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The nursing process in mental health nursing; not a straightforward process –

A mental health student nurse account.

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Abstract.

Mental health nursing has moved on from the days of asylum but what is obvious today, is the objective approach adopted by government to allocate resources i.e. payment by result. This is tantamount to limited resources commissioned for meeting the vast unmet needs of service users, bearing in mind the figure spent on yearly basis in addressing physical health conditions. This article is a mental health student nurse's account of the tremendous expectations placed on qualified nurses and the emphasis on the need for genuine promotion of recovery in service users. Through reflection on experiences gained in different clinical settings, as a student nurse, author raised suggestions for the betterment of the nurse education curriculum and highlighted what is expected of qualified nurses in contemporary mental health service delivery.

Introduction.

In recent times, debates around the potential changes to be made to the undergraduate nurse education curriculum (Ion and Lauder, 2015; Hemingsway et al. 2016; McIntosh, 2017), limited resources invested in mental health services by the government (Quaile, A. 2017), as well the impact of negative professional socialization has been prominent in mental health service delivery discourse (Ion et al. 2015). Integral to these commentaries and debates, is the subtle advocacy for service users' personal recovery in the grand scheme of things.

In the United Kingdom (UK), personal recovery is strongly advocated for, within policies of mental health service delivery such as No Health Without Mental Health (Department Of Health, 2011) and Five Year Forward View for

Mental Health (National Health Service, 2016a). However, misperception of this concept of personal recovery is evident in today's practice as there is a dichotomy between what the university lecturers teach via theory and what is facilitated and feasible in practice. Within this article, personal recovery will be discussed to a large extent; the role of Care Programme Approach (CPA) vis-à-vis nursing process in the recovery of service users shall be highlighted. Personal reflection as a mental health student nurse will be used to contextualize the subject of recovery. Knowing that universities are working on necessary modalities needed to facilitate the draft and components of *Standards of proficiency for registered nurses* (NMC, 2017), the author believes it would beneficial to suggest approaches that could potentially equip student nurses better for the future to come, with regards to service users different journeys to recovery.

Recovery Model

The recovery-orientated model of care delivery has been around for over two decades, if we go by the self-reporting of people who have lived with mental health conditions (Deegan, 1988). Contemporary nursing has likewise adopted the term 'recovery-focused practice' (Ramon et al 2007), with government's mental health policies in the UK such as *No Health without Mental Health* (DOH, 2011) and all over the world (Davidson et al 2005). Therefore, laying huge emphasis on the need to promote personal recovery in service users. The essence of the recovery model is essentially to empower, and strengthen the self-esteem of service users' (McCranie, 2011; Slade et al, 2014) and creating an alternative pathway, by augmenting the prominent medical model in contemporary nursing.

Despite this, people living with severe mental conditions are likely to live significant shorter life span (Crump, et al 2013; Nwebe, 2017). For instance, obesity in mental health service users is not uncommon, mostly attributed to prescribed atypical antipsychotic medications and people living with severe mental health conditions are highly predisposed to significant physical health challenges, when compared with the general populace (Glasper, 2016). Importantly, other risk factors such as smoking make service users more prone to cardiovascular diseases (Ratcliffe et al 2011; Collins et al 2013). As such, questions can be asked with regards to the place of recovery as it is evident that the mortality rate must be reduced drastically, in order for people living with severe mental health conditions to be able to contribute to the economy of the nation as recommended by the Mental Health Taskforce (NHS, 2016a).

