



FEATURE ARTICLE

What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use

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ABSTRACT: *Mental health nurses are in challenging positions. They have the opportunity to support people hospitalized for the treatment of mental illnesses on their recovery journeys, but are simultaneously required to manage a burgeoning administrative burden, maintain organizational 'order', and contain risk. While obliged by policy to engender an environment that promotes recovery, they receive little guidance about how this should be achieved. When feedback from people hospitalized in our service indicated the experience of care was variable, we undertook a pragmatic inquiry examining consumers' views about what makes an excellent mental health nurse. We interviewed 20 people with lived experience of hospitalization and analysed transcripts thematically. To ensure findings were relevant and useful, we consulted mental health nurses about nurses' needs, and incorporated this with the views of service users. The analysis demonstrated that personal qualities, professional skills, and environmental factors all influence the experience of mental health nursing. Our findings highlight a need for renewed attention to the basics of relationships and the importance for nurses of self-awareness and support. We urge nurses to make time to really get to know the people for whom they provide care, and to work to maintain passion for mental health nursing. It seems likely that attention to the simple things has the potential to improve levels of satisfaction among service users, decrease distress, and support the development of an environment in which can nurture recovery.*

KEY WORDS: *mental health nursing, patients' experiences, quality improvement, recovery, user involvement.*

INTRODUCTION

The view that people who use mental health services have important contributions to make to service development is widely endorsed. The principle of 'user involvement' is embodied in legislation and policy across the Western world, and endorsed by various professional associations, including peak nursing bodies (e.g. the Australian College of Mental Health Nursing). Arguments have been made

that service users and carers are well placed to identify the qualities, skills, and abilities which constitute best practice (Aston & Coffey 2012; Edwards 2000). However, it has also been observed that service users have been afforded limited opportunity to express their views about treatment and what supports recovery (Borg & Kristiansen 2004; Ning 2010). With this in mind, we report the views of people with experience of hospitalization for mental illnesses about the type of care they want from mental health nurses. Before doing so, we set the scene by describing the challenging context within which mental health nurses work.

Brief acute inpatient care is an integral component of mental health systems in developed countries. The hospitalization of people for the treatment of mental illnesses, sometimes involuntarily, might serve diverse

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functions for individuals and/or society (Quirk & Lelliott 2002). These include contributing to the containment of risk, the provision of safety, crisis management, assessment, and enabling (re)integration in the broader community (Baguley *et al.* 2007; Bowers 2005; Bowers *et al.* 2009a). However, the effectiveness of inpatient care is uncertain, and patients are inconsistently satisfied with care as a whole or components of that care (Kuosmanen *et al.* 2006; MIND 2004). Optimization of the process and outcome of hospitalization is an ethical imperative. However, this is more easily said than done; contemporary psychiatric inpatient units (PIU) are dynamic systems located within complex socio-political environments.

The operation of PIU is shaped by a myriad of ethical, legal, and social factors; professional roles and staff mix, and the characteristics of people admitted necessarily affect dynamics in any given situation. In Australia, legislation requires treatment in the least restrictive environment, and reflecting government endorsement of the 'recovery approach' (Leamy *et al.* 2011), policy obliges mental health services to provide enabling environments and empower individuals to work towards personally-meaningful goals.

People admitted to PIU are typically acutely unwell, are often distressed, and have complex needs. Already vulnerable, they enter regulated environments and transient communities comprising people with whom they have little in common (except the diagnosis of a mental illness) and might prefer not to interact. Although modernization of mental health care has supported a substantive shift from the total institution described by Goffman (1968), the smooth operation of the units is dependent on structure and conformity. Patients are subject to constraints on movement, regulation of activities of daily living, and are constantly 'observed'. Research demonstrates that patients' experiences of care are mixed, but many feel bored and unsafe, and mental health nurses have been perceived as inaccessible (Bee *et al.* 2007; MIND 2004; Remnik *et al.* 2004). While the exception, rather than the rule, so-called 'challenging behaviours' (i.e. violence, absconding, self-harm, rule breaking, and medication refusal) emerge in some circumstances, negatively impacting patients, staff, and the therapeutic milieu (Hamrin *et al.* 2009). Tensions abound as teams of professionals with diverse training and experience attempt to balance the requirements to contain (real or perceived) risk, complete administrative duties, and provide person-centred care in the least restrictive environment.

