Approaches to specialist training at pre-registration level: an international comparison

Sarah Robinson
Peter Griffiths

National Nursing Research Unit
November 2007
Acknowledgements

This review of international approaches to pre-registration educational preparation for mental health and learning disability nursing forms part of ongoing work on contemporary nursing careers and working lives, based at the National Nursing Research Unit, King’s College London. The review was commissioned by the Department of Health to inform forthcoming deliberations about the future of pre-registration nurse education in the UK. While much of the information in the review was obtained from publications and websites, we also contacted key personnel in many of the countries included in the review for an up to date account of developments in their country and would like to thank them all for their help. We also record our thanks to: Gian Brown, Unit Manager, for report production; Caspian Dugdale for a computerised literature search; and Michael Robinson for translation of French and German material.

Sarah Robinson, Senior Research Fellow
Peter Griffiths, Director

National Nursing Research Unit
King’s College London
James Clerk Maxwell Building
57 Waterloo Road
London
SE1 8WA

www.kcl.ac.uk/schools/nursing/nru
email: nru@kcl.ac.uk

November 2007

This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health. The views expressed are not necessarily those of the department.
## Table of Contents

**Executive Summary**

**Section 1: Context, methods and models**......................................................... 1

1  Introduction .......................................................................................................... 1
2  Impetus for the review .......................................................................................... 1
3  Methods .................................................................................................................. 2
4  Diversity of models for pre-registration nurse education ............................... 3

**Section 2: Pre-registration education for mental health nursing**....................... 5

5  Debates and diversity of approaches: mental health nursing ......................... 5
6  Case studies: approaches to pre-registration mental health nurse education .......................................................................................................................... 10

**Section 3: Pre-registration education for learning disability nursing** .......... 25

7  Debates and diversity of approaches: learning disability nursing ................. 25
8  Case studies: approaches to pre-registration learning disability nurse education .......................................................................................................................... 28

**Section 4: Discussion** ......................................................................................... 31

9  Implications for the UK of international evidence on pre-registration nurse education .................................................................................................................. 31
10 Conclusion .............................................................................................................. 34
References .................................................................................................................. 36
Executive Summary

Many countries are in the throes of debate about the structure and content of pre-registration nurse education. This report considers international evidence available on the outcomes of forms of pre-registration educational preparation for mental health and learning disability nursing which differ from that in the UK.

Commissioned by the Department of Health to inform deliberations about possible changes to pre-registration nurse education in the UK, the review drew together research evaluating perceptions and impact of change; descriptions of change; and expert opinion and debate. Seventeen developed countries, selected for economic comparability were included in the review; differing degrees of information were available.

Models of pre-registration nurse education comprise a continuum from wholly specialist to wholly generalist:

1. Specialist qualification following a direct entry course
2. Specialist qualification following a common core and then branch specialization
3. Generalist qualification following a common core and then specialist options
4. Generalist qualification following a generic course with no specialist options.

Countries reviewed included representatives of each model. The most common change had been a move from Model 1 (wholly specialist) to Model 4 (wholly generalist).

Learning disability nursing

Far fewer countries include learning disability nursing than include mental health nursing in nurse education programmes.

Debates focus on the kind of health professional most appropriate to provide care for clients with learning disabilities and what form of pre-registration education for nurses will best prepare them to meet the needs of these clients. We focused on the latter.

In countries that have always had, or have moved to a generic training, there is little focus on learning disability nursing knowledge and skills in the undergraduate programme.

Responses to this lack of focus include: reintroduction of a specialist option, development of a post-registration speciality, and regret at the loss of nursing skills in the care of clients.

The UK core plus branch model

The international evidence suggests that were the UK to consider moving from the core plus branch model to the generic model, this would generate significant challenges to the production of competent beginning
practitioners in mental health and learning disability nursing. Issues of predominance of general nursing in the curriculum, providing placements, funding post-registration courses to develop basic competencies, and providing sufficient preceptorship and supervision are equally likely to be pertinent to the UK situation as elsewhere.

After an initial move to generic training, some countries are moving to a model that combines common and specialist components within the pre-registration course.

Ireland which still maintains five points of entry to the register following direct entry courses is deciding whether to retain this model or move to the UK core plus branch model, professional stakeholders and organizations having concluded that the generic model would not be appropriate.

The international evidence suggests that the UK model of a common period of training followed by a period of branch specialisation may be the most appropriate for modern day realities of mental health and learning disability service delivery.
Section 1: Context, methods and models

1 Introduction

1.1 Purpose and aims of review
This review considers international evidence available on the outcomes of forms of pre-registration educational preparation for mental health and learning disability nursing which differ from that in the UK. Commissioned by the Department of Health, the purpose of the review is to inform forthcoming deliberations about the future of pre-registration nurse education in the UK.

Specific aims of the review are to assess whether evidence exists of the impact of changes on:

- Course recruitment and student attrition
- Confidence and competence to practice
- Service user outcomes and service provision
- Links with post-registration specialization
- Career pathways
- Staff morale and retention

1.2 Structure of report
The next section outlines the impetus for the commissioning of the review and this is followed by methods employed for obtaining evidence from the countries selected for inclusion (Section 3). The different models that exist for pre-registration nurse education as a whole and those that have been adopted or considered at different times in the UK are outlined in Section 4; these provide a context for the subsequent sections on mental health and learning disability nurse education respectively.

Our initial intention had been to consider the country specific evidence for mental health and learning disability nurse education concurrently. The review showed, however, that in many countries, approaches for the two were very different. Hence at this point the report divides into sections focusing on mental health (5 and 6) and then those on learning disability (7 and 8). Section 5 focuses on debates about approaches to education for mental health nursing and the range that exists in the countries reviewed. Section 6 then provides case studies of these approaches. Tuning to learning disability nursing, Section 7 focuses on debates about approaches to education for this specialty and the range that exists in the countries reviewed. Section 8 provides case studies for learning disability nurse education. Section 9 considers the implications of the international evidence for the future of pre-registration mental health and learning disability nurse education in the UK. Section 10 contains concluding observations.

2 Impetus for the review
The impetus for the review arose from several concurrent streams of work: ongoing deliberations at the Nursing and Midwifery Council (NMC) about the structure and content of pre-registration nursing education; work at the Department of Health (DH) on nursing education and careers following the publication of 'Modernising Nursing Careers' (DH 2006); and negotiations about the future of nurse education in light of the Bologna Declaration to harmonise higher education across Europe.

In 2001, the forerunner of the NMC, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) published a review of various aspects of pre-registration education in which five alternatives were proposed to the current model of a common foundation programme followed by all students prior to selection of a branch (adult, child, mental health or learning disability). The UKCC recommended that further work on the feasibility of each option should be undertaken (UKCC 2001).
In ‘Modernising Nursing Careers’, the DH argued that changes are needed to pre-registration education as a basis for reforming the nursing careers framework, developing a competent and flexible workforce and achieving the optimum balance between specialist and generalist roles. The specific action point is to:

‘assess whether changes are needed to the content and level of pre-registration education’.

The NMC has recently stated that ‘it is timely to both address the priorities identified in ‘Modernising Nursing Careers’ and explore the recommendations from the UKCC Post Commission Development group through a review of pre-registration nursing education. The NMC will take this lead in this important work’ (NMC 2007). This is to be achieved by developing proposals on the basis of a policy and literature review and then undertaking a national consultation from November 2007.

In many countries in Europe and elsewhere, nurse education is based wholly or partly in the higher education sector. Consequently, deliberations about nursing in European countries, including the UK, have to take account of how potential changes might fit with moves to achieve comparability of credits and competencies at first degree, masters degree and doctoral level and to facilitate transferability of qualifications across national borders (e.g Zabalegui 2006).

Since the NMC review will consider changes to the structure of pre-registration nurse education, the DH asked the National Nursing Research Unit (NNRU) to review international evidence on countries that had different approaches to the UK and the reasons given for adopting one approach rather than another. The experience of other countries, both those in Europe and outside, are likely to be helpful in informing decisions about the future of nurse education in the UK. A key debate in the UK is whether those wishing to work in mental health, learning disability or children’s nursing are best prepared by specialist pre-registration education or by generalist pre-registration education followed by specialist education and qualification at post-registration level; consequently this was one of the key foci of this review. Moreover, this debate is particularly pertinent in the context of the Bologna Declaration which advocates less specialized education at undergraduate level and more specialized education at graduate level; many European countries have in fact already adopted a generalist approach to undergraduate nurse education.

3 Methods

Since we were aware that there is very limited research on the impacts of different forms of pre-registration education, evidence was defined as including:

1. Research evaluating perceptions and impact of change
2. Descriptions of change
3. Expert opinion and debate

As far as possible, we searched for information about the countries selected for our previous review of nurse education and regulation (Robinson and Griffiths 2007). These were OECD countries selected for economic comparability; twelve were European (Belgium, Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Spain, Sweden and Switzerland) and five non-European (Australia, Canada, Japan, New Zealand and the United States).

Methods included: undertaking a hand and computerised literature search (CINAHL, Medline and PsychINFO); accessing websites of professional and statutory bodies; identifying and corresponding with key personnel in the selected countries. There was a greater volume of literature about mental health than learning disability nursing, reflecting the fact that fewer countries include nurses among the professional groups involved in the care of clients with learning disabilities.
As we searched for material in English, most of the published material related to English speaking countries. Australia and New Zealand featured particularly prominently, reflecting the current debates in these countries about the impact of moving from direct entry to mental health and learning disability nursing to a generic course for all students.

Much of the information about developments in European countries has been obtained through personal communication with senior members of the nursing profession in each country. As far as possible, the situation described in published material has been checked with senior members of the nursing profession in the country concerned to ensure that this review is as up to date as possible.

4 Diversity of models for pre-registration nurse education

This section provides a brief overview of the different models in existence for pre-registration nurse education as a whole in the countries reviewed and those that have been adopted and proposed in the UK. This provides a context for investigating the different approaches to pre-registration mental health and learning disability nurse education in these countries.

4.1 Models of pre-registration nurse education

The key difference in approaches to pre-registration nurse education is whether it leads to a specialist qualification for practice in a particular branch of nursing or to a general qualification with specialist qualification for branches following at post-registration level.

Branch of nursing is used here to refer to a particular type of nursing associated with a client group and with nurses specially trained in the care of persons from that client group. In the UK, pre-registration nurse education focuses on four branches: currently referred to as mental health, learning disability, adult and child. Other countries more commonly use psychiatric for mental health, intellectual disability (occasionally mental handicap/retardation) for learning disability, paediatric or sick children for child and general for adult. Our approach has been to use mental health and learning disability in sections about the UK and those are not country specific, but when writing about other countries we adopt the country specific terminology.

Drawing on the information about pre-registration nurse education in the countries reviewed and a paper by Norman (1998) we developed four models that form a continuum from an entirely specialist course to an entirely generic course with two variants in between.

Model 1: Specialist qualification following a direct entry course
Students select the branch for which they wish to train and enter a course focusing on that branch from the start of the course.

Model 2: Specialist qualification following a core plus branch course
In this model, all students start with a period of common training and this is followed by a period in which they specialize in a branch. In some instances, students make a choice of branch during the common training period, in others the choice has to be made at time of application for course entry.

Model 3: Generalist qualification following a generic course with specialist options
All students take core components and have a choice of specialist components; the final qualification is a generalist not a specialist one. The specialist components of the course vary between, and sometimes within, countries in terms of the proportion of the course it occupies and whether it is offered as a major running through the course, a specialist option towards the latter part of the course, or as a branch programme

Model 4: Generalist qualification following a generic course without specialist options
This model does not make a distinction between branches/specialties of nursing for the entire duration of the student’s training although students have opportunities to experience specialties. The term ‘integrated training’ is used, for example in the US, to indicate the lack of specialist division during the pre-registration course.
A specialist/generalist continuum

We use this specialist/generalist continuum of four models as a framework for the rest of the report. It should be noted that we are referring to distinctions at first level training. Some countries that offer first level (registered nurse) and second level (enrolled or licensed practical nurse) training have a generalist approach at one level and a specialist approach at the other.

4.2 Moving from one model of pre-registration education to another

The majority of countries reviewed have adopted one of the two models leading to a generalist qualification with most previously having had direct entry (Model 1). Some countries are in the process of implementing or considering further change. In countries in which pre-registration nurse education leads to a generalist qualification, requirements for post-registration practice in specialties varies considerably. In some countries, nurses can practice in their branch of choice following initial qualification, in others subsequent qualification is required, sometimes after a period of work in the specialty concerned.

Turning to the UK’s pre-registration nurse education history, then as in most countries, the model was originally direct entry; in the UK case to general, sick children’s, psychiatric or learning disability nursing. Options existed for those qualifying for one branch of nursing to take a shortened post-registration course for one of the others. The UK also offered second level training (enrolled nurses) in general, psychiatric and learning disability nursing.

