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ORIGINAL ARTICLE

Mental health nursing capability development: Perspectives of consumers and supporters

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ABSTRACT: *Mental health nursing requires a specialist range of capabilities and values. In Australian contexts, the preparation of nurses to work in mental health settings has attracted criticism from government reviews, academics, and graduate nurses. Insufficient mental health content and clinical placement experience in undergraduate nursing courses have been central to this criticism. The study aim was to identify the areas and modalities of capability development of graduate mental health nurses, from the perspectives of end point users. In order to meet the aim, a four-item cross-sectional online survey with three additional and open-ended questions was developed. The questions were co-designed with consumer academics and reviewed by consumer and carer organizations. The survey was widely distributed across Australian consumer and carer organizations, with 95 useable responses. Findings indicated strong support for lived experience being integrated into teaching teams for nurses, as well as support for undergraduate direct entry for mental health nursing. Themed content from open-ended responses reflected the survey outcomes as well as prioritizing skill development to support better therapeutic relating and nurse self-care. Key findings included strong support for greater lived experience input into mental health nurse education, specialist undergraduate preparation and a focus on developing relational capabilities in the mental health nurse workforce.*

KEY WORDS: *carers, consumers, cross-sectional survey, mental health capabilities, mental health nurse education, mental health nursing.*

INTRODUCTION

Mental health nursing is specialist clinical practice for a consumer population with complex and often unmet mental and physical health needs. There is little evidence that the current preparation of the mental health nursing (MHN) workforce in Australia is adequately meeting the holistic needs of these consumers (Happell *et al*. 2015). Arguably, this is unsurprising in the context of existing structures for preparing nurses for mental health practice. Undergraduate mental health nursing content is minimal and at some universities absent in Australian settings (Happell *et al*. 2020). Graduates of the comprehensive training system are not required to undertake specialist training to work in mental health

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settings as a neophyte registered nurse (Australian Nurses and Midwifery Accreditation Council 2022). Where individual public mental health services offer transition to practice programmes for recent graduates, they are undertaken in the absence of a national curriculum or benchmarking by accrediting specialist bodies such as the Australian College of Mental Health Nurses (ACMHN; Bakon *et al*. 2018). Such programmes may produce graduates that meet the needs of employers and the roles of nurses as defined by health services, but it is unclear whether the needs of consumers are being optimally met through the present educational approaches. Numerous public enquiries in Australia have strongly asserted that the mental health system is grossly deficient, the training of mental health professionals inadequate to meet current and future needs and that the needs of consumers are not currently being met (Productivity Commission 2020; State of Victoria 2018–2021).

Despite not being compelled to do so by regulation, many nurses in Australia do seek and undertake post-graduate education, which is often incentivized by employers through qualification allowances. However, the majority of post-graduate mental health nursing preparation have minimal if any skills-based components and are not benchmarked against national frameworks for post-graduate mental health nurse (MHN) education (Australian College of Mental Health Nurses 2016). Where MHNs have attained specialist education and developed advanced practice capabilities there are limited options to enact their full scope of practice. Restrictions include narrow approaches to treatment roles, exclusion from government primary mental health funding streams and widespread stigma and ignorance regarding the complexities of mental health work (Hurley *et al*. 2020b).

BACKGROUND

Drawing from recent reviews into specialist MHN capabilities, it is evident that MHNs and the treatments they offer in response to mental illness are complex, multi-layered and most importantly, specialized (Hurley & Lakeman 2021). While attitudinal and relational capabilities have been identified as important by mental health consumers and carers (Gunasekara *et al*. 2014; Lakeman 2010), the need to overlay these non-technical capabilities with specialist skills is equally important. While not exhaustive, technical capability areas emergent from the recent Australian reviews into mental health include: Psychological therapies; Prevention and early intervention; Suicide prevention; Psycho-social interventions; Assessment and screening; Psychopharmacology; Risk mitigation and Behaviour management; Co-morbidity both physical and substance; Physical health screening and interventions; Crisis responses and Systems navigation (Hurley *et al*. 2022). These capability areas then need to be overlayed with technical skills and knowledge on: Cultural applications; Technology applications; Lifespan applications; Trauma-informed applications and Mental health legislation. Additionally, engaging in supported decision making in contexts of human rights and legislation, recovery practices, and advocacy for carers and consumers are also technical specialist capabilities in mental health settings. Importantly, both technical and non-technical capabilities are underpinned by the capacity to think critically and to self-reflect on a personal level (Lakeman & Hurley 2021).

