in accents and languages which will serve to reflect the cosmopolitan nature of the event, the commonality which is always present at these events forged by experience in the front line of mental health care and the wonderful facility with which psychiatric nurses celebrate life, work and friendship.
Since returning from Malta I have been planning next year's holidays around this spectacular event. I hope many more Irish nurses will join me in exploring this wonderful, historic island; in celebrating the contribution of our nurses to contemporary mental health care; in enjoying good weather by the pool or on the beach; in networking with colleagues from across the world; and in enjoying the wonderful nightlife, whether at the various Horatio organised events or in the hot spots in town.

Remember, at a Horatio Festival or Conference there are no strangers, only friends who have yet to meet!!!!!
For more information check:
http://www.horatio-web.eu/festivalpsychiatric-nursing.html

CLIENTS' EXPERIENCES OF HOMECARE

Mary Fell (Clinical Psychologist) & Lorna Sweeney (Research Assistant),
(in collaboration with the Ballyfermot/ Lucan homecare team)

Home care services

In recent decades, there has been an increasing role for community-based services in the treatment of serious mental health problems. Research indicates the benefits of home-based care, or at least similar outcome, when compared to hospital based care.(Burns, Raftery, Beadsmoore et al., 1993a, 1993b; Catty, Burns, Knapp, et al., 2002; Marks, Connolly, Muijen et al., 1994), as well as its cost-effectiveness. While the very definition of homebased care varies between studies, possibly depending on resources and stage of service development, it can be broadly defined as treatment in the home (Catty et al., 2002). While home-care exists in Ireland, it has received little formal review apart from studies such as Keogh (1997), and those reviewing the Cavan-Monaghan services (Fleming, 2001)

Current study

The aim of the current study was to begin to evaluate the work of the Ballyfermot/Lucan homecare service, by exploring the experiences of service users. It was hoped that this would allow greater understanding of what makes the service successful or unsuccessful.

This homecare service began in April 2003, and provides a seven-day service from 9 a.m. to 4.45 p.m. It was comprised of a caseload coordinator, a consultant psychiatrist, a clinical nurse manager, three psychiatric nurses, a psychiatric social worker, an occupational therapist, and two project workers with a background in psychology. The latter two staff members were involved for 18 months and not replaced. This research was carried out from September to November 2005.

The Ballyfermot/Lucan homecare service aims to "provide a comprehensive multidisciplinary community based adult mental health service giving choice of care programmes to patients and support and education to families". The service aims to reduce hospital admissions and length of hospital stay, to develop care programmes which can operate from the home, to promote rehabilitation for the service user, and to support and educate families.

Methodology

The semi-structured interview of the current study followed the methodology of critical incident technique. (Flanagan, 1954).

Participants

Following ethical approval, participants were drawn from those receiving continuing care with the Ballyfermot/Lucan homecare service for a minimum of six months. Each of the seven keyworkers on the homecare team, from the various disciplines, randomly selected at least two of their clients as potential participants, and sought their participation. Nineteen of the clients consulted agreed to participate. Six participants were male,13 were female, aged from 25 to 69 years. The average length of involvement with the homecare service was 21 months, ranging from 10 months to 3 years. With regards to diagnoses, 9 of the participants had been treated for schizophrenia, 4 for bipolar disorder, 1 for puerperal psychosis, 1 for agitated depression (with psychosis), 3 for anxiety and 1 for depression.

Procedure

All interviews were conducted by the same researcher on a one-to-one basis, and recorded on paper.

Analysis

Analysis of data was based on interpretive phenomenological analysis. The two researchers separately conducted a thematic analysis of each interview. For purposes of cross validation, the researchers then discussed their individual findings, and attempted to bring these together meaningfully.

Results

The Purpose/Aims of the Homecare Service

Table 1 outlines themes mentioned by participants when asked as to the purpose and aims of the service, as they experienced it. A general communicative role for the homecare service emerged, for example, "Just to know there's someone there at the end of the phone", "Before if I was down I'd say everything was alright because I'd be afraid of going to hospital, but now I say how I'm feeling more". Also, some participants referred to the homecare service being a practical communicative link with the mental health centre.

Some participants suggested that the purpose of the service is to monitor their general well-being: "They make sure patients are alright with their general care, their health, their living". Included in this theme were opinions that the homecare service aims to prevent hospital re-admission: "To keep you out of hospital…I was able to go through everything within these four walls".

The supportive role of the homecare service included comments such as "They're out to help and support you, let you know someone is there if you need it", "She's my back-up". Participants believed the service aimed to monitor and assist with medication ("to keep me in a routine with the tablets"), to motivate clients ("It's something to come for. It motivates me to keep going"), to assist in availing of other services for various needs ("sometimes she would tell you about other stuff, like about houses and stuff"). Helping clients to understand more about their own mental health was evident: "They break it down and explain it back to me, help me understand what's happening".

Table 1: Themes re. Purpose/Aims of the Service

Theme	No. (percentage) of participants
Communication	10 (52.6%)
Ensure General Welfare	9 (47.4%)
Personal Support	6 (31.6%)
Medication Support	4 (21.1%)
Motivation	3 (15.8%)
Availing of Other Services	3 (15.8%)
Understanding Mental Health	2 (10.5%)

Incidents with positive impact

Themes are outlined in Table 2 below, along with the number of participants who mentioned each theme.

Availability of the service included the general availability of the homecare service itself and also the availability of someone to communicate with. The availability and consistency of the service itself seemed important: "you know if you ring her she'll come down", "I can't remember ever making a phone call that wasn't answered", "They're the one constant that's there for me".

Participants referred to the link between the homecare service and the mental health centre, particularly with the psychiatrist: "Its handy when the doctor forgets to bring you a script too, she'll bring it to you", "having a key nurse is great, you can get through to the doctor then". They also mentioned the help they received in dealing with other life needs, through the interaction of the homecare team with other services, "I had other problems beside schizophrenia, with accommodation, a job, financial things, he can help with that".

'Individual clinical intervention' included references to the clinical aspects of the homecare service, such as educating and explaining regarding specific mental health difficulties/ issues, increased contact in times of greater distress, and providing motivation for clients in a clinical context. Participants referred to the information provided about mental health: "The outreach came and talked me through everything all the techniques and everything I'd learned before…", "She's helping me, she puts it into layman's terms. You know, she brings it to my level…It helped me understand more about it all", "They educated me to what the illness I had was, they taught me about it…A few times she gave us information and she'd go through it all, talk about it all, she gave us stuff to read"

The homecare team revisiting clients on a more regular basis in times of greater difficulty was valued: "She came every day then when that was going on". The role of the homecare team in encouraging and motivating clients was found to be positive: "I started to come out of the bedroom more, she taught me to get dressed…".

Participants also noted the support given to their family in understanding mental health issues. Comments included "For the first time in ten years there was direct involvement with my family", "She talked to my family about what had happened, she explained to them about after-care and what to expect", "She got them involved and they were able to understand more what I was going through and they could be there for me…it was better to get us all together and give them information about what was happening with me".

The homecare team ensure medication is taken for some, and took steps if it is not: "when I stopped taking my tablets he came down and got me taking them again".

The personal nature of the homecare service was positive for some: "I know that's her job, but it was just so great to see a friendly face and she went out of her way". Participants referred to the social activities the homecare service encourage: "You can go for coffee outside home with the homecare team".

Table 2: Themes of incidents with positive impact

Theme	No. (percentage) of participants
Availability of the Service	13 (68.4%)
Link with other Services	13 (68.4%)
Individual Clinical Intervention	9 (47.5%)
Support/ education for the Family	6 (31.6%)
Medication Support	4 (21.1%)
Personal Aspect	4 (21.1%)
Providing a More Normalised Routine	4 (21.1%)

Incidents with negative impact

Themes are contained in Table 3 below, along with the number of participants who mentioned each theme.

A sense of frustration with the supervisory role of the homecare service was expressed by some: "I suppose sometimes you get that feeling that you can do it on your own, people calling all the time can feel like a burden…I mean it was fine people coming in but when you're better you feel you can do everything on your own", "sometimes it got a bit full-on", "Maybe if you don't see them as often when you're well, but then I don't find it intrusive, but sometimes I've plans". However, these participants also recognised their own processes in that sense of frustration: "That's only human nature though I suppose, to feel that you're better on your own". Within this, some claimed that any negative outcomes during their time using the service were contributed to by aspects of their own life, or their own efforts: "Anything that caused me to feel like that was going on in my own life, like getting my kids back from care, moving house and that".