Given their central role in PIU and the ethic of care that underpins their profession, nurses are perhaps more subject to these tensions than most. With perceptions of

the quality of care inexorably entangled with satisfaction with nursing (Edwards 2000; Remnik *et al.* 2004), mental health nursing practice has been subject to scrutiny. Questions are asked about the rightful role of mental health nurses, and substantial literature describes barriers to enacting the therapeutic relational role that was historically central to mental health nursing. Relatively less attention, however, has been paid to what is done well (Cleary *et al.* 2012). Although required to nurture a 'recovery' culture, nurses are provided with little guidance about how this is best achieved, and there is a paucity of advice on how nurses should interact with people in their care to ensure that needs are met (Bowers *et al.* 2009b).

It is to this gap our paper is addressed. We aim to inform consideration and development of practice by representing the views of service users and carers with respect to nursing care, supplemented by advice from senior mental health nurses about how best practice can be achieved.

METHODS

Setting and background

The inquiry was undertaken at Metro North Mental Health–Royal Brisbane and Women's Hospital (MNMH–RBWH) to inform quality improvement. MNMH–RBWH provides specialist mental health care to a population of approximately 330 000 living within a geographically-defined catchment, encompassing inner city and suburban areas. Four community-based multidisciplinary teams are linked to three adult PIU to which 210–260 admissions are made each month. In line with National Standards for Mental Health Services (Australian Government 2010), MNMH–RBWH undertakes continuous quality improvement activities and endorses service user experience as a measure of quality. The active involvement of service users and carers in service development is facilitated by consumer and carer consultants and a formally-constituted consumer and carer feedback group (CCFG). The consumer (IG, who has experienced multiple PIU admissions) and carer (TR) consultants routinely undertake diverse consultation activities and represent constituents' interests in service decision-making processes. The CCFG, comprising eight people with experience of mental illnesses or caring for someone who has (including TP, who identifies as a carer) is an advisory body with links to health and community agencies.

Design

The inquiry, as depicted in Figure 1, was initiated when analysis of feedback gathered from suggestion boxes on

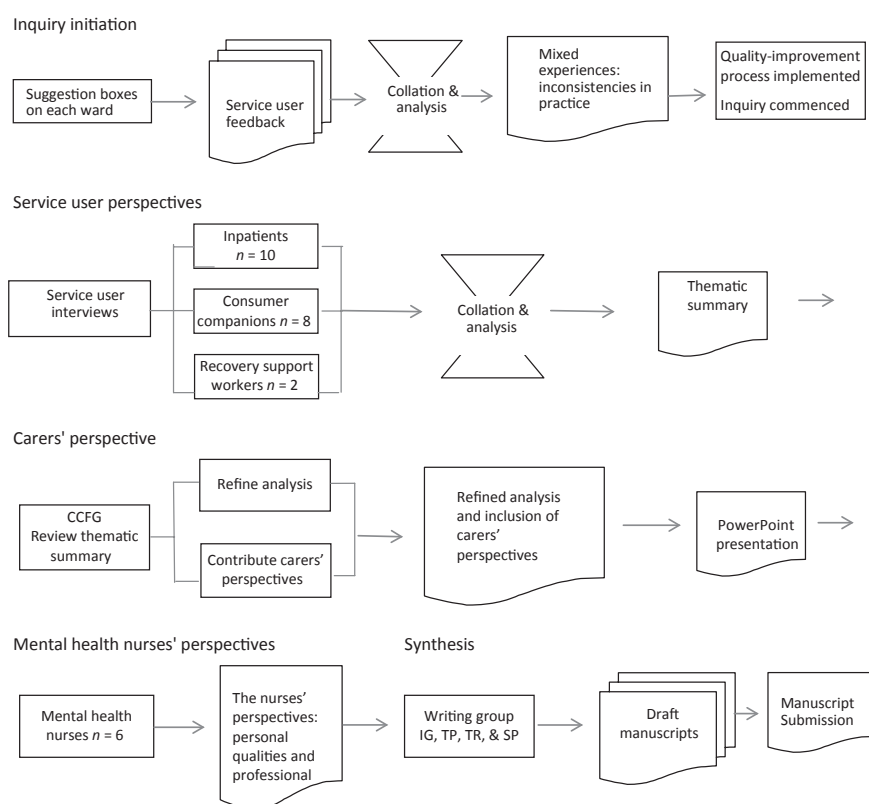


FIG. 1: Inquiry process and development of findings. CCFG, consumer and carer feedback group.

PIU demonstrated mixed experiences of care. In response to this, IG set out to more fully understand the experiences of service users. Specifically concerned to establish what people hospitalized in PIU wanted from nurses involved in their care, IG formulated the question: What makes an excellent mental health nurse?

