The role of research in the mental health nurse consultant

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ABSTRACT

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The non-medical nurse consultant was introduced in 1999 (National Health Service Executive, 1999; Scottish Executive Health Department, 1999; 2001). Its function was to provide and influence high-level expert practice, policy and service delivery. It identified four core functions:

- Expert clinical practice
- Professional leadership and consultancy
- Education, training and development
- Practice and service development, research and evaluation.

This article evaluates the role of research in current mental health nurse consultant practice.

Background

There have been a number of studies evaluating the impact of the nurse consultant (NC). Mullen et al (2011) used a multi-method study including literature review, questionnaires and focus groups with current NCs to evaluate their impact upon practice. They found the role to be effective across the core functions, particularly in relation to quality improvement, productivity and service effectiveness. Research came towards the bottom of the list of activities (*Figure 1*), virtually equivalent with operational activities, which were not originally conceived as an aspect of the nurse consultant role.

Mullen et al (2011) found research to be one of the least significant aspects of the nurse consultant's role. This is a consistent finding in the literature, and one of the reasons Currey et al (2011) called for a specialist nurse research consultant to address the issue in Australia. While this call is rational, it does not address the apparently general finding that nurse consultants are not doing as much research activity as originally envisaged (Ball, 2005). It does not mitigate the underlying need for nurse consultants to undertake original research to continuously improve practice or add to clinical knowledge.

Kennedy et al (2012) writing in the *Journal of Advanced Nursing*, noted research activity was not even explicitly stated as an important aspect of NC activity. Kennedy et al (2012) conducted a systematic review on the impact of the NC role in the UK, concluding that there was evidence for positive impact, but that the quality of the evidence was weak. By omission this review gives the strong impression that research is not an explicitly important aspect of the NC role. Their recommendations identify plenty of research projects exploring the impact of the NC role, but describe these recommendations as something 'researchers' (Kennedy et al, 2012: 20) should be doing: we would strongly suggest that these 'researchers' should also be the NCs.

Woodward et al (2005), the only authors to focus on the NC research role, found NCs to be underprepared and insufficiently skilled in both undertaking and disseminating research findings. They found that many had presented at conferences and most had got requisite masters level study, but few had published or intended to publish their research (Woodward et al,

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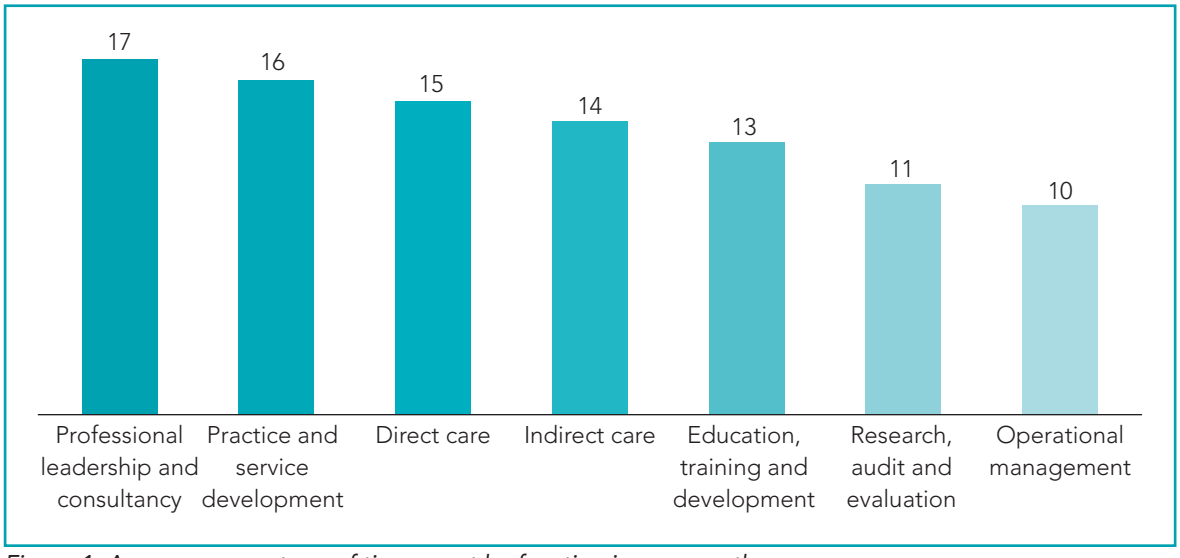