One participant felt that more social work involvement was needed in the homecare service. Another expressed the desire for greater links between the service and training for employment, while yet another wished for a stronger link employment, while yet another wished for a stronger link between the homecare service and the psychiatrist "Sometimes when you got to the doctor it might be better if one of them comes in with you, to round it all up a bit more".

Frustrations included appointment arrangements being changed ("Well maybe just when she couldn't come, like she was supposed to come today, but she didn't realise she had a meeting, so she rang and said she wouldn't be able to make it"), and appointment times not suiting. Another participant felt that more personalised information about mental illness should be provided by the service: "…the information I got from her was really just a few leaflets."

Table 3: Themes of incidents with negative impact/ Improvements to the Service

Theme	No. (percentage) of participants
Increased Autonomy and Independence	3 (15.8%)
Recognition of Own Role in Contributing to Negative Outcomes	3 (15.8%)
More links Between Services	3 (15.8%)
Changing Appointments	1 (5.3%)
Visiting Times	1 (5.3%)
More information re. mental health	1 (5.3%)

3.4 Characteristics of Homecare Team Members

These characteristics are contained in Table 4 and Table 5 below, along with the number of participants who mentioned each.

Participants (73.7%) mentioned a wide range of interpersonal characteristics which were collectively interpreted as an ability to build rapport with their clients. These included:
"a positive attitude"; trustworthy; "approachable"; non-judgemental; "straight"/"open"; personal characteristics such as "caring", "kind", "friendly", "relaxed".

Understanding was explicitly referred to as a characteristic needed in the homecare team and/or one which has been experienced: "they were so understanding, they could talk without making you feel you were stupid". Also mentioned was patience. Participants specifically commented the service's support: "I wouldn't be where I am today without that support". Participants also referred to the listening skills of the team members and their ability to talk with ease with their clients: "They're good listeners", "You have to be able to talk to them, I think that's the way they are".

Table 4: Interpersonal Characteristics Needed in Homecare Team

Characteristic	No. (percentage) of participants
Ability to Build Rapport	14 (73.7%)
Understanding	5 (26.3%)
Patience	4 (21.1%)
Supportive	4 (21.1%)
Good Communication	4 (21.1%)

The more specific clinical skills of the homecare team members which became apparent from participants' responses were the ability to explain mental health issues ("they could explain to me all the things that I'd been through and that I didn't even understand myself"), organisational ability ("They've an awful lot of other people, but she's always there for me at 3 o'clock"), ability to take authority/responsibility, flexibility ("They're never repetitive, if one way doesn't work they'll try other techniques"), motivating others and being motivated themselves ("sometimes you think you're getting nowhere, they can point things out you didn't even think you did"), and being boundaried ("They're very professional…they'll never tell you anything about their own lives…I don't really know anything about them"). These skills are contained in Table 5 below, along with the number of participants who mentioned each skill.

Table 5: Clinical Skills Needed in Homecare Team

Skill	No. (percentage) of participants
Ability to Explain Re. Mental Health	5 (26.3%)
Organisation	2 (10.5%)
Taking Authority/ Responsibility	2 (10.5%)
Motivating	2 (10.5%)
Flexibility	1 (5.3%)
Motivation	1 (5.3%)
Boundaried	1 (5.3%)

Discussion

Results suggest that staff work in a way consistent with their mission statement. Enabling communication, monitoring general mental health, reducing hospital admissions, providing support at personal and clinical management levels, accessing other social services, motivating, and providing education on mental health issues were all evident in client's responses, and in the stated aims of the service.

Incidents which clients experienced as impacting positively highlighted the relative strengths of the service as viewed by its users, while incidents with a negative impact may indicate areas of possible change or improvement. As with previous studies, medical, psychological and social dimensions of care were all commented on. It was not just that contact and communication with the home care team existed but its availability and immediacy, and the apparent ease with which it accessed, that seemed crucial to many. There was a sense that, for some, homecare provided what might be the re-establishment of social contact. For these service users, homecare also provided a link with busy and often impersonal psychiatric and social systems of care. However, not all benefited from this, such as the clients who requested more social work involvement and stronger links with psychiatry. It may be that clients were not aware that, for example, all clients have access to a social worker. Clients may not be fully aware of team functioning, or information may not be adequately passed on or received at times.

Participants were able to highlight particular interventions that they saw as useful, both for themselves and for their families, whom they saw as also needing support. An important aspect of the work was providing education on mental health issues in an intelligible way, again both for clients and families. There was also a request for more information. It may be that the amount of information given varies between team members or disciplines, or it may be that some clients are viewed as more/less ready to receive or comprehend information depending on symptomatology. This may be important to address as provision of adequate information and education may serve to involve the client more actively in her care and at various decision points. This sense of combined responsibility in turn is important in reducing hospitalisation (Catty et al, 2002; Mental Health Commission, 2005a).

Continued involvement of home care when the client wished for increased autonomy seemed to cause some frustration. Participants also acknowledged that they may be premature in wanting less contact. However, it can be said that our psychiatric system may be slow to acknowledge and facilitate individual independence (Mental Health Commission, 2005b). It may be that, in these instances, continued involvement should be explicitly negotiated, with both viewpoints articulated. Similarly, when times are to be arranged or appointments changed, there may be room for more discussion on the their impact. Staff should be cognisant of the impact of this, given the importance of contact from homecare staff to the participants. Comments relating to the possibility of more links between different aspects of the service and with outside agencies serve to highlight what may seem like disparate parts to our mental health system.

Interpersonal characteristics of building rapport, understanding, patience, good communication and supportive mentioned here as inherent in staff are reminiscent of non-specific factors in psychotherapy which are thought to contribute to therapeutic change (Lambert, Shapiro & Bergin, 1986). They are important factors in and of themselves, and their presence is intrinsically linked to the effectiveness of any clinical intervention. While their contribution to a working alliance was evident in clients' accounts, there was also a strong sense of a 'real' and 'human' relationship, central to any psychological growth (Clarkson, 2003).

The most frequently mentioned clinical skill was the ability to clarify mental health issues, a crucial aspect of the work, and discussed above. This may reflect the more collaborative approach of homecare, with clients obviously valuing this. Again, it is important to emphasise that such knowledge may enable greater client involvement in care decisions, ultimately impacting on outcome.

In this study, there may have been biases here of which the staff and researchers are unaware. Service users are often afraid of criticising their service, due to the fear that future care may be compromised (Powell, Holloway, Lee, et al., 2004) Equally, it is possible that some clients may not have felt comfortable responding to questions from a stranger about their personal experiences with the homecare service. Although the interviewer was independent of the homecare service, the homecare team were relied on to initially approach participants in relation to the purpose and nature of the study. This may have led participants to perceive a link between the researcher and the homecare service, causing them to feel restricted in their responses. Also, many elements of the mental health service impact on the effective delivery of any home care service such as funding, working environment, access to impatient crisis care, etc. These were not addressed here and may be more immediate concerns of staff rather than clients, although they ultimately impact on clients also.

In all, there were certain themes that featured strongly in the final analysis, such as the consistency and availability of personal contact, and receiving education and support on managing mental health for both clients and families. While not exclusive to homecare staff, such values are inherent in homecare philosophy and practise, and may be central to the effectiveness of home care. Perhaps the challenge now is how to practically integrate such commentary into service planning and delivery so that service users become more active participants. Undoubtedly, the care provided by the homecare service to the continuing care programme is valued by service users. The commentary here, as well as giving voice to the experience of care, highlights the contribution service users can make to service development.

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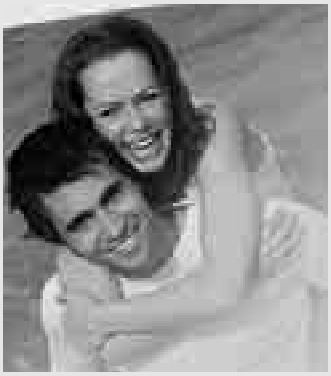
Permission: This study has been approved by the ethics committee of St. James's Hospital and Federal Dublin Voluntary Hospitals.

For further information: You can get further information or answers to your questions about this study from Mary Fell, who can be contacted at Ballyfermot Mental Health Clinic, 01- 6234040.

