Accessible Summary

What is known on the subject

Studies portray sufficient evidence for the incorporation of psychosocial interventions (PSI) and PSI training for mental health nurses (MHN) in clinical practice settings.

What this paper adds to existing knowledge?

- Highlights the gap in knowledge on the topic of PSI in Ireland's changing mental health services.
- Explores Irish MHNs experiences of PSI in a range of mental health care settings.
- Highlights PSI skills training.
- Presents the similarities and differences in services.
- Presents the concerns of MHNs on the topic.
- PSI guidelines can make a difference in helping MHNs employ PSI in practice across both inpatient and community settings.

Implications for Mental Health Nursing

This study sheds light on how MHNs still closely attach themselves with the biomedical approach and that PSI offerings to clients are not consistent. This needs further examining if recent PSI developments such trauma-informed care and the recovery movement is be visible in the reality of MHNs day-to-day practice. In order to achieve this, the development of PSI universal guidelines are necessary, so that there are not different expectations in the mental health services in relation to nurses offering PSI. There is more to do, as MHNs strive to provide best evidence to enhancing client experiences and positive PSI recovery outcomes.

Description

The paper will report on the interview data of trained MHNs' experiences of using PSI within the Irish context. This observational data will be reported elsewhere (Smyth *et al*. 2020 – under review)

Introduction and Background

This paper presents findings of a qualitative study on the use of psychosocial interventions by mental health nurses in Ireland. Psychosocial interventions (PSI) are recognised and recommended internationally. Research evidence suggests that they are an essential factor in promoting recovery and preventing patient relapse and are therefore considered essential to the provision of effective mental health services (National Institute of Clinical Excellence [NICE] 2009, 2014). This is driven by policy in the United Kingdom (UK) (NICE 2002, 2009, 2014) but also in Ireland. Nonetheless, empirical research on clinical practice in Ireland and the UK shows that the uptake of PSI is limited (Gournay 1995, Fadden 1997, Farhell & Cotton 2002, Grey 2002, Sin & Scully 2008, Butler *et al.* 2013, McCluskey & de Vries 2020), despite these policy drivers.

There is no universally accepted type of PSI because of their broad diversity. PSI is an umbrella term that describes many different therapeutic models, including dialectical behaviour therapy (DBT), cognitive behaviour therapy (CBT) and interpersonal therapy (Turnton 2015). These models incorporate a variety of therapeutic techniques such as engagement, assessment, use of outcome measures, adherence to medication, relapse prevention and coping strategies (Mullen 2009). The different types of PSI can be classified into four different categories: psychologically/cognitively orientated; social; family interventionist; and educative (Morrissey *et al.* 2018). This diversity means that it is not always clear what is meant when the use of PSI is discussed in publications.

Seminal research conducted by Brown *et al.* (1972) and Zubin & Spring (1977) has been influential in the growth of PSI. Their work demonstrated the potential to develop interventions other than medication that could support clients to manage their lives in ways that lessen their tendency to develop psychiatric symptoms. As far back as the 1960s and the 1970s, psychosocial approaches and operant approaches, known as token economy strategies, were popular, as they improved the behaviour of patients in long-stay hospitals (Healy *et al.* 2006, cited in Gamble & Brennan 2006). In response to this existing research on different illnesses, it was highlighted that mental health professionals needed to be trained to meet the needs of clients. In the UK, the ‘Thorn’ programmes, which include PSI training initiatives, have been the most familiar model for training professionals.

Brooker *et al.* (1994) pioneered the first PSI training for community psychiatric nurses (CPNs) that became the blueprint for the development of PSI training across the UK. A key influential Irish report leading to these changes was that of the Commission of Nursing in 1998 (Government of Ireland 1998), which represented one of the major challenges to the discipline of mental health nursing. Consequently, since this report, mental health nures (MHNs) are now required to develop their roles and take on more expanded positions (Health Service Executive, [HSE] 2015).

Evidence shows that the management of mental illness should include PSI as an addendum to pharmacological interventions (Gilliam 2002, Monaghan *et al.* 2008), which is also supported in the Irish mental health commission (MHC) reports (MHC, 2015, HSE, 2017, 2019b). These reports further reinforce that there should be more treatment options and choices to reduce the dependence on medication and that PSI/ talking therapies are key to delivering recovery-focused care for people experiencing mental distress, and staff need to be highly trained. Research also reveals that the therapeutic role of MHNs may improve if nurses adopt PSI such as cognitive-behavioural therapy (CBT) in their daily work (Butler *et al.* 2013). When trained MHNs have a solid foundation in the different PSI skill sets, this knowledge allows nurses to support clients through recovery and provide them with a higher quality of care (Turton 2015).

