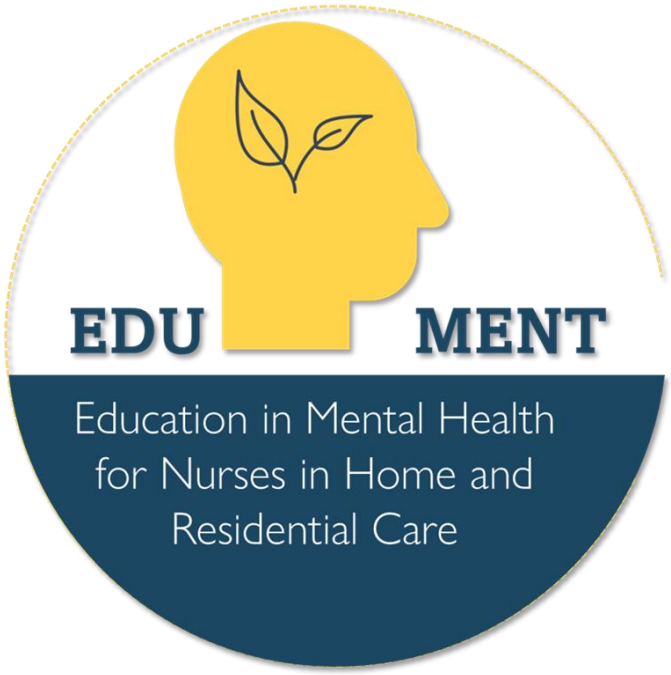
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R5_5_Guidelines for MH-I Nurse Education and Quality Assurance (R5_5)

Intellectual Output – R5.5	
Title:	**R5_5_Guidelines for MH-I Nurse Education and Quality Assurance**

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Description:	This output provides practical guidelines to support the design, implementation, and quality assurance of mental health interventions (MH-I) education for nurses in home care and residential long-term care. It addresses competence development, organisational conditions, ethical and data protection considerations, and quality assurance mechanisms that support consistent, safe, and sustainable mental health-related care. The guidelines are intended for care organisations, education providers, and nursing leadership and are adaptable to different national and organisational contexts.
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1. PURPOSE AND POSITIONING OF THE GUIDLINES

1.1. PURPOSE

These guidelines support the design, implementation, and quality assurance of mental health interventions (MH-I) education for registered nurses working in home care and residential long-term care. Their purpose is to provide practical orientation for care organisations, education providers, and nursing leadership that seek to strengthen nurses' capacity to deliver safe, consistent, and high-quality mental health-related care in everyday practice.

The guidelines aim to support nurses and organisations in:

- recognising early signs of psychosocial strain and mental health-related risks,
- responding with appropriate nursing measures and timely referral where needed,
- using structured approaches, including digital screening tools where available, to support consistent observation, documentation, and follow-up,
- cooperating effectively with other professionals such as physicians, psychologists, and social services.

In addition to educational aspects, the guidelines explicitly address quality assurance and continuous improvement of mental health-related service delivery. They provide orientation on how MH-I education can be linked to organisational quality processes and how competence development contributes to safe, ethical, and sustainable care practices. Guidance is also provided on training completion, competence maintenance, and certification logic, without introducing formal accreditation or regulatory requirements.

The guidelines are designed to be applicable across different national contexts, organisational sizes, and levels of digital maturity. They focus on what is realistically feasible in routine care settings, taking into account time constraints, staffing realities, and varying levels of professional experience.

1.2. TARGET GROUPS AND PRACTICAL USE

The guidelines are intended for several target groups that play complementary roles in MH-I education and quality assurance.

For **care organisations**, including management, HR, quality leads, and nursing leadership, the guidelines support the planning and implementation of MH-I education as part of organisational quality and staff development strategies. They provide orientation on how education can be embedded into everyday workflows, how responsibilities can be clarified, and how learning outcomes can be linked to quality assurance and service improvement.

For **education and training providers**, such as vocational education providers, universities, CPD providers, and trainers, the guidelines offer a framework for aligning MH-I education with practice

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realities and organisational expectations. They support the design of education that contributes not only to individual learning outcomes but also to consistent and sustainable care practices.

For **registered nurses**, including training participants and practice mentors, the guidelines clarify expected competences, professional responsibilities, and the link between education, everyday nursing practice, and quality of care. They support reflective practice and responsible application of MH-I competences within defined professional roles.

1.3. Scope and Application

The guidelines focus on post-registration education and competence development for nurses involved in mental health-related care in home care and residential long-term care settings. Within this scope, they address:

- core MH-I competences relevant to everyday nursing practice,
- the use of structured observation, assessment, and digital screening tools,
- the connection between education, service delivery quality, and organisational processes,
- principles for training completion, competence verification, and continued professional development,
- essential considerations related to quality assurance, ethics, and data protection.

The guidelines are intended to be flexible and adaptable. They can be applied to short CPD formats, modular programmes delivered over time, and blended learning approaches that combine online learning with practice-based activities. They support organisations and providers in selecting approaches that fit their specific context while maintaining a focus on safe and consistent mental health-related care.

1.4. Limits, Application Logic, and Underlying Approach

These guidelines do not replace national laws, professional regulations, accreditation frameworks, or formal certification systems. They do not prescribe a single curriculum, training pathway, or digital platform, nor do they introduce mandatory audits or external quality control mechanisms.

Clinical diagnosis and treatment decisions are explicitly outside the scope of this document. Structured screening and assessment are understood as tools for early identification, monitoring, and support, not as diagnostic instruments.

Where national or organisational requirements exist—such as CPD accreditation rules, documentation standards, or defined referral pathways—users of the guidelines are expected to align implementation accordingly.

The underlying approach of the guidelines is competence-oriented, practice-focused, and proportionate. Emphasis is placed on feasibility in daily work, clear links between education and

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service delivery, safe and ethical use of structured approaches, and continuous improvement rather than compliance or perfection. The guidelines are intended to support learning, reflection, and organisational development over time, contributing to sustainable improvements in mental health-related nursing care.

2. MENTAL HEALTH INTERVENTIONS (MH-I) IN HOME AND RESIDENTIAL CARE

2.1. Mental Health Interventions in Everyday Nursing Practice

Mental health interventions in home care and residential long-term care primarily concern **promotion, prevention, and early intervention**. In these settings, mental health issues often do not present as acute psychiatric conditions. Instead, they tend to emerge gradually through changes in mood, behaviour, social participation, or coping ability. Because of their ongoing and close contact with clients, nurses are frequently the first professionals to notice such changes.