'No Panic'



Conference (June 6, Stillorgan, Co.Dublin)

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at the Stillorgan Park Hotel, Stillorgan, Co.Dublin.

Caroline McGuigan, Irish Co-Ordinator, No Panic:
An introduction to No Panic (IRELAND)

Professor (Emeritus) Kevin Gournay, Institute of Psychiatry, London:
Self Help For Panic

Julian Beckedahl, Operations Manager, Community Network, London:
How Teleconferencing can benefit Anxiety Disorder Sufferers

Dr. Tony Bates, Founder/CEO Headstrong
Social Phobia

No Panic Help-liners:
A help-liner's role

Professor Roz Shafran, Charlie Waller Chair in CBT, Reading University, UK:
Self Help For OCD

Professor Paul ·alkovskis, Clinical Director of the Maudsley Hospital Centre for Anxiety Disorders and Trauma, London:
Self Help For Phobias

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The Human Rights Implications of the Mental Health Act 2001: 16 to 18 year olds.

Examined by Marylouise Coffey (Bachelor of Laws in Law and European Studies)

The Mental Health Act 2001

For the first time in Irish mental health law a definition is provided for mental disorder, for which a person may be involuntarily admitted, detained and treated. The Mental Health Act 2001 lays down a concise definition for "mental disorder" which means:

"mental illness, severe dementia or significant intellectual disability where because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons."

The Voluntary Admission of Children under the 2001 Act

There are no procedures outlined for the voluntary admission of children in the 2001 Act.

It is noteworthy at this juncture that the Act defines a "child" as any person who is under the age of 18 other than a person who is or has been married.

This is in stark contrast with section 23 of the Non-Fatal Offences Against the Persons Act 1997, which states that for the purpose of medical treatment, an individual over the age of 16 has the capacity to consent. Ultimately the 1997 Act and the 2001 Act are at odds. It is not clear what status the consent or refusal of consent, of a child between the ages of 16 and 18 years, to treatment for a mental disorder will have.

It is laid down however that a voluntarily admitted "child" may not be afforded the same rights as an involuntarily admitted adult, such as their right to apply for the review of their confinement.

They are purportedly present of their own free will and do not need the same protection as involuntarily admitted patients.

What of the children who are admitted voluntarily by virtue of their parent's consent, who are in dispute with their parents? The rationale here is strained. It can be argued that the Irish Constitution accords supremacy to the rights of the family and guarantees to respect the inalienable rights of the parents to provide for the intellectual, physical and social education
of their children.

It can be deemed that the parents are acting in the best interests of the child in question.

The Mental Health Act 2001 protects the rights of those that are involuntarily detained. Ultimately the 2001 Act creates a modern legislative framework for the admission, detention and treatment of persons with mental disorders, in compliance with international standards and obligations. However the 2001 Act changes the age of consent to psychiatric treatment from 16 to 18 years. For those in this age group, rights that were previously afforded to them now have been removed under the new legislation, with notable repercussions.

The criteria for voluntary patients to consent to treatment for mental disorder is similar to the consent needed for other forms of medical treatment and are governed by common law.

They require, in summary (a) that the patients consent be voluntary; (b) that the patient has the capacity to understand the nature and possible effects of the proposed treatment; and (c) that the patient has been given enough information to enable them to give informed consent.

The fundamental rule is that no psychiatric treatment may be given to a voluntary patient without their consent and he also has the right to withhold consent to treatment.

This issue is dealt with under section 57 of the Mental Health Act 2001:

"The consent of a 'patient' shall be required for treatment except where in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition or to relieve his or her suffering and by reason of his or her mental disorder the patient concerned is incapable of giving such consent"

The concept of consent itself, in relation to the patient, is defined in section 56 of the Mental Health Act 2001. It is of note that patients involuntarily admitted to a psychiatric hospital, who may have at the time of admission lacked the capacity to make decisions regarding their treatment, can regain this capacity over the course of their stay.

The consent required in the case of children is not clear.

Legally effective consent may be given by a parent, where the procedure is in the best interests of the minor and the minor is incapable of consenting on their own behalf.

Under the Mental Health Act 2001, the term "child" is defined as any person under the age of 18 years, other than a person who is or has been married.

Under the Non-Fatal Offences Against the Person Act 1997, section 23 states that a minor over the age of 16 has the capacity to consent to medical treatment, and no additional consent is required from their parents.

This section states that:

"surgical, medical or dental treatment includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure which is ancillary to any treatment as it applies to that treatment."

Psychiatric treatment, including drug therapies, would fall under this idea of medical treatment. There is a direct conflict between the 1997 Act and the 2001 Act; it is still unclear what status the consent or refusal of consent of a child to treatment for mental disorder between the ages of 16 and 18 will has under the 2001 Act.

The Mental Health Commission acknowledges this difficulty stating "The Commission's legal advice is that attempts to reconcile Section 23 NFOAP act 1997 with the provisions of the Act give rise to significant difficulty."

Section 2.11 and 2.12 of the Code of Practice Relating to Admission of Children under the Mental Health Act 2001, published by the Mental Health Commission 2006 goes on to outline the following :

"The Commission's legal advice is that while there are cogent arguments in favour of applying Section 23 NFOAP Act 1997 to the Act, the position is not so clear as to enable the commission to proceed, or advise that there is significant uncertainty as to whether Section 23 NFOAP Act 1997 has any application in relation to admission for and provision of treatment for mental illness. Medical and health professionals may need to obtain legal advice in relation to individual cases.

The present position, therefore, is that the Commission cannot advise mental health professionals to operate on the assumption that Section 23 NFOAP Act 1997 means that the consent of children aged 16 and 17 is effective to permit treatment under the ACT. It appears that, as a matter of fundamental principle, the more extensive and / or far – reaching the intervention proposed, the more cautious the treating professional should be in relying exclusively on a child's consent. Such caution would be particularly indicated where the parent(s) of the child are opposed to intervention. The commission's legal advice is that irrespective of whether children aged 16 and 17 years are capable as a matter of law or fact of providing an effective consent to treatment , the views of 16 and 17 year olds as to their treatment should be sought as a matter of course."

These conflicting definitions are a matter that needs to be resolved by the legislature. It appears that the voluntary admission of a minor is governed by common law under the 2001 Act.

Under the Mental Treatment act 1945 the source of consent for those under the age of 16 was parental. These individuals were admitted as voluntary patients in name, but in actuality were involuntary. It was therefore possible for children to be admitted and detained against their will, despite being competent to make their own decisions. Under the Mental Health Act 2001, theoretically this would apply to those 18 years and under due to the supremacy afforded to the family under the Irish constitution.

If the autonomy of all of those under 18 was recognised and they were afforded the opportunity to consent of their own accord, but not the autonomy to refuse to consent, parental consent would still override their refusal. They would still be admitted as voluntary patients, but in actuality be involuntary patients minus the rights.

If those between the ages of 16 and 18 were afforded unadulterated autonomy over their consent to medical treatment, they could be treated as a separate legal entity. Mature minors could be admitted as both voluntary and involuntary patients where necessary, and treated as such in both name and nature.

Britain: Gillick Competence

When looking at the question of the ability of mature minors to consent to medical procedures, English law provides a useful approach to adolescent consent and capacity, for here the judiciary has actually examined the issue.

In Britain today the current age for consent is defined by the Family Law Reform Act 1969, which states that consent of a minor, who is 16 years and over, to any surgical, medical or dental treatment is as effective as that of an adult.

The leading English case concerned with the capacity of minors to consent is Gillick v. West Norfolk and Wisbech.

This case held that adolescents under the age of 16 are more properly understood as being burdened with a rebuttable presumption of incapacity. If they cannot displace this burden, their medical decisions remain the responsibility of their parents.

Pursuant to the decision made in the Gillick case, The British Medical Association and Law Society of England and Wales in their Report on the Assessment of Mental Capacity Guidance for Doctors and Lawyers offered guidelines for assessing a minor's maturity for the function of consenting to medical treatment.

An assessment of a minor's capacity should include considerations of the young persons:

ability to understand that there is a choice, and that choices have consequences;

willingness and ability to make a choice (including the option that someone else makes treatment decisions);

understanding of the nature and the purpose of the purposed procedure;

understanding of the proposed procedure's risks and side effects;

understanding of the alternatives of the proposed procedure and the risks attached to them and the consequences of no treatment; and freedom of pressure.

In essence, the case distinguishes that a child's decision-making aptitude will improve incrementally with increased maturity and that milestones founded on age are arbitrary and capricious.