This breadth of required MHN capabilities suggests the Mental Health Productivity Commission Inquiry recommendation for direct entry MHN education does not emerge from a vacuum or because current undergraduate training structures for MHNs have evidence of being effective (Productivity Commission 2020). Rather, this recommendation emerges from repeated consumer and carer experiences of an under-prepared nursing workforce (Productivity Commission 2020; State of Victoria 2018–2021), as well as from multiple studies on the inadequacy of comprehensive nurse training from graduate nurse' perspectives (Foster *et al*. 2019b; Hemingway *et al*. 2016; Molloy *et al*. 2016).

There is a long-standing lack of mental health theory and exposure to clinical practice in undergraduate nurse education (McCann *et al*. 2010). This lack of mental health content even fails to reflect the original intent of comprehensive nurse training that sought to produce graduates with holistic skills and knowledge for all clinical settings, inclusive of mental health and physical health (Happell & Cutcliffe 2011). Mental health content is often excluded on the grounds that there is already overcrowding of curricular content (Happell *et al*. 2014) and that mental health is a specialist topic for post-graduate study. This erosion of mental health content across Australian university nursing courses is occurring in stark contrast to expert advice. The Australian College of Mental Health Nursing developed and then updated their national framework for pre-registration training in 2018 (Australian College of Mental Health Nurses 2018). This guidance has been steadfastly ignored, despite the growth in the

need for a specialist mental health nursing workforce (Productivity Commission 2020). Additionally, there is no evidence that comprehensive undergraduate nurse training has improved consumer outcomes since its instigation over 30 years ago in the context of ingrained stigma by undergraduate nurses towards consumers (Happell *et al*. 2020). Contextually, the inadequacy of MHN undergraduate preparation occurs under the leadership, priority setting and decision making of the national generalist nursing bodies such as Australian Nurses and Midwifery Accreditation Council (ANMAC) and the Australian Council of Deans of Nursing and Midwifery.

In this context, the aim of this study was to identify the areas and modalities of capability development that graduate MHNs require, from the perspectives of end point users – consumers, and family, supporters or carers. In this context, supporters are those who, while not offering a caring role to consumers, are otherwise advocating for them. Of importance to this study is that, to date, consumer and carer views on the required capabilities for MHNs and how they should be educationally prepared to deliver these capabilities have not been sought from consumers and carer perspectives (Moyo *et al*. 2022).

METHODS

In order to meet the study aim, an online cross-sectional survey design with four closed and three open-ended questions was used. A team of university-based consumer academics co-led the development of the survey instrument. The wording of each question was constructed through repeated zoom meetings with the consumer academics and other members of the research team. The survey wording and dissemination process was also reviewed by a state-based mental health carer organization. This resulted in accessible, respectful and trauma-informed language being used. Additionally, the option for participants to have support to complete the survey by telephone was included. Two participants utilized this option. A pilot of the survey was undertaken for readability and face validity prior to the survey being formally launched. Feedback from those participating in the pilot survey was then incorporated into the final version of the survey. Pilot responses were not included in the data reported in this paper. The study is reported using EQUATOR network recommendations for quantitative (STROBE) data (Vandenbroucke et al. 2007).

Data collection

The project received approval from Southern Cross University Research Ethics Committee. The survey comprised four closed ended questions and three open-ended questions and was distributed via the Qualtrics survey platform with several follow-up distributions. This paper reports findings related to the amount and type of training for MHNs with additional findings being reported elsewhere. The full survey instrument is in Appendix 1. Recruitment was initially by an email invitation distributed through mental health consumer and carer networks nationally. Snowballing and social media strategies were then undertaken from June 2021 to May 2022 resulting in n = 113 survey responses being received.

Data analysis

Quantitative responses from the five-point Likert scale questions were downloaded into excel spreadsheets and reported as descriptive statistics.

There were n = 86 open-ended responses to the question 'What are the most important skills that nurses need in mental health care?' and n = 78 responses to the question 'Is there anything else you would like to tell us to better prepare nurses to work in mental health settings?'. This rich qualitative data underwent content analysis using a directed approach with multiple members of the research team confirming findings (Hsieh & Shannon 2005).