Mental health interventions in nursing practice therefore focus on recognising early warning signs, monitoring developments over time, and responding in ways that support **well-being, safety, and autonomy**. Interventions may include supportive conversations, practical nursing measures, structured observation, documentation, and coordination with other professionals. The emphasis is on **early and proportionate action**, rather than on responses that are triggered only once a situation has escalated into a crisis.

2.2. Typical Mental Health-Related Risk Situations and Context

In home care and residential settings, mental health risks are often closely linked to life circumstances and increasing care dependency. Common situations include loneliness and social isolation, emotional distress following loss or illness, rising stress related to declining functional abilities, and cognitive or emotional changes that affect everyday functioning.

Such risks rarely occur in isolation. They often interact with physical health conditions, medication use, environmental factors, and the availability of social support. As a result, mental health interventions in nursing require an understanding of the **broader context** of a person's life and care situation, rather than a narrow focus on individual symptoms. Recognising patterns and combinations of factors is therefore a key aspect of effective mental health-related nursing practice.

2.3. Role of Nurses, Structured Approaches, and Implications for Continuing Education

Nurses play a key role in mental health interventions because they are well positioned to observe changes, build trust, and ensure continuity of care. Their responsibilities typically include noticing and documenting psychosocial and emotional changes, initiating supportive nursing actions within

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their scope of practice, communicating concerns clearly within the care team, and coordinating or initiating referral to other professionals when needed.

This role does not require nurses to diagnose mental illness. Instead, it relies on competences in observation, professional judgement, communication, and coordination. **Continuing education in MH-I is essential** to strengthen these competences and to support nurses in acting confidently and responsibly in complex situations.

Structured approaches—such as agreed observation criteria, standardised documentation, or screening tools—can support nurses by providing a shared frame of reference. When used appropriately, they help reduce uncertainty, improve consistency, and facilitate communication within teams and across professional boundaries. In practice, such approaches are most effective when embedded into everyday workflows and combined with professional judgement. They should support, not replace, the nurse's assessment and relationship with the client.

Given the nature of mental health interventions in home and residential care, continuing education should closely reflect real-life practice. This includes focusing on typical situations nurses encounter, strengthening observation and decision-making skills, and supporting collaboration with other professionals. Training that links mental health interventions to everyday nursing tasks, organisational realities, and available resources is more likely to result in **sustainable practice change**. Chapter 3 therefore addresses the **competence-oriented requirements for continuing education in MH-I**, building directly on these practice realities.

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3. ONTINUING EDUCATION REQUIREMENTS FOR MENTAL HEALTH INTERVENTIONS(MH-I)

3.1. COMPETENCE-ORIENTED FOCUS

Continuing education in mental health interventions should primarily strengthen **competences that nurses can apply directly** in home care and residential long-term care. In these settings, mental health-related risks often develop gradually and are closely connected to physical health, functional ability, life events, social participation, and environmental conditions. For this reason, MH-I education should support nurses in combining structured approaches with professional judgement in real-life situations.

A competence-oriented focus means that nurses are able to move from observation to action in a safe and proportionate manner. This includes noticing psychosocial changes, evaluating their significance over time, and choosing appropriate nursing responses within their role. It also includes recognising when a situation exceeds nursing scope and requires referral or coordinated action with other professionals.

Competence development in MH-I therefore includes:

- **recognition and monitoring competences** (what to notice, how to observe trends, what constitutes a relevant change),
- **decision-making competences** (what to do now, what to monitor, what to escalate),
- **communication and coordination competences** (how to communicate findings and needs clearly and efficiently),
- **ethical and relational competences** (respectful communication, sensitivity, boundaries, and dignity in mental health-related conversations).

3.2. PRACTICE-ORIENTED LEARNING OUTCOMES

Learning outcomes for MH-I continuing education should be closely linked to **everyday nursing situations** in home and residential care. They should describe what nurses are expected to do in practice and how they apply professional judgement, rather than focusing primarily on theoretical knowledge.

Well-defined learning outcomes typically enable nurses to:

- recognise early signs of psychosocial strain and emerging mental health risks,
- use structured observation, assessment, and documentation approaches appropriately,
- interpret findings in relation to the person's overall life and care context,
- translate observations into feasible nursing actions and short care plans,
- communicate findings and recommendations within teams and interprofessional settings,
- reflect on their own role, responsibilities, and professional limits.

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Learning outcomes should remain realistic and achievable under routine working conditions. They should be adaptable to different organisational contexts and national frameworks, while maintaining a clear focus on safe, responsible, and person-centred practice.

3.3. Learning Formats and Methods

Mental health interventions require nurses to integrate knowledge, judgement, communication, and reflection. For this reason, continuing education in MH-I is most effective when it combines different learning formats rather than relying on information transfer alone.

Experience from practice-oriented programmes shows that learning is strengthened when self-directed preparation is combined with guided application and discussion of realistic cases. Case-based learning allows nurses to connect abstract concepts with concrete situations and to practise prioritising concerns, making decisions, and communicating effectively. Reflection on these processes helps nurses understand how professional judgement is formed and how organisational and personal factors influence care.

Learning formats should always be selected with regard to staffing realities, time constraints, and varying levels of experience and digital confidence among participants. Flexible and modular approaches can support participation without placing excessive additional demands on nursing staff.

3.4. Assessment, Reflection, and Transfer to Practice

Assessment in MH-I continuing education should primarily serve the purpose of **supporting learning and improvement**, rather than functioning as a formal examination. Given the practice-oriented nature of mental health interventions in nursing, assessment approaches are most effective when they focus on how participants apply knowledge and judgement in realistic situations. Methods such as working through case scenarios, engaging in guided discussions, or completing short written reflections allow educators and participants alike to assess whether learning outcomes are being achieved in a meaningful way.

Reflection is a central component of safe and responsible mental health-related nursing practice. Nurses need structured opportunities to reflect on how they interpreted situations, how they communicated concerns, and how their decisions were influenced by personal experience, emotional load, or organisational conditions. Reflection also supports ethical awareness and helps nurses maintain professional boundaries when addressing sensitive mental health topics with clients and their families.

Transfer to practice should be considered from the outset when planning continuing education in MH-I. Training is more likely to lead to sustained changes in practice when learning activities are closely linked to everyday workflows and real care situations. Opportunities for feedback, peer exchange, and follow-up discussions support nurses in integrating new competences into their daily routines. From an organisational perspective, such supportive conditions reduce the risk that

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continuing education remains an isolated learning event and increase its potential to contribute to **consistent and lasting improvements in care practice**.