Following the ruling in Re R (A Minor) (Wardship: Consent to Treatment), a Gillick competent child may consent to treatment but if he declines to do so, consent can be given by someone else with parental rights. Compulsory psychiatric treatment was deemed legal on the basis of parental consent alone. The upshot for the mature minor is that the efficacy of any sufficient refusal by him is dependant upon his parent's willingness to respect it.

Could Gillick Be Applied in Ireland?

If the concept of Gillick competence were made applicable to the situation of a minor's consent to psychiatric treatment in Ireland, it would mean that a minor under the age of 18 years, who understands the nature and the consequences of that treatment, could give a valid consent for it.

Illustrated in the cases Re W and Re R, the refusal of a competent child under 18 years to consent to psychiatric treatment can be overridden by his or her parents or the person in loco parentis.

Many Irish authors such as Tomkin and Hanafin argue that the Irish Constitution, in the form of Articles 41 and 42, also supplies a barrier to Gillick competence.

Article 41 places the marital family on an elevated pedestal with immunity from excessive interventions by the state.

In the case of North Western Health Board v. W(H) it was found by the majority of the Supreme Court that the welfare of the child is best served by deferring to health care decisions made by the parents, in keeping with family rights under the constitution.

However Keane CJ dissented, recognising the existence of the particular individual and personal rights of the child within the family. He held that the best interests of the minor were the paramount consideration of the court under the Constitution and the law, and that those best interests prevailed over the wishes of the parents.

All of the judges also recognised that there were certain circumstances where decisions could be made by parties other than the parents.

Mills notes that the courts did not attempt to define these rights or stipulate the circumstances where the rights of the child could possibly take precedence over the parents, yet it seems that, on some very ill-defined level, the right of mature minors to consent to treatment does exist.

Though we are far from the acceptance of Gillick competence in this state, this author is of the opinion that we are at least beginning to recognise the concept of a minor's capacity to consent. Due to the prominence of Article 41 and 42 of our constitution,

the prospect of the incorporation of Gillick is improbable without some form of a constitutional amendment recognising the mature minor's autonomy in certain circumstances. However, the recognition of Gillick competence alone, in this authors view, would be insufficient. The ideal would be if a mature minor could also be afforded the capacity to refuse consent to psychiatric treatment. Under such circumstances, they could be admitted as some form of an "involuntary mature minor" patient and be treated as such, in both name and nature.

Human Rights Implications of the Mental Health Act 2001

The Mental Health Act 2001 outlines the procedures necessary to protect the innate privilege of liberty which is bestowed upon every Irish citizen.

With reference to mature minors, the question is, if they are admitted as voluntary patients as a consequence of parental consent, are their rights being waived and thus infringed?

There was no specific provision made for the detention of mentally ill children under the 1945 Act,

however a child could be admitted to an institution as a "voluntary patient," though their consent was never given, waiving all the safeguards against inappropriate admission as afforded to involuntarily detained patients.

Prior to November 1st 2006 those individuals between the ages of 16 and 18 were, afforded the right to consent under section 23 of the Non-Fatal Offences Against the Persons Act 1997, which was in line with the Mental Treatment Act 1945. However with the full implementation of the 2001 Act, new problems arise.

The 2001 Act raises the age of consent for psychiatric treatment from 16 to 18, the implications of which is cause for great concern.

The 2001 Act puts safeguards in place for the protection of the rights of adults; these protections shall not be afforded to those between 16 and 18 years of age.

One of the prominent changes brought about by the Mental Health Act 2001 is the increased rights afforded to those involuntarily detained.

Under section 16 of the new legislation, their detention or admission will be automatically reviewed by the Mental Health Tribunal.

These safeguards are all in place to prevent unfair admissions, and to protect the rights of the involuntarily detained. These protections came to fruition because the Mental Treatment Act 1945 was deemed to be in breach of the European Convention of Human Rights.

The Crooke v. Smith Case

Ireland is a signatory of the European Convention of Human Rights, under which Article 5 guarantees the right of liberty to our citizens.

This right is not absolute, but it may only be taken away or abridged in accordance with the law. Anyone who is deprived of their liberty is entitled to take proceedings, by which the lawfulness of their detention shall be decided speedily. If deemed unlawful, their release shall be ordered.

In the case of Crooke v. Smith,

The plaintiff had been involuntarily detained in a psychiatric hospital in 1994 and claimed that the lack of independent and speedy review of this detention violated the Convention. When the Supreme Court upheld the constitutionality of his detention, he appealed the issue to the European Court of Justice.

His application was deemed admissible and was subsequently the subject of a friendly settlement with the State, which contained an undertaking by the government to pass new mental health legislation which would provide a review procedure;
borne out of this was the Mental Health Act 2001.
Human Rights Violations: 16 – 18 Year Olds

Good mental health legislation is the guardian of civil liberties. Under the Mental Health Act 2001, there are many protections afforded to adults, which children are denied due to their voluntary status, to the detriment of their civil liberties.
Protection against unfair admission – the right to complain and advocacy.
The right to apply for a review of their confinement to an independent Mental Health Tribunal is one that is afforded to involuntary adult patients under the Mental Health Act 2001.

A mature minor, who is admitted to psychiatric hospital as a voluntary patient due to consent given by their parents, is denied this right.

The logic behind this denial is that because voluntary patients are present of their own accord, they are free to leave if they decide to and thus do not need the same protection as involuntary patients. In the case of mature minors who are detained voluntarily and desire to leave, it is their parents who apply for such a release the mature minor is never free to leave of their own accord. All of the aforementioned safeguards against unfair admissions, such as access to legal representation, are not afforded to those detained voluntarily, based on this rationale.

But what of those between the ages of 16-18 that are in conflict with their parents at the time of admission? The underlying principle is strained.

The 1991 UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, also known as the MI Principles, elaborate the basic rights and freedoms of people with mental illness under the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

They state that "special care should be given…to protect the rights of minors"
MI Principle 21 also provides for the right of every child with mental illness or being treated within the mental health services "to make a complaint through procedures as specified by domestic law." Ireland is obliged to ensure that the appropriate mechanisms are in force for the "submission, investigation and resolution of complaints."

A child should also have access to an independent advocate when admitted to a mental facility, when a family member is unavailable, as the MI Principles reinforce.

"Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including if necessary, the appointment of a personal representative other than a family member."

MI Principle 12(3) states that a patient who has the necessary capacity can nominate a person to represent their interests to the authorities of the facility. The 2001 Act is deficient in not providing an effective complaints procedure; building an efficient advocacy and complaints process into the legislation is important to ensure that the individual children and individual children's concerns and issues are not neglected.

Admission as an involuntary patient – section 25

Section 25 of the Mental Health Act 2001 provides for the circumstances where a Health Service Executive may make an application to the District Court, for an order to refer a child to an in-patient facility.

Worryingly, section 25(3) and 25(4) dispenses with the need for prior examination of a child by a Consultant Psychiatrist, when the parents or guardians refuse to consent to such an examination or cannot be found.

Under section 25(4), it is only after admission that the Health Service Executive may be directed, by the District Court, to have an examination performed by a Consultant Psychiatrist, to ascertain if the child is actually suffering from a mental disorder.

The Irish College of Psychiatrists, in it's views published on the new mental health legislation in 2001, stated that they found this to be a possible serious infringement of children's civil liberties.

"Under these circumstances…the provisions of the Child Care Act 1991, section 13(7),
should be invoked in the first instance, rather than the mental health legislation, where there has been no examination."

A Court order under section 25(1) lasts for up to 21 days and may be renewed by the courts, yet the right to a review of the detention by the Mental Health Tribunal is not afforded to children; nor is the right to change their status from involuntary to voluntary, as is granted to adults.

Sufficient services for adolescents.

The implementation of the Mental Health Act 2001 raises the age of a child from 16 to 18 years and will bring the legislation into conformity with provisions of the Child Care Act 1991.

This will mean new legal procedures for detaining persons aged 16 to 18. The legislative change has accelerated the debate on the service needs of 16 to 18 year olds and how these can be met.

For children who require mental health interventions, services and support are seriously out of step with need.

MI Principle 1 states that "all persons have the right to the best available mental health care, which shall be part of the health and social care system." The lack of satisfactory facilities for minors suffering from psychiatric problems has been emphasised by cases such as DG v. Ireland.