Figure 1. Average percentage of time spent by function in one month

2006a). The domain that all NCs in this study found the most difficult was undertaking research themselves. Most NCs explicitly prioritised clinical work, and there was wide agreement that managers undervalued non clinical work. One consultant commented: 'Nobody's said to me, 'Why haven't you done any research yet?'' (Woodward et al, 2006a: 275), the culture of the NHS made it difficult to be seen doing anything other than clinical work (Woodward et al, 2006b)

In line with Mullen et al (2011), Woodward et al (2006b) found those NCs with strong links to universities to be the most research active. In their sample of 10, only one post holder was jointly employed by an NHS trust and a university, with 20% of her salary paid by the university. The practical advantage of this was clear however. She described her role as 20% research, suggesting a straightforward capacity for quantification according to funding. This separation of research activity from the rest of the role may therefore be a way forward at present, or may perpetuate the false dichotomy between the clinical and research pillars.

The basis for the focus group which underpins this paper is the premise that, in line with the stated core functions of the role, NCs should be undertaking, disseminating and publishing research to support the contemporary clinical practice in their own clinical delivery and that of others. However as noted above, many feel underprepared for this, do not see the value of it or have the time to do it, and have increasing managerial aspects to their role that were not originally intended. The current literature does little to explicitly support the importance of research to the NC role, despite calling for better research about the NC role. This paper seeks to study the impact of this position to mental health nurse consultants in Scotland.

Aim

To articulate the place and function of research in a cohort of mental health nurse consultant nurses in Scotland.

Objectives

- Establish what is referred to as research activity
- Establish the level of current research activity
- Establish the benefits of research activity to this group
- Establish the barriers to research activity
- Develop an ideal for the place of research in clinical practice.

Method

The Mental Health Nursing Forum Scotland members are senior nurse leaders, consultant nurses and academic colleagues from every region of Scotland, including NHS Education Scotland (NES), the Chief Nursing Officer's team (SG) and the Mental Welfare Commission for Scotland (MWC). It was the Expert Reference Group to the national review of mental health nursing in Scotland (Rights, Relationships and Recovery, Scottish Executive, 2006).

The focus group comprised five nurse consultants from clinical practice, three associate nurse directors, four academics from Scottish universities, three nurse managers, senior nurse leaders from NHS Education Scotland, the Scottish Government and Mental Welfare Commission for Scotland. The focus group was conducted under the Chatham House rule (Horton, 2010) so as to facilitate candid views. With the explicit consent of those present a digital recording of the group interactions was made and transcribed by Austyn Snowden (AS) and analysed by all three authors (Cutcliffe et al, 2009).