Many of the competence requirements described above are closely connected to the use of **structured assessment and screening approaches** in practice. Chapter 4 therefore addresses the role of digital screening tools in continuing education and the competences required for their safe, ethical, and meaningful use.

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4. DIGITAL SCREENING TOOLS IN MH-I CONTINUING EDUCATION

Digital screening tools represent a central innovation in the continuing education of nurses for mental health interventions. Their value lies not only in digitalisation as such, but in the way structured screening supports early identification, consistent documentation, and informed decision-making in everyday care. When embedded in continuing education, digital tools can help nurses develop shared understanding, confidence, and professional judgement in addressing psychosocial and mental health-related risks.

This chapter focuses on how digital screening tools can be meaningfully integrated into continuing education for nurses, using the EDU-MENT screening tool as a concrete example. The emphasis is on educational use, interpretation, and application in practice, rather than on technical specifications. Ethical and data protection principles relevant to the use of digital tools are addressed in a dedicated chapter later in this guide and are therefore referenced here only where necessary.

4.1. Purpose and Added Value of Digital Screening Tools in MH-I Education

In home care and residential long-term care, mental health-related risks often develop gradually and may be difficult to identify through unstructured observation alone. Digital screening tools support nurses by providing a **structured and systematic approach** to observing psychosocial, emotional, cognitive, and contextual factors that influence mental well-being. In the context of mental health interventions, their primary purpose is to support **early identification and informed follow-up**, not to establish diagnoses.

Within continuing education, digital screening tools serve as a **learning instrument** as much as a practice instrument. They help nurses understand what to observe, how to document observations consistently, and how to interpret patterns over time. By working with structured domains and standardised questions, nurses learn to distinguish between low-level concerns that require monitoring and more pronounced risk situations that call for further assessment or referral.

Compared to unstructured observation, digital screening tools offer several educational advantages. They provide a shared reference framework that supports discussion and reflection during training. They make implicit observations explicit and comparable, which is particularly important in team-based and interprofessional settings. In addition, visual outputs such as summary reports or risk indicators can support communication and help nurses explain concerns to colleagues and other professionals in a clear and transparent way.

It is essential to emphasise that digital screening tools are designed to **support professional judgement**, not replace it. Screening results need to be interpreted in relation to the nurse's knowledge of the person, the care context, and observations from daily practice. Continuing education should therefore explicitly address both the **added value and the limits** of digital screening. Nurses need to understand what screening can and cannot do, how to avoid over-interpretation, and how to use digital outputs responsibly as part of a broader care process.

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By integrating digital screening tools into continuing education in this way, training programmes can strengthen nurses' competence in structured observation, interpretation, and communication, while maintaining a person-centred and ethically grounded approach to mental health interventions.

4.2. The EDU-MENT Digital Screening Tool: Structure and Logic

The EDU-MENT digital screening tool is designed to support nurses in the **early identification of psychosocial and mental health-related risks** in home care and residential long-term care. Its structure reflects the complexity of everyday care situations by combining health-related, emotional, social, and environmental aspects into a single, coherent screening process. For continuing education, this structure provides a clear and practical framework that helps nurses understand what to observe, how to organise observations, and how to interpret results in a consistent way.

The tool is organised around **six core domains** that together capture key factors influencing mental well-being and psychosocial stability. These domains cover demographic and contextual characteristics, health and comorbidities, cognitive and emotional functioning, sleep and nutrition, community and lifestyle factors, and the personal living environment. By structuring screening in this way, the tool encourages nurses to look beyond isolated symptoms and to consider the broader life and care context of the person.

Each domain consists of short, structured questions that can be completed efficiently within routine care. The design allows flexibility: nurses may complete the full screening or focus on specific domains depending on the situation, such as during admission, routine follow-up, or after a significant change in health or behaviour. From an educational perspective, this flexibility is important, as it reflects real practice conditions and supports proportionate use rather than rigid application.

A central element of the tool's logic is its **risk-based scoring system**, which transforms responses into a visual summary for each domain. Results are displayed using a simple colour-coded scale that indicates low, moderate, or higher levels of concern. This visual logic is intentionally intuitive, enabling nurses to quickly recognise which areas require closer attention. In continuing education, this supports learning about prioritisation and pattern recognition, rather than focusing solely on numerical scores.

The output of the screening process is the **Patient Report**, which presents results in a clear and structured format. The report is designed as a decision-support and communication tool, not as a diagnostic document. In training contexts, it provides a concrete basis for discussion, interpretation exercises, and reflection on possible nursing actions or next steps. Working with the Patient Report helps nurses practise how to explain findings, justify decisions, and communicate concerns within teams or to other professionals.

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Importantly, the logic of the EDU-MENT screening tool consistently reinforces the distinction between **screening and diagnosis**. The tool signals potential risk and the need for attention or follow-up, but it does not label conditions or replace clinical assessment by appropriately qualified professionals. Continuing education should explicitly address this distinction, helping nurses understand both the strengths and the limits of the tool and supporting responsible, ethically grounded use in practice.

4.3. Risk-Based Interpretation and Professional Judgement

A defining feature of the EDU-MENT digital screening tool is its **risk-based interpretation logic**, which is designed to support nurses in making informed and proportionate decisions in everyday care. Screening results are presented in a visual, colour-coded format that indicates different levels of concern. This approach is intended to help nurses recognise patterns and priorities quickly, rather than to produce precise measurements or diagnoses.

In continuing education, it is essential that nurses learn how to **interpret these risk indicators correctly**. A low level of concern signals that no immediate action is required beyond continued observation, while moderate levels indicate areas that should be monitored more closely or discussed within the care team. Higher levels of concern point to the need for further assessment, targeted nursing actions, or referral to other professionals, depending on organisational procedures and scope of practice. Education should emphasise that these categories indicate **risk**, not certainty, and that they always require contextual interpretation.

Professional judgement plays a central role in this process. Screening results must be considered alongside the nurse's knowledge of the person, observations from daily care, recent life events, and environmental or social factors. Continuing education should therefore support nurses in combining structured digital outputs with their own observations and experience, rather than treating screening results as stand-alone conclusions.

Another important learning aspect concerns the **limits of interpretation**. Nurses need to understand that digital screening tools simplify complex realities and cannot capture every relevant aspect of a person's situation. Education should explicitly address the risk of over-interpretation or false reassurance and encourage nurses to reflect on uncertainties, inconsistencies, or missing information. This reflective approach strengthens safe practice and supports ethical decision-making.

By focusing on risk-based interpretation and professional judgement, continuing education helps nurses use digital screening tools responsibly. Nurses learn not only how to read results, but how to **translate signals into thoughtful action**, balancing structured guidance with person-centred care and professional responsibility.