The physical health problems mentioned above, as well as the undesirable side effects of prescribed antipsychotic medications (Lambert et al 2004) for instance, makes it important that recovery in mental health nursing is to be taken seriously. In recent times, lack of physical health skills in mental health nurses have been identified to be an extensive problem and it remains unclear as to whether it is a case of negative attitudes of practitioners towards physical health or a curriculum-based issue (Blythe and White, 2012; Walker and McAndrew, 2015). Even though, due to the subjectivity of recovery as it is unique to individuals, its' components are vague and very difficult to quantify. The recovery model has been identified to help challenge thoughts and assumptions that people living with severe mental health conditions can only get worse (Farkas, 2007). As such, it is therefore

imperative to note that as much as the recovery model embraces service user involvement in their care, which is dependent on the process of care planning, embedded in the therapeutic relationship between practitioners and service users (Grundy et al 2016); it is evident that there are still some ambiguities with regards to the implementation of the recovery model, bearing in mind the dependence of the treatment of mental health conditions on the bio-medical model (Kidd et al 2014).

Nursing Process and Positive Risk Taking.

The bio-medical model within the healthcare context can be described as instances whereby doctors diagnose service users and prescribe medication(s) solely based on physical symptoms (Hamilton and Price, 2013). Additionally, diagnosis appears to be motivated by the wish to treat and possibly cure, hence making the bio-medical model an easier option in terms of implementation (Paris, 2017). In order to see individuals from an holistic point of view attributed with sentient approach and action, putting into consideration the significance of the stress-vulnerability model (Zubin et al, 1977) as well as engineering problem solving skills for care provided by nurses (Melin-Johansson et al, 2017), the nursing process (Barrett et al 2012; Yura and Walsh 1967) becomes fundamental.

All nurses are conversant with the elements of nursing process ASPIRE (Assessment, Systematic nursing diagnosis, Planning, Implementation, Recheck and Evaluation) (Barrett et al 2012) and within the mental health service delivery, the Care Program Approach (CPA) (Department of Health, 2008) mirrors the nursing process. The concept of recovery is well integrated within the CPA framework as it helps in systematic

and holistic assessment of both health and social needs and creates a care plan based on individualized needs, identification of someone to coordinate care and the need to review care (Williams, 2013). However, the CPA framework has been identified to be a managerial tool as the significance of CPA approach has been undermined amid administrative demands (Rinaldi and Watkeys, 2014; Williams, 2013).

Ideally, positive risk taking and risk management are significant components of the CPA approach (DH, 2008). It is the nurses' responsibility to help service users in the context of their recovery, through assessment of risks by harmonizing the advantages of taking risk as oppose to the negative effects of endeavoring to avoid risk altogether (Joseph Rowntree Foundation, 2014). Reinforcing therapeutic risk taking involves consciously exploring what service users' capabilities and means are (Bifarin, 2017), as against their deficiencies and focusing extensively on the need to demonstrate compliance and conformity (Stickley and Felton, 2006). However, the blame culture evident in mental health service delivery (Ward, 2017) appears to take precedence over positive risk taking which is a fundamental step to achieving personal recovery, perhaps due to the complexities highlighted to be associated with promoting therapeutic risk taking (Felton et al. 2017b), as it has been suggested that preoccupation with risk management can be counterproductive (Szmukler and Rose, 2013). As such, questions should be continuously asked with regards to how genuine recovery of service users can be made viable in contemporary nursing.

Reflection: Nurse Education and Professional Socialization.

Levett-Jones and Lathlean (2009) suggested that student experiences and improving experiences is an integral part of effective pedagogy. A series of support mechanisms have been put in place to safeguard and improve the experiences of nursing students, especially while on placement via the Practice Education Lecturers (PELS) and the Practice Education Facilitators (PEFS). This has been of help with authors professional socialization, however, due to the vast differences in personal and professional experiences of mentors across the board, the differences in their implicit and explicit philosophies and values adopted in delivering mental health care, there could be potential questions raised pertaining to student nurses' belongingness and their professional identity as this can be linked to the quality of care delivered and overall job satisfaction (Bifarin, 2016).