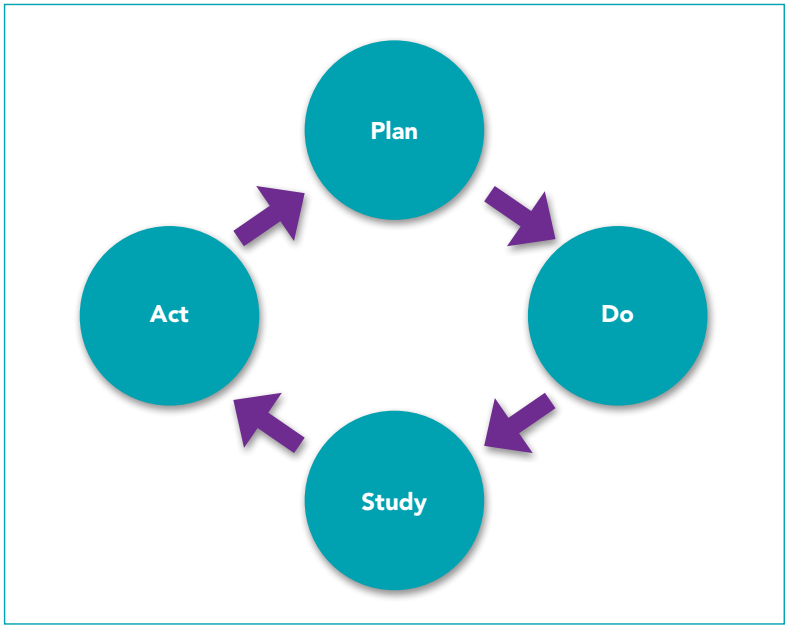


Figure 2. Plan, Do, Study, Act

Results

The background presentation (by AS) sparked a lively discussion prior to the focus on research, particularly as operational aspects that were seen as both a benefit and a hindrance to the role. There was an element of frustration at this position, best expressed by the phrase 'toothless tiger' in reference to instances where the nurse consultant had no operational accountability. However, this was counterbalanced with the acknowledgement that the ability to influence without authority (Bennis, 1989; Mintzberg, 1999; Day and Harrison, 2007; Alimo-Metcalfe and Bradley, 2008) remained a critical aspect of the role: a construct/attribute not reserved solely for the nursing profession (Ham and Dickinson, 2008; Edmonstone, 2011). Research was seen as a valid method of overcoming this perceived 'toothlessness', primarily because it was assumed that research active nurse consultants would be better valued as a source of expert contemporary evidence in relation to their particular speciality.

It was also pointed out that Scottish nurse consultants had evolved somewhat different to the mainly English evidence presented in the above. In Scotland, for every individual NC post to be created a case had to be made to the chief nursing officer detailing the impact the role would have. This suggested that metrics for success should have been built into these proposals, which in turn suggested that research activity should have been particularly integral to the role in Scotland. Unfortunately, this turned out to be only partially true.

Results of the focus group

1. Establish what is referred to as research activity

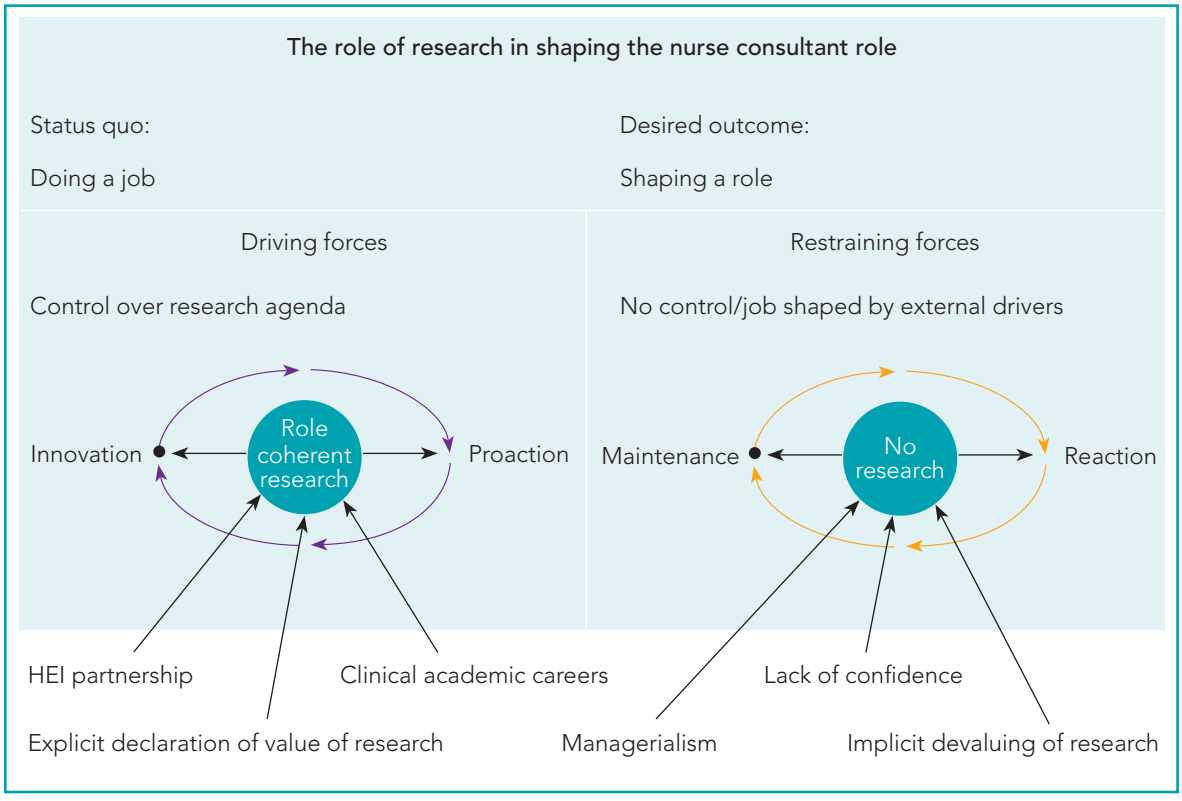
There was a discussion on the distinction between audit, evaluation and research. The conclusion was that all investigative activity was useful and it sat on a spectrum, from small and simple audits to large multicentre research projects. Improvement methodologies such as Scottish Patient Safety Programme PDSA cycles (Plan, Do, Study, Act) (*Figure 2*), active methods of rapid cycling, mall research steps in practice, that have their value and place.