PSI implementation by mental health nurses

While empirical evidence supports the use of PSI, there are on-going and persistent barriers to their delivery and implementation in practice across many countries. Studies from the UK, Australia, Italy and New Zealand have concluded that there was a lack of support from managers and organisations (Kavanagh *et al.* 1993, Devane *et al.* 1998, Bailey *et al.* 2003, Bowers *et al.* 2005b, Griffiths & Harris 2008). More recent studies conducted by Prytys *et al.* (2011) and Jolley *et al.* (2012) have continued to draw attention to barriers to implementation of PSI in the workplace after training, such as lack of protected time, heavy caseloads, high workload and lack of support.

In a UK study, McCann & Bowers (2005) evaluated the roll out of PSI training to qualified psychiatric nurses and unqualified mental health staff on seven acute psychiatric admission wards over a three-year period. Facilitating factors included supportive leadership and management styles,

sufficient training and clinical supervision. However, the barriers to PSI implementation were prominent. These involved delays in releasing nurses for the training; nurses who attended had difficulty engaging in the process, as the demands on the acute units were high. Moreover, the acute areas often had to rely on temporary staff that resulted in high staff turnover, which meant that there was an inconsistency in nurses' delivery of effective CBT or family interventions (FI). These findings are comparable with Fadden's (1997) and Sin & Scully's (2008) research, they found that workload demands and staff shortages were barriers to PSI application. Mullen (2009) highlighted that a tradition of custodial approaches to care and over-reliance on medication were the main barriers. The adverse side-effects of some medications, such as drowsiness, were also reported as a barrier, which meant that the medication effects worked against the MHNs engaging with clients (Sullivan *et al.* 2007).

A more recent study using semi-structured interviews with MHNs in acute settings in Ireland showed very little use of PSI (McCluskey and de Vries 2020). Among the obstacles to this were, like elsewhere, an overreliance on the use of medication, high caseloads, understaffing and lack of training. A less recent Irish quantitative study by Butler *et al.* (2013) specifically explored experiences of PSI-trained MHNs. This study (n=58) involved a mail survey aimed at MHNs who completed PSI training between 2005-2010 in one Irish training institution. While the results indicated statistically significant increases in the use of PSI overall following PSI training, core PSI interventions, in particular Cognitive Behavioural Therapy (CBT) and Family Interventions (FI), were not implemented often. On the positive side, other elements of PSI such as assessment and outcome measures and relapse prevention were utilised. Increased awareness of relapse indicators, improved coping skills and fewer inpatient admissions were all perceived positive outcomes for service users.

There is a dearth of more recent studies focused on PSI-trained MHNs in Ireland, so it is unclear whether subsequent developments have improved the situation. It is evident from policy papers (Department of Health & Children [DoH&C] (2006), MHC 2007, 2015, HSE 2012, 2013, 2015, 2017, 2019b) that this is considered a necessary step. The current reform of mental health governance in Ireland demands a clarification of the key skills and supports required MHNs to further increase and embrace recovery-orientated ways of working. Thus, the urgency to conduct new research on how

MHNs construct their use of PSI has never been more crucial. Therefore, this study functions as a response to the gap in knowledge within the Irish context on this important topic and has the potential to contribute to a clearer understanding of MHNs' experiences of PSI going forward for Irish mental health services.

Aim and objectives

This paper explores PSI-trained MHNs' experiences of using PSI within Ireland. The objectives included exploring an understanding and interpretation of PSI; perspectives on knowledge and skills; factors that help or hinder using PSI; similarities and differences in experiences.

Method

Design

A multiple case study approach (Stake 1995) was adopted which provided a useful investigative methodology that was well-placed to capture the multiplicity of perspectives, especially where the researcher had no control over such as they unfolded during the research (Stake 1995, Richie & Lewis 2003), and it helped provide explanations of the participants perspective in their 'real' settings (Yin 2014). The interpretive paradigm as the underpinning philosophical approach (Denzin & Lincoln 2003) provided a practical framework to guide the researcher's entry (SS) into the research field.