Direct entry ceased, along with second level training when the education of nurses was brought into the higher education sector with the implementation of the Project 2000 proposals (UKCC 1986). All students took a common foundation programme (CFP) of 18 months followed by a further 18 months in one of the four branches. Decision about which branch to take did not have to be made at the outset of the course but the CFP provided opportunity for placements in each speciality to enable informed choice. The Project 2000 report (UKCC 1986) revealed that there was much debate at this time about whether to adopt a generalist or specialist model of training. In view of evidence and opinion at the time, a decision was made to end direct entry training but rather than change to the generalist model to adopt a common training followed by specialization leading to first level qualification in the specialty. While it was argued that subjects common to branches should be taught jointly, achieving beginning competence in each branch required a period of specialization prior to initial registration (UKCC 1986).

Various concerns emerged about the new course, in particular that the major emphasis in the CFP was on adult nursing and that 18 months was insufficient time to gain sufficient confidence and competence for speciality practice (Jowett et al 1994). In relation to preparation for mental health nursing, these concerns were prominent in a 1994 review of the profession (DH 1994). Following the UKCC’s 1999 review of nurse education 'Fitness for practice' the common foundation programme was reduced from 18 months to one year, allowing a longer period of time for specialist preparation. A second change was that students had to make their branch choice at the outset of the course rather than during the CFP; this was in order for Workforce Development Confederations to be able to commission the number of places per branch to meet their projected workforce demands.

A review of the branch structure was also recommended (UKCC 1999) and in a subsequent review of nurse education 'Fitness for practice and purpose' (UKCC 2001), various models for the future of pre-registration nurse education were outlined. These included retaining the current structure, variations on the branch structure, and replacing the branch structure with a generalist nurse preparation with specialisation following registration.

Having set the scene in terms of overall models of pre-registration nurse education, the report now focuses first on mental health pre-registration nurse education (Sections 5 and 6) and then on learning disability pre-registration nurse education (Sections 7 and 8).
Section 2: Pre-registration education for mental health nursing

5 Debates and diversity of approaches: mental health nursing

This section first outlines some of the debates about the appropriateness or otherwise of different models of pre-registration nurse education for mental health nursing (5.1). This is followed by the models adopted in the countries included in the review (5.2).

5.1 Debates about adopting particular models for mental health nurse education

In the UK, debate has continued since the publication of the UKCC 2001 report as to the advantages and disadvantages of specialist (direct entry or core plus branch) and generalist models and, in particular, the impact on recruitment and competence to practise of the minority branches. Here we consider views expressed in these respects in relation to mental health nursing in the UK and elsewhere. The main sources drawn upon are Norman 2005, Cutcliffe and McKenna 2006, Grant 2006, Younge and Boschma 2006.

5.1.1 Generalist versus specialist positions on mental health nurse education

The nature of mental health nursing is central to the debate about generic versus specialist education. In recent years there has been considerable debate about the nature of the mental health nurse’s role and problems in clarifying core skills has resulted in problems in securing appropriate educational preparation (Grant 2006). Moreover, ambiguity and difficulty in defining mental health nursing work has left the profession vulnerable during a period of intense change.

Supporters of generic nurse education focus on the increasing recognition of the importance of providing holistic care in both the general and the mental health setting (Wynaden et al 2000). There is a high incidence of mental health problems in the general setting and physical problems exist concurrently with psychiatric problems. Furthermore an outcome of mainstreaming of psychiatric services into the general health system is that nurses working in general hospitals now have increased contact with patients experiencing mental health problems (Sharrock and Happell 2002).

Generalists maintain that students require a broad and holistic approach and there is place for specialisation but only after a solid grounding in core nursing principles. Generalists have argued that caring interactions are the basis for unity of nursing. A generic model prepares nurses with a comprehensive knowledge and generalist nursing competencies that equip them to enter professional practice as a generalist nurse who may practice in a range of care settings and with a range of client groups.

Specialists, however, argue that there is a vital difference is the nature of the illness experienced by patients in different environments and its impact on the focus and priority of care provided. While they recognise the complex inter-relationships of the physical, psychological and emotional aspects of health, they assert that the focus of each nursing discipline remains fundamentally different. For mental health nurses, the prime concern is the patient's mental state and mental health as opposed to physical well-being. Consequently, the well-defined physical skills required for general nursing are often not necessary in psychiatric nursing (Grant 2006). It is argued that the difference in focus of these two types of nurses calls into question the capacity of generic programmes to effectively prepare graduates to work in all areas of nursing (Grant 2006).

A second line of argument advocated for the specialist position is that specialist skills are required from the point of qualification to work in community and in-patient settings. Work in the community involves: recognition of the need for health promotion; improved detection and treatment of mild to moderate mental illness and provision of mental health care to clients with severe mental illness who traditionally received care in secondary services. Pre-registration
programmes also need to prepare nurses for the increased complexity of hospital based treatment that has resulted from increased acuity levels. In the UK and elsewhere, a preference for community-based management has led to patients entering acute facilities at a later stage in their illness than previously and as such presenting with severe clinical symptoms and increasingly disturbed and problematic behaviours (SNMAC 1999, Cleary 2003).

Some of those opposed to generalist training nonetheless regard the direct entry model of specialist qualification as uneconomical because of duplication of content across branches. Further for mental health, the direct entry model meant it was isolated from other branches of nursing and this combined with attachment to individual hospitals was not conducive to the development of practice (Norman 2005). Generic training, however, is not perceived as the way of addressing the problems of the direct entry model. For example, Norman (2005) maintains that generic training will dilute mental health nursing expertise and diminish the focus on specialist skills. There are fears that generic training will be rooted in the bio-medical tradition of general nursing and that the centrality of the inter-personal relationship is unlikely to be advocated.

Grant (2002) argued that there is insufficient common ground between nursing branches to permit amalgamation within a generic training. Moreover, it was not prudent to believe that nursing students can integrate different knowledge and skills from a diverse number of nursing divisions or that disciplinary maturity will occur with post-basic registration (Grant 2002). Prebble (2001), on the basis of experiencing the move from specialist to generic training in New Zealand, argues that the new graduate nurse must have more advanced beginning level competencies than those currently expected. Moreover a solid foundation of mental health nursing skills provides the basis upon which nurses can build the specialist and advanced skills that will equip them for complex in-patient and community care (Prebble 2001).

Another aspect of the specialist/generalist debate is the impact on recruitment. Altschul (1997) observed that people who want a career in psychiatric nursing are different from those who want to be general nurses and generic training limits or prevents students from immersing themselves in the subject in which they are interested. In relation to the UK core plus branch course, Norman (1998) observes that many would be applicants with an interest in mental health nursing are reluctant to apply for the course while it remains dominated by general nursing, a trend that would be exacerbated by the introduction of generic training. On the other hand, a common period of training that provides all nurses with experience of the different branches may be a means of recruitment into mental health (and learning disability) nursing. Research into the initial branch choice of nurse diplomates in the UK, showed that 17% of mental health and learning disability qualifers had started on a different branch, most likely adult, and had subsequently changed following a clinical placement in mental health or learning disability (Hardyman and Robinson 2000).

The core plus branch model
As the continuum described in Section 4 made clear there are two types of pre-registration education between the wholly specialist and the wholly generalist models. Both involve a common period of training and a specialist period of training, but whereas the core plus branch leads to a specialist qualification, the core plus specialist option leads to a generalist qualification.

In reviewing the various approaches to pre-registration education as a pre-requisite to decisions about changes that might affect psychiatric nursing in Ireland, Grant (2006) argues that the common core followed by specialist programmes leading to separate divisions of the register is the best way to overcome the problems associated with the specialist and generalist models.

She identifies the advantages of the core plus branch model as follows:

**The core:**
- Provides a base on which subsequent learning can be built and its generic structure enables students to learn about the commonalities in nursing theory and practice, including physical and psychological aspects of care.
• Mainstreaming of services means that all nurses need to be able to meet clients’ physical and psychological needs

• Prevents wasteful duplication of the direct entry specialist approach

• Enhances a sense of unity in the profession without sacrificing the real strengths of specialization.

The branch specialization:
• Provides opportunities for theoretical and practical exposure to psychiatric nursing and its sub-specialties

• Facilitates being prepared for embarking upon subsequent post graduate education

• Is more likely than generic training to produce graduates interested in becoming psychiatric nursing educators.

• Maintaining the psychiatric nursing register affords the profession independence in relation to future recruitment, and education and practice developments.

In the UK, mental health nursing organizations tend to favour retention of the core plus branch programme. For example, in 2005 the Mental Health Nurse Academics UK (MHNAUK) has recently stated their position as follows: ‘nursing education programmes at the pre-registration level for mental health nursing must focus largely on mental health nursing and should not be generic (Callaghan and Owen 2005, p. 640).

Developments in mental health provision
In many countries, mental health service delivery is changing fast and providing new opportunities for collaboration between health professionals in the field. If mental health nurses are to play a part and take the clinical lead in healthcare teams, they need to be highly skilled health professionals who have in-depth knowledge of social, psychological and medical aspects of mental health and illness (Prebble 2001). If however, their skills are diluted through generic training, some have argued that this may contribute to the emergence of a new kind of mental health worker: Holmes (2006) for example proposes the development of a graduate specialist who stands outside existing disciplinary identities.

5.2 Approaches to pre-registration nurse education
We found that there is not a one-to-one correlation between a country’s overall approach to pre-registration nurse education and that adopted for mental health nursing. There were six different approaches; these are shown below with the countries falling into each and indication of which are the subject of Case Studies in Section 6. At the time of writing, some countries, or states within countries, are making changes, in particular moving from Model 4 to Model 3.

Model 1: Specialist qualification following a direct entry course
Of the countries reviewed, only Ireland offers direct entry on a nationwide basis to mental health nursing along with general, children and general integrated, intellectual disability and midwifery. These are four-year courses leading to a degree (4.5 for children and general integrated). Ireland is currently in the throes of considering whether to change from the direct entry model to one of the other three models identified in Section 4.1; the details are in Case Study 1 (Section 6.1).

Model 2: Specialist qualification following a core plus branch course
The UK alone offers the core plus branch system in which all students follow a common foundation programme followed by a branch programme in mental health, learning disability, adult or children’s nursing in which they gain a specialist qualification. The course is 3 years long leading to a diploma or degree in England and degree only in Wales, Scotland and Northern Ireland.
Model 3: Generalist qualification following a generic course with specialist options
Some countries adopted a model in which students share a common basic training but at some point in their course can choose a specialist option, which can include mental health. In some cases this followed a move from direct entry specialist courses. The proportion of the course spent on mental health varies between, and sometimes within, countries and can take the form of a major, a specialist option, or a branch. Graduates are, however, registered as general nurses and can subsequently gain a specialist mental health qualification. So although the format has similarities to the UK system in having core and specialist components, it differs in resulting in a generalist rather than a specialist qualification at registration.

Countries adopting this model include:

- **Finland**: 3.5 year course degree course based in polytechnic sector, the last six months is spent in a specialist option

- **Sweden**: Sweden has a 3-year generic degree course, students can chose to specialize in mental health during the later stages of their course, although having done so is not necessarily a pre-requisite for working in mental health areas (Nolan and Brimblecombe 2007). A one-year post-registration course is available. Psychiatric nursing care in Sweden is also provided by second level licensed mental nurses who have had a 3-year education at upper secondary school level.

Some countries that initially did not offer specialist options in mental health have now implemented such an option (along with other specialist options) or are considering doing so. Such countries include:

- **Holland**: 4 year diploma (degree level) based at school of nursing. Students follow a 2-year common course and then chose a specialist option for their third and fourth years. The specialist option followed is noted on their diploma. Details for Holland are in Case Study 2 (Section 6.2)

- **Australia**: 3-year generic degree: some states are now offering/considering offering a major/specialist option in mental health nursing within the generic undergraduate course. Details are in Case Study 4 (Section 6.4).

Model 4: Generic training without specialist options
Many countries moved to, and retain a generic training that provides all students with some experience of specialties but does not include periods when students can chose a branch of nursing in which to specialise.

Countries adopting this model include:

- **New Zealand**: 3-year generic degree at university; there are continuing concerns about the impact of generic training on psychiatric nursing and arguments advanced by some in favour of introducing specialist options. Details are in Case Study 3 (Section 6.3).

- **US**: In the US, there are three routes to first level registration: 4-year university degree; 2-year associate degree in community college; and 3-year diploma in school of nursing. There is also a second level licensed vocational nurse qualification. There are concerns about the impact of generic training on mental health nursing. Details are in Case Study 5 (Section 6.5).

- **Japan**: Japan also has three routes to first level registration: 4 year university degree, 3 year associate degree in community college; and 3 year diploma in school of nursing. There is also a second level licensed practical nurse qualification.

- **Italy**: In Italy, there used to be a one-year course for people who worked in psychiatric hospitals; these people were mainly men and were not nurses. Subsequently it became mandatory to have a registered nurse qualification to work in psychiatric hospitals. This is currently a 3-year course university-based generic degree. More recently, a post-
Registration one-year specialist course has been introduced as the generic qualification is felt to be an inadequate preparation for working in mental health settings.

- **Norway**: Norway has a 3-year generic degree that includes 8 weeks of clinical practice in psychiatric nursing. A study by Kloster et al. (2007) indicated that the popularity of psychiatric nursing increased considerably during the course, reaching third place by the end. This is noted here since we do not include a case study on Norway; this finding is different from the popularity of psychiatric nursing as a career among students on generic courses in other countries (Case studies on Australia and the US).