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4.4. From Screening Results to Nursing Action and Collaboration

The value of digital screening tools in mental health interventions becomes evident when screening results are **translated into concrete nursing actions and coordinated follow-up**. In continuing education, nurses need to learn how to move beyond interpreting results towards deciding what to do next, within their professional role and organisational context.

Screening results can inform different types of action depending on the level and nature of identified risk. In situations with low levels of concern, results may confirm that current care approaches are appropriate and that continued observation is sufficient. Moderate levels of concern often indicate the need for closer monitoring, targeted supportive measures, or discussion within the care team. Higher levels of concern typically signal that further assessment, adjustment of care planning, or referral to other professionals should be considered.

A central element in this process is the **use of the Patient Report** as a decision-support and communication tool. The report summarises screening results in a clear and visual way, making it easier for nurses to explain observations, justify concerns, and discuss next steps with colleagues. In continuing education, working with the Patient Report helps nurses practise how to present findings clearly, avoid alarmist language, and communicate risk in a balanced and professional manner.

Digital screening tools also support **interprofessional collaboration**. Structured results provide a shared reference point that can facilitate communication with physicians, psychologists, social workers, or other professionals involved in care. Continuing education should therefore address how screening results can be used to support timely and focused communication, clarify reasons for referral, and contribute to continuity of care without overstepping professional boundaries.

Importantly, nurses need to understand that screening does not dictate action automatically. Decisions should always take into account the individual situation, the nurse's professional judgement, and organisational procedures. Continuing education should encourage nurses to reflect on how digital screening results interact with their own observations and with input from other team members, supporting coordinated and proportionate responses to identified mental health-related risks.

4.5. Use of Digital Screening Tools in Continuing Education and Organisational Context

Digital screening tools should be integrated into continuing education in a way that reflects **real practice conditions** and supports sustainable competence development. In training settings, the EDU-MENT screening tool is not primarily used to teach technical操作, but to help nurses develop confidence in **interpreting results, making decisions, and communicating appropriately** in mental health-related situations.

For educational purposes, the tool is particularly well suited for **case-based learning**. Anonymised or fictional cases can be used to demonstrate how different risk patterns emerge across domains and how these patterns influence nursing decisions. Working with the Patient Report in training

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allows participants to practise interpreting visual results, discussing priorities, and justifying proposed actions. Such exercises also help clarify the distinction between screening and diagnosis and support responsible use of structured tools in practice.

Continuing education should explicitly address typical challenges that arise when digital screening tools are introduced into everyday care. These include time pressure, uncertainty about interpretation, differences in professional experience within teams, and concerns about responsibility or follow-up. Discussing these issues openly during training helps nurses develop realistic expectations and strengthens their ability to use the tool confidently rather than defensively or mechanically.

From an organisational perspective, the effective use of digital screening tools in continuing education depends on **clear roles and supportive conditions**. Organisations need to define when and how screening is used, how results are documented and communicated, and how follow-up actions are coordinated. Continuing education should therefore be aligned with organisational procedures and workflows, rather than remaining an isolated training activity.

Digital screening tools and related processes may evolve over time. Continuing education should support nurses in adapting to updates, reflecting on new experiences, and maintaining competence as tools or organisational practices change. This reinforces the understanding that competence in digital screening is not acquired once and for all, but develops through **ongoing learning, reflection, and practice**.

Ethical principles and data protection requirements relevant to the use of digital screening tools apply equally in training and practice contexts. These principles are addressed in detail in a dedicated chapter of this guide. In continuing education, they should be referenced where relevant, for example when discussing anonymisation of cases, respectful communication of results, and appropriate sharing of information within care teams.

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5. ORGANISATIONAL CONDITIONS FOR SUSTAINABLE MH-I CONTINUING EDUCATION

Sustainable continuing education in mental health interventions (MH-I) depends on more than high-quality learning content. Whether nurses can apply new competences in daily practice is strongly influenced by the **organisational environment** in which they work: priorities set by leadership, how responsibilities are defined, whether time and support are available, and whether learning is connected to routine workflows.

This chapter outlines **practical organisational conditions** that help continuing education lead to consistent practice improvements in home care and residential long-term care. The intention is to provide realistic guidance that can be adapted to different organisational sizes and national contexts. It does not introduce new regulatory requirements; instead, it supports organisations in making informed and feasible decisions that enable staff development in mental health-related care.

5.1. Organisational Readiness and Leadership Support

Organisational readiness is a key precondition for sustainable MH-I continuing education. It describes whether an organisation is prepared to support mental health-related competence development as a normal part of care delivery, rather than treating it as an optional or temporary topic. Readiness does not mean that all structures must be in place from the beginning. It means that the organisation has a shared understanding of why MH-I matters, and that it is willing to take realistic steps to enable learning and application over time.

Leadership support is central to readiness. In both home care and residential settings, nurses often face high workload, competing priorities, and time pressure. If leadership does not actively legitimise MH-I continuing education, participation may remain low and transfer to practice inconsistent. Support should therefore be visible in how leadership communicates priorities, allocates resources, and reinforces the relevance of mental health-related care as part of quality and safety.

In practical terms, leadership support is reflected in three areas: **prioritisation, clarity, and protection of time**. Prioritisation means that MH-I continuing education is explicitly recognised as relevant for routine care, not as an additional task “if time allows.” Clarity means that leadership communicates what is expected after training in realistic terms—for example, that structured observation and documentation should become more consistent, or that communication pathways should be used more systematically where concerns arise. Protection of time means ensuring that participation in education and follow-up reflection is possible without placing undue burden on staff or creating informal pressure to complete learning outside working hours.

A readiness assessment can be kept simple and proportionate. Organisations can use the following questions as a practical orientation:

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- Is there a shared understanding among leadership and staff that psychosocial strain and mental health-related risks are relevant in everyday care, and not limited to specialist services?
- Are responsibilities clear for initiating education, supporting participation, and coordinating follow-up where concerns are identified?
- Is there a realistic plan for participation (time allocation, scheduling, back-up coverage where feasible)?
- Are there agreed pathways for discussion and escalation when a nurse identifies a relevant concern (within the team and, where needed, with other professionals)?
- Is there a willingness to review experiences after implementation and adjust procedures based on feedback?

Readiness is also influenced by organisational culture. A supportive culture encourages nurses to raise concerns, discuss uncertainty, and seek advice without fear of blame or stigma—especially when dealing with mental health-related topics. Leadership can foster this by promoting respectful communication, encouraging reflective discussion, and making clear that structured screening or documentation is used to improve care and coordination, not to label individuals or assign fault.