Sample and setting

Forty PSI-trained nurses were interviewed as part of a larger study (Smyth 2017). The research sites were both inpatient and community that included two rural and two urban settings (Table 1). In this study, the focus on case selection was to select MHNs who were trained PSI-nurses in four cases that constituted the research sites where the nurses worked and who were currently using PSI as an integral element of their practice (Table 2).

[INSERT TABLE 1 HERE]

[INSERT TABLE 2 HERE]

Access to participants was gained via the Directors of Nursing. Following this, the letter of invitation along with a participant detailed information leaflet and a consent form were sent to the participants. Once a response was received from nurses indicating an interest in being involved in the study, potential participants were contacted via email or telephone; suitable times and dates were arranged. The inclusion criterion for involvement was talked through with the participants prior to arranging the times. The inclusion and exclusion criteria were developed using the population, intervention, comparison and outcome (PICO) model (Sacket *et al.* 1997) (Table 3).

[INSERT TABLE 3 HERE]

Data collection

Semi-structured interviews were conducted as they were considered key to enable each MHN who had the relevant PSI experiences to share their story (Charmaz 2006). The interview guide is provided in Table 4.

[INSERT TABLE 4 HERE]

Ethical aspects and approval

Ethical approval was sought from the appropriate University Research Ethical Committee and the four clinical research sites. The ethical principles of the Helsinki Declaration (World Medical Organisation 1964) governing research with human subjects guided this research; at all times, the participants' wellbeing was given priority over this research study.

Data analysis

In keeping with the interpretive paradigm, Ritchie & Spencer's (1994) five stage framework provided the method for the interview analysis (Table 5). An audit trail was kept (Lincoln & Guba's 1985) as part of measures to ensure trustworthiness and credibility of the study.

[INSERT TABLE 5 HERE]

The interviews were transcribed verbatim. While the assistance of a transcriber was sought, the majority was performed by the primary researcher (SS) to enhance immersion in the data and to add to the depth of the analysis. All data were imported into the date management software programme NVivo for analysis (Bazeley 2007, Bazeley & Jackson 2013).

Findings

Three overarching themes were derived (Table 6). With each overarching theme excerpts of the interviews are included to highlight the salient issues, and identified by case number and participant identifier (e.g. case 1, participant 22).

[INSERT TABLE 6 HERE]

Theme 1: PSI-Trained MHNs' Understanding and Use of PSI

This first overarching theme represents the nurses' understandings of PSI, defined by the participants as interventions that include a range of *formal* and *informal* approaches. The participants reported mixed understandings comprising positive and negative aspects in relation to using PSI in their daily work. The *formal* types, as described by the participants, mainly include CBT, recovery and family type interventions (FI). The *informal* PSI approaches that were identified comprised medication adherence and monitoring, psychoeducation, relapse prevention and intervention, and educational type programmes.

Sub-theme 1: Formal and Individualised Application of PSI

This sub-theme is defined by participants as including types of PSI that have a formality attached to them, in terms of structure and delivery, and are usually utilised on a one-to-one basis or in groups to clients. The MHNs had undertaken PSI-specialised training such as CBT and were well-experienced with high levels of clinical skills that are required to implement the structure and planning attached to these formal types of interventions. There was reference made to CBT about their understanding of a

formal structured CBT session. CBT is a collaborative approach with the client and entails active engagement both in and outside the therapy sessions, as detailed by this participant, '*The session would be structured … at the beginning of the session, what the last session did, or a piece of homework that you had planned together ... the task … say the depressed client, an activity schedule … a few sheets of a couple of days that they charted. And what you might find is they are actually doing a little bit more than they thought, and they have increased their activity a little bit … that might then have an impact on their mood. … or they might come with their own agenda … the end of the session … what would they like to focus on between now and the next session? … setting a task; or homework* …' (case 3, participant 10). This excerpt highlights that the MHN takes the lead from the client and, from this, the CBT components, such as reflections on homework, will be determined.

Also, those participants who had experience offering CBT components described these interventions as being delivered within a rigid structure and based on evidence. However, this may not be always the case as the rigid form may not be suitable for some clients. In this situation, nurses need knowledge and experience of being able to dip into other approaches, depending on the needs of their clients, as illustrated by this participant, *'... I tried to stick rigidly to this sort of formulating the problem, as the CBT therapist … using the cognitive model … using the research-based methods … over the years I have realised that not everybody fulfils the model, or the illness model as I would like to see it, nothing is very clear-cut ...'* (case 3, participant 14).