- **Denmark**: Nurse education is provided in schools or departments of nursing which are part of centres of higher education based in the professionally oriented college sector as opposed to the university sector. From 2005 onwards, some of these centres fulfilling certain quality criteria have been awarded the label of university college. The nursing course is 3.5 years in length and leads to a generalist qualification. Psychiatric nursing is a compulsory part of both college-based (4 weeks) and practical training (10 weeks). The generic course provides students with general rather than specialty nursing skills. Specially knowledge and skills are learnt through practice as a novice nurse and by post-registration education; in the case of psychiatric nursing this is a one-year course usually taken after 2 years psychiatric nursing experience (Personal communication 2007a).

- **France**: used to have direct entry training but this was replaced by a generic 3-year diploma course attached to a school of nursing.

- **Switzerland**: used to have direct entry; this was replaced with generic training in 1991. Switzerland is currently in a period of transition to two routes to first level registration: 3-year diploma based in a school of nursing and 3-year Bachelor’s degree in a University of Applied Science. A specialist post-graduate course in psychiatric nursing is now being developed.

Details for France and Switzerland are in Case study 6 (Section 6.6).

**Other models**
Two variants of the four models also existed in relation to mental health.

**Specialist qualification following direct entry but not including mental health**

- **Germany**: Has three direct entry branches based on the life course (paediatrics, adult and geriatric) through a 3-year course attached primarily to a school of nursing, although some university education is now being developed. These courses have little coverage of mental health principles and following concerns about conditions in psychiatric hospitals, a one year post-registration specialist course in psychiatric nursing has been introduced (Schoppmann 2005). Arguments have been advanced that the direct entry courses should be replaced by a generic training, partly because specialist qualifications are not always recognized across European boundaries (Zophy 2000).

**Variation within country**

- **Canada**: In Canada, direct entry and specialist registration have been replaced by generic training and registration in the eastern provinces of the country but not in the some of the western provinces. Details are in Case Study 7 (Section 6.7).

- **Belgium**: In Belgium, there is a 3-year degree offered in schools of nursing based in the university college sector; the course leads to a generalist qualification and the amount of psychiatric nursing content varies between schools. Second level training is a 2-year course with the second year comprising a branch in general or psychiatric nursing. Details are in Case Study 8 (Section 6.8).
6 Case studies: approaches to pre-registration mental health nurse education

Several of the above countries are in the throes of debate about the wisdom or otherwise of their current system; some have made changes, others are in the process of doing so. The information available has been drawn together into eight case studies that illustrate the different perspectives currently existing.

- Debating whether to retain direct entry
- Introducing specialist branches/options into generic training
- Debating the impact of generic training
- Maintaining the profile of psychiatric nursing in a generic course
- Professional concerns about the effect of generic training
- Maintaining specialist and generalist models

Differing amounts of detail were available for each case study. The implications for the UK raised by these case studies are brought together in Section 9.

6.1 Case Study 1: Ireland - debating whether to retain direct entry

6.1.1 Nurse education in Ireland

Ireland is unique among the countries reviewed in retaining the direct entry model of pre-registration nurse education during the transfer of nurse education to higher education. Direct entry courses leading to separate parts of the register are currently available in general nursing, psychiatric nursing, intellectual disability nursing, and integrated children’s and general nursing course, and midwifery; these are 4-year university based degree courses (4.5 for the children and general integrated course). The final year emphasises consolidation with a prolonged rostered placement of 36 weeks, during which time students are remunerated at 80% of a first year staff nurse salary.

There are four post-registration courses leading to additional registration: children’s nursing, midwifery, Public Heath Nursing and Nurse Tutor (as at 17/8/07). Shortened post-registration courses in general, psychiatric and learning disability nursing that were once available have been withdrawn and so nurses wishing to qualify subsequently for one of these branches have to take the full pre-registration course.

Discussions have been in progress since the late 1990s about the following:

- whether to maintain separate points of entry to the register or move to generic training
- If separate points of entry to the register are to be maintained, is there a case for a period of common training at the outset, which all nurses would follow before starting a branch programme in their speciality
- whether to reintroduce the shortened post-registration courses.

Discussions about the most appropriate form of pre- and post-registration education as these pertain to psychiatric nursing are taking place in the context of policies to improve mental health services, increasingly diverse and expanding roles for psychiatric nurses, but a shortage of this group of nurses that is likely to be exacerbated by its ageing profile.

6.1.2 Discussions about the future of pre-registration education in Ireland

A brief summary of the conclusions of key publications on the subject is compiled from a report of research carried out by University College Dublin (UCD) for the statutory body for nursing and midwifery An Bord Altranais in 2005 (ABA/UCD 2005) and a paper by Grant (2006).

Prior to the 1990s, the Department of Health recommended to An Bord Altranais (ABA) that consideration be given to introducing generic training and that schools of nursing should experiment with such schemes with provision for specialization at post graduate level. In the early 1990s, ABA did not rule this out as a future possibility for consideration; in the meantime however, they recommended that pre-registration programmes continue as before with direct entry leading to specialist qualification. However, ABA also observed that a common period of
training at the outset should be considered, given that there were commonalities in the preparation for each division of the register and that having five entirely separate trainings was wasteful of resources.

In 1998, a government commission on nursing in Ireland recommended that direct entry should be retained for general, psychiatric and intellectual disability nursing. The belief that retaining the distinct identity of the branches was desirable in best providing care for these patient/client groups was central to this recommendation. Retaining direct entry for psychiatric nursing was also advocated in 2004 by the Department of Health and Children as this would best serve the mental health strategy that they were developing in terms of preparing nurses for practice in the mental health services that they envisaged.

In 2001, the Nurse Education Forum recommended that An Bord Altranais undertake further research to examine the rationale for and impact of maintaining five points of access to the register. Following a tendering process, the research was awarded to a team at the School of Nursing and Midwifery, University College Dublin.

6.1.3 Research into retaining five points of entry to the register in Ireland
The aim of the research was to discover the views of all relevant stakeholders about whether to retain the five entry points model and a multi-method design was adopted. This included: documentary analysis; public consultation through a national call for written submissions from individuals and organizations regarded as key stakeholders; and focus group interviews with representatives of the five divisions of the register including clinical staff, students, managers and educators, professional associations and consumer groups. Individual interviews were held with key informants involved in strategic policy planning and/or management of services in respective divisions of the register. Finally, a postal questionnaire survey of nurses and midwives on the active file of the register was undertaken using a nationally representative, random sample of 8000 nurses and midwives (response rate just under 60%).

Findings in the report are presented for all respondents and for those in each of the five divisions. The overall picture to emerge indicated strong support for maintaining distinct registration programmes in each of the five divisions. There was also support for a common basic training period at the outset of the course prior to branch specialisation and registration (like the UK model). Although there was some support for the possible advantages of generic training such as increased international mobility, these were countered by perceptions that generic training would be dominated by general training to the detriment of gaining specialist knowledge needed at the point of registration in the minority branches of nursing.

The report's authors recommended: retention of the five divisions of the register; and reintroduction of the shortened post-registration courses in general, psychiatric and intellectual disability nursing. In reaching these conclusions, the research team acknowledged that these were at variance with the international trend of moving to generic training. They observed, however, that several countries that had gone down the generic training route were now debating its impact on the specialist knowledge and skills of minority branches (as indicated elsewhere in this report). Retention of five points of entry to the register was recommended on the grounds that this represented the view of nurses, midwives and other stakeholders in the healthcare workforce in Ireland.

6.1.4 Current situation with nurse education in Ireland
The Department of Health in Ireland has recently stated that it is difficult to justify retention of five separate and independent programmes given the cost and international trends (DH 2006) and have recently endorsed the common core plus branch model as follows:

' a common foundation core program for all students nurses for a specified period of time. For a further specified period of time, students undertake a specialist program up to the point of registration in general, psychiatric or intellectual disability nursing' (DH 2006).
At the time of writing, An bord Altranias are offering direct entry specialist programmes for 2008 entry.

6.2 Case Study 2: Holland-introducing specialist branches into the generic course

6.2.1 Pre-registration nurse education in Holland
Holland used to have direct entry into psychiatric nursing and maintained a separate register for psychiatric nurses (Younge and Boschma 2006). Although this form of training was regarded as encouraging recruitment of people with a diversity of age ranges and life and work experiences, it was regarded as inefficient from an educational perspective because of the overlap of some of the course content with that of other direct entry courses (Personal communication 2007b).

Consequently direct entry courses were replaced with a generalist training in the form of a four-year diploma at bachelor degree level based in a school of nursing. All students followed a general education during which time they had opportunities to gain experience and develop interest in a specialist field. Employers, however, found this to be financially inefficient since graduates from this generalist programme required further training in order to practise in specialist areas such as mental health (Personal communication 2007b).

Further changes were therefore introduced to ensure competency in specialist fields. During the first two years of the course, students have short periods of practice in all fields of nursing. Towards the second year, they now choose the branch of nursing in which they want to specialize and then spend the second two years concentrating on this speciality. The aim of this move was for employers to be more certain that graduates are competent practitioners at the point of qualification and do not require further education to reach this point. The diploma remains a generalist qualification but with the area of specialization noted (Personal communication 2007b).

6.2.2 Post-registration education in mental health nursing in Holland
Post-registration education in mental health nursing now builds on this two-year period of specialization in three ways (Personal communication 2007b):

- One-year courses are available to enable specialization with client groups: child and adolescents, adult, elderly and forensic. The courses are worth 60 European Credit Transfers (ETC) and are not the subject of formal legislation.

- Professional masters courses leading to qualification as a clinical nurse specialist or a nurse practitioner in mental health are available and of at least two and usually three years in length. The difference between these two qualifications is likely to disappear in time.

- Scientific masters courses based at university and of four years duration prepare students for a research role in general or psychiatric nursing.

6.3 Case Study 3: New Zealand - debating the impact of generic training on psychiatric nursing

6.3.1 Nurse education in New Zealand
New Zealand used to have direct entry courses, including one for psychiatric nursing, but these were replaced by a three-year degree level generic course at the same time as the move of nurse education into higher education in the 1980s. Midwifery is a direct entry three-year university based course. There used to be second level courses leading to a certificate qualification that comprised two modules: one general and one with a speciality focus. These courses have now ceased and been replaced with courses for nurse assistants.

New Zealand is witnessing increasing demand for mental health services and a shortage of mental health nurses (Grigg and Hughes 2007). The role of generic nurse education in
preparation for and recruitment to the mental health nursing workforce has been the subject of continued debate.

6.3.2 Developments in nurse education in New Zealand
The key developments in the history of psychiatric nursing after comprehensive nurse education was introduced in 1983 are provided in a paper by Prebble (2001), then writing as a member of the mental health services department of the Auckland District Health Board. The impetus for moving from specialty focused, hospital-based education to a generic nurse education based in the tertiary sector resulted from a 1971 review of nurse education by the Department of Health. The review was undertaken by Helen Carpenter, a visiting nurse academic from Canada. She identified many of the deficiencies in the hospital-based apprenticeship system that had also been identified in the UK deliberations that led to the introduction of the higher education based nurse diploma course. The option recommended for New Zealand, however, was a comprehensive course followed by all students and not the core plus branch model adopted in the UK. Prebble (2001) argues that Carpenter’s views on education for psychiatric nurses were influenced by the mainstreaming of psychiatric services with general services and the move from institutional to community-based care; developments which led to the conclusion that psychiatric nursing would no longer be necessary as a separate discipline. Carpenter recommended that as an interim measure, psychiatric courses be closed and general courses have an increased mental health component. This reflected a dominant theme in the nursing literature of the time; namely a focus on interpersonal relationships as central to good nursing practice.

A subsequent review that focused on moving nurse training as a whole into generalist education-based programmes, concurred with Carpenter’s view and concluded that as the traditional separation of mental health services from health services was disappearing, it was no longer appropriate to train nurses for the promotion of mental health and the care of the mentally ill in separate programmes. Prebble (2001) observes that the introduction of comprehensive higher education based nursing has been very positive in many respects but notes that the psychiatric nursing profession has increasingly voiced the opinion that in the process, psychiatric nursing has been minimalized and marginalized. Nurses are not receiving a grounding in the foundational skills and knowledge of psychiatric nursing. At the same time, people with psychiatric illnesses still need skilled intervention and care, albeit more likely in community rather than institutional settings. At the root of the problem is the confusion over the mental health skills needed by general nurses and the skills required by mental health nurses for care of patients in both in-patient and community settings.

The 1990s saw a number of government reports concluding that comprehensive nurse education programmes were not meeting the needs of the mental health speciality. One such report by the Ministry of Health in 1996 led to the New Zealand Council of Nursing reviewing mental health education and then establishing undergraduate level mental health competencies and new graduate and advanced mental health practice programmes. The Mental Health Commission of 1999 also concluded that undergraduate education was not adequate and a subsequent report by the National Mental Health Workforce Development Committee recommended that all comprehensive nurse graduates wanting to enter mental health nursing should first participate in a graduate mental health programme. Prebble (2001) comments that this was an admission that comprehensive programmes could not adequately prepare nurses for mental health practice. Continuing concerns led to a Ministry of Health forum in 2000 which concluded that the mental health component of the undergraduate course was insufficient to equip nurses to a satisfactory level of understanding and skill in mental health. Again the solution proposed was to insist on post-registration courses before entry to practice.