An innocent but mentally disturbed child was sent to a penal institution in the absence of any appropriate psychiatric unit.

The Mental Health Act of 2001 was enacted for the purpose of protecting the rights of those who are deprived of their liberty. It is clear that these protections are only of relevance to those over the age of 18. In 1992, Ireland ratified the UN Convention on the Rights of the Child, making a commitment to protect the rights of those under 18 provided therein. This convention has had unprecedented success on an international scale, yet this author is of the opinion that with the implementation of the Mental Health Act 2001, those between the ages of 16 – 18 shall suffer human rights violations on a large scale.

Conclusion

No longer deemed to have the capacity to make decisions regarding their own mental health, consent for the voluntary admission of the mature minor, under the 2001 Act, is parental. Irish law is prominent for its lack of jurisprudence on the ability of mature minors to make decisions regarding their medical treatment. The imposition of a constitutional amendment, affirming the mature minor's right to self autonomy in certain limited circumstances, would allow this group to consent, and more importantly refuse to consent, to psychiatric treatment. If refusal was allowed, they could be admitted as involuntary patients and afforded rights as such.

The situation under the 2001 Act allows for those between 16 and 18 years to be voluntarily admitted at the hands of their parents or guardian. As such, they are denied basic rights, such as the ability to review their detention and access to legal representation. This is in breach of the European Convention of Human Rights, the UN Convention on the Rights of the Child 1989 and goes against the 1991 UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. The lack of services and facilities available for the mental health care of mature minors in this State can also be looked upon as an infringement of their human rights.

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Federation of Voluntary Bodies Providing Services to People with Informing Families National Best Practice Guidelines

In response to a proposal by the National Federation of Voluntary Bodies to mark the European Year of People with Disabilities 2003, the Health Services National Partnership Forum agreed to provide funding for a project which would make a real difference to people with disabilities in Ireland and particularly to their families.

Having consulted with families and people working in the Disability Sector, it was agreed that the development of National Best Practice Guidelines for how families are told of their child's disability would be a significant way to mark the year, while also leaving a substantial legacy by way of addressing an important issue which has remained unaddressed over many years.

Having distressing news disclosed to us in a manner which lacks sensitivity or in an environment which is inappropriate causes additional stress at what is likely to be a difficult time. The central aim of the Informing Families Project was therefore to develop evidence based national best practice guidelines, education and training on appropriate procedures to inform families of their child's disability when communicating a diagnosis or concern. The intention of the guidelines is to ensure:

Improved outcomes for families being told of their child's disability, through the implementation of best practice; and

Improved support, guidance, education and training for professionals in the important and sensitive task of delivering this news.

The development of the National Best Practice Guidelines is the product of rigorous research and exhaustive consultation carried out over the past two and half years.

left to Right: Larry Walsh (Chief Executive, Health Services National Partnership Forum), Alison Harnett (Informing Families Project Co-ordinator, National Federation of Voluntary Bodies)
Brian O'Donnell, (Chief Executive, National Federation of Voluntary Bodies)
Photo: Tom Clancy

Full Report can be accessed at www.fedvol.ie

DEVELOPMENT OF NATIONAL BEST PRACTICE GUIDELINES

In 2004 the National Federation of Voluntary Bodies, with support from the Health Services National Partnership Forum (HSNPF), began a project to develop national best practice guidelines for how families are informed of their child's disability. The development of these Guidelines was initiated in response to feedback from many parents to National Federation member organisations, that the news of their child's disability had been conveyed insensitively or in inappropriate environments; and that their experience of being told the news had caused additional distress at the time of disclosure. Similarly, feedback from professionals delivering the news indicated that they felt there was an absence of training and clear guidance available to support those undertaking the sensitive and challenging task of giving a family the news that their child has a disability.

The development of the Guidelines was guided by the Informing Families Steering Group which is chaired by Dr. John Hillery (President of the Medical Council of Ireland 2004-2007 and Consultant Psychiatrist with intellectual disability service providers Stewart's Hospital and St. John of God Hospitaller Services). The Steering Group had representation from key stakeholders such as parents, disability service providers, the HSNPF, the Health Services Executive, the Department of Health and Children, the Royal College of Physicians of Ireland, the National Federation of Voluntary Bodies and nominees from the professional bodies and trade-unions of various disciplines involved in informing families.

Alex and Max Crowe at the launch of the Informing Families Best Practise Guidelines
Photo: Tom Clancy

Aims

The aim of the Informing Families Project was to develop evidence-based National Best Practice Guidelines, education, and training; on appropriate procedures to inform families of their child's disability when communicating a diagnosis or concern. The fundamental goals of implementing these Guidelines are:

To ensure improved outcomes for families being told of their child's disability, through the implementation of best practice

To provide improved support, guidance, education and training for professionals in the important and sensitive task of delivering this news

The scope of the Guidelines includes the disclosure of a child's diagnosis of physical, sensory, intellectual, and multiple disabilities, and autistic spectrum disorders. The Guidelines relate to the diagnosis of a child's disability during pregnancy; at birth; or in the case of a diagnosis which evolves over time.

Informing Families National Best Practice Guidelines

Methodology

In order to ensure that the guidelines would be informed by wide ranging consultation and partnership with all key stakeholders and that they would be grounded in evidence-based research, the Informing Families Steering Group directed the undertaking of a comprehensive consultation and research programme. This process included:

Stage 1

A review of relevant national and international literature, and an examination of the
national policies relating to this area

Initial exploratory research with families and professionals

Stage 2

Seven consultative focus groups with parents of children with disabilities (physical, sensory, intellectual, multiple disabilities and autistic spectrum disorders), from around Ireland. Consultative focus groups with 15 disciplines of professionals involved in communicating to parents the news that their child has a disability, or in supporting them immediately thereafter.

Stage 3

A National Questionnaire Survey disseminated to 584 parents of children with disabilities A National Questionnaire Survey disseminated to 1588 professionals in 27 disciplines who provide the news to families of their child's disability, or support families who have just received a diagnosis

The consultation and research strands explored disclosure practice across the range of hospital, community, and disability service settings in which parents may receive the news of their child's disability. Each of the stages undertaken informed and led to the next stage, and the results of the consultation and research in the literature, focus groups and national questionnaire survey were collated and analysed to produce the National Best Practice Guidelines for Informing Families of their Child's Disability.

Informing Families National Best Practice Guidelines

The findings of the consultation and research led to specific recommendations in a number of key areas that are relevant to the process of informing a family of their child's disability:

The Setting/Location and the People Present at Disclosure
Communication
Information and Support
Culture and Language
Training, Education and Support for Professionals
Organisation and Planning
Referral
Dissemination

Further details on the Informing Families Project and a comprehensive report of the findings of the consultation and research is available at www.fedvol.ie .

The National Best Practice Guidelines for Informing Families of their Child's Disability fall into two sections; Guiding Principles and Best Practice Recommendations. The Guiding Principles apply regardless of the circumstances of disclosure. The Recommendations are non-prescriptive, and in addition to being informed by the above principles will require adaptation to the circumstances of disclosure, including:

Hospital / community / disability service setting /
family home
Ante-natal diagnosis / diagnosis at birth /
evolving diagnosis
Physical / sensory / intellectual / multiple disabilities
and autistic spectrum disorders
Unexpected event / predicted disclosure following assessment or tests

"…and its not just a sentence, every word is important because you are hanging on to everything they say and you will remember every word that they say, it sticks in your mind. They need to really plan their sentences and their words because this is going to stay with you for the rest of your life."

Parent, Informing Families Focus Groups

Infoming Families of their Child's Disability National Best Pracvtice Guidelines

Guiding Principles

Whilst every disclosure event is unique, the National Best Practice Guidelines for Informing Families of their Child's Disability have identified that the following Guiding Principles should be applied in every case.

1. Family Centred Disclosure

Disclosure must be family-centred and tailored to the emotional and informational needs of each individual family. The family should be provided with choice and options in the support that they receive during the disclosure process (e.g. family-friendly appointment times, private accommodation, contact with other families, counselling, etc.).

2. Respect for Child and Family

At all times it is necessary to demonstrate respect for the child and family. This should include using the child's name, acknowledging and supporting the family's dignity, emotions and reactions, and respecting cultural and linguistic diversity.

3. Sensitive and Empathetic Communication

Sensitive communication that is open, honest, empathetic and understanding is essential. Whilst unavoidable difficulties in implementing best practice in other areas may be understood by parents, blunt or insensitive communication invariably leads to significant and lasting dissatisfaction.