Sub-theme 2: Informal, Unstructured and Individualised Use of PSI

These PSI types are delivered by MHNs in an unstructured fashion and considers PSI as generally accepted to be much broader than the formal CBT or family work. These can even include from *'... having a conversation with service users …'* (case 3, participant 10), to daily activity monitoring, giving time, engagement, assessment, problem-solving, medication management and providing education, of which offer meaningful interventions to meet the needs of some client groups. For example, one participant commented by explaining that informal types of PSI cover nearly everything that nurses do with clients, *'... we might use medication boxes … just to keep it … as simple for them*

… Everything [medications] would be filled out with them [patients] … depending on how well or unwell they are. But, you would always be explaining it to them and the family, what you are doing, all the time …' (case 4, participant 19).

Some participants discussed that the MHN role is about the client and nurse working together; this involves setting clear goals with the client to work on, '*… it is very important that you are on the same page as somebody, but we would always strive for clear goals with [clients]'* (case 4, participant 19). While it is important to work collaboratively, the issue of trust was also important for many participants. The reason is that, when trust is established within a therapeutic relationship, this offers the MHN the ability to engage with clients in a meaningful way, as one participant described, *'... I think PSI are really interventions that are carried out that act on the best nature of the patient'* (case 3, participant 9).

Theme 2: Facilitating Factors Supporting Use of PSI by PSI-trained MHNs

This second overarching theme describes the facilitating factors in the delivery and implementation of PSI methods. The faithful implementation of PSI is dependent on a range of supports in MHN workplaces.

Sub-theme 1: Supportive Culture and Working Environment

MHNs need to work in an environment in which there is a culture of supporting and developing PSI-nurses. Participants frequently mentioned elements relating to 'support from managers, colleagues, and multidisciplinary teams (MDTs)', 'PSI guidelines', 'clinical supervision', 'confidence and autonomy of nurses', 'role fulfilment' and 'time', *'... you have staff that has an interest in developing and staff that is interested in starting something new … and being able to then go out and try it [PSI]'* (case 1, participant 39).

In particular, participants in one research setting who worked in inpatient and community settings spoke strongly about the benefit of having local PSI guidelines in place. There was an agreement that PSI guidelines can provide direction supported by evidence and a delivery pathway for the offering

and delivery of different types of PSI. Some participants identified that these guidelines promote an expectation that every patient should have a one-to-one PSI daily. As this participant articulated, *'... the guidelines are written on the walls that each patient is due his one-to-one psychosocial intervention daily ... we have guidelines of how to write it [PSI] into the nursing document ... on how to deliver a one-to-one PSI session'* (case 1, participant 22). This view was further supported by another participant, *'... it [PSI] is an expectation, but it is an expectation that everyone would embrace'* (case 1, participant 24).

Many participants also expressed similar views about how managers in the services have a pivotal role in supporting and prioritising how PSI be delivered and implemented in the reality of practice. A MHN participant described how PSI should be safeguarded and prioritised, commenting that *'[PSI] has to be ring-fenced ... there has to be an expectation rather than it being a luxury ... so, on an adult inpatient unit, it should be that you will deliver at least these sorts of groups ...'* (case 4, participant 17).

Additionally, data showed that nurses who work in community settings are not as constrained by time to conduct PSI compared with nurses in the inpatient settings. As one participant reported, '… *you see your people by appointments ... in the hospital setting you have to manage your time a bit better maybe, and set aside time to do your PSI'* (case 4, participant 20). Another participant highlighted, '*I think it is much easier in a community setting; you are much more able to allocate time to it [PSI], ... if it's a group coming to attend a group, or if you are doing individual stuff there is an expectation; this is what you are coming out to do ...'* (case 4, participant 17). This leads to *'... the conclusion that when MHNs have time, this allows them the space to focus on using PSI, and also the clients know what to expect coming to PSI sessions*' (case 1 participant 37).

Moreover, many of the participants commented on the value of clinical supervision. Of the 40 PSI-nurses, only nine received clinical supervision (six of whom were located in one setting). They spoke about clinical supervision as support from one another as it was beneficial in deliberating over clinical issues and clarifying concerns as regards clients on their caseloads. As reported by a participant, *'... just cushions [clinical supervision] really, it [clinical supervision] just works. Because you need it [clinical supervision] ... you need it working with peoples' lives'* (case 3, participant 11). Another

participant remarked, *'... survival ... would probably be the first thing I'd say, at a personal level. I'm blessed that I have a lot of supervision ...*' (case 4, participant 1).