Prebble (2001) argued that if New Zealand is to produce a psychiatric nursing workforce capable of meeting service needs then graduate nurses must have more advanced beginning level competencies that at present and cited student surveys indicating that most of the three yeas is focused on the philosophy and practice of general nursing. While some nursing schools were endeavouring to increase the mental health components, others were not and that the ‘visibility of mental health depended on the personalities and qualities of one or two teachers’ (Prebble 2001, p. 141). She argued that while ongoing education is essential for
developing specialization and advanced skills, it cannot replace a solid foundation of psychiatric nursing skills.

Prebble (2001) recommended that the UK approach of a speciality branch be adopted. A return to direct entry was not favoured given the benefits of some comprehensive components for all nurses; these included enabling appreciation of the breadth of general health care issues and exposure to some mental health theory and practice which might lead to development of interest in psychiatric nursing as a career choice (Prebble 2001). Lack of recognition of psychiatric nursing as a distinct speciality ran the risk that it will disappear from the mental health system and be replaced by other allied health professionals. Subsequently, the New Zealand Nursing Council published conclusions of another review of nurse education which recommended: removal of specific undergraduate mental health competencies in favour of comprehensive competencies; including focused experience modules for third year students in mental health or other areas of specialty interest; and that entry into psychiatric nursing practice requires completion of a speciality practice programme.

6.3.3 Current situation with nurse education in New Zealand
Concerns about the adequacy of undergraduate preparation for mental health nursing and shortages of mental health nurses have not abated. Given increasing demand for mental health services and a shortage of mental health nurses (Grigg and Hughes 2007), a national framework for mental health nursing has been developed. This aims to create a sustainable workforce that entails stakeholders working together to develop creative recruitment and retention strategies and new ways of working (Ministry of Health 2006). One of the recommendations of the Ministry of Health’s 2006 document is that the Nursing Council of New Zealand in conjunction with mental health nursing professional bodies should again review undergraduate mental health nursing education for its relevance to the mental health sector. This recommendation was part in response to research published in 2005 indicating that new graduates still perceive the mental health component and clinical exposure to mental health to be severely limited (Ministry of Health 2006).

6.4 Case Study 4: Australia - introducing specialist options into the generic course

6.4.1 Nurse education in Australia
In Australia, separate direct entry programmes were replaced by a three-year generic course with the move of nurse education into higher education. The generic course is followed by graduate transition programmes into particular specialities (available in some states) and post-graduate courses offering further specialization. Subsequently midwifery was changed to become a direct entry course. A second level training has been maintained; this is based in the vocational, educational and technical sector and leads to an enrolled nurse qualification. Most second level nurses work in the elderly care sector. Enrolled nurses can take university courses to upgrade to become graduate nurses and some universities are considering offering an associate diploma at enrolled nurse level.

In recent years, Australia has been in the course of implementing strategies to improve mental health services and in which nurses are seen as playing a key role. At the same time, there are serious shortages of mental health nurses, with recent evidence indicating that this situation is likely to get worse (Gough and Happell 2007). Since the format and content of nurse education is regarded as influencing not only the extent to which nurses are adequately prepared for practice, but also recruitment and retention into the profession, the impact of the change from direct entry to generic training has been the subject of continued debate. A series of articles on the subject have appeared since the early 1990s. Moreover, it has been the subject of discussion in various reports on mental health service provision, workforce planning, and/or nurse education produced by government and professional organizations at state and national level.

6.4.2 Developments in nurse education in Australia
As described for New Zealand above, the impetus for moving to generic training in Australia is attributed to Carpenter, a Canadian nursing academic (Grant 2006). The case was made that a specialist pre-registration course would no longer be needed in Australia in light of changes
in the provision of mental health services (closure of large mental hospitals; increased focus on community-based care; and mainstreaming of mental health services with general health services, such as psychiatric units based in district general hospitals). Rather, mental health and general nursing population needs would better be met by graduates from a comprehensive programme that would equip nurses for beginning practice in a range of mental health and general care settings (Cleary and Happell 2005).

Several authors have argued that the proponents of generic training confused the psycho-social knowledge and skills required by all nurses and that enable those in general settings to recognise mental health needs of patients on the one hand, with the specialized psychiatric knowledge and skills required in caring for clients with mental illness in both inpatient and community settings on the other (e.g. Wynaden et al 2000). The result of this confusion is that generic training is essentially general nurse training with increased content on mental health concepts; furthermore in some universities these concepts are taught by academics without expertise in mental health nursing (Wynaden et al 2000, Clinton and Hazleton 2000).

While it has been recognized that the generic model is advantageous in some respects, to date its use has resulted in many insurmountable difficulties in providing students with adequate theoretical and practical experiences in psychiatry and fails to prepare graduates to work as a beginning practitioner in the mental health area (Clinton and Hazleton 2000). Various scoping studies undertaken between 1996 and 2001 of the content of both the theoretical and clinical components of the undergraduate course conclude that both focus primarily on general nursing with medical and surgical nursing predominating and that the amount devoted to mental health nursing has been less than 10% in the majority of courses surveyed in the country as a whole (e.g. Farrell and Carr 1996, Clinton and Hazleton 2000).

Holmes (2006) observed that the closure of a separate register for mental health nurses and the loss of direct entry training means that recruitment to mental health nursing is dependent on graduates from the generic courses. Research by Happell (1999) indicated that mental health nursing is perceived by undergraduate students as one of the least popular areas of practice and the Australian Health Workforce Advisory Committee (2003) concluded that limited exposure to mental health nursing at the undergraduate level has contributed to the decreasing numbers of graduates entering the specialty.

Despite calls from employers and graduates for mental health placements to be included in undergraduate programmes, concerns did not subsequently diminish. The Australian Health Workforce Advisory Committee (2003) concluded that students are typically exposed to little in the way of knowledge and skills relevant to mental health nursing and gain limited or no clinical experience. Consequently, very limited opportunities exist to develop clinical competencies and confidence in mental health nursing or to develop an awareness of, and sensitivity to, the issues affecting people experiencing mental illness (Cleary and Happell 2005). Research showed that having good clinical experience increases the likelihood of developing an interest in a career in psychiatric nursing (Rushworth and Happell 2000). Consequently, several studies have sought to investigate how clinical experience could be improved; in particular ensuring that students have a preceptor during their placement (Charleston and Happell 2004) and attempts to develop clinical learning partnerships between students and staff (Arnold et al 2004).

Questions have also been raised as to whether the generic curriculum provided a sufficient foundation upon which to build postgraduate study and that in the first instance, such courses would have to address deficiencies in essential knowledge and skills (Clinton and Hazleton 2000). Another aspect of concern about generic nurse training was that it did not meet the goal of providing general nurses with sufficient generic mental health skills to recognise the mental health needs of patients in general care settings (Happell and Platania Phung 2005). The development of medical surgical skills predominated in the course and while these are crucial to meeting the healthcare needs of society, their privileging over other skills cannot be justified (Happell and Platania Phung 2005).
6.4.3 Transition to practice programmes/experiences in Australia

Following the introduction of generic degree programmes, many states introduced graduate nurse programmes (GHPs). These are typically one-year programmes that aim to assist newly graduated nurses during the transition from nursing student to registered nurse. The effectiveness of these programmes has been promoted as an important potential retention strategy given high turnover of rates of new graduates (Cleary and Happell 2005). Some research exists on the transition experiences of Australian graduates to mental health practice.

A study by Cleary and Happell (2005) investigated a 2002 Transition programme into Mental Health nursing in Sydney. Findings obtained from a questionnaire survey (76/79 returned) indicated that availability of clinical support was the primary attribute of a positive transition process, with the lack of such support being most commonly identified as a significant reason for nurses to leave the profession early in their career. Preceptorship was the aspect of the course that received the lowest level of satisfaction and the authors argued that greater emphasis needed to be placed on ensuring that strong preceptorship is available, especially given the importance of high quality clinical support for new mental health nurses (Cleary and Happell 2005).

From a review of the descriptive and research literature on graduate transition programmes to mental health nursing, Hayman White et al (2007) concluded that an adequate orientation to clinical areas and ongoing support are important determinants of new graduates' satisfaction with the initial post qualification period. These authors also observed that available evidence suggests that while the transition from undergraduate nursing student to professional nurse can be stressful for all nurses, the inadequacy of the mental health content in undergraduate programmes creates additional difficulties within this speciality area of practice. Positive preceptorship experiences are therefore particularly important for this group of graduates.

On the basis of their review, Hayman-White et al (2007) outlined guidelines to ensure that mental health transition programmes are successful and argued that further evaluation is needed of their effectiveness. The guidelines included:

- rotation through main clinical areas;
- supernumerary status throughout the orientation period as graduates may be developing basic mental health skills not taught in the undergraduate programme;
- availability of preceptorship and supervision;
- aggression management training;
- clinical assessment and performance review.

6.4.4 Current position with nurse education in Australia

Of key interest to this review is whether changes have been made in response to the events and concerns described above. As at 2006, various alternatives had been proposed to the current generic programme to overcome the difficulties of inadequate preparation for mental health practice experienced by Australian nurse graduates (Homes 2006). These included: return to direct entry; replacing the 3-year generic course with a 4-year course that leads to qualification as both a general and a psychiatric nurse; introducing specialist options into the generic courses; and replacing psychiatric nursing with a university trained generic mental health worker who stands outside current disciplines. These options are discussed further in Section 9.2.2.

The preferred option in Australia when changes have been made has been to introduce specialist options into the generic course in the form of a mental health major. This approach was advocated in a review of undergraduate nurse education in relation to preparation for mental health practice undertaken by the Victorian branch of the Australian Health and Community Services Union (HACSU 2005). This union represents the majority of staff employed in the psychiatric, intellectual disability and alcohol and drug services. The review concluded that no evidence was available that indicated generic training had been beneficial to mental health nursing, but indicated incontrovertibly that the course failed to prepare beginning practitioners in mental health.
A major within an undergraduate course is defined as a sequence of courses that develops a particular academic theme across all three years of the programme. The form of the mental health major as described by HACSU (2005) is one in which subjects in the first year should constitute core subjects for all students but at least two units should clearly and unambiguously relate to mental health. All students have a clinical placement in mental health settings during their basic training; this would provide all students with an introduction to the specialty and for some invoke interest in mental health as a possible career. Thereafter students can chose to complete a major with stand-alone mental health subjects in years two and three. Such a course will provide for those who know from the outset that they wish to major in mental health and an opportunity for others to develop an interest in the area in year 1. HACSU (2005) recommended that completion of a mental health major should be noted on the student’s degree certificate. In 2005, the Department of Human Services in Victoria in put out a call to tender for a pilot Bachelor of Nursing program with a major in mental health.

During 2006/7 there has been considerable activity at national level to strengthen the mental health component of pre-registration courses. A mental health nurse education taskforce has been convened under the auspices of the Australian Health Ministers Advisory Council (Mental Health Standing Committee) and the Council of Deans of Nursing and Midwifery (Australia and New Zealand) to provide advice and recommendations on directions in mental health nurse education. Information available on the taskforce’s website indicated that it has undertaken: a literature review; a survey of mental health in current programmes in all Australian universities; national consultations; proposed a set of core values underpin the learning and teaching of mental health nursing; and has developing recommendations about the future mental health content of pre-registration programmes (MHNET 2007). The final report is about to be published (Personal communication 2007c).

During the period while the taskforce has been undertaking its work, several universities in various states have been making changes to the mental health content of their undergraduate nursing programme. In Victoria, two universities (La Trobe and Ballarat) won the tender to run a pilot programme for a mental health major. The aims of this major are to increase interest in developing a career in mental health nursing and prepare students ideally to work in mental health but also to be able to manage the complexity of situations encountered in any setting. The La Trobe University pilot started in December 2006 and comprises an experiential encounter in Year 1 to promote mental health nursing as an exciting and positive career option, and three specialist units in Year 2 and three in Year 3. The major will constitute a quarter of the 3-year course and is the subject of ongoing evaluation (Farrell and McConnachie 2007, McConnachie and Kenny 2007). Other universities developing mental health majors include: Flinders in South Australia; James Cook and the University of the Sunshine Coast in Queensland; Newcastle University in New South Wales; Murdoch University in Western Australia (Personal communications 2007c). Curtin University (Western Australia) is reported as having a strong focus on mental health within the undergraduate nursing course (Personal communication 2007c).

A recent national initiative has taken the form of centrally funded additional undergraduate nursing places in universities that focus specifically on enhancing mental health components including clinical placement experience. While all graduates continue to be generalists, it is hoped that those who have had an enhanced mental health educational experience will be more likely to opt for career pathways in the speciality (Personal communication 2007c).