Additionally, as much as long-term experiences of mentors can be considered to be a great advantage, there is a possibility that this could also make mentors become cynical in their approaches by overgeneralizing the demands of care delivery (Hellzén et al 2003). Perhaps, this is due to the dominance of the 'top-down' approaches adopted within health and social care reform and to a large extent, disregarding the complex adaptive characteristics of contemporary nursing (Sturmberg and Njoroge, 2016). Regardless of these constraints, it is vital to accentuate that the personal recovery of service users is central to mental health care delivery, which is directly proportional to effective therapeutic relationships between nurses and service users. Hence, making the role of mental health nurses a vital position in terms of treating service users as 'co experts' in their own care (Simpson et

al, 2016), improving their experiences and promoting clinical governance altogether.

To contextualize the aforementioned subject with regards to the significant role of therapeutic relationships, it is not uncommon to see mental health nurses trivialize service users' mental health presentations as being 'behavioural', which in turn result into unconscious reproachful transactions. In support, Felton et al (2017) in their research findings stated that the nursing process, which helps facilitate decision-making, could be focused on the deficits in service users, to a degree that could be detrimental for their recovery journey. It could then be argued that this could result in non-therapeutic defensive practices such as obsessive documentation (Manuel and Crowe, 2014) to a point that the idea of positive risk taking becomes an obscure concept (Henderson and Jackson 2017), which is at odds to the concept of personal recovery.

Conversely, there are other practitioners who are willing to help services users with regards to their intrinsic values such as core beliefs, thought processes, triggers, and managing emotions via Evidenced-based interventions such as Cognitive Behavioural Therapy (CBT). However, due to radical changes being implemented by management within organizations, stressing the need for equity delivery of mental health care, which does not necessarily conforms with the ideology of person-centred care and putting into consideration the judicial precedence associated with Clinical Commissioning Groups (CCGs), it becomes evident why 'postcode lotteries' still manifest in contemporary health and social care delivery.

Practitioners appear to be dispirited as there is evidence of moral distress (Bifarin and Stonehouse, 2016), disputably responsible for the increase in attrition rate for all mental health staff as the number of nurses leaving mental health trusts have increased from 10.5% to 13.6% (Health Education England, 2017). There are concerns that these changes been made will certainly erode the quality of care received by service users (Liang and Nolan, 2015) and if this is how the mentors in placement feel about their profession, then changes that will empower mental health nurses should be urgently considered.

On reflection as a student nurse, knowing that no single theory can be used to explain the aetiology and pathogenesis of mental health illnesses (Hickie et al. 2013), it would be ideal to adopt a model that impeccably supports the concept of recovery, influenced by service users (Jacobson and Greenley 2001; Leamy et al. 2011). However, it appears that the nurse education framework undermines the importance of psychosocial interventions in the context of psychiatry and this ties into what Gray, (2015) suggested to be the lack of knowledge or exposure amongst student nurses, hindering them from addressing all clinical possibilities, as the framework appears to be generic centric, and there is a huge disparity between theory and practice.

This disparity can be baffling and knowing that the principles of personal recovery perfectly align with the research approach of phenomenology (Cutler et al. 2017), questions should be asked why researchers are not exploring this gap between theory and practice in more detail, in order to provide a panacea. Additionally, it is quite worrisome that

mental health student nurses at the point of qualification cannot generally boast of their proficiencies in series of psychosocial approaches such as CBT in this day and age of mental health care recovery oriented care.

The experiences I have encountered have been very different to my expectations before I enrolled for the Pre-registration nursing course. However, I have learnt to embrace these challenges as I am about to transition to a Registered mental health nurse but importantly, there is a crucial need to enhance the training of future mental health nurses, with particular reference to psychosocial interventions as this is where the future of this profession lies.

Knowing that the nurse education curriculum is about to be updated, it is important that future mental health nursing education is not underestimated as it could be argued that hopes of some service users, who expect improvement in their mental health interventions with the 'Improving Access to Psychosocial Therapies Programme (IAPT)', have been dashed. More importantly, the end goal after qualification should be to enable mental health nurses to be able to adhere by the professional values, underpinning their duty of care and yet be creative and confident enough to wholly embrace the concepts of personal recovery and facilitate positive risk taking.