Overall, organisational readiness and leadership support provide the foundation for all later steps: integration into workflows, role clarity, sustainable learning formats, and continuous improvement. Without this foundation, continuing education risks becoming an isolated event rather than a driver of lasting practice development.

5.2. Integration of MH-I Continuing Education into Organisational Workflows

For continuing education in mental health interventions to have a lasting effect, learning must be **embedded into existing organisational processes and everyday workflows**. When education remains detached from routine practice, nurses may struggle to apply new competences consistently, especially under time pressure. Integration helps ensure that MH-I is perceived as part of normal care delivery rather than as an additional or optional activity.

In practical terms, integration means aligning MH-I continuing education with processes that nurses already use, such as admission assessments, routine reviews, care planning, handovers, and team discussions. Structured observation or screening outcomes, for example, can be linked to existing documentation practices or discussed during regular case meetings. This reduces duplication and supports continuity of care while reinforcing learning through repeated application.

Integration also involves aligning continuing education with organisational quality and safety processes. When mental health-related competences are connected to quality improvement goals, audit activities, or internal reflection processes, their relevance becomes more visible to

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both staff and management. This does not require new or complex systems; even simple alignment, such as including MH-I topics in regular quality discussions, can strengthen sustainability.

Another important aspect of integration is **timing**. Continuing education is more effective when it is linked to meaningful moments in practice, such as organisational change, introduction of new tools or procedures, or identified care challenges. Linking learning activities to real needs increases motivation and helps nurses immediately see the value of applying new competences.

Finally, integration requires attention to consistency across teams and settings. In organisations with multiple units or mobile care teams, differences in practice can undermine the impact of continuing education. Clear guidance on how MH-I approaches are embedded into workflows helps ensure that learning outcomes are applied in a similar way across the organisation, while still allowing flexibility for local adaptation.

By embedding MH-I continuing education into everyday processes, organisations create conditions in which learning is reinforced through practice. This supports routine use of new competences, reduces the risk of fragmented application, and contributes to sustained improvements in mental health-related care.

5.3. Roles, Responsibilities, and Support Structures

Clear roles and responsibilities are essential to ensure that continuing education in mental health interventions leads to **coordinated and consistent practice**, rather than depending on individual initiative alone. When expectations are unclear, nurses may hesitate to apply new competences, and follow-up actions may remain fragmented.

At organisational level, it is helpful to define **who is responsible for what** in relation to MH-I continuing education. This does not require creating new positions, but it does require clarity. Responsibilities typically relate to initiating and planning education, supporting participation, facilitating reflection and follow-up, and ensuring alignment with organisational procedures. In smaller organisations, these responsibilities may be combined within existing leadership or coordination roles; in larger organisations, they may be shared across different functions.

For nursing staff, clarity about roles supports confidence in practice. Nurses need to understand their responsibilities in observing, documenting, communicating, and initiating follow-up actions related to mental health concerns. They also need clarity about boundaries: when an issue should be managed within nursing care, when it should be discussed within the team, and when referral or escalation is required. Continuing education should reinforce this role clarity and link it to organisational expectations.

Support structures play a key role in sustaining competence development. These structures can be formal or informal and should be proportionate to organisational size and resources. Examples include regular team discussions, opportunities for peer consultation, access to guidance materials, or designated contact persons for questions related to mental health interventions.

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Such structures provide nurses with spaces to discuss uncertainty, share experiences, and reflect on challenging situations without fear of blame.

Equally important is the role of trainers, mentors, or practice leaders who can support the transfer of learning into practice. Their function is not to control or supervise, but to facilitate learning, encourage reflection, and help integrate MH-I competences into routine care. This supportive role is particularly important when new tools or approaches are introduced, as it helps nurses move from initial learning to confident application.

By clearly defining roles and providing appropriate support structures, organisations create an environment in which continuing education in MH-I can lead to **shared responsibility, consistent practice, and sustained improvement**, rather than remaining dependent on individual motivation or isolated expertise.

5.4. Addressing Barriers and Enablers in Practice

Even when continuing education in mental health interventions is well designed and supported by leadership, its impact can be limited if **practical barriers** are not recognised and addressed. Organisations benefit from explicitly acknowledging these challenges as part of planning and implementation, rather than assuming that learning will automatically translate into practice.

Common barriers in home care and residential long-term care include time pressure, high workload, staff turnover, and varying levels of experience or confidence in mental health-related topics. Nurses may also feel uncertain about responsibilities, particularly when screening or observation indicates a potential concern but follow-up pathways are not clearly defined. If such uncertainties are not addressed, staff may hesitate to act or revert to familiar routines.

Continuing education can help mitigate these barriers when it openly addresses typical constraints and supports nurses in developing **realistic strategies** for applying MH-I competences. This includes discussing how to prioritise observations under time pressure, how to document efficiently, and how to communicate concerns in a concise and focused way. Organisational support is crucial in reinforcing that proportionate action and consultation are appropriate responses, even when situations are not clear-cut.

At the same time, organisations should actively build on existing **enablers**. These may include established team communication practices, experience with interprofessional collaboration, a culture of reflection, or previous engagement with quality improvement initiatives. Identifying and strengthening such enablers increases acceptance of MH-I continuing education and supports consistent application across teams.

Reflecting on barriers and enablers should not be a one-time activity. Regular review, for example through team discussions or feedback loops, allows organisations to adapt procedures and support structures as practice evolves. By treating challenges as part of a learning process rather than as failures, organisations create conditions in which continuing education can lead to continuous improvement rather than isolated change.

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5.5. Sustainability and Continuous Improvement

Sustainable continuing education in mental health interventions requires a **long-term perspective** that goes beyond single training activities. Organisations need to consider how MH-I competences are maintained, refreshed, and adapted over time as staff, care contexts, and tools evolve. Sustainability is not achieved through repetition alone, but through deliberate integration of learning into organisational routines.

One important aspect of sustainability is ensuring that MH-I competences are supported when new staff join the organisation. Introductory processes and mentoring arrangements can help familiarise new nurses with mental health-related approaches, expectations, and available tools. This supports continuity of practice and reduces reliance on individual experience.

Continuous improvement is strengthened when organisations create **feedback loops** between practice and education. Feedback from nurses about what works well, what creates difficulties, and where clarification is needed can inform adjustments to training content, workflows, or support structures. Simple mechanisms, such as periodic reflection sessions or short review discussions, are often sufficient to capture relevant insights.