6.4.5 Conclusion to the Australian case study

The Australian case study indicates that the move from direct entry to generic nurse training has been perceived as having a deleterious impact on mental health nursing in terms of both recruitment to the specialty and the extent to which new graduates are adequately prepared for practice. Considerable concerns about this situation have been expressed at local and national government level and by the mental health nursing profession. Various local and national initiatives are in progress in a drive to overcome these problems within the context of the undergraduate course.
6.5 Case Study 5: The United States of America - maintaining the profile of psychiatric nursing within a generic course

6.5.1 Nurse education in the US
The US maintains two levels of nurses: first level registered nurses and second level licensed vocational nurses (LVNs, also known as Licensed Practical Nurses). There are three courses leading to registration: a three-year hospital-based diploma, a two-year associate degree based in community colleges and a four-year baccalaureate university-based degree. The second level qualification (LVN) is a one-year diploma course based at a community college. There are opportunities for second level nurses to take further study leading to a registered nurse qualification and opportunities for diploma and associate degree trained nurses to upgrade to the baccalaureate degree qualification. Qualifiers from all programmes also have to pass a national examination held by the National Council of State Boards of Nursing designed to test knowledge, skills and abilities essential to safe and effective practice at entry level.

The courses are all generic and the focus on specialities, such as psychiatric nursing, has varied over time and between courses and institutions. Psychiatric nursing qualifications are gained post-registration; these include certificate courses provided mainly by the American Nurses Credentialling Centre (ANCC) and nurse practitioner and clinical nurse specialist courses offered as post-graduate courses. For the purpose of this review, the key issue of interest is the impact of generic training on recruitment to, and preparation of nurses for working in, mental healthcare settings.

6.5.2 The US mental health nursing workforce
In the US, mental health problems are identified as one of the leading causes of death and disability (Waite 2004, Williams Barnard et al 2006, McBride 2007) but the country is faced with shortages in many sectors of the mental health workforce. As far as nursing is concerned, employers face challenges in recruiting and retaining nurses in all healthcare services but particularly so in mental health where high vacancies remain (Valente and Wright 2007).

The problem of an ageing workforce affects the US nursing workforce as a whole, with half predicted to reach retirement age by 2020 (Waite 2004). An analysis of data in the 2000 National Sample Survey of Registered Nurses, however, demonstrated that hospital-based psychiatric nurses are older than hospital nurses in other fields and that there is a significantly lower proportion of younger entrants in psychiatric nursing than in other specialties (Hanrahan and Gerolamo 2004). The proportion of newly registered nurses opting for psychiatric nursing has been declining (Perese 2002, Waite 2004, Robinier 2006). There are also problems in recruiting and retaining licensed vocational nurses in mental health (Valente 2005). More psychiatric nurses are needed at basic and advanced levels to meet the mental health needs of the population (Waite 2004) and to address specific challenges such as the growing number of older adults with major psychiatric illnesses (Valente and Wright 2007).

Leading figures in psychiatric nursing in the US, such as McCabe and McBride, have recently observed that psychiatric nursing is at a critical juncture in its history (McCabe 2006, McBride 2007). On the one hand, there are increased opportunities for expanding practice (for example in child and adolescent mental health and gero-psychiatric nursing), a new undergraduate curriculum has been developed and there has been substantial innovation in graduate education at both certification and advanced practice levels. The latter followed a period of debate about the respective roles of clinical nurse specialist and nurse practitioner (e.g. Delaney 2005, McBride 2007). On the other hand, there are concerns that the pre-registration generic course has increasingly marginalised psychiatric nursing and that this has had an adverse effect on recruitment to and preparation for the speciality. Moreover, many conditions traditionally considered as falling within the domain of psychiatric nursing are increasingly treated in community settings by non-psychiatric care providers.

Most of the literature on the impact of having a generic course on psychiatric nursing relates to the four-year integrated baccalaureate degree although some information is available about the other routes to registration and to licensed practice. Several interrelated issues emerge from the literature: reduction of psychiatric nursing content in the curriculum; difficulties in
finding clinical placements; and a lack of interest in pursuing a career in psychiatric nursing by graduates from this programme. These issues are discussed in the following sections together with some of the counter strategies adopted.

6.5.3 Developments in psychiatric nursing education in the US

The pre-registration curriculum

Specialist mental hospital training in asylums ceased in the USA particularly after the second world war in the wake of the movement to develop mental health care provision in the community (Younge and Boschma 2006). Psychiatric nurses were regarded, however, as not appropriately prepared to provide treatment in the community in the way envisaged by the Community Mental Health Centres Act of 1963 and a series of conferences was convened to address this issue (Cu kr et al 1998). The outcome was that most of the funding allocated to provide training was at the graduate level (Cu kr et al 1998) and psychiatric nursing education evolved in the USA as a post-registration specialty with a general introduction to the subject included in the undergraduate course (Younge and Boschma 2006).

The dominant view of nursing practice in the US is described as one centred in a holistic view of the individual in which the physical and mental health aspects of care should be considered jointly (Calloway 2007). Hence the focus at undergraduate level has been on achieving a generalist rather than a specialist qualification.

Various studies have indicated a substantial and increasing reduction for the typical undergraduate nursing student in both psychiatric mental health content and clinical experience (e.g. McCabe 2000, Waite 2004, McCabe 2006, Patzel et al 2007). This reduction appears to be the case whether psychiatric knowledge and skills are the subject of separate courses or are integrated across all courses. The integrated approach to specialties has been favoured in recent years. In relation to psychiatric nursing, Perese (2002) describes the development of an integrated course which suggests that this is more likely than separate courses to lessen the stigma and fear that students attach to working with psychiatric patients and increase the likelihood of developing an interest in a psychiatric nursing career.

The integrated approach was also recommended by a task force of the American Psychiatric Nurses Association (Connolly et al 2007) convened to review the 2005 revised curriculum for psychiatric nursing; this comprised three components; core nursing content; essential psychiatric/mental health content; and learning outcomes deemed as clinical competencies. The review authors advocated an integrated approach that would expose students to experiences and learning across the entire BSN programme on the grounds that this would facilitate general nurses understanding mental health and mental health nurses being able to assess the physical component of the patient’s health (Connolly et al 2007).

The revised curriculum took account of many changes in the mental health field such as an increasing focus on the neurological basis of mental illness and changes in health care such as the growing emphasis on evidence based practice and demonstrable outcomes. This reflected the trend to reconceptualize mental health nursing as integrating behavioural and biological sciences and addressed the view that the specialty’s emphasis on the behavioural rather than the biological made it seem rather dated. Lack of focus in the curriculum on the new advances in the scientific basis of mental disorders was identified by students taking part in a focus group study as a barrier to pursuing a career in psychiatric nursing (Puskar and Bernardo 2003). Recently, it has been argued, however, that research based and evidence based guides for the psychiatric curriculum are lacking (Valente and Wright 2007).

Providing clinical experience

Various papers draw attention to problems encountered in providing students with clinical experience in mental health care settings (e.g. Puskar and Bernardo 2003, Patzel et al 2007). Clinical experience in diploma, associate degree and baccalaureate degree programmes is typically on acute inpatient units but many of these have been closed with the move of care to the community. Students rarely see recovery in community settings, however, since it is much more complicated and difficult to supervise students in community-based centres and to give
them access to more than observational experiences. Hence, psychiatric experience is often limited to a month or two in the whole course.

A survey by Patzel et al (2007) revealed the clinical and academic obstacles that members of psychiatric nursing faculties may encounter in providing clinical experience for students. The authors had difficulties in establishing a base number of eligible participants; 160 respondents returned the on-line questionnaire of the 507 sent to members of the Education Council of the American Psychiatric Nurses Association. Most respondents were responsible for baccalaureate programmes but faculty members providing associate degree and diploma courses were also included. Clinical obstacles to providing sufficient placements included: clinical site availability; competition for clinical sites; lack of staff role models and lack of staff support for students. Academic obstacles included a shortage of staff in psychiatric nursing faculties, and a perception by those staff in post that their specialty is neither valued nor supported by non-psychiatric faculty. The latter was attributed to a lack of understanding of the skills and knowledge needed for psychiatric nursing and an increasing reduction of course content to meet the increasing demands of medical and surgical nursing (Patzel et al 2007). The former point reflected a long-held observation; namely the equating of psychiatric nursing with the interpersonal skills needed by all nurses rather than the care needed by the severely and persistently mentally ill (e.g. Carter 1986 cited in McBride 2007).

Concern has been expressed that if students are not given adequate exposure to clinical settings and opportunities for skill development and are not supported during placements they will be unlikely to chose a career in psychiatric nursing once they graduate (e.g. McCabe 2000, 2006, Puskar and Bernardo 2003, Williams- Barnard et al 2006, Patzel et al 2007). Attempts to improve student experiences of practice placements through professional learning partnerships is described by Williams- Barnard et al (2006). A study using a convenience sample in an acute setting was designed to identify factors that contribute to a successful learning partnership between students and practising nurses. Communication skills and attitudes towards teaching and learning were rated most highly as contributing to a successful partnership while unit staffing and workload expectation were rated the least important. Clinical experience in mental health settings was provided in the fourth year of the course and the authors recommended earlier experience upon which that in the last year could build (Williams-Barnard et al 2006).

The licensed nurse vocational qualification
The amount of psychiatric nursing content has also been reduced in courses for licensed vocational nurses. Drawing on information mainly from California but also other states in the US, Valente (2005) observes that in the 1970s and 80s, licensed vocational nurse (LVN) programmes included psychiatric content and LVNs worked in psychiatric settings and some from that period of training still work in the specialty. More recently however, specialty content in the LVN curriculum, including psychiatric nursing, has been minimized in favour of increased attention to gerontology and medical-surgical nursing. In California, psychiatric nursing is not currently a requirement for inclusion in the LVN programme (Personal communication 2007d).

Continuing concerns
Another contributory factor to decreasing the psychiatric nursing content of courses has been the decision in 2004 of the National Council of State Boards of Nursing to reduce the amount of psycho-social questions in the licensing examination which graduates from all programmes have to pass (Waite 2006, Patzel et al 2007). Given the tendency for schools of nursing to emphasise curriculum content that will support passing the licensing examination, this may have an adverse impact on psychiatric nursing content.

Writing in 2006, Susan McCabe, the then president of the International Society of Psychiatric Mental Health Nurses (ISPNN) concluded ‘it is a time when undergraduate nursing curricula are integrating basic psychiatric nursing content, often diluting it into almost unrecognizable permutations’ (McCabe 2006, p.1). And again, ‘ in many places, nursing students may graduate without ever having experienced caring for a patient with a psychiatric disorder or planning mental health care for a community population’ (McCabe 2006, p1).
At the same time, Calloway (2007) argues that one of the premises underlying the integrated curriculum; namely that all nurses will have the opportunity to learn about the importance of promoting mental health of all patients is not always realised. This is attributed to: vagueness in defining mental health promotion; the traditional task orientation of nursing which does not sit easily with promoting mental health; and that mental health is regarded as synonymous with mental illness and thus tends to be avoided.

**6.5.4 Effects of reducing psychiatric nursing content in the generic curriculum in the US**

Several outcomes emerge from the reduction of psychiatric nursing content in the US nurse education curriculum: students are unlikely to develop an interest in developing a career in psychiatric nursing; the importance of transition programmes for those that do so; and programmes to recruit more licensed vocational nurses into mental health nursing.

**Popularity of psychiatric nursing**

As Williams-Barnard et al (2006) observe, for more than 20 years psychiatric nursing has been reported in the literature as an undesirable career option for many undergraduate nursing students. This, combined with sharply reduced exposure to psychiatric nursing at the baccalaureate level, means that few graduates leave the course motivated to work in this area, since it is difficult to become motivated to pursue graduate study for a subject with which they have little familiarity (McCabe 2000). Numbers entering graduate psychiatric courses have steadily declined (Waite 2004, Robinier 2006, McCabe 2006) and some courses have closed. The lack of exposure to psychiatric nursing in licensed vocational courses is regarded as contributing to difficulties in recruiting this group into the mental health workforce (Valente 2005). Suggestions have been made that practising psychiatric nurses be deployed to encourage students to consider psychiatric nursing as a career and for those on graduate courses to act as mentors (Puskar and Bernardo 2003).

**Transition programmes**

Previously, nurses have required some medical/surgical experience as a qualified nurse before being considered for work in mental health settings, but demand for nurses in recent years has led to them being employed directly after completion of their educational programmes (Waite 2004, 2006). Such nurses are not only facing the transition from student to qualified nurse but also transition to an area of care for which they are not likely to have been well prepared. Transition programmes for this group are therefore of particular importance in encouraging continued commitment to psychiatric nursing (Waite 2004), a point which also emerged from the Australian literature (Section 6.3.3).

Key factors in achieving successful transition emerged from research by Waite (2004, 2006). In-depth interviews were held with 15 nurses employed in diverse mental health facilities in Philadelphia; respondents had either an associate or a baccalaureate degree. Findings revealed the importance of having had practical experience in mental health settings during the undergraduate courses (only one respondent had done so); a finding reflected in other work (e.g. Perese 2002). Other important factors included: structured orientation periods in situations with adequate staffing ratios during the transition course; and comprehensive mentoring/preceptor programmes with personnel who actively desire these roles and are appropriately trained to fulfill them (Waite 2004, 2006).