Prominently, there might be need for changes to be made pertaining to how competency is to be ascertained within the nurse education framework. The competency framework could be arguably likened to be a reductionist model, as human and institutional attributes can be over-rationalized, complex practices can also be reduced to a set of skills and at the same time disregarding less noticeable qualities such as accrued experience, implicit

knowledge and instinct (Antonacopoulou and FitzGerald, 1996). Importantly, Lingard (2009:627) based on social learning theories argued for a 'collectivist discourse of competence that move our focus beyond capturing, codifying and documenting knowledge of individuals, and towards the ways through which knowledge is shared, discussed and innovated in a collective setting'.

In this premise, it could then be asserted that mental health student nurses in the UK will highly benefit from innovative mental health clinical placements such as recovery camps; designed with the aim to embed student nurses in the reality of people living with mental health conditions, in order to enable student nurses to participate in immersive and collaborative care provision, which hinges on building therapeutic relationships with service users and promote the person-centred care ideology (Perlman et al. 2017). Perhaps, this approach could help ingrain the concept of recovery by turning attention away from 'patients', 'service users' to persons as described by Peplau (1995), which echoes a concept Barker (1989:138) described as 'trephotaxis', a Greek word, meaning 'provision of the necessary conditions for the promotion of growth and development'.

This will certainly help make sense of what mental health nursing entails for people who undermine the significant role this professional ought to play if adequately supported. Importantly, this idea of recovery based camp placements could arguably align with the idea of being an 'expertise by experience' (Oates et al. 2017), by enabling student nurses to focus on salutogenic dimension to treatment as against the pathogenic viewpoint (Jormfeldt 2011). As such, help foster the notion of belongingness; based on

the different type of exposure these student nurses will gain, which will be somewhat different from what current placements offer.

This will significantly help place genuine recovery at the heart of contemporary mental health nursing as Henderson and Jackson (2017) argued that mental health services are in an almost inevitable stage whereby risk aversive practices are becoming the norm and yet being expected to practice defensibly i.e. service users are engaged, involved and empowered in their personal recovery journey. Against all odds, this is a situation that could help in building competence, capabilities to identify and address unwarranted variations in care delivery, a commitment identified within the National Nursing and Midwifery strategy, *Leading Change and* adding *Value* (NHS, England, 2016b).

In the history of public service, Anderson et al. (2013) asserted that mental health nursing is going through a very difficult phase and following the Francis (2013) report, the study conducted by Csipke et al. (2016) showed that service users' experiences are not improved and the triage system designed to take pressure off hospital beds, have been detrimental to staff. Burnout in mental health nurses is becoming the norm, perhaps due to lack of necessary and appropriate support mechanisms. Rose et al. (2013) suggested that emotional exhaustion in staff members could be attributed to lack of adequate knowledge and limited internal coping skills, associated with managing difficult situations. It could then be argued that emotional intelligences which encompasses the concepts of self awareness, self regulation, motivation, empathy, and social skills (Goleman, 1999), an invaluable asset in mental health nursing and student nurses will benefit from

formal resilience workshops and assessments, as equanimity will go a long way in helping professions think critically about care provision, in the premise of personal recovery. This in turn, will potentially improve the experiences of service users.

Conclusion.

This article has been a personal account of the present and project into the future of mental health nursing, asserting how the value of the nursing process could be marginalized by virtue of the conscious and/or unconscious efforts of mental health nurses. Promoting personal recovery of service users is key to professional identity and positive professional socialization of student nurses. Importantly, it is about time student nurses paid attention to changes that should be made in practice; not necessarily bad practice but perhaps critically thinking about available pathways associated with mental health condition treatments. This in turn, will help with regards to safeguarding the future of mental health nursing in the United Kingdom in all ramifications, as no precedence of any kind should be allowed to restrict the greatness and creativity of mental health nurses.

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