RESULTS

Participants

A total of n = 113 respondents commenced the survey, and n = 95 completed all or most questions including 65 people who identified as consumers or consumers and 30 people who identified as carers, family, or supporters. Consumers reported an average of 17.5 years of experience (SD = 10.3) of involvement with mental health services, and supporters an average of 21.4 years (SD = 12.1). 93.8% of participants had direct contact with MHNs in the past 10 years, with 59% (N = 67) of those being within the past 2 years or less.

Responses to Question One: what percentage of their (MHN) training should be solely on mental health? Collectively, the mean response was 40.5% of the curriculum (SD = 22) with no significant difference between consumers or supporters.

Respondents were next presented with the following statement, 'Registered nurses currently need to be educated to a level that makes them safe clinicians for both physical and mental health needs' and invited on Question Two to express their preference for training on a five-point Likert scale from 'Strongly disagree' (1) to Strongly Agree (5). As illustrated in Table 1 the least supported modality for undergraduate MHN preparation was continuing current comprehensive training with an aggregate mean rating of 2. Those actively disagreeing (strongly and somewhat disagree) with continuing current comprehensive training was 73% of responding participants. The most supported modality for undergraduate MHN preparation was for nurses to train solely as MHNs with 81% of respondents somewhat or strongly in agreement ($M = 4$). Consumers endorsed this option significantly higher ($M = 4.4$ vs 3.6) than supporters ($t = 3.031$, $df = 92$, $P = 0.003$). There was also strong endorsement for registered nurses working in mental health to have post-graduate qualifications with 73% of respondents somewhat or strongly endorsing this option. The strongest overall support for any statement was to require people with lived experience of mental health difficulties to be part of the teaching team (91% support, $M = 4.7$). Consumers were significantly more in favour of this option ($M = 4.9$) than supporters ($M = 4.3$, $t = 3.184$, $df = 92$, $p = 0.002$).

Content analysis of open-ended questions reflected the survey findings with three clear themes.

Theme 1: Dissatisfaction with current preparation and the need for specialized training

Many respondents referenced specialty aspects of mental health nursing: 'I agree they should have their own degree. It is a very different area to physical health and there is a lot of grey areas'. A consumer respondent emphasized the importance of well-trained MHNs form their experiences:

> Those that know how to be really capable, do it consistently and help people in their lives, are not usually from Australia originally. This is sad and most likely because the training here is not adequate. Other nurses focus on giving out pills for every little distressing setback, measuring blood pressure, sugar levels, temperature, getting samples etc. It's general nursing, but often not what is needed, or it isn't enough. I am alive and thriving today because of good mental health nursing, and also despite bad mental health nursing.

Respondents referenced the quality of overseas specialist-trained MHNs from the United Kingdom where MHN has its own branch in undergraduate nurse education: 'Time to stop relying on overseas trained MH nurses from England, Ireland and Scotland. Start training our own'. The importance of specialist capabilities that was evident in the survey data was further reflected here:

> At the moment they rely heavily on sedatives because so many nurses are totally out of their depths and have

TABLE 1 *Modality of training*

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)	Combined mean score	Mean score for service users	Mean score for supporters
Continue with the comprehensive programme as it currently exists	40%	33%	19%	6%	2%	2.0	2.0	1.9
Continue with the comprehensive programme but with greatly increased mental health content	8%	9%	5%	32%	42%	3.9	4.0	3.7
Commence a programme for nurses to train solely as mental health nurses if that is their area of interest.	11%	6%	1%	20%	61%	4.0	4.4	3.6
Require registered nurses who work in mental health to complete mandatory post-graduate qualifications.	6%	5%	15%	26%	47%	4.0	4.1	3.9
Regardless of how registered nurses are prepared to work in mental health, people with lived experience of mental health difficulties should be members of the team teaching them	3%	1%	3%	8%	83%	4.7	4.9	4.3

> no skills to handle people who are in these states. Training to ensure that they have an understanding of how to deliver culturally appropriate care…. be an effective advocate ….and how to identify toxic families causing the patients' issues.

The need for specialist MHN preparation was evident through many responses listing multiple required skills for MHNs from the perspectives of consumers and supporters:

> Skills include a complete mental health assessment plus physical assessment. Decision making in mental health clinical care, obtaining a social history. Have the ability to recognize where trauma has impacted… Understanding relationship between alcohol and other drug use and mental health. Communication skills to work effectively with patients with mental ill health - who are likely to be vulnerable.