**Programmes for licensed nurses**

Valente (2005) describes a programme at the Veterans Affairs Greater Los Angeles Healthcare system to address the problem of staff shortages in the psychiatric facilities by recruiting more licensed nurses. Attempts to recruit licensed and registered nurses had both been unsuccessful. A new course focusing on mental health was established which aimed to recruit students from the Licensed Vocational Nurse course who were already licensed or were pending licensure and who planned to study for upgrade to the registered nurse degree. The course included a four-month paid internship, one to one preceptorship, nursing orientation, a new graduate programme on transition to the workplace, management of assultive behaviour and a state board review examination. Ongoing evaluation of the course indicated that preceptors were not always available and so additional preceptors were trained.
Since 2003, the programme has recruited and retained 37 licensed vocational nurses (a retention rate in excess of 90%). These nurses are valued by nurse managers and have substantially reduced the hospital costs for temporary staff; moreover they have increased ethnic diversity among the nursing workforce since a higher proportion of LVNs than registered nurses originate from such groups (Valente and Wright 2007). Most have entered the upgrade to registered nurse programmes. The authors found that LVNs were eager to work in psychiatric nursing in contrast to the lack of interest of those on undergraduate degree programmes. In addition to the benefits of retention in psychiatric nursing, the LVN group also possessed medical and surgical skills needed by many mental health patients.

6.5.5 Conclusion to the US case study on psychiatric nurse education
In short, the US literature indicates a demand for psychiatric nursing care to help meet the challenges posed by mental health problems and illness. Many opportunities exist for psychiatric nurses to develop and expand their practice. The generic nature of the courses for both registered and licensed nurses, however, is such that there is insufficient content to engage students’ interest in the psychiatric nursing as a career or prepare them for practice. Consequently, much effort is expended on what Norman (2005) refers to as shoring up the boundaries of psychiatric nursing in both its theoretical and practical aspects, and in making good deficits in essential psychiatric nursing knowledge and skills at the post-registration level.

6.6 Case study 6: France and Switzerland - professional concerns about moving to generic education

6.6.1 France
Prior to 1992, mental health nurses were trained via a three-year direct entry course and were not registered as professional nurses. The French nursing system was changed in 1992 and direct entry courses were replaced by a generic course with a single curriculum for all nurses. The generic course is three years long, based in a hospital school of nursing and leads to a diploma level qualification (Robinson and Griffiths 2007).

By 1998, concerns were expressed at the proportion of the generic course devoted to psychiatric nursing; 440 of the 2080 hours of theoretical instruction and 770 hours of the 2275 hours spent in clinical placements (Tyrell and McCarthy-Haslam 1998). Many specialists in the mental health field think that the competencies of nurses graduating from the generic course are ‘less than required to be operational in a mental health setting’ (Personal communication 2007e).

Attempts have been made by the French nursing profession to develop a specialist post-registration course in mental health nursing and papers published arguing for the necessity of this (e.g. Perrin-Niquet 2001). As at 2007, this has not as yet received approval from the Department of Health and nurses only have an orientation period when they are appointed to work in a mental health setting (Personal communication 2007e).

6.6.2 Switzerland
Direct entry to psychiatric nursing was replaced with a generic course for all nurses in 1991; this is offered as a 3-year diploma based in a school of nursing in the higher vocational training sector or as a 3-year Bachelor’s degree in a University of Applied Science. Some schools of nursing initially maintained a training which was very ‘psychiatry’ orientated, but this has changed with more recent reforms. A post-registration course in psychiatric nursing is being developed.

Ever since direct entry psychiatric training was replaced with the generic course, psychiatric nurses in clinical practice, teaching and management have very much regretted the loss of specialised psychiatric nursing. In the French speaking part of the country, the regret was less loudly formulated, as in exchange for generalised training in this region, nursing training moved to the higher education sector (Personal communication 2007f).
6.7 Case study 7: Canada - maintaining specialist and generalist models

6.7.1 Two approaches to mental health nurse education in Canada

Canada maintains two approaches to the pre-registration education of mental health nurses, with some of the Western provinces having direct entry while in the rest of the country, psychiatric nursing has become integrated into generic programmes with specialization occurring at post-registration level. The reason for this distinction lies in the separate history of psychiatric nursing in the two parts of the country (Younge and Boschma 2006).

In eastern Canada, although direct entry to psychiatric nurse training existed a separate register for psychiatric nursing never evolved and with the national move to generic programmes for nursing in the 1960s, psychiatric nursing in eastern Canada was integrated into the new generic programmes. Post-registration certification through examination in mental health nursing is available after a period in practice. In western Canada, different circumstances prevailed (Younge and Boschma 2006). There were difficulties in establishing links between speciality training in mental hospitals and general training, staffing of mental hospitals in isolated rural areas of the western provinces was difficult and mental hospital superintendents supported the retention of speciality education partly as a means to alleviate staffing problems. A separate register for psychiatric nurses was created in the 1950s in the western provinces and this, along with direct entry courses has been retained.

6.7.2 Current issues in Canadian mental health nurse education

Across Canada as a whole, generic courses are currently offered as 4-year baccalaureate degree programmes or 3-year diploma programmes. There is, however, a move towards all degree and consideration of the diploma qualification being awarded to second level nurses, currently known as Licensed Practical Nurses (Robinson and Griffiths 2007). As far as psychiatric nursing is concerned, different circumstances continue to prevail in the eastern and western provinces.

The generic model, the only option in the eastern provinces, has been the subject of similar concerns as those that emerged in Australia and New Zealand (Cutcliffe and McKenna 2006). The Canadian Federation of Mental Health Nurses’ position paper of 1998 commented on evidence to the effect that Canadian nursing students declined the option of a psychiatric nursing placement since this is not an area in which they would chose to work. Knowledge of psycho-social nursing and basic interpersonal theory is taught in the generic programme and is not viewed as strictly belonging in the domain of psychiatric nursing (Gallop 2005). The latter is rather regarded as specialist knowledge required for helping people experiencing mental disorder or distress to manage their illness and recover their lives (Gallop 2005) and as such is a post-registration speciality.

Cutcliffe and McKenna (2006) refer to the body of evidence reported by the Canadian Federation of Mental Health Nurses, that in many Canadian Schools of Nursing, clinical placements in mental health settings are either not required or represent only a fraction of a student’s total clinical experience (Chan et al 1998). In this respect, it is of note that Lowe (2006) reports that many Canadian universities are finding it extremely difficult to provide appropriate mental health clinical placements given changes in service provision and rapidly increasing student numbers. A period of preceptorship with an experienced nurse has been introduced in some services as a means of making good this acknowledged deficit in clinical experiences. Lowe (2006) observes, however, that this has not proved popular with a workforce that already feels overstretched over providing adequate client care.

In the western provinces, registered psychiatric nurse training moved into the higher education sector at diploma and increasingly degree level. Opportunities have also been developed for registered psychiatric nurses to obtain a registered nurse diploma and more recently, for example at the University of Alberta to complete a baccalaureate nursing degree (BScN) and then a masters in psychiatric nursing. No evidence could be found to indicate that the Western provinces intend to cease direct entry training to psychiatric nursing.
Case Study 8: Belgium: different approaches and current debates

8.1 First level and second level education for psychiatric nursing in Belgium
Belgium has two levels of nurse: bachelor nurse (first level) and diploma nurse (second level). Up to 1994, some nursing schools, especially in Flanders, provided first level direct entry into what was known as psychiatric and social care nursing. After 1994, all direct entry courses were replaced by generalist courses. These are currently three-year degree courses provided by nursing schools at higher technical education level, although some pre-registration education is now provided in universities.

The second level course comprises a three-year vocational programme based on an apprenticeship model and provided as a secondary school vocational training programme. The exit qualification is a diploma (Flemish community) or a certificate (French and German communities). Students follow a common first year and then chose a branch programme in either psychiatric or general nursing.

8.2 Debates about the future of psychiatric nurse education in Belgium
The extent to which psychiatric nursing is covered in the curriculum may vary between schools in the same part of the country since the colleges are autonomous. For example, information about 12 nursing schools attached to one university indicates that in one school baseline competencies in psychiatric nursing are covered within generic course components, two others provide a one-year option in psychiatric nursing (60 study points) while others fall between these two extremes with psychiatric nursing options of between 20 and 40 study points. Master courses in psychiatric nursing are aimed at developing analytic knowledge and skills in a manner that enables nurses to become advanced practitioners. (Personal communication 2007g).

Throughout Belgium those responsible for psychiatric practice settings are arguing for a more specialised psychiatric nursing programme since the generically trained bachelors nurse is perceived as not possessing sufficient knowledge and skill to care for patients with more complex psychiatric disorders. There is much debate about how competence in psychiatric nursing skills and knowledge should be achieved. One association of psychiatric nurse educators favours a one-year bachelor programme in psychiatric nursing to be taken after the three-year generic course on the grounds that psychiatric nurses require general as well as psychiatric nursing skills Other prefer a greater focus on specialist psychiatric nursing options within the generic course. (Personal communication 2007g).

One of the problems with a post-registration course is the question of finance. Government subsidises bachelors degrees and masters programmes, but budget restrictions mean it is unlikely that employers will want to finance a post-registration course to develop sufficient confidence and competence to practice in psychiatric practice settings. Employers’ expectation of the bachelors course is that it should produce nurses who are able to care for patients with complex disorders. At present however, this is perceived as not being the case. (Personal communication 2007g).
Section 3: Pre-registration education for learning disability nursing

7 Debates and diversity of approaches: learning disability nursing

The review showed that the international situation for learning disability nursing is very different to that for mental health nursing in that some countries do not offer any specific training in nursing clients with learning disabilities at either pre-registration or post-registration level. In those countries that do provide such education, then coverage during the pre-registration nurse education course is very variable. Key debates in the education of learning disability nurses are outlined in Section 7.1 and the range of approaches in the countries reviewed is summarised in Section 7.2.

7.1 Debates about adopting particular models for learning disability nurse education

There has been ongoing debate in the UK and elsewhere about the desirability or otherwise of learning disability nursing remaining in the nursing fold. This debate has partly been attributed to ambiguity surrounding the role of the learning disability nurse that, in turn, has been attributed to the tension between the various models of care extant in services for clients with learning disabilities (ABA/UCD 2005).

The role of the learning disability nurse has been defined as including: education and skill training in relation to decision making for parents of children with learning disabilities; advocacy of social inclusion in a range of educational, recreational, employment and health and social care services; promotion of autonomy; and meeting the complex health care needs experienced by many clients (Mitchell 2004). There is debate, however, about whether care for this group should be grounded in a model of wellness as opposed to illness (ABA/UCD 2005).

7.1.1 Meeting healthcare needs of people with learning disabilities

There is widespread international recognition of poor health outcomes for people with learning disabilities and that nurses have a key role in the recognition and management of these (New South Wales Council on Intellectual Disability 2005).

A substantial volume of UK research shows that people with learning disabilities have higher levels of health needs than the general population and these are often unrecognised and unmet (Cooper et al 2004). They have different patterns of health need, with some conditions more commonly experienced than in the general population, and they have lower life expectancy than the general population with the commonest causes of death also differing. Barriers to accessing health services are experienced and this contributes to ongoing health inequality, chronic ill health and premature death (Cooper et al 2004). Echoing the UK research, Australian research has also revealed lower life expectancy, undiagnosed medical conditions, obesity, underweight, dental disease, and lack of diagnosis and treatment of psychiatric disorders (New South Wales Council on Intellectual Disability 2005).

Poor physical and mental health outcomes for people with learning disabilities have been attributed to: communication problems between clients and professionals; inadequate training of health and disability professionals; and lack of time for health professionals to spend with clients (Cooper et al 2004, New South Wales Council on Intellectual Disability 2005). The Australian organization has argued that all health professionals need education in relation to learning disability clients that includes communication, diagnostic approaches where communication is limited, equal rights to access, addressing symptoms for what they are rather than mistakenly seeing them as part of the disability.

In the UK, Signposts for Success (NHSE 1998) was concerned with ensuring that this client group has proper access to healthcare and this has been reiterated in the White Paper ‘Valuing People (DH 2001) which advocates dedicated specialist health services. More
recently, it has again been argued that there is a critical need for guidelines on health promotion and clinical and preventative services specific to health concerns of people with learning disabilities (Cooper et al. 2004).

7.1.2 Educational developments in learning disability nurse education in the UK

Turning specifically to developments in the UK, then as Laverty (2005) observes ever since the 1971 White paper ‘Better services for the mentally handicapped (DHSS 1971), much has been written about who is best placed to care for people who have a learning disability. The key point in this history from the perspective of nursing has been whether to retain a distinct learning disability branch at pre-registration level. The Committee on Nursing (1972) and the Jay Committee of Enquiry into mental handicap nursing (1979) both recommended the development of a new caring profession that had a social services rather than a nursing oriented training (Robinson et al. 2001, Mitchell 2004). The government did not accept these recommendations, however, and subsequently learning disability nursing was included as one of the four branches following a common foundation programme when nurse education moved to higher education, a move that by and large was welcomed by learning disability nurses (Tuddenham and Beacock 1989).