Sub-theme 2: Educational Needs and Training

This sub-theme describe how postgraduate education and training can positively encourage and influence PSI-nurses. One participant stated, *'... the post-grad; it did develop us ... because that was the main concept of the course [PSI] so I think my training did change my perspective ... I am utilising PSI within practice'* (case 1, participant 38).

However, some participants referred to the decreased time that MHNs have for partaking in further education and training. One participant reported, '*Barriers would probably be to do with time and the management ... they probably should start encouraging us or letting us have protected time each week, where you would look at some literature, or start looking at evidence-based practice …*' (case 4, participant 19).

MHN participants also had concerns in relation to education and the knowledge base of nurses. One participant recalled that MHNs are not sufficiently educated, stating that '… *the education requirement for staff is very, very low as well. We are not educated ... we are carrying it through from our experience and what we have picked up maybe from consultants, from the small one day course …'the medical model is still a huge dominance and there is still that lack of challenging ability*' (case 3, participant 9). Furthermore, some nurses feel devalued by doctors, as they appear not to have the appropriate psychopharmacological knowledge, ' … *there is a lack of confidence there as regards to actually delivering it [PSI] ... that we haven't studied the relevant psychopharmacology, so there was no way that we could actually carry that forward'* (case 3, participant 9).

Theme 3: Obstacles Limiting the Use of PSI by PSI-trained MHNs

The final overarching theme defines the obstacles that limit nurses practising PSI in their workplaces.

Subtheme 1: Pressured and Constrained Working Environment

The reality is that MHNs often face many obstacles due to increased pressures of staff shortages in both community and inpatient settings and the reduction of beds within the services. In particular, in inpatient settings, nurses multitask and there is an expectation that some PSI-nurses will manage acute units as well as coordinating a caseload of clients. As one participant stated, *'[we are] exceptionally busy because we have had a reduction in beds. So, … our reduction in staff as well … so you are multitasking … trying to manage the ward … a caseload*' (case 3, participant 9).

Often MHNs working at the front line in inpatient settings feel isolated and fearful, as the need to keep each other safe is important. This means that PSI will not be consistently offered to clients or indeed be considered, as the focus for the MHNs is to get through day-to-day practice, ensuring that the work environment is as safe as possible for staff and clients. '… *we are at the front line of the war and we are just keeping ourselves safe and that is what we are doing …*' (case 4, participant 2).

In contrast, MHNs working in community settings face concerns about large caseloads. The demands of large caseloads mean that nurses have less time with clients and stretch themselves thin, as they have to prioritise whom they care for, '… *you could quite easily have a thousand clients on your list … you are restricted in a sense that there are only a certain amount of people that you can see within that time frame, so you very much have to prioritise'* (case 1, participant 39).

Sub-theme 2: Challenges with Engaging Unwell Service Users

MHNs face challenges of engaging in their day-to-day practice with a mixed population of service users with varying degrees of mental health issues. Specifically, in the context of inpatient settings, MHNs' observations and duties are significantly taken up by the legal status and admission circumstances of clients rather than the use of PSI. This, in turn, can frustrate and distress clients, as they often feel that they have lost their rights to freedom and choice in their psychiatric treatment. Additionally, some service users may disagree with their medical diagnosis, resist being detained and disagree with taking prescribed medications, or indeed wish to decline the offer of any kind of therapeutic interventions.

The data across both the inpatient and community settings highlighted how MHNs can be constrained by the type of PSI that they plan with service users. As one participant mentioned, *'I think you cannot have a "one size fits all", you can have the fundamentals … but that does have to be tailored and adapted to the individual and their circumstances*' (case 1, participant 39). Other common responses from participants working in inpatient environments reported that some MHNs are still in favour of offering medications to clients, '… *there is no other way except for medication [nurses see medication as the main treatment for clients], I feel that you would often be told that "Look, they're never going to change, and this is not going to change for them, and don't waste your time trying to figure out why they are doing it*" …' (case 4, participant 20). One could suggest that some MHNs still rely on medication, but the motive could be that the care in the context of the nurse's work is directed to medication and medically-led, as summed up by this participant: '*From working in both areas, in the inpatients and in the community setting … I could honestly say that I have not seen much PSI in the inpatient setting. Because it is very routine, it is very busy … I think it is all very medicated focused, very consultant focused* …' (case 4, participant 18).