4. Appropriate, Accurate Information

Meeting the family's information needs is a key priority that influences subsequent levels of parental stress and satisfaction. It is essential to pace the information in accordance with the needs of the individual family; (including how recently they have received the diagnosis, any current medical needs, and potential levels of distress or shock) to provide sufficient information whilst avoiding information overload.

5. Positive, Realistic Messages and Hope

Realistic, positive messages and hope should be given with the diagnosis - not merely the worst case scenario. The emphasis should be on the child first, and the disability second. Encouraging staff members to support parents who wish to celebrate their child may include disability awareness training and an exploration of various definitions of hope which parents find appropriate and helpful (e.g. reassurance that support and help are available).

6. Team Approach and Planning

Informing a family of their child's disability is a process rather than a once-off event. Preparation, planning, team work, close communication between staff members and liaison between agencies/service providers is essential to successful implementation of best practice.

7. Focused and Supported Implementation of Best Practice

Support for implementation of the Guidelines is required at all levels, including management, to ensure that planning takes account of the need for appropriate physical environments; provides for information ownership; and facilitates agreed protocols for dealing with different disclosure scenarios.

The Guidelines will require adaptation to the circumstances of disclosure, including:

Hospital / community / disability service setting /
family home

Ante-natal diagnosis / diagnosis at birth /
evolving diagnosis

Physical / sensory / intellectual / multiple disability and autistic spectrum disorders

Unexpected event / predicted disclosure following assessment or tests

RECOMMENDATIONS FOR INFORMING FAMILIES OF THEIR CHILD'S DISABILITY

1. Setting/Location and People Present at Disclosure

In relation to the location and the people that are present, the Guidelines recommend that:

1.1 The diagnosis is given in a private place with no interruptions. The room in which this takes place is:

Quiet

Free from interruptions

Comfortable and user-friendly

Available for the family to spend time in, absorbing the news after the consultation

- There is a kettle, phone, tissues, tea, coffee and water available

Within the hospital setting there is a need for private rooms to be made available in both in-patient and out-patient settings. Ideally, the consultation does not take place in a room that the family will be using again such as the labour ward or ultrasound scanning room, as this may leave parents with a negative association with this room for the future.

The diagnosis is made verbally (not in writing) and in person (not over the phone).

Both parents are present when the diagnosis is given.

If it is only possible to have one parent present, the option is given to have another family member or friend present to provide support.

When a parent hears the news alone, arrangements are made as soon as possible to inform the other parent and close family members.

If the parents are very young, it may be appropriate to invite extended family members such as grandparents as support for the parents.

The news is given by an appropriately trained staff member who is responsible for delivering and confirming the diagnosis.

A second professional, preferably known to the family, is present and remains to support the family after the initial disclosure.

The number of professionals present is limited and does not greatly outnumber the family members.

No extra staff are present purely for training purposes. (Any staff members in training that are present should also have a role in providing further care to the family).

If the news of a child's disability is given close to the time of birth, it is important that the parents have seen the baby before the diagnosis is given, and if at all possible the parents are given the opportunity to spend some time with the baby before any disclosure takes place. This can facilitate the parents in identifying with their infant as a child first and the disability as secondary.

It is critical that the parents can see the baby when they are being prepared for difficult news. (This is necessary to avoid any misunderstandings that may lead to assumptions that the child has died.) If the baby cannot be present, the parents should first be sensitively reassured that the difficult news to be imparted does not mean that their child has died or is dying.

If a baby is being cared for in the intensive care unit, the parents are facilitated to visit as soon as possible after the diagnosis is given, including facilitating a mother who herself may be recovering from surgery such as a Caesarean section.

Unless the diagnosis takes place close to the time of birth, it is not recommended that the child should be present for the disclosure, so that the parents have an opportunity to absorb the news and express their emotions.

Parents are given time alone together to absorb the news in private, if they wish. They are made aware that there is a staff member they can contact for support at any time.

Whilst respecting the parents' need for privacy it is also important to ensure that the parents are not isolated after being given the diagnosis - if parents wish, a staff member should engage with them at this time to sit and spend time with them.

2. Communication

In relation to the communication of the child's diagnosis to the family, the Guidelines recommend that:

2.1 The news is communicated with:

Empathy
Sensitivity
Honesty
Respect
Compassion
Understanding

It is important that positive, realistic messages are conveyed, and hope is given along with the diagnosis. Positive messages can include describing support and assistance that will be available to the family and focusing on the individual child as a person, with the disability secondary. Rather than listing all possible negative implications of the diagnosis and presenting only the worst case scenario, parents have indicated that where possible it is helpful to be informed of the range of possible outcomes of the disability or condition, and the percentages of children who experience different aspects of the syndrome.

Staff members giving the news use language that is:

Simple
Understandable!
Straightforward
Appropriate

Prior knowledge of parents is assessed before explaining a diagnosis. (Parents have suggested that open questions such as 'Have you any concerns?' or 'What have you heard so far?' are helpful, but closed questions such as 'Does he look like anyone else in the family?' are not.)

Any medical terminology used is clearly explained, along with the implications and significance of any information given about the child's diagnosis.

Explanations are given at a level parents can understand, taking into account socio-economic, linguistic and cultural factors.

Listen to parents. Listening to parents allows for communication to be tailored to the individual needs of the family.

Parents are encouraged to ask questions.

Staff members check that parents have understood what has been discussed.

The child is shown respect; the child's name is always used, and they are not referred to by their diagnosis. For example, instead of saying 'this Down Syndrome baby' staff members say 'Ben, who has Down Syndrome'.

The appointment is not rushed. Families and professionals agree that informing parents of their child's disability should be seen as a priority, and consequently adequate time must be allocated, including time for the parents to ask questions and express emotions without interruption.

Pagers and mobile phones are switched off.

Team members reinforce the information already given, at appropriate times, so that families have several opportunities to absorb and clarify information provided.

Staff members are aware of their body language and how this can be interpreted by parents. Avoid whispering in front of parents, or giving negative non-verbal signals that could raise concerns with parents before the news has been communicated to them.

Parents' concerns are acknowledged, treated seriously and followed up.

The reaction of parents is acknowledged, supported and taken into account when communicating with the family. (Parents will have different reactions and different coping mechanisms. Some may feel the need to 'walk away' for a period of time to come to terms with the news, others may be in shock and take in very little, still others may wish to have significant interaction, information and support from staff members.)

Dismissive, impatient, aggressive or judgemental language is never used when speaking to parents or children.

3. Information and Support

In order to meet the information and support needs of parents at the time of diagnosis, the Guidelines recommend that:

Parents are kept up to date at all times, with honest information. This includes acknowledging any uncertainty that exists about the diagnosis, and explaining any suspected diagnoses that are being investigated. There should never be a large gap between what parents know about the diagnosis and what professionals know or are investigating. Building trust with parents is a priority, particularly since the initial diagnosis may be the beginning of a long term parent-professional relationship.

At the end of the initial consultation, parents are offered factual, accurate, up to date, relevant written material on the disability, support groups, entitlements and benefits, and on the Early Services that will be available for their child.

Information on support groups for specific syndromes is particularly important to parents and is therefore provided when at all possible. Where support groups do not exist in Ireland, contact with such groups in other countries is investigated and facilitated.

The amount of information provided is tailored to the

individual parent's needs - avoiding information overload for parents who may feel overwhelmed, and meeting the information needs of parents who seek further details.
Care is taken in the timing of the delivery of news so that the consultation takes place at the appropriate time; taking into account for instance in a neonatal diagnosis that the mother may be recovering from the birth or surgery.
A contact number for a member of the staff team is provided to the family at the initial diagnosis, which they can use if they have questions or concerns.

A follow up appointment is always scheduled before the consultation is over so that the family leave with a plan, knowing when they will next have contact with those who provided the diagnosis, and giving them an opportunity to prepare questions and raise concerns. This appointment takes place no longer than two weeks after the diagnosis is given.
Parents are given a written summary of the consultation and receive copies of all correspondence between professionals relating to their child's diagnosis.
Next steps are carefully outlined and explained to the family - including any tests that will be carried out and any referral to other agencies.
Parents' preferences are sought and facilitated, including how much information they wish to receive, whether they would like to have visitors or support in limiting visitors while they come to terms with the news, whether they would like input from pastoral care teams. Meeting this recommendation will include listening to parents during the consultation to assess whether they are overwhelmed by information already received or are seeking further information.
The family are provided with guidance on appropriate Internet sites which contain relevant and accurate information on their child's particular disability. This can avoid unnecessary anxiety when parents read information that may not be relevant to their child's particular case.
The option of counselling is made available to families following the diagnosis, if appropriate.
The option of meeting the parents of other children with disabilities or similar diagnoses is offered following the diagnosis, where appropriate.