Various concerns such as difficulty in recruiting students and finding placements led to a further review that recommended ending the learning disability branch, increasing the learning disability element in other branches and developing a new post-registration course. This met with considerable opposition, primarily on the grounds that specialist nursing practice could not emerge without a pre-registration foundation of core knowledge and skills (Birchenall 1993). A subsequent decision was made to continue with the pre-registration branch with a greater emphasis on developing the role of LD nurses in community services (Department of Health 1995). Of note is another proposal at the time that learning disability nursing should be assimilated with the pre-qualification social worker syllabus, and subsequently joint learning disability/social work courses were developed at some universities (Sims 1999).

Opposing views have emerged about the success or otherwise of the core plus branch model for learning disability nursing. Some have argued that the process of self-examination resulted in the branch being stronger and more enthusiastic and creative than before (e.g. Barr 2004). On the other hand, research into the course by Alasewski et al. (2001) concluded that the new training programme has failed to enhance the quality of education, the course is fragmented and disorganised and has failed to offer adequate opportunities to develop practical skills.

Currently, various models have been proposed: maintain a separate branch within the current structure of the diploma/degree course, include learning disability skills and knowledge within a generic nursing course, or develop a new rehabilitation specialist with a focus on disability across a range of client groups. As part of this debate the UK Learning Disability Consultant Nurse Network (2007) submitted a paper to this review; key points include:

- The present programme enables LD nurses to be fully skilled and equipped to support people with a learning disability in both mainstream and specialist services and should be maintained and strengthened. This undergraduate preparation provides a foundation for further specialization.

- There is a distinction between having an understanding and some basic skills to support people with a learning disability that might be obtained in the course of a generic programme and the skills needed to support people with complex health needs and which require specialist training. A generalist training would dilute the specialist skills required.

- Continued debate about the future of learning disability nursing is likely to be detrimental to recruitment as it was the uncertainty of the past. Moreover, a generic course is unlikely to provide a good recruiting ground for the profession as indicated by the evidence from other professions that have a generic training.
• At a time when the health needs of this group are firmly on the agenda with Valuing People (DH 2001), the present system of training needs to be strengthened rather than weakened and preceptorship needs to be more widely available.

• The common foundation training should include learning disability skills and knowledge since all nurses need an awareness of the physical and mental health needs of this group.

In relation to the last point, Barriball and Clark (2004) noted that schools of nursing vary considerably in the amount of time devoted to learning disability nursing in the CFP with some student having the opportunity of a clinical placement and others receiving lectures only. They describe the development of strategies in one institution to ensure that all students have the opportunity to develop skills and knowledge in the care of this client group and argue that this is essential if their health care needs are to be met (Barriball and Clark 2004).

The selected case studies that follow of systems other than that adopted in the UK, indicate how the issues and concerns described in this section have been manifest.

7.2 Approaches to pre-registration education for learning disability nursing

Model 1: Specialist nursing qualification following a direct entry course

Of the countries reviewed, only Ireland offers direct entry on a nationwide basis to intellectual disability nursing along with general, children and general integrated, psychiatric nursing and midwifery. These are four-year courses leading to a degree (4.5 for children and general integrated). Ireland is currently in the throes of considering whether to change from the direct entry model to one of the other three models identified in Section 4.1 (Details in Case Study 1, Section 8.1).

Model 2: Specialist nursing qualification following a core plus branch course - UK

The UK alone offers the core plus branch model for learning disability nursing. All students follow a common foundation programme followed by a branch programme in mental health, learning disability, adult or children’s nursing in which they gain a specialist qualification. The course is 3 years long leading to a diploma or degree in England and degree only in Wales, Scotland and Northern Ireland.

Model 3: Generalist qualification with some parts of country offering specialist options

Holland.

Holland used to have provision for direct entry intellectual disability nursing but this ceased with the move to a generic 4-year diploma course (degree level). In some parts of the country a specialist option is being introduced in order to produce nurses who can better meet the needs of this client group. As with mental health nursing, this is in the latter part of the course, with students making their choice of specialization during the common part of the training.

Model 4: Generalist qualification following generic course without specialist options

Australia and New Zealand

Used to have direct entry training for learning disability nursing but this ceased with the move to higher education and the introduction of a generic three-year university based degree course. There has been considerable concern about the impact on the client of this loss of specialised nursing skills and knowledge (Details for Australia in Case study 2, Section 8.2).

Other models

Various other models were found to exist for the preparation of professionals involved in the care of clients with learning disabilities.

Developing a nursing speciality at post-registration level.

Canada and the US

At varying times and in different states in Canada and the US, pre-registration courses have included some focus on nursing for clients with intellectual disabilities. Intellectual disability nursing was not however recognized as a speciality area until 1997 and post-registration certification has been developing (Details in Case study 3, Section 8.3)
Specialist qualification in learning disability nursing and social work

UK: Some UK universities offer a combined learning disability nursing and social work course leading to qualification in both professions.

No specific learning disability nurse training

Several countries reviewed have never had a speciality of learning disability nursing. Registered general nurses are involved in the care of clients, particularly those with severe disabilities. In Switzerland for example, people with learning disabilities are mostly cared for by social assistants or specially trained educators and untrained helpers. Nurses are sometimes part of the caring team, especially in the care of severely handicapped people.

8 Case studies: approaches to pre-registration learning disability nurse education

8.1 Case study 1: Ireland - debating whether to retain direct entry

The debates that have taken place about the future of pre-registration nurse education applied equally to intellectual disability as to mental health nursing as indicated in Section 6.4.1, to which the reader is referred.

In summary, the recent research into the views of stakeholders in nurse education in Ireland, including representatives of intellectual disability nursing, led to recommendations for retaining the separate parts of the register (University College Dublin, An Bord Altranais 2005). There was, however, some support for a period of common training with other branches during the course, with caution to be exercised over the extent to which this might be dominated by general nursing. Most recently, the Department of Health has recommended that a common core followed by specialist training and registration be adopted (DH 2006).

8.2 Case study 2: Australia - concerns about impacts of generic training

The history of intellectual disability nursing in Australia is well documented in a review of service delivery to people with an intellectual disability in Victoria and Australia (Davis et al 2005). The review was commissioned for a review by NHS for Scotland of the contribution of nurses to the care and support of people with an intellectual disability (NHS for Scotland 2005).

The Davis et al (2005) review focused specifically on the State of Victoria while observing that the situation there is relevant to the whole of Australia. Specialist training in what were then called mental retardation services began in the 1960s with the introduction of a mental retardation nursing course. This was a three-year course focusing on health issues and based on an apprenticeship model. The course was located within institutions since this was the setting where most care was provided.

The 1980s saw a recognition that the curriculum needed to change to reflect the view that the essential nature of intellectual disability was developmental rather than illness based and that the focus of care was moving to the community. The Mental Retardation Division for Victoria wanted to see mental retardation nursing as the primary generic professional resource in the area of intellectual disability. For this to be the case, however, the Division argued that the new community and developmental focused nursing course should be based in the tertiary education sector and in Departments of Psychology and Intellectual Disability Studies rather than Medical Departments. The Steering Committee developing these proposals emphasised the differences between mental retardation, mental health and general nursing. This view, however, was at odds with the Commonwealth Government’s preference for only funding comprehensive nursing courses once nursing as whole moved into higher education. Mental Retardation Nurses feared a downgrading of their speciality within a comprehensive nursing course.

Subsequently, two developments occurred in Victoria. Mental Retardation Nursing became incorporated into comprehensive nurse education and ceased to be registered as a separate branch of nursing. However, mental retardation nursing skills and knowledge were gradually eliminated from the comprehensive nurse education course. Concurrently, a Bachelors degree
of applied Science (Intellectual Disability) was developed and graduates from this course now play a leading role in services for those with intellectual disabilities. These graduates, however, do not have a professional or registering body and are not permitted to perform any nursing tasks beyond that permitted of a lay person. Lack of a group of health professionals with the specialist nursing skills and knowledge required by clients with intellectual disabilities is now perceived as a major gap in service provision for this group.

The disappearance of learning disability nursing from comprehensive nurse education was also the subject of critical comment by the New South Wales Council for Intellectual Disability (2005) submission to the productivity commission on the health workforce. The Council observed that whereas there used to be separate courses in general, psychiatric and mental retardation nursing, these were merged on the basis that there would be a comprehensive course covering all these aspects of nursing. Inquiries into the mental retardation nursing content of the comprehensive course, however, revealed that the University of Wollongong is the only university of the 19 in New South Wales that has a discrete and compulsory subject on intellectual disability. In other universities there is some very limited coverage of the subject within generic components of the course. Noting that there is poor uptake by health professionals of training materials on intellectual disability, the Council advocated the development of specialists in the fields of the physical and mental health of clients with intellectual disability.

In summary, the move to a comprehensive nurse education that has minimal coverage of mental retardation nursing and the development of a new developmental disability professional without nursing skills, has resulted in a loss of nursing skills in the care provided for clients with learning disabilities.

8.3 Case Study 3: US and Canada - developing a post-registration speciality

Unlike Ireland and Australia, the US and Canada have not had a separate speciality of intellectual disability nursing at pre-registration level. In fact, it has only been recognised as a nursing speciality since 1997.

8.3.1 Learning disability nurse education in the US

Information about the US (Nehring 2004) indicates that the care of people with intellectual and developmental disabilities (IDD) did not fully enter the nursing curriculum until the 1950s at which time it was primarily included in paediatric and public health courses. Prior to that time, IDD nursing was taught mainly in psychiatric nursing courses since the condition was regarded as a subset of ‘mental illness or insanity’. In the early 1960s, educational funding for IDD nursing did become available to nursing schools and there was increased emphasis on the subject in nursing courses into the 1970s. Since then, however, interest and funding has waned.

As community integration continues to be promoted in all states, all nurses are likely to see individuals with IDD in community and specialized clinics and provide care for this client group in the arenas of maternal and newborn, medical and surgical, paediatric, psychiatric and public health. Consequently, there has been increased recognition that nurses require specialized knowledge and skills in order to adequately care for these individuals and their families. Since the curriculum content on the subject in undergraduate nursing programmes is usually limited to discussions in a general/paediatric course, alternative routes to skills acquisition are being developed. The American Association on Mental Retardation are developing a core curriculum for nurses and health professionals specialising in this field and on line learning modules and a Web based internet program on nursing and IDD have been developed.

A registered nurse can now pursue specialist training in developmental disabilities at postgraduate level in those universities that have centres of excellence in developmental disabilities. These courses are inter-disciplinary in nature and not nursing specific. The American Developmental Disabilities Nursing Association (DDNA) was established and aims to provide opportunities for nurses working in developmental disabilities to explore common issues. In 1995, the DDNA commenced certification of nurses in developmental disabilities based on experience and examination. In 1997, the American Nursing Association officially recognized the speciality of developmental disabilities nursing (Nehring 2004).
Considering the future of IDD nursing in the US, Nehring (2004) maintains that the care they provide should be holistic, not only involving health care but also coordination and collaboration in accessing educational, employment financial, housing, recreational, and social services systems. Nehring (2004) observes that IDD nursing in the US is a speciality that has been stigmatized, just as the population it serves has been. Moreover, nurses involved in the care of this group are less likely to be educated to baccalaureate level than nurses involved in all other branches of nursing. Nehring (2004) maintains that encouraging an increase in the proportion of graduate nurses in the field will contribute to the development of nurse leaders and that this will be essential in developing nursing perspectives and roles in IDD inter-disciplinary teams.

8.3.2 Learning disability nurse education in Canada
The situation in Canada is similar in that pre-registration nurse education does not include any lengthy specialized training in the field of IDD but nurses can take the DDNA certificate in IDD nursing (Broda 2004). Describing developments in Montreal, Broda (2004) reports that a case management model of care, with an emphasis on a multi-disciplinary approach, now directs the delivery of community based services. The teams include professional educators, social workers, nurses, psychologists and psychiatrists; other health professionals can be brought in as required. It is recognized that medical and nursing staff need advanced training to recognise and manage the complex health needs of individuals with intellectual disabilities (Broda 2004).
Section 4: Discussion

9 Implications for the UK of international evidence on pre-registration nurse education

The final section of the report draws together the international evidence on the outcomes of forms of pre-registration educational preparation for mental health and learning disability nursing that differ from that in the UK and considers its implications for reviewing pre-registration education in the UK.

9.1 Models of pre-registration nurse education

The evidence indicated that four models of pre-registration education are in existence in the countries reviewed (Section 4.1):

Model 1 Specialist qualification following a direct entry course
Model 2: Specialist qualification following a core plus branch course
Model 3: Generalist qualification following a generic course with specialist options
Model 4: Generalist qualification following a generic course without specialist options

The majority of countries reviewed have moved from a wholly specialist form of preparation (Model 1) to a wholly generalist form of preparation (Model 4). Some have opted for Model 3, while others are moving to this model having initially changed to Model 4 i.e. they are reintroducing specialist options into a generic course. Just one country of those reviewed (Ireland) has retained the direct entry Model 1. The outcomes of the move from specialist to generalist training and the responses to these outcomes are discussed first in relation to mental health nursing and second for learning disability nursing.