Discussion

Across settings, there were many similarities and differences within the findings. The first theme identified similar understandings shared by participants of PSI in which many attributed PSI to recovery. Overall, MHNs had good knowledge of the wider ranges of PSI. A distinction was made between formal and informal PSI. Other similarities included the need for longer type courses so that in-depth practice of taught PSI skills are delivered, as the shorter type courses limit MHNs' use of PSI, as the trainees are not fully equipped with the necessary PSI knowledge and skills. This supports evidence that also found that eduction and training alone in relation to hearing voices does not provide the solution (McCluskey & de Vries 2020).

The findings in theme 1 convey that many MHNs had experienced difficulty obtaining work release from practice particularly within inpatient settings to undertake further supplementary training on PSI. Some participants reported that management does not often acknowledge the importance of

PSI supplementary sessions; hence, many of the nurses reported that they do not get enough organisational support to do their job adequately. This can result in many of the participants having less confidence in practicing the skills with their client groups. These findings are consistent with an Irish study conducted by Gaffey & Cooney (2014) that also showed that staff had little support in terms of attending educational programmes for recovery. The question here could be how can PSI training for staff play a pivotal role in transitioning services from a traditional model to a recovery approach to service delivery. One could argue that the discouragement shown by management from releasing MHNs for training and education facilitate and strengthen the dominance of the medical model in care delivery, thus reducing the power/autonomy of MHNs. This issue reflects a qualitative study that reported that a psychiatrist did not always trust the assessment skills of some MHNs and insists assessing the patient himself (Elsom *et al.* 2007). A more recent study indicates that MHNs are also often limited by the system they work (McCluskey & de Vries 2020).

Another similarlity in the findings was MHNs tend to use every strategy that would appear meaningful by including almost everything they do under the PSI remit, suggesting a rather general and non-specific perspective on what PSI entails. This could be due to lack of confidence in their knowledge and PSI skills. Also, participants in three of the sites showed little weight on the less structured PSI approaches across both settings. One could suggest that the practical demands of clients are very immense when they engage in the formal types of PSI.

In the second theme, the participants reported that clinical supervision was pivotal in supporting the success of PSI implementation. However, a difference was that only one setting had access to ongoing clinical supervision. This setting has mainly nurses who work as cognitive behavioural therapists in community settings. A possible explanation is that there is a mandatory requirement for therapists to seek on-going clinical supervision post-CBT training. While, the inpatient nurses who had completed the generic PSI type training had no mandatory requirements for on-going supervision. The nurses who had regular clinical supervision reported that they had the ability to enhance their PSI skills; therefore, this led to an increase in their confidence in implementing PSI with their client groups.

Other similar PSI studies found that mental health professionals' taught skills increase when they are in receipt of regular clinical supervision in their workplaces (Repper 1998, Milne *et al.* 2001, Bradshaw 2002, Sin & Scully 2008, Butler *et al*. 2013).

The second theme also suggests that local PSI guidelines facilitate the implementation of PSI in practice settings. These PSI guidelines can offer expectations in the services that all MHNs utilise psychosocial skills into routine daily practice with their clients. A recommendation made in Butler *et al*.'s (2013) study was the need to support PSI guidelines. Thus, the development of PSI guidelines would provide nurses the evidence base in offering PSI in their daily work, which supports the NICE (2014) clinical guidelines.

The third theme revealed similarities across sites in relation to the importance of recovery policies in developing Irish mental health services (DoH&C 2006, MHC 2007). Both the inpatient and community settings seem to remain encapsulated by the biomedical paradigm of care. Particularly, MHNs in the inpatient setting position themselves closely with the biomedical model of care, suggesting that medication is still very much the focus and that there is a culture of over-reliance on medication prescribed by psychiatrists. This finding concurs with a recent study by Goodwin *et al*. (2020) that found that MHNs still have a preference for a medical approach to care delivery. Thus, this impacts negatively on how MHNs' offer PSI. Also, similar responses showed that modern MHNs are challenged in that recovery and PSI principles do not fit well with the former medical model. The Irish MHC survey (2007) support these findings, which highlighted that the medical model was still dominant and, thus, a barrier in promoting recovery-orientated practices. This is also consistent with a publication on behalf of psychiatric/mental health nursing in Ireland (HSE 2012) that stated that the medicalised approach to care is still very much apparent within Irish mental health services. This finding is also comparable with existing literature that show that inpatient services can still be over-reliant on the medical approach to practice (Cutcliffe & Stephenson 2008, Marsh 2010, McCluskey & de Vries 2020). Evidence shows that medication activities are ranked highest, with more time devoted to administering medications and a very small amount to providing medication-related psychoeducation (Goulter e*t al.* 2015). Thus, the question is, if the biomedical approach remains in its current form, how can recent PSI developments such as the recovery trauma-informed care