4. Culture and Language
In order to provide the diagnosis in a way which respects cultural and linguistic diversity, the Guidelines recommend that:
A formal interpreter is provided if the parents have limited English proficiency, and the role of the interpreter is explained.
Family members/friends are not nominated as interpreters. Formal interpreters should be used, as the use of family members/friends is inappropriate.
The interpreter is briefed on what will be discussed prior to the consultation so that he/she is prepared when the news is given.
The cultural and religious backgrounds of all families are acknowledged and respected.
When families from diverse cultural backgrounds are being given a diagnosis of their child's disability particular attention is paid to gaining an insight into the meanings that each family assign to disability. Accurate information is provided to explain the diagnosis and dispel any unhelpful misunderstandings of the disability that become apparent.
The written information given to parents is in their first language. The information being explained to parents during disclosure of a child's disability can be quite complex and this is further complicated when there is a language barrier to be overcome.
At a national level equitable access to appropriate professional interpretation services is provided, with interpreters available in person to attend consultations in which parents are inforrmed about their child's disability.
At a national level widespread access to written materials in languages other than English is provided to staff members, for supplying to parents.
The Informing Families Project recommends that further research is undertaken into how families of children with disability should be supported at the time of diagnosis to ensure culturally competent care.

Informing Families National Best Practice Guidelines
5. Training, Education, and Support for Professionals
In order to provide appropriate training, education and support for professionals who undertake the task of informing families of their child's disability, the Guidelines recommend that:
Staff members are trained in best practice for informing families of their child's disability.
The training provided includes:

communication skills training
disability awareness training
cultural awareness and diversity training
listening skills
skills to guide staff members on appropriate responses to reactions the news may cause, including shock
reflective practice
counselling skills

Role playing/experiential training forms a central part of training
As this can be a distressing area for professionals, it is important to have two staff members present at the sharing of the news.
Appropriate support is given (identified locally) including debriefing and mentoring by senior staff members for those in training.
There is an input from parents into training provision.
There are many disciplines across various settings who are involved in informing families of their child's disability. Good linkage across these disciplines and settings is central to a positive experience for parents. Therefore, interdisciplinary collaborative skills training should be provided to all members of staff who may be involved in communicating to families the news of a child's disability, or supporting them thereafter.
An ethos of continuous quality improvement is promoted,

with quality assurance and feedback mechanisms put in place to evaluate practice in how families are informed.

6. Organisation and Planning

Interdisciplinary team working, preparation for the different circumstances of disclosure that may occur and strong team communication are important when informing families of their child's disability. The Guidelines therefore recommend that:

Staff members consult with one another and prepare individually and as a team prior to the consultation with parents. Providing a diagnosis of disability to a family is a priority task, and therefore calls for adequate time to be allocated, along with good planning.

All staff members who may come in contact with the family liaise to ensure that no conflicting information is presented to the family and that all members have the same picture of what has already been told to the parents, to ensure that families are not inadvertently told new information without adequate preparation.

Staff members share information, so that parents do not have to give the same history or information to many different people.

As family circumstances vary, the team share information on how best to facilitate each family.

Care is taken at staff shift changeover times to alert staff members coming on duty that a family has been given the news of their child's disability.

A liaison person is assigned to the family to provide support and information from the time of diagnosis until such time as the family are being supported by appropriate early intervention services. Some of the key aspects of the liaison person's role include:

Providing a single point of contact for the family

Providing information to the family on entitlements and benefits, and services and supports available

Providing assistance with paperwork and applications for services if required

Ensuring that an 'Informing Families' checklist is completed and that all tasks relating to best practice in the disclosure process are carried out

Providing a central point of contact to support services and organisations for the supply of up to date information to the interdisciplinary team Providing a co-ordinating role within the interdisciplinary team, to ensure that information is shared and coherent communication takes place with the family (including, if necessary, team conferences with the family) and ensuring that at least one person is present at the initial disclosure who will be available to meet with the family again to provide continuity of care and information

The liaison person should have appropriate training to understand the needs of families of children with disabilities. The liaison person will have a key role in disseminating best practice guidelines for informing families of their child's disability.

Written information is provided between professionals when referring on, detailing what parents have already been told, so that parents are not inadvertently given significant news without adequate preparation. Written information back to the referring party is also provided, to keep all parties up to date on the child's diagnosis. This needs to be sent to the parents, the GP (with parent's consent) and the referring party. Information is also written on the child's chart in the hospital setting, to ensure that all team members are kept up to date

Birth Notification to the Public Health Nurse includes information about how the family has received the news of their child's disability.

Preparation and planning at a local level is required to ensure the availability of private settings in which to communicate the news; to ensure that staff members have available accurate, up to date, relevant written material for supplying to parents; and to plan the team communication and response that should take place when a child is diagnosed with a disability.

7. Referral

The topic of referral pathways for a child diagnosed with a disability is an area beyond the scope of the current project and is an area in which further research is recommended. However, a smal number of specific recommendations in relation to referral were brought forward through the various strands of consultation and research of the Informing Families Project:

Parents are referred to Early Services as soon as possible.

Parents are given information about the service they are being referred to.

8. Dissemination

Professionals who took part in the research of the Informing Families Project discussed the necessary actions that would be required for successful dissemination and implementation of the Guidelines. Their suggestions included the following:

Management buy-in at all levels for implementation of the Guidelines.

Various formats of information to be provided including leaflets, booklets, checklists and laminated sheets containing the Guidelines - displayed in staff areas in Primary, Community and Continuing Care (PCCC), disability and hospital service settings.

Training to be provided as detailed above.

Direct communication of the Guidelines through professional bodies, trade unions and academic faculties.

The Guidelines to be provided as part of hospital orientation/induction.

The Guidelines to be included in hospital accreditation processes.

The formats for training and dissemination most widely chosen by professionals in the course of this research were 'training course with peers' and 'interdisciplinary training course'.

These Guidelines adopt a person-centred approach whereby the child and the family are at the centre of the measures undertaken at the time of disclosure and in the ongoing parent-professional relationship.

TRINITY COLLEGE
University of Dublin

School of Social Work and Social Policy
Diploma in Addiction Studies 2008/2009

Full Time

Applications are invited for this one-year course commencing in October 2008, from

- people already working in the alcohol and drugs field with individuals, families or communities experiencing problems as a result of the use of alcohol or illicit drugs;
- those wishing to work in the field;
- those who work in a range of social care and service areas who wish to augment their knowledge and return to their workplaces with new learning and experience, e.g. community workers, social workers, child care workers, homelessness workers, probation officers, gardai, nurses, doctors, counsellors, etc.;
- and those who are involved in the administration of services or the formulation of policy in this area.

The Diploma in Addiction Studies is a level 7 special purpose award and has a credit weighting of 60 ECTS. The Diploma leads to enhanced professional competencies and specialised knowledge across a variety of areas.

Further information and application form available from:

Addiction Studies,
School of Social Work and Social Policy
Trinity College, Dublin 2.
Tel: 896 1163
Fax: 671 2262
E-mail: addiction.studies@tcd.ie
http://www.socialwork-socialpolicy.tcd.ie/courses/undergraduate/addiction.php

Closing date for receipt of applications: 18th April 2008
Please note - Interviews for shortlisted candidates will be held on
Monday 26th May 2008

CONTRIBUTIONS FROM OUR STUDENTS

Rostered Students Nurse's Experience of Developing Information Leaflets

The Information Leaflets for the Kerry Mental Health Services were launched by the Director of Nursing Kathleen Collins at the Solas Building, Institute of Technology Tralee (ITT) November 2007. The leaflets were developed, as a joint venture between, the Practice Development Team Mental Health, 4th year BSc in Psychiatric Nursing Students and their preceptors. The leaflets aim was to emphasise the importance of communicating information to service users that is concise, gives clear messages in plain language to facilitate them in making choices.