Sustainability also depends on the organisation's ability to adapt to change. Digital tools, care models, and regulatory frameworks may evolve, requiring updates to practice and training. Continuing education should therefore be designed with flexibility in mind, enabling organisations to update content and approaches without starting from scratch.

By embedding MH-I continuing education into a cycle of reflection, feedback, and adaptation, organisations can move from project-based implementation towards **stable and continuously improving practice**. This approach supports consistent quality of care and reinforces mental health-related competences as a permanent component of nursing practice in home and residential care.

6. QUALITY ASSURANCE, SERVICE DELIVERY, AND GOVERNANCE FRAMEWORK

Mental health interventions in home care and residential long-term care require not only appropriate education of nurses, but also clear quality assurance mechanisms that support safe, consistent, and sustainable service delivery. Continuing education, everyday practice, and organisational responsibility are closely interlinked, particularly when mental health-related risks are identified and addressed over time.

This chapter provides a consolidated framework for quality assurance, ethical responsibility, data protection, and governance in the context of MH-I nurse education and practice. It links educational quality with the quality of mental health supports delivered in care settings and outlines how organisations can use training, reflection, and feedback to continuously improve

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practice. In addition, the chapter provides orientation on training completion, competence maintenance, and certification logic, while respecting national regulations and avoiding the creation of new accreditation requirements.

The framework is designed to be proportionate and adaptable. It supports care organisations, education providers, and nursing leadership in establishing clear responsibilities, safeguarding ethical standards, and embedding learning and quality improvement into routine care processes.

6.1. Purpose and Scope of Quality Assurance in MH-I

Quality assurance in mental health interventions (MH-I) has a practical purpose: it helps care organisations ensure that mental health-related support provided by nurses is consistent, safe, and appropriate across different situations, staff members, and care settings. In home care and residential long-term care, where mental health risks often develop gradually, quality assurance supports timely recognition, proportionate responses, and reliable follow-up.

In the context of these guidelines, quality assurance focuses on **how MH-I education is translated into everyday practice**. It supports organisations in checking whether nurses are able to apply what they have learned, whether structured approaches are used as intended, and whether identified risks lead to appropriate nursing actions or coordination with other professionals. Quality assurance is therefore closely linked to routine care processes such as observation, documentation, communication within teams, and referral pathways.

The scope of quality assurance covered here includes three practical areas. First, it addresses **education-related quality**, such as whether MH-I training content is relevant to real care situations and whether nurses feel sufficiently prepared to use structured approaches responsibly. Second, it addresses **practice-related quality**, including consistency in recognising psychosocial changes, clarity in documentation, and continuity of mental health-related support over time. Third, it addresses **organisational quality**, meaning whether roles, responsibilities, and workflows support nurses in acting on identified concerns.

Quality assurance in this sense does not rely on formal audits or complex indicators. Instead, it builds on simple and feasible measures that fit routine care, such as:

- regular team discussions on mental health-related cases,
- reflective review of how screening results or observations were handled,
- feedback from nurses on barriers encountered in practice,
- clarification of responsibilities when concerns arise.

An important principle is proportionality. Quality assurance measures should support nurses in their work and help organisations learn from experience, rather than creating additional administrative burden. Small, well-integrated actions are often more effective than extensive reporting systems, particularly in settings with limited time and resources.

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By defining quality assurance in this practical way, the guidelines support care organisations and education providers in linking MH-I nurse education directly to the quality of mental health supports delivered in everyday care. This creates a foundation for continuous improvement that is realistic, adaptable, and focused on service delivery rather than formal compliance.

6.2. Quality Assurance in MH-I Nurse Education

Quality assurance in MH-I nurse education focuses on ensuring that training activities actually prepare nurses for the mental health-related situations they encounter in daily care. From a practical perspective, this means that organisations and education providers need to look beyond whether training has taken place and consider how well nurses are able to apply what they have learned in routine practice.

A key quality criterion is the relevance of training content to everyday care situations. MH-I education should be reviewed regularly to check whether examples, case work, and learning activities reflect current challenges in home care and residential long-term care, such as gradual psychosocial changes, uncertainty about escalation, or coordination with other professionals. Feedback from participating nurses is an important source of information for identifying gaps between training content and practice realities.

Quality assurance also concerns how training is delivered. Trainers should be able to relate educational content to concrete care situations and support nurses in discussing uncertainty, limits of responsibility, and ethical considerations. Organisations and education providers should ensure that training formats allow sufficient time for interaction, reflection, and discussion, rather than focusing exclusively on theoretical input. This is particularly important in MH-I education, where sensitive topics and personal experiences may arise.

When structured approaches or digital screening tools are part of MH-I education, quality assurance requires that their use is clearly explained and practised in a controlled and reflective way. Education should demonstrate how tools are used in typical care situations, how results are interpreted, and how they inform nursing actions or communication within the care team. Trainers and organisations should check whether nurses feel confident using these tools and understand both their added value and their limitations.

Assessment and feedback are practical tools for quality assurance when they are used proportionately. Instead of formal examinations, organisations and education providers can use case-based exercises, short reflections, or guided discussions to assess whether learning outcomes have been achieved. Feedback from these activities helps identify areas where further clarification or follow-up is needed.

Finally, quality assurance in MH-I nurse education includes follow-up after training. Organisations should consider simple ways to support transfer to practice, such as brief team discussions, opportunities to ask questions after initial application, or inclusion of MH-I topics in regular

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meetings. Such follow-up helps ensure that education does not remain a one-off activity but contributes to ongoing competence development and consistent practice.

By focusing on these practical aspects, quality assurance in MH-I nurse education supports organisations and education providers in delivering training that is relevant, usable, and directly linked to the quality of mental health supports in everyday care.

6.3. Quality Assurance of Mental Health Supports in Practice

Quality assurance of mental health supports in practice focuses on how nurses' competences, once acquired through MH-I education, are applied consistently and responsibly in everyday care. In home care and residential long-term care, mental health-related support is often delivered over time, across shifts, and by different staff members. Quality assurance therefore helps ensure continuity, clarity, and proportionality in how mental health-related concerns are recognised and addressed.

From a practical perspective, quality assurance in service delivery begins with **consistent observation and documentation**. Organisations should support nurses in using agreed approaches to record psychosocial observations, screening results where applicable, and follow-up actions in a clear and understandable way. This does not require additional documentation systems, but rather consistency in how existing tools and records are used. Regular review of documentation practices can help identify whether relevant information is being captured and whether it supports continuity of care.