> Empathy, understanding and training in areas of childhood trauma. Being sensitive to the nature of discussion topics. Don't indicate you're in a rush. Make time to have 1:1 contact with each shift. Be knowledgeable about the medications prescribed, especially side effects. Check that client has been eating and is hydrated. Help client feel comfortable.

The impacts of insufficient specialist training were evident in consumer and carer comments seeking 'Training to ensure that MHNs they consider the whole person' and for basic expectations of MHNs such as 'needing training to understand the impact mental illness have on people' as well as for MHNs to have had training so that there 'should be no coercion no forced treatment, no solitary confinement'. The importance of specialized preparation extended into not just theory but placement experiences: 'Mandatory placements in both inpatient units and community mental health care settings. The stigma and myths around mental health nursing is absolutely crazy' and for nurses to have 'Exposure through undergraduate training to a number of mental health environments'.

Theme 2: Specialist skills enabling better relating

Content analysis indicated a strong consumer and supporter priority towards MHNs having specialist relational capabilities. This was powerfully encapsulated in this consumer response: 'They (MHNs) need to understand that healing happens in relationships'. The complexity of required MHN capability training was evident in the diversity of capabilities that underpin effective relating including 'Empathy. Curiosity. Kindness. Non-judgmental. Some would say these aren't skills, but I do believe they are and they can be strengthened through education' and 'Self-awareness, be perceptive, kindness, patience, compassion, ability to listen well'. These capabilities were frequently contextualized to crisis and critical events with many consumers identifying the importance for MHNs to apply relational skills in challenging contexts 'Genuine de-escalation skills, the ability to be calm and centred and constructively communicate with very distressed and psychotic patients', *and have calmness and ability to stay regulated in the face of dysregulated people*. Consumer responses indicated the importance of education to development of these relational skills:

> Show empathy and understanding and have the initiative to expand their knowledge on mental health and never think they know "enough" or have seen it all. There is always ways to improve the way you are for people, always

> Nurses should be trained in how to be supportive and build relationships. Consumers and Carers and often frightened. This can be misinterpreted as being rude or aggressive. Staff should be trained to recognize fear and to calm a situation

A frequent perspective that consumers and supporters identified to enable better therapeutic relating was to have training for MHNs that de-emphasized diagnostic labels 'Stop thinking about people only from the paradigm of the DSM', and 'Treating the patient as a person not just paperwork'.

Many consumers and their supporters identified that unless MHN undertake better self-care that they are less able to relate effectively: 'They need ongoing proactive support of their own mental health', and 'do self-care (for themselves), counselling if needed'. The poor mental health of MHNs was connected by respondents to negative experiences of care, 'The stress, frustration and fatigue of the nurses is making it hard for the patients', and 'they (MHNs) are paid money to "care" for others. Instead, they are burnt out, isolated, and this resonates to the patients'.

Theme 3: Support for lived experience input

As found in the survey data there was a theme within the consumer and supporter open-ended responses advocating for lived experience presence within MHN education:

> Have input and training from consumers of mental health with lived experience to help nurses better understand what it is like for the client. Consumers who have lived through it and had help and support from mental health nurses are the best people to advise on what can help improve things and share feedback.

Lived experience input into undergraduate nurse education was connected to empathic responding to consumers 'We can only truly empathise if we can connect to an experience, and we can only do that if we listen to people's lived experience' as well as having placements outside traditional in-patient settings 'Be taught by lecturers with lived experience and spend time with people with mental illness outside of acute settings'. Consumer also expressed the need for undergraduate nurses to have greater contact with them: 'Work with lived experience people to have a greater understanding of the complexes and diversity of mental health issues; one method will not treat all'.

DISCUSSION

This study aimed to identify the modalities and areas of capability development that graduate MHNs require, from the perspectives of end points users. Findings indicate that the current comprehensive nurse training is not meeting expectations of consumers or their allies. Additionally, there was a strong preference for direct mental health nurse undergraduate training. Greatly increasing the mental health content within the current comprehensive model also attracted strong support. These findings reflect previous studies of nursing graduates reporting they are insufficiently prepared to work in mental health (Happell *et al*. 2014; Happell & Cutcliffe 2011), as well as the views of leading MHN academics (Molloy *et al*. 2016) and the peak professional body in Australia, the Australian College of Mental Health Nurses (2018). The need for enhanced mental health clinical placements was also indicated in the findings. Current clinical placement arrangements in Australian settings are not meeting the needs of the students, consumers, or the services they are being placed within. Universities frequently use aged care settings as replacements for mental health and student experiences are not fostering a desire to work in mental health following graduation (Buus *et al*. 2020).