The student nurse's experiences of leaflet development was explored in collaboration with the Clinical Placement Co ordinator utilising a questionnaire.

The key experiences they documented were as follows:

- All indicated that it was an enjoyable, exciting, educational and beneficial experience. They felt rewarded by the final product expressing a sense of satisfaction at having given something back to the services.
- Learning to participate as a team member was enhanced, along with listening to and giving recognition to the ideas of other team members. Realisation and learning that one has the ability to create an information source that is valuable to service users assists with personal and professional development..
- Identifying team by their professional grade rather than using individuals' names. Being more assertive and open-minded about creating an information source, taking extra time to research the information and procure increased involvement of the service users were identified as things they would do differently.
- Student Nurses felt their contribution was appreciated by nursing staff who were interested in the project and provided them with encouragement.
- Understanding of the nurses role in health promotion and as part of the rehabilitation team in day care centres was highlighted as enhancing their knowledge and experiences in placement
- Difficulties experienced with the project were few, however, deciding on an exercise routine that was appropriate to all age groups was highlighted, along with problems in accessing information.
- Students experienced that clients began to take charge of their health and even began to facilitate groups themselves using information leaflets.
- launch of the information leaflets took place during Master Classes. This was viewed positively as a suitable method of communicating to members of the Kerry Mental Health Services and student nurses that leaflets had been developed and were available.
- The Launch was concluded by two 3rd year student nurses playing and singing the
  Motivational and Inspirational song 'River'.

In the words of this song the rostered student nurses who developed these information leaflets demonstrated that they didn't:

'Sit upon the shoreline and say you're satisfied'
But they
'Choose to chance the rapids and dare to dance the tide'.

Student group involved in this project:

Karen Kiney
Jennifer Lenihan
Jamie Kelly
Norma Moriarty
Carmel Conway
Shivaun O Sullivan
Siobhan Wharton
Emma Moran
Alison O Shea
Lorraine Moriarty

Student group involved in music:

Michelle Gaynor on guitar and lead signer
Mary Frances Brosnan provided the accompaniment

If you require any further information please contact:
Mary Myers CPC
or
Contact Mobile Number: 087 6853835
Student Nurse Jamie Kelly

1

3

2

1. The Full Team, Students, Management & Nurse Practice Development Staff!

2. Information leaflets

3. Michelle Gaynor & Mary Frances Brosnan

1

2

3

1. Chairman Mr. Liam McNamara welcomes PNA student nurses to Annual Delegate Conference

2. Noel Early, Vice Chairman Limerick Mental Health Services Branch Rebecca Ryan Std Nurse, Louise Byrne Std Nurse, Jim Blackwell Commitee Member Limerick

3. PNA Limerick Students

St. Angela’s College, Sligo
College of the National University of Ireland

St. Angela’s College offers opportunities for Psychiatric Nurses to develop their knowledge and skill to meet the ever increasing demands of supporting service users in their illness and their recovery

Modules can be done as part of personal professional development with no assessment; or as a stand alone or as part of an organised programme leading to a specific award where assessment will be completed.

Specific emphasis is given to the application of all modules to the everyday work of the Psychiatric Nurse. Students will be expected to apply acquired knowledge to their service users. For assessment purposes specific application is required.

PSYCHOSOCIAL INTERVENTIONS
Could you do more to support your service user with his mental ill health and recovery?
This module supports the development of day to day interventions to support people living and recovering from their illness. Examples include relapse prevention, medication management, supporting family members, risk assessment and assessing in a holistic way.

THERAPEUTIC COMMUNICATION
This module supports the development of key communication skills important in the therapeutic relationships with service users.

POST GRADUATE DIPLOMA IN NURSING (COMMUNITY MENTAL HEALTH)
Nurses considering working in the community setting would find this 2 year part time course very appropriate in equipping them with the skills, techniques and competencies required for the challenging role of a Community Mental Health Nurse.

POST GRADUATE DIPLOMA IN NURSING (COGNITIVE BEHAVIOURAL PSYCHOTHERAPY)
This 18 month full time course will equip psychiatric nurses with this collaborative, structured form of therapy, which is the treatment of choice for a wide range of psychiatric illnesses such as eating disorders, depression, anxiety, obsessive compulsive disorder and post traumatic stress disorder.

MASTER OF HEALTH SCIENCES
This multi disciplinary course can be taken over a maximum of 5 years. Modules reflect contemporary thinking in many aspects of health care delivery. Assessments are specifically related to aspects of the current role and responsibilities of students.

Closing Date for above programme May 2nd 2008.
For further information and application forms
for the above programmes please contact
Mr. Tom O’Grady, 071 01 43580 extension **311.**
Or visit our website on http:// www.stacs.edu.ie.

Remember to Log on to the PNA website for all your information requirements

www.pna.ie

Psychiatric Nurses Association, Station House, The Waterways, Sallins, Co. Kildare.
Tel: 045 852300 Fax: 045 855750 Email: info@pna.ie Website: www.pna.ie

Our Vision is to Provide: Dynamic, value driven leadership, developing and maintaining diversity within the Association and maintaining integrity and ethical practice of Mental Health/Intellectual Disability Nursing. Our Association provides leadership to promote Psychiatric/Intellectual Disability Nursing, to improve health care for individuals, families, groups and communities and shape health policy for the delivery of health services. The PNA provides a variety of communications vehicles, to assist members in their growth and development as leaders and facilitate internal and external liaisons for the Association. Providing learning and growth inherent in relationships, partnerships, and networks with advocacy, consumer and other professional groups. Maintaining careful allocation and prudent stewardship of the Association's resources.

Our aims and objectives are:

- To promote and protect the interests of members and in particular to provide professional and industrial leadership for the nursing profession
- To improve statutory rights and benefits of members with improved salaries and conditions of work, through to representing members in relation to work matters.
- To improve career progression and the personal development of our members.
- To ensure a healthy and safe workplace for our members.

MEMBERSHIP APPLICATION FORM

Name: ______________________________
(BLOCK CAPITALS) State whether Mr. or Ms.

Grade: ______________________________
(e.g. Student, Staff Nurse etc)

Postal Address: ______________________________
______________________________ (BLOCK CAPITALS)

Qualifications: (please tick): R.P.N. ☐ R.M.H.N. ☐ R.G.N. ☐
R.N.T. ☐ If Other ☐ Please Specify ______________

Date of Birth ☐☐ ☐☐ ☐☐☐☐
Day Month Year

Current Practice Address:
____
____
____

Tel. No. ______________________________ (Home or Mobile)

If you are currently or have in the past twelve (12) months been a Member of another Union, please state which Union: ______________

Email Address: ______________________________

I wish to apply for Membership of the ***Psychiatric Nurses' Association of Ireland.***

Local PNA Branch: ______________________________

Signed: ______________________________

Date: ______________________________

Please return signed Mandate to PNA Head Office, Station House, The Waterways, Sallins, Co. Kildare.
This will then be forwarded by Head Office to the appropriate Health Service Executive Location or Employing Authority.

DEDUCTION FROM SALARY MANDATE

To: Payroll Officer ______________ (H.S.E. Location/ Hospital). Please arrange to have deducted from my salary the sum of,
Tick Box ☐ Weekly €5.00 ☐ Fortnightly €10 ☐ 4 Weekly €20 ☐ Calendar month €21.67 *(Subscription Deduction Period must equate with your Salary Payment Period)* ☐ *Yearly €15.00 Associate Membership (Retired Nurses only)* in respect of **Union Subscriptions** and remit this amount to,
National Treasurer, Psychiatric Nurses Association of Ireland, Station House, The Waterways, Sallins, Co. Kildare.
Essential info marked * must be filled in

***Signed:** ______________________________ ***H.S.E. Location/Hospital:** ______________________________

***Payroll Ref. No.:** ______________________________ ***Date:** ______________________________

I accept that there may be periodic adjustments to the above level of contribution as determined by the National Executive of the P.N.A. and I also accept that these adjustments may be notified directly to my employer by Head Office of the P.N.A. I also understand that advance notice of any change in subscriptions will issue through a General Circular and that individual advance notice will not be issued.

I further authorise you to discontinue payment of contribution to any other Trade Union with effect from the implementation of this mandate.

I acknowledge that this deduction is made for my convenience and may be terminated by the H.S.E/Hospital at any time. I am aware that the H.S.E./Hospital does not accept any further liability for amounts so deducted and paid over the Psychiatric Nurses Association.

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AVC
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