Another key aspect is **clarity of response and follow-up**. Quality assurance involves checking whether identified mental health-related risks lead to appropriate nursing actions, monitoring, or coordination with other professionals. This includes reflecting on questions such as whether concerns are discussed within the team, whether follow-up is planned and carried out, and whether responsibilities for next steps are clear. Simple case reviews or team discussions can help organisations assess whether responses are proportionate and timely.

Communication within teams and across professional boundaries is also central to service quality. Quality assurance measures should therefore pay attention to how mental health-related concerns are communicated, for example during handovers, team meetings, or referrals. Structured communication formats can support clarity, but their value depends on how consistently they are used. Organisations can strengthen quality by agreeing on when and how mental health-related information should be shared and by reviewing communication practices when misunderstandings or delays occur.

Feedback from practice is an important source of quality improvement. Nurses should have opportunities to report where MH-I approaches work well and where they encounter difficulties, such as uncertainty about escalation, lack of time for follow-up, or unclear collaboration pathways. Collecting and discussing such feedback allows organisations to adjust procedures, provide additional support, or clarify expectations without assigning blame.

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Quality assurance of mental health supports should also consider the **experience of care recipients** where appropriate and feasible. While formal outcome measurement may not be realistic in all settings, informal feedback from clients, families, or representatives can provide valuable insights into whether mental health-related support feels respectful, consistent, and responsive to needs.

Overall, quality assurance in MH-I service delivery is not about controlling individual practice, but about supporting reliable care processes. By linking education, documentation, communication, and reflection, organisations can use quality assurance to continuously improve the delivery of mental health supports and ensure that MH-I competences contribute meaningfully to everyday nursing care.

6.4. Data protection and information governance in MH-I education and practice

Mental health interventions involve particularly sensitive personal information. When continuing education includes structured observation, documentation, or digital screening tools, data protection and information governance become central elements of quality assurance and professional responsibility. Effective data protection does not only ensure legal compliance, but also safeguards trust, supports safe decision-making, and contributes directly to the quality of mental health supports delivered in practice.

In the context of MH-I education and service delivery, it is essential to clearly distinguish between **training-related data** and **care-related data**. Training-related data include learning platform activity, quiz results, reflections, and case-based exercises used for educational purposes. Care-related data include observations, screening results, and documentation related to individual clients. These two data contexts follow different purposes and must not be mixed without explicit justification and appropriate safeguards.

As a general principle, MH-I education should rely primarily on **anonymised, fictional, or simulated cases**. When real practice examples are used for learning, all identifying information must be removed so that individuals cannot be recognised directly or indirectly. The use of live or identifiable client data in training should be avoided unless it is clearly permitted under national regulations, organisational policies, and supported by appropriate consent procedures. This applies equally to face-to-face training, digital learning environments, and hybrid formats.

When digital screening tools are used, organisations and education providers should define clear rules regarding data handling. These rules should specify:

- what data are collected and for which purpose,
- who is authorised to access screening results,
- where data are stored and for how long,
- how data are protected against unauthorised access,

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- how training data are separated from routine care documentation.

The principle of **data minimisation** is particularly important in MH-I contexts. Only data that are necessary for education, reflection, or care coordination should be collected and retained. Visual summaries or risk indicators generated by digital tools should be used responsibly and interpreted within the broader care context, without unnecessary duplication or prolonged storage.

Transparency is another key element of information governance. Nurses participating in MH-I education should be informed about how their learning-related data are used, documented, and retained. Similarly, in practice settings, clients and care recipients should be informed, in line with national requirements, about the purpose and handling of mental health-related observations or screening activities. Clear communication supports trust and reduces uncertainty for both staff and care recipients.

From a quality assurance perspective, organisations should regularly review whether data protection practices support or hinder safe and effective MH-I practice. This may include reflecting on whether documentation supports continuity of care, whether access rights are clear, and whether staff feel confident in handling sensitive information. Such reviews can be integrated into existing quality or governance processes and do not require separate or complex systems.

By embedding data protection and information governance into everyday MH-I education and practice, organisations reinforce professional responsibility, protect the rights of individuals receiving care, and strengthen the reliability and credibility of mental health supports.

6.5. Ethical practice and professional responsibility

Ethical practice is a foundational element of mental health interventions and closely linked to both education quality and service delivery quality. MH-I education must therefore support nurses not only in acquiring technical competences, but also in developing ethical awareness, reflective judgement, and professional responsibility when dealing with sensitive and complex situations.

A central ethical principle in MH-I is **respect for dignity and autonomy**. Nurses should be supported in engaging with individuals in a respectful, non-stigmatising manner, particularly when addressing psychosocial strain, emotional distress, or cognitive changes. Quality assurance in MH-I education includes ensuring that language, case examples, and learning activities reinforce person-centred perspectives and avoid labelling or pathologising behaviour.

Proportionality is another key ethical principle. Mental health-related observations or screening results indicate potential risk, not certainty. Ethical MH-I practice requires responses that are appropriate to the level of concern identified and to the nurse's professional role. Education and organisational guidance should reinforce that careful observation, monitoring, and supportive nursing actions are often appropriate and ethically sound responses, and that escalation or referral should be based on professional judgement rather than automatic thresholds.

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Professional responsibility also involves **clear role boundaries**. Nurses must understand the distinction between screening, assessment, and diagnosis, and be supported in recognising when a situation exceeds their scope of practice. Structured tools and digital screening outputs are intended to support decision-making and communication, not to replace clinical judgement or specialist assessment. Quality assurance mechanisms should reinforce this distinction to protect both care recipients and nursing staff.

Ethical responsibility extends to **communication and collaboration**. Nurses should be supported in communicating mental health-related concerns clearly and respectfully within teams and across professional boundaries. This includes sharing relevant information without breaching confidentiality and explaining concerns in a way that supports coordinated care rather than alarm or misunderstanding.

MH-I education also has ethical implications for the **learning environment itself**. Training often involves discussion of emotionally demanding situations and, at times, personal experiences. Trainers and organisations should create learning settings where participation is voluntary, boundaries are respected, and confidentiality within the group is clearly addressed. Ground rules for discussion, respectful facilitation, and opportunities to step back from sensitive topics are important quality safeguards.

Finally, ethical practice in MH-I is not static. Situations evolve, and nurses may encounter dilemmas where competing values, organisational constraints, or uncertainty about next steps arise. Quality assurance should therefore support ongoing reflection on ethical challenges through team discussions, supervision, or reflective learning formats. Treating ethical uncertainty as a normal part of professional practice encourages openness, learning, and responsible decision-making.

By integrating ethical principles and professional responsibility into MH-I education and service delivery, organisations strengthen trust, support safe and respectful care, and ensure that mental health interventions remain aligned with professional values, organisational responsibilities, and the needs of individuals receiving care.