However, the strongest survey finding was that lived experience educators need to be members of teaching teams for undergraduate nurses. There is cross disciplinary and international recognition of the value of having lived experience inform mental health education. Having lived experience education experts influences future professional identity and triggers transformational learning (Ward *et al*. 2022). Additionally, it fosters hopeful recovery-orientated attitudes and reduces theory-practice gaps for students (Jack 2020). Importantly, having lived experience meaningfully integrated into mental health education improves consumer outcomes and reduces stigmatizing power differentials between professionals and consumers (Boaz *et al*. 2016; Boote *et al*. 2015). Despite this and recommendations for enhanced participation (National Mental Health Commission 2014), lived experience education in current Australian nurse education is largely absent, and where present is mostly tokenistic to satisfy bureaucratic needs (Happell *et al*. 2021).

Findings related to the required capability development of MHNs demonstrated the breadth and complexity of mental health nursing. All 18 capability areas (See Appendix 1) were considered important by respondents, demonstrating the complex and at times abstract nature of MHN work. The most emphasized areas for capability development could be clustered around emotional intelligence, namely those of empathy, self-awareness and emotional regulation. This reflects multiple previous studies linking these emotional intelligent capabilities to effective MHN clinical work (Powell *et al*. 2015), more successful MHN student clinical placements (Hurley *et al*. 2020a) and enhanced MHN resilience (Delgado *et al*. 2022; Foster *et al*. 2019a). Additionally, findings prioritized capabilities that enabled effective and valued engagement with consumers and their supportive networks, including adopting holistic, compassionate, and hopeful perspectives reflective of both recovery-based and trauma-informed principles. Findings also indicated that the efficacy of such approaches may be diminished where MHNs have not been educated on effective mental well-being self-care (Delgado *et al*. 2022). The delicate interplay of developing capabilities to effective relate and then also have medication, legislative, and psychotherapeutic knowledge while maintaining self-well-being far exceeds current outcomes from undergraduate preparation for MHNs (Happell *et al*. 2020; Happell & Cutcliffe 2011).

CONCLUSION

Australian reviews have shown the future for mental health services (Macleod 2022; State of Victoria 2018–

2021) that has specialty workforce embedded within the community, ramping up prevention, early intervention, and primary mental health. The need for tertiary mental health care is to be considered as not doing this early work well. Consumers and supporters from this and previous studies share the vison to educate MHN to develop capabilities for such service structures, arguably current nursing leadership in Australia does not. As a result, our graduate MHN workforce is not job-ready (Macleod 2022) and are diminishing in number, in part due to the lack of a specialist undergraduate preparation (Macleod 2022; Productivity Commission 2020). The current undergraduate/pre-registration nurse training arguably works very well for preparing medical and surgical nurses. However, it does not work for holistic care provision and preparing MHNs to provide effective care for consumers. It is a failed 30-year real-world experiment that we need to move on from, with some urgency. A four-year double degree as an additional pathway into the specialty is a MHN/RN is a very viable solution, given the protracted resistance to direct entry training (Happell *et al*. 2020). This maintains having physical health capabilities while offering enhanced MHN knowledge and skill development. However, this must allow the nurse to have the option to undertake MHN as a first degree to then 'top up' to comprehensive status. Oversight of such qualifications cannot sit solely within the same nursing bodies that has seen MHN capability education decay over the last 30 years.

The challenges for the MHN workforce are significant yet simultaneously potentially transformational. There has been an urgent need to grow the MHN workforce for nearly a decade, with no discernible growth with numbers remaining static at around 85fte per 100 000 population (Australian Institute of Health and Welfare (AIHW) 2022). This shortfall can be best addressed by offering a 4-year double degree for undergraduate entry and having allocations of mental health funding to support primary community-based MHN services (Lakeman *et al*. 2020). Clear practice standards for MHNs need to be developed to guide direct entry training, as well as the capabilities and roles that are evident in recommendations for future mental health workforce (State of Victoria 2018–2021). Such capability development would require not only taught theoretical content but also access to a diverse range of clinical placement settings (Foster *et al*. 2021).