9.2 Key findings for mental health nursing

9.2.1 Outcomes for mental health nursing

The international evidence indicates that the move from a specialist to a generic form of pre-registration education is perceived as having deleterious consequences for mental health nursing. The courses tend to be dominated by general nursing and little time is spent on the theoretical or practical skills and knowledge required to be a competent beginning practitioner in mental health nursing. Providing sufficient clinical experience for nurses to develop practical skills may be compounded by problems of providing clinical placements in mental health settings. Some evidence emerged that mental health concepts are taught by people without mental health experience.

The view that a generic course can provide beginning level competencies in all branches of nursing appears not have been borne out by the international evidence on mental health nursing.

The consequence of producing qualifiers who are regarded as not sufficiently competent or confident to practice has been twofold. First, the need to provide post-registration courses to develop this level of competence; this has financial implications for employers and for nurses if they are not paid a salary at the same time. Second, good quality and sufficient preceptorship and supervision are required for a period after qualification to an even greater degree than for nurses who have had sufficient grounding in mental health during the undergraduate course. If part of this orientation period is to be supernumerary to enable development of clinical confidence and skills, then this too has financial implications as well as being dependent on sufficient numbers of trained staff to provide the required support. The importance of being able to provide high quality support to new graduates wanting to work in mental health was identified as an important contributor to retention.

Problems over recruitment and retention in mental health nursing were identified as likely to increase with generic training. Courses with little mental health content may be less likely than
specialist courses to attract people with an interest in a mental health career in the first instance and do not provide the opportunity for such interests to develop.

9.2.2 Proposed solutions for mental health nursing
Various solutions have been proposed, mainly in the Australian and New Zealand literature, to address the problems that have emerged.

One approach is to increase the mental health nursing component of the generic training. Wynaden et al (2000) for example, have argued that to do so requires recruiting academics with mental health nursing expertise who can clearly define the requisite body of knowledge and skills. If such people are not available, then generic course programmers should facilitate the engagement of expert mental health nurses in curriculum planning to increase the likelihood of integrating and consolidating mental health concepts throughout the programme. Moreover regulatory bodies monitoring nursing courses must ensure that both course content and staff are appropriate in relation to mental health (Wynaden et al 2000). Various national bodies have recommended a greater focus on mental health in the undergraduate curriculum (Cleary and Happell 2005). In relation to this option, concerns have been expressed that it is not possible to add more into an already overcrowded curriculum and that a number of other claims for increased content have also been made.

Clinton and Hazelton (2000) considered the desirability and feasibility of introducing either a 4 year combined degree course in general and mental health nursing or a 4-year course leading to a mental health nursing degree and a general nursing degree. A 4-year double degree was introduced by La Trobe university but recruitment was reported as difficult partly because of the rural location and partly because potential students had the same employment options as after a 3-year course (HACSU 2005). Holmes (2006) observes that neither students nor employers may wish to fund the cost of an additional year.

A third option is to introduce some form of specialization during undergraduate education. While some have argued in favour of a return to direct entry (e.g. Stuhlmiller 2005), more commonly a mix of generic and specialist training has been advocated. Prebble (2001) maintains that unless nursing bodies mandate a specialist mental health option within the undergraduate programme, mental health nursing in Australia and New Zealand will be on the brink of extinction. The National Review of Nursing Education (Commonwealth of Australia 2002) while reiterating a commitment to comprehensive education as the preferred model acknowledged the need for a solid undergraduate foundation to produce more graduates for the mental health field and that this could be achieved either by specialization within an extended undergraduate course or occur at post-registration level.

A fourth option proposed for example by Holmes (2006) as a possibility for Australia and elsewhere, is that nursing should be abandoned in favour of a university trained generic mental health worker. The arguments advanced for and against such a proposal are outwith the remit of this review but it is of note that some commentators observe that such an outcome might become more likely if mental health nursing numbers continue to decline.

9.2.3 Actions taken in relation to mental health nursing
Although dissatisfaction with generic as opposed to specialist training appeared to be widespread among members of the mental health nursing profession in the countries reviewed, it could be argued that this is a manifestation of regret over reduced professional independence that does not necessarily have an impact on service delivery and patient outcomes.

What is more to the point, however, is whether employing organizations and government organizations have seen fit to make changes to generic training with a view to enhancing competence of qualifiers. In this respect, Holland reintroduced a specialist option into the generalist course, some Australian states have introduced a mental health major into the generic course and the Irish government prefer the core plus branch model to the generic model should there be a change from direct entry. Those countries that have opted for reintroducing a specialist option have either chosen the mental health major (Section 6.4) or a branch programme after common core (Section 6.2.1)
9.2.4 Implications for mental health nurse education in the UK
The evidence suggests that the UK model of a common core followed by a specialist period may be the right balance and one that some other countries are now seeking to employ. There is a difference, however, in that specialist registers are not being reintroduced. Of note is that there is not a call for a return to direct entry and it is recognized that a common core is an important part of nurse training for healthcare today. The common core enables those not planning to specialise in mental health to nonetheless be aware of the mental health needs of the wider patient population and for those who are planning to specialise in this field to be aware of the physical health needs of their clients.

The international evidence indicates that the UK would have to address the following if a change from the core plus branch model to a generic model were to be considered:

• the recognition that the specialist mental health skills and knowledge required to provide care in community and inpatient settings might be diluted
• the need to provide sufficient mental health placements for all nurses to gain practical experience
• sufficient staffing levels to provide preceptorship and supervision for qualifiers likely to be less competent than today’s diplomates and graduates
• possibility of increasing mental health nursing coverage by extending the course to four years or providing a supernumerary post-registration year.
• possibility of reduced recruitment to the specialty

9.3 Key findings for learning disability nursing
Much less information was available about learning disability than mental health nursing, primarily because far fewer countries prepare specialist learning disability nurses at either pre-registration or post-registration level. The international evidence, however, identified several issues that are likely to be germane to deliberations in the UK.

9.3.1 Meeting healthcare needs of clients with learning disabilities
There is international evidence that the healthcare needs of people with learning disabilities are more likely than those of the general population to be unrecognized and unmet (Section 7.1.1). Although there is recognition that a nursing input is needed to meet these needs, there are a diversity of approaches to the kind of health professional doing so: these include a specialist learning disability nurse, a general nurse working with others specialising in learning disability, or a developmental disability/rehabilitation specialist who may or may not have nursing skills.

In countries that do include specialist learning disability nurses in the team of professionals caring for learning disability clients, there are different approaches to the format of pre-registration education to produce such nurses; representing different points along the specialist/generalist continuum outlined in Section 4 and shown in relation to learning disability nursing in Section 8.1.

9.3.2 Outcomes of loss of specialist preparation for learning disability nursing
We regarded it as outside the remit of this review to consider the evidence for and against the UK developing a new health professional, different from specialist learning disability nurses. Rather we focus on the impacts of different approaches to the pre-registration education for developing specialist learning disability nurses.

The main change in approach to the pre-registration education of learning disability nurses has been to move away from specialist direct entry courses, most likely to a generic nursing course or, in the case of the UK, to a core plus branch course. The former move as indicated by the evidence from Australia is that learning disability nursing, like mental health nursing, gradually gets squeezed out of the curriculum by the demands of educating people to be competent general nurses. In Holland, the introduction of generic training meant that at the point of qualification nurses were inadequately prepared to care for the client with learning disabilities.
9.3.3 Proposed solutions for learning disability nursing

Proposed solutions have focused on reintroducing specialist options into the undergraduate nursing curriculum and/or ensuring that the group of health professionals involved in caring for clients with learning disabilities includes those with dedicated nursing skills. In the latter regard, the authors of a report on the implication of the Australian experience for the Scottish review (Davis et al. 2002), emphasised the importance of retaining a group of registered professionals with expertise in skills required to meet the higher than average health, mental health, challenging behaviour and developmental needs of people with intellectual disabilities. Such professionals also require skills associated with supervising and training direct care staff, managing services, planning support services, ensuring community participation and promoting of self determination for people with intellectual disabilities.

The report authors concluded that if Scotland makes the decision to no longer have learning disability nurses, then a new profession should be established to ensure that the gaps in service delivery experienced in Victoria do not occur (NHS for Scotland 2002).

9.3.4 Actions taken in relation to learning disability nursing

In Holland, rather than introduce a post-registration course to develop basic competencies, some areas have introduced a specialist learning disability option into the undergraduate programme. In those countries that have never had specialist learning disability nurse training at pre-registration level, such as Canada and the US, the integrated generic training contained little in the way of preparation for care of the client group; hence a post-registration speciality has been developed. Reviewing the evidence about the impact of generic training on minority branches and assessment of views of stakeholders has led to the conclusion in Ireland to retain direct entry or move to the UK core plus branch model. In Australia, at the time of writing, considerable regret has been expressed by organizations involved in the care of clients with learning disabilities about the loss of nursing skills.

9.3.5 Implications for pre-registration nurse education in the UK

As far as preparing nursing students to be competent beginning practitioners in caring for clients with learning disabilities, the international evidence indicates that a move to generic training would likely have the same result as that witnessed elsewhere. It appears unrealistic that within a three or four-year generic course students can be prepared to be competent beginning practitioners in learning disability as well as in mental health and general nursing.

10 Conclusion

The evidence suggests that the UK model of a common core followed by a period of specialization may be the right balance for preparing students to work in settings in which care for mental health and learning disability clients is provided. That is not to say that the present system is without problems; research indicates that there are some deficiencies in preparing nurses for present day complexities of care in community and in-patient settings; lecturers may experience difficulties in keeping up to date with clinical practice; and preceptorship and supervision are not always readily available to support nurses in early career.

The international evidence suggests, however, that such problems are likely to be exacerbated by a three or four-year generic training, the option adopted by most other countries that have systems different from that in the UK. The belief that a generic course can prepare students to be a beginning practitioner in all aspects of health care is not borne out in practice in many of the countries we reviewed and in Ireland has been rejected as an option for the future. It appears not to be feasible to include the requisite knowledge and skills within a three or even four-year programme and general nursing components tend to dominate at the expense of the minority specialties. This is perhaps not surprising since it may well take three or four years to prepare a nurse to be competent to practise as a general nurse. Given the growing evidence that nurses in the UK may be spending a shorter period of time in the profession than hitherto, employers may require them to be competent to practise in mental health or learning disability nursing at the point of qualification rather than fund post-registration courses to achieve this point as is the case in some of the countries reviewed. Moreover, the development of a post-registration education framework and of advanced practice roles, may have to start with developing basic skills and knowledge if these are not gained during undergraduate courses.
One of the problems, however, with the core plus branch model in the UK is that whereas students used to choose their branch during the common foundation programme, now the choice has to be made at the outset of the course. This curtails a potential recruiting avenue for specialties such as mental health and learning disability with which students are less likely to be familiar prior to the course. Research indicated that just under a fifth of qualifiers from the mental health and learning disability branches started on another branch, most likely the adult, and changed following exposure to these specialties (Hardyman and Robinson 2000). Generic courses do allow for choice of specialization during the course; however, the international evidence suggested that the course contains such little psychiatric or learning disability nursing content that students are unlikely to develop an interest in these areas.

Some of the arguments advanced in favour of generic training focus on the greater mobility that this would afford in Europe since, as Nolan and Brimblecombe (2007) observe, specialist qualifications may not meet employment requirements when a general nursing qualification is needed to work in any health setting including mental health. It could be argued that UK undergraduate courses should contain specialty branches but still lead to a generalist qualification and that further specialist qualifications could be obtained at post-registration level. The loss of specialist registers, however, in countries that once maintained them may contribute to the loss of recognition of the distinct nature of a specialty and of associated control over pre-and post registration education. As others have maintained (e.g. Nolan and Brimblecombe 2007), seeking to adopt a pan European approach to training may fail to take account of the diversity of mental health needs and services across the region.

The evidence suggests that a move to generic training would be out of keeping with the modern day realities of mental health and learning disability service delivery in the UK and the economic pressures under which such services operate. In some countries the generic model has proved unsuccessful, certainly with mental health nursing, and there have been moves to reintroduce specialist options in the form of branches and majors. On the basis of evidence reviewed, we conclude that systems other than the core plus branch UK system do not appear to offer any advantages as far as mental health and learning disability nursing are concerned.
References


An Bord Altranais, University College Dublin (2005) An examination of the rationale for and impact of maintaining the five points of entry to the register of nurses. An Bord Altranais, Dublin


Committee on Nursing (1972) Report of the committee on nursing (Chairman: Professor Asa Briggs) Cmd 5115. HMSO, London


Personal communication (2007a) Discussion with senior members of mental health nursing profession in Denmark (November 2007)
Personal communication (2007b) Discussion with senior members of mental health nursing profession in Holland (August and September 2007).
Personal communication (2007c) Discussion with senior members of mental health nursing profession in Australia (September to November 2007)
Personal communication (2007d) Discussion with senior members of mental health nursing profession in the US (September and October 2007)
Personal communication (2007e) Discussion with President of the French Nursing Association (September 2007)
Personal communication (2007f) Discussion with senior members of nursing profession in Switzerland (June and September 2007)
Personal communication (2007g) Discussion with senior members of nursing profession in Belgium (June and September 2007)
Rushworth L, Happell B (2000) Psychiatric nursing was great but I want to be a ‘real’ nurse. Is psychiatric nursing a realistic choice for students? Australian and New Zealand Journal of Mental Health Nursing 9: 128-137