This pragmatic view of research (Rorty, 1982; Isaacs et al, 2009) prioritises utility over epistemological distinctions. If investigative enquiry is clinically useful then it is valuable research. Nevertheless epistemological distinctions were recognised as important, and the importance of understanding the politics and methodological suppositions of research hierarchies for the purpose of credibility of claims to knowledge. That is, although mental health nursing does not and should not necessarily lend itself to randomised controlled trials, the advantages of constructing such studies was recognised as part of the decision making process in establishing the best way to address any research question (Scottish Intercollegiate Guidelines Network, 2010; Cawthorne & Barron, 2012).

Clinical governance was considered as potentially constraining genuine enquiry, shifting the balance away from difficult questions such as 'how do we help people?' towards more easily auditable questions such as 'how do we measure what we are doing?'. In this regard there is a tendency to measure what can be measured, rather than what is necessarily important. The role of the nurse consultant therefore,in relation to research activity, is to keep on top of these issues and recognise the interplay and impact of various political, professional and philosophical factors.

2. Establish current research activity

The group demonstrated academic activity from masters completions to clinical doctorate training, incorporating a range of publication activity. There was acknowledgement that some had difficulty in writing their work up for publication, and obtaining funding for further research, although not through lack of funds being available, more related to the lack of focus on this aspect of their role. A discussion on 'partnership' broadly concluded, that those NC posts affiliated and part funded by universities were more likely to publish and have access to successful funding than those that did not have this formal resource.



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3. Establish the benefits of research activity to this group

The benefits were clear to the NCs. They valued research as activity in itself and all had their own areas interests. Where activity had demonstrated improvements in clinical practice this had enhanced their capacity to facilitate positive change. They saw the benefit of learning something new and were drawn to it because it was difficult; a challenge to them. They saw research as enhancing their credibility as clinicians and also in furthering their careers. The most highly valued activity was that which was synergistic with their other clinical focus. This activity also supported them in unpick presuppositions inherent in day to day practice. They saw research as a method to challenge poor practice and to question the benefit and harm of current clinical practices. The value of research was greatest when it was integral to the role of the NC. Research meant learning something new, challenging oneself and leading by example.

4. Establish the barriers to research activity

The barriers were closely related to the benefits, some challenges could appear overwhelming. For example a PhD was considered by some to be very difficult to envisage. The main personal barriers pertained to confidence and perceived personal gain. Organisational barriers e.g. little/no dedicated time and funding, alongside profession specific barriers were also noted. Whilst medics and psychologists have considerable funding to develop high quality research, this did not appear to be the case in nursing in general, an issue highlighted by Barker & Ritter as far back as 1997.

This led on to a discussion about whether nurses at this level should be expected to spend some of their personal time writing for peer reviewed publication as a core professional (as opposed to operational) aspect of their role. Certainly all the people with multiple publications did this. The idea was questioned, and the suggestion that people should be expected to work in their non work time was not unanimously popular, although this discussion concluded that optimal work/life balance is a function of happiness with that balance (Eijnatten & Vos, 2002; Boniwell, 2005), rather than any simplistic objective criteria.