framework be visible in the reality of MHNs day-to-day practice? A recommendation would be that MHNs need to be addressing these elements and adhering to their NMBI (2014) scope of practice.

Another similarity in theme three was the effects of workloads in relation to extra responsibilities outside the participants PSI roles and high caseload numbers. Many of the participants expressed unease about how workloads and high caseload numbers were deterrents to embracing PSI. Not unexpectedly, these findings reinforce earlier research that highlighted a low presence of PSI due to increased workloads/caseloads within services, including acute inpatient units (Cleary *et al.* 1999, McCann & Bowers 2005, Butler *et al.* 2013). The difference was that MHNs on in-patient units were bound by busy routines particularly that were too focused on stressful task-orientated duties. Consequently, these busy routines tend to prevent PSI happening. This finding is also comparable with existing studies (Sin & Scully 2008, Thibault *et al.* 2010; McCluskey & de Vries, 2020) that refers to acute in-patient units being busy, chaotic, and increasingly challenging in the context of acute psychiatric care. It is also reasonable to conclude that, if there were more focus on one-to-one PSI sessions, this would reduce MHNs being too absorbed with the task-orientated activities, particularly within the inpatient settings. The difference for MHNs who worked in the community settings reported having more time and had not the pressure of the stressful task-orientated duties.

One Irish study has referred to mental health settings as being very restrictive in that their climate and culture reflects that of a 'mini-institution' in which only a few therapies or activities were offered (Tedstone Doherty *et al.* 2008, p. 8). This echoes theme 3 findings, in which some MHNs conveyed that they were often obstructed in delivering PSI due to the pressured and constrained working environments in which they worked, and the constant interruptions while working, and whereby MHNs have a responsibility to keep the environment safe where lives are at stake. The difference for the MHNs in the community was that they did not have the same demands and had more autonomy over their workload.

Study Strengths and Limitations

Although while the qualitative nature of this study's findings means that they are in principle limited in their application to the group of participants studied, it is important to take into account that

participants worked in a range of mental health settings over large geographical sites. Thus it is highly possible that the findings have common application across other mental health care settings.

Secondly, while there was the potential for interviewer bias, strategies such as an interview guide was put in place to avoid this from the onset to ensure that the study was conducted transparently. The interview guide ensured that each MHN had the opportunity to tell their story in the same way, while all nurses were invited to add anything they wished at the end of the interview. Following interviews, some participants were asked to confirm findings, and finally an experienced nurse researcher was asked to review the extent to which themes were representative of the data. This supports evidence that suggests that data confirmation enhances the credibility of findings (Murphy & Casey 2009).

Conclusion

Given the evidence in this study, there are significant findings that show the current practice of offering PSI to clients may not be enough. PSI nurses are often stuck between a rock and a hard place; on one hand, the MHNs were generally positive and supportive of the need to use PSI with their client groups in line with the recovery policies to care delivery. On the other hand there was a sense of discontent with the lack of PSI updating with the challenge on how to continue supporting PSI-nurses after training to positively influence practice in a recovery-orientated approach or indeed how best to prepare trainees to be PSI-orientated lynchpins in systems of care, as the dominance of the biomedical discourse in contemporary mental health care is still featuring in the services. This certainly can affect client outcomes in that some clients will have PSI offered, while other clients will not as they could be in environments where there is little scope for nurses to offer PSI on a consistent basis.

Thus, the results of this study allow us to glean important similaries and differences on the offering of PSI in Irish mental health services and questions if MHNs are able to deliver PSI in current reccovery practices. It is hoped that these study findings help to provide further clarity to clinicians, researchers and policymakers about MHNs' delivery of PSI. However, there is more to do, as MHNs strive to provide best evidence to enhancing client experiences and positive PSI recovery outcome.

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