RELEVANCE FOR CLINICAL PRACTICE

Unless adequately prepared, future MHN roles will be confined to small pockets of in-patient acute care. This would represent an astounding loss of workforce capability given the scope of practice a specialist MHN can undertake. A 4-year double degree will significantly add quality to MHN clinical practice and potentially grow workforce numbers into the future.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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APPENDIX 1:

PERSPECTIVES OF CARERS AND CONSUMERS ON THE PREPARATION OF MHNS

Perspectives of Carers and Consumers on the preparation of MHNs

Start of Block: Default Question Block

Info
Mental health nursing capability development: Perspectives of consumers and carers

Thank you for contributing to this anonymous survey. To have been invited to participate you will have had some experience working with nurses in a mental health service context.

Identity In what capacity have you worked with or encountered nurses working in mental health?

- ○ As a patient, service user, client or consumer (1)
- ○ As a family member, supporter or carer (2)

Info The following information may assist you to complete the survey questions:

To become a registered nurse in Australia you need complete a two to three year comprehensive training course at a university. There is no mandated minimum number of hours for taught mental health content theory, or for mental health clinical placement within these courses. Nurses graduate as "comprehensively trained" registered nurses and are considered to be prepared for safe practice across healthcare settings, including mental health.

Q1 Registered nurses currently need to be educated to a level that makes them safe clinicians for both physical and mental health needs.

	0 10 20 30 40 50 60 70 80 90 100
What percentage of their training should be solely on mental health? ()	

Q2 Please express your preference for how mental health nurses should be educated

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Continue with the comprehensive programme as it currently exists. (1)	○	○	○	○	○
Continue with the comprehensive programme but with greatly increased mental health content. (2)	○	○	○	○	○
Commence a programme for nurses to train solely as mental health nurses if that is their area of interest. (3)	○	○	○	○	○
Require registered nurses who work in mental health to complete mandatory post-graduate qualifications. (4)	○	○	○	○	○
Regardless of how registered nurses are prepared to work in mental health, people with lived experience of mental health difficulties should be members of the team teaching them (5)	○	○	○	○	○

Q3 The following questions ask you to indicate the importance for mental health nurses to have training in specific technical skills. Please indicate how important you perceive each skill to be for mental health nurses.

	Not at all important (1)	Slightly important (2)	Moderately important (3)	Very important (4)	Extremely important (5)
Counselling or focused psychological strategies (1)	○	○	○	○	○
Knowledge of medications used in mental health (2)	○	○	○	○	○
Working with families, carers or the person's supportive network (3)	○	○	○	○	○
Undertaking psychiatric assessments (4)	○	○	○	○	○
Undertaking risk assessments (5)	○	○	○	○	○
Responding to and intervening to prevent suicide (6)	○	○	○	○	○
Physical health assessment (7)	○	○	○	○	○
Physical health intervention (8)	○	○	○	○	○
Navigating the mental	○	○	○	○	○

health system (9)					
Working with children and youth (10)	○	○	○	○	○
Provide specialist advice to general practitioners and other non-specialists (11)	○	○	○	○	○
Supported decision making in human rights and legislation (An example of this is to maximise choice in consumers' lives) (13)	○	○	○	○	○
Advocacy for carers and consumers (An example of this would be to promote social inclusion) (15)	○	○	○	○	○
Critical thinking and self-reflection (17)	○	○	○	○	○
Conveying caring, empathy and understanding (18)	○	○	○	○	○
Respond effectively in	○	○	○	○	○
crisis situations (19)					
Work with people in their own home (20)	○	○	○	○	○

Q4 - Have you had a helpful experience with a mental health nurse?
Yes

No

Q5 - What did the nurse do that you found helpful?

_____
_____
_____
_____

These last questions are open ended so you can write as little or as much as you choose:

Q6 - What are the most important skills that nurses need in mental health care?

_____

_____

_____

_____

Q7- Is there anything else you would like to tell us to better prepare nurses to work in mental health settings?

_____

_____

_____

_____

_____

Thank you for completing this survey. On completion you will be offered the opportunity to receive information about the findings of this study. If you are not redirected you can access the request for more information here.

End of Block: Default Question Block