6.6. Roles, Governance, and Continuous Quality Improvement

Clear roles and governance structures are essential for ensuring that quality assurance in MH-I education and service delivery is applied consistently and does not depend solely on individual commitment. In home care and residential long-term care, responsibilities are often distributed across different roles and settings, making clarity particularly important.

At organisational level, responsibility for MH-I quality assurance typically involves management, nursing leadership, and quality or education coordinators. Organisations should define who is responsible for planning MH-I education, supporting participation, monitoring implementation in practice, and initiating follow-up where challenges arise. This does not require creating new roles, but it does require making existing responsibilities explicit and known to staff.

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Education providers and trainers have a specific governance role in ensuring that MH-I education is delivered according to agreed standards. This includes using approved training materials, applying assessment and feedback methods consistently, and ensuring that ethical and data protection principles are respected during training. Trainers should also provide feedback to organisations on recurring challenges observed during training, such as uncertainty in interpretation or difficulties with transfer to practice.

Nurses themselves are active participants in quality assurance. Governance frameworks should make clear that nurses are responsible for applying MH-I competences within their professional scope, documenting observations appropriately, and raising concerns when situations exceed their responsibilities or competence. Quality assurance is strengthened when nurses are encouraged to report uncertainty and seek guidance rather than feeling pressure to act independently in complex situations.

Continuous quality improvement is achieved when organisations create regular opportunities to reflect on how MH-I education and practice are working in reality. This can be done through simple and proportionate measures, such as periodic team discussions, review of selected cases, or brief feedback rounds after implementation phases. The focus should be on learning and adjustment rather than fault-finding.

Governance structures should also allow organisations to respond to change. Updates in digital tools, organisational procedures, or external requirements may require adjustments to training content or workflows. A clear governance framework helps ensure that such changes are communicated effectively and that staff receive appropriate support.

By combining clear roles, proportionate governance, and regular reflection, organisations can embed MH-I education and quality assurance into routine practice. This supports continuous improvement in mental health-related service delivery and helps ensure that MH-I competences remain a stable and valued component of nursing care over time.

7. TRAINING COMPLETION, COMPETENCE MAINTENANCE, AND CERTIFICATION LOGIC

Continuing education in mental health interventions requires transparent approaches to training completion, competence verification, and recognition of learning outcomes. Institutions offering such education operate within different national, regulatory, and organisational frameworks. Universities, vocational education providers, research institutes, and other training organisations may therefore apply different certification or recognition models.

This chapter provides **transferable guidance** for institutions designing or scaling up MH-I education. It outlines **typical approaches** to documenting training completion, maintaining competences over time, and aligning education with national continuing professional development (CPD) systems. Examples drawn from the EDU-MENT project illustrate possible implementation pathways but do not define mandatory or exclusive models.

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7.1. Training Completion and Competence Verification

Training completion in MH-I education should be based on demonstrated engagement and competence development rather than attendance alone. Institutions are encouraged to define clear and proportionate completion criteria that reflect the learning objectives and the practical realities of nursing work in home and residential care.

A transferable completion framework typically combines several forms of evidence. These may include documented participation in required learning components, completion of self-study units, and engagement in guided or facilitated learning activities. Such documentation supports transparency and comparability across cohorts and providers.

Knowledge verification is commonly achieved through short, structured checks that confirm understanding of key concepts before application in practice. Multiple-choice tests are one feasible option, particularly in blended or online formats. They can cover topics such as recognition of psychosocial risk factors, the purpose and limits of screening, interpretation principles, ethical considerations, and referral logic. Their primary function is formative and quality-assuring rather than selective.

Practical competence verification should focus on application in realistic situations. Institutions may use case-based tasks, interpretation of structured assessment outputs, communication exercises, or short action-planning activities. These approaches allow trainers to assess whether participants can integrate observations, apply professional judgement, and translate findings into appropriate nursing actions. Simple criteria or checklists are usually sufficient and avoid unnecessary assessment complexity.

Reflection provides additional evidence of competence development. Short written reflections or facilitated discussions help demonstrate that participants can explain their reasoning, recognise uncertainty, and apply ethical considerations. Together, these elements provide a balanced and defensible basis for confirming training completion across different institutional contexts.

7.2. Reflection, Follow-Up, and Continued Professional Development

Competence in mental health interventions develops over time and benefits from regular reinforcement. Reflection and follow-up should therefore be considered integral elements of MH-I education, regardless of the provider or certification model.

Structured reflection supports nurses in consolidating learning and integrating MH-I competences into their professional role. This may take place during training, shortly after initial application in practice, or within team-based settings. Reflection helps nurses review decisions, discuss challenges, and adapt approaches in response to real-life conditions.

Continued professional development does not necessarily require repeated full training programmes. Scalable and realistic approaches include refresher inputs, discussion of challenging

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cases, updates related to tools or procedures, and integration of MH-I topics into existing team meetings, supervision, or quality discussions. Such approaches are particularly relevant in care settings where mental health-related situations arise intermittently.

Institutions and employers play a key role in enabling continued competence development by providing time, organisational support, and opportunities for reflection. Training providers can support this process through modular learning offers, update materials, or guidance that can be reused across different organisational settings.

7.3. Certification Logic and Alignment with National CPD Systems

Certification or formal recognition of MH-I education serves to document training completion and competence development. It should not imply new professional qualifications, diagnostic authority, or specialist clinical roles unless explicitly defined by national regulation.

Different institutional contexts allow for different certification models. Universities may integrate MH-I education into continuing education programmes and award ECTS or university certificates. Vocational education providers or research institutes may issue certificates of completion or seek recognition through national CPD systems, professional bodies, or competent authorities. These approaches are examples rather than prescriptions and depend on national frameworks and institutional mandates.

To support recognition and scalability, institutions are encouraged to document MH-I education in a transparent and structured way. Useful elements include a clear description of learning objectives, workload, learning formats, assessment methods, trainer eligibility, and quality assurance processes. Such documentation supports alignment with national CPD requirements and facilitates dialogue with accrediting or recognising bodies.

Certificates or confirmation documents should clearly describe the scope of the education, the learning outcomes achieved, and the workload or credits where applicable. Wording should avoid overclaiming and should make clear that certification confirms completion of MH-I education within a defined framework rather than conferring specialist status.

By applying a flexible and transparent certification logic, institutions can adapt MH-I education to diverse national and organisational contexts while maintaining credibility and transferability. This approach supports scaling up mental health-related nurse education beyond individual projects and contributes to sustainable improvement in service delivery.

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