The perceived barriers to writing up 'current work' included time and confidence, lack of experience in how to write for publication; which journal to target and why, how to handle reviewer comments etc. In this regard experienced partners were seen as essential to raise the potential quality of the work. There was a sense that some of the research findings of the group were not particularly strong and they only wanted to publish 'important' findings. There was also confusion as to who owned certain data for the purpose of publication, and what to do with negative findings. There was also the persistent undercurrent that research takes some NCs away from what they consider

KEY POINTS

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to be direct care. For example according to Balas and Boren (2000) it takes 17 years to implement 14% of research into practice, which in itself underlines the relative lack of importance the research has on the day to day clinical practice.

In summary the barriers pertained to issues of individual confidence and commitment within the context of the wider research culture. This was compounded by the anecdotal claim that mental health nurses take their skills and competence for granted, and thus do not necessarily see the value in developing evidence of work they see as routine. This requires academic maturity currently seen as lacking.

Figure 3 encapsulates the positive and negative drivers impacting on the research activities of the nurse consultant cohort.

5. Develop ideal for research in clinical practice

It was felt that the ideal place of research would be coherent with the individual's specialism and integral to their role. The type of research activity would be cyclical and directly relevant to 'where the post is at'. There was unanimous agreement that research should be better valued, supported and facilitated. The idea of separating out the task of research by creating a dedicated specialist research nurse consultant as suggested by Currey et al (2011) was unanimously rejected.

Discussion

The outcomes of this brief thematic analysis highlight a number of points for action for nurse consultants, for senior nurse leaders and managers and for the higher education sector, the value of research was clear to all participants.

However, the day to day reality of the current NC job meant that it always assumed a lower priority than any other activity. Despite claiming a degree of autonomous practice this priority setting seemed to be disconcertingly out of the consultants' control. The results demonstrated a perceived lack of power to oppose the creeping managerialism of some posts. It also unearthed a lack of authority to undertake non clinical tasks, most notably where posts did not have formal links to universities. However the assumption that most managers only valued clinical work was not tested. It was agreed that one of the negative consequences of not testing these presumptions is that it runs the risk of the post holder doing a job rather than 'shaping a role'. This is particularly worrying in relation to research because there is no other nursing role that has research as an explicit outcome. This is therefore both potentially a discrete strength of NC role but also a unique challenge for those charged with achieving it.

On the positive side, one approach which seems to have delivered some co-ordinated benefit in practice was the advent of Alzheimer Scotland Dementia Nurse Consultants. These posts all work towards a shared agenda and key priorities, although the direct application of these within individual boards may vary. While the focus of these roles is dementia, with the district general hospital setting, the sphere of influence was envisaged as being beyond that of a clinical nurses 'specialist' into a strategic, profession leadership role, grounded in evidence based practice. However most of the current NC posts are offered on a short term basis; 2 or 3 years (e.g. most of the Alzheimer Scotland Dementia Nurse Consultant) and this may be problematic in delivering meaningful research outputs.

Conclusions

Developing an action plan

The proposed action plan has three strands: practical, professional/political, and educational. These will be discussed in turn

Practical. In order to achieve the ideal described above dedicated time would need to be built into personal development planning. Ball (2005) found short term priorities often overtake long term plans and take precedence on a day to day basis. So, whilst the ultimate ideal would be to integrate research into day to day practice, paradoxically this also needs protected time in the short term in order to achieve longer term integration. Practical solutions such as being away from open offices, or being in the company of academics were widely agreed to help facilitate this activity.

Professional and political

It was stated that the CNO's office is keen to support development of clinical academic careers, which is a potential route to bring the research and practice agendas closer together. Additionally financial support is being made available to the Scottish Mental Health

Nursing Network, via the CNO's office to promote the importance of research as a key activity for mental health nurses. The professional aspect of the research agenda is probably more in the hands of the NCs than they currently appear to imagine. Overcoming the confidence issues required to move this agenda forward will require practical targeted support from HEIs.

Educational

It was clear from the literature and focus group that the more successfully research active NCs had joint funded posts with HEIs. One university (The University of the West of Scotland) has an active programme of engagement to address practical application of clinical research through their Institute of Mental Health, a collaborative network focused towards delivering clinically relevant research and development between the university and their NHS partner Boards. Partnerships such as these are essential in the absence of more formal contractual arrangements.

Perhaps this year the Mental Health Nursing Forum Scotland will be able to make an award in its 'research into practice' category. Let's hope so. BJMHN

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