Consistent with the goal of understanding experience, a qualitative approach was adopted. The inquiry was predicated on interactionist construction of experience (Strauss 1993), and designed to inform quality improvement, was underpinned by commitment to coherently representing the views of service users and developing solutions to real world problems on the basis of shared understanding. The inquiry was thus philosophically pragmatic.

Participants

Participants included people with lived experience of inpatient care for the treatment of mental illnesses (i.e. service users), carers, and mental health nurses involved with MNMH-RBWH in various capacities. Participants were selected purposively, because they had experience and knowledge pertinent to the inquiry. All were recruited by IG.

Service users were people currently inpatients at RBWH psychiatric wards, and recovery support workers and consumer companions (i.e. service users employed to provide), employed by MNMH-RBWH to provide non-clinical and peer support to inpatients, were approached as appropriate to circumstances. In her consumer consultant capacity, IG has unfettered access to PIU, which she visits regularly to meet with inpatients. When attending wards for this inquiry, IG approached nurse unit managers (NUM), and confirmed that it was appropriate to approach inpatients in shared spaces. IG approached service users who were sitting alone, introduced herself as someone with lived experience of hospitalization, and explained her role. Each person approached was advised that IG was gathering opinions regarding experience of nursing care, particularly what was done well and what could be improved. Half of the 20 inpatients approached declined to be interviewed. IG invited the two recovery support workers employed by MNMH-RBWH to be interviewed during routine business, and each of the eight consumer companions employed by the service was contacted by telephone. All agreed to participate. Carers were recruited through the CCFG.

Mental health nurses, selected purposively on the basis that they had specialist knowledge relevant to the inquiry, were invited to participate after data from people with lived experience of hospitalization were analysed. NUM of each PIU, the nursing director, and two community-based nurses, whose roles encompass provision of support to people in PIU, were invited in person to contribute to the inquiry. IG explained the work undertaken to date, and that she was interested in learning what nurses considered necessary to enable delivery of the kind of care service users valued.

Procedure

Data were collected in various ways, dependent upon stakeholder group, during February 2012, in three waves; first from service users, next from carers, and subsequently from mental health nurses.

Data were collected from service users by IG in unstructured interviews. Interviews were conducted in a space and manner that afforded comfort and privacy convenient for each participant. Service users were interviewed within the wards to which they were admitted, recovery support workers in office spaces, and consumer companions by telephone.

A conversational, solution-oriented approach was taken to interviews. While enabling participants to share matters of concern to them, conversations were guided by the two broad questions that were central to the quality improvement process: (i) What makes a fantastic mental health nurse?; and (ii) What can we do better? IG used active listening skills and unscripted prompts to encourage exploration of expressed views.

The interviews varied in duration, from 3 to 15 min, with most lasting 8–10 min, and reflected participants' differing roles, personalities, and expansiveness. Interviews were manually documented, including verbatim quotations.

Data collection continued until all recovery support workers and consumer companions had been interviewed, and saturation was achieved with respect to inpatients.

Data analysis and development of carers' perspectives

Data from service users were analysed iteratively by IG and six members of the CCFG. The analysis, informally occurring as IG reflected during interviews, was formalized when data collection was complete. IG repeatedly read the records to develop familiarity with the data. Next, a process of constant comparison of data within and between records was used to identify similar content.

While a complete record of each interview was retained, similar data were grouped as themes, with each group labelled descriptively.

This thematic analysis was presented by IG to members of the CCFG at a scheduled meeting. Discussion supported consensus that identified themes that resonated with members' experiences and 'made sense'. However, members also proposed that the carers' perspectives be included, and considered further analysis to be warranted. The group agreed to develop the carers' perspectives and undertake further analysis. TP coordinated these tasks, liaising with members to identify carers' concerns and develop analysis. Subthemes were developed, and the relationships between themes were modelled. IG developed this revised analysis, incorporating the carer perspectives, into a PowerPoint presentation.

Development of mental health nurses' perspectives

Nurses were collectively shown the PowerPoint presentation, and were invited to discuss its content and make recommendations. Their feedback suggestions were documented and synthesized with findings in relation to service users and carers.

Synthesis

The analysis and interpretation of findings necessarily continued as the authors, including SP, a health service researcher employed by MNMH-RBWH, further explored the data and developed this account of the inquiry. A critical, reflective approach was adopted, as authors played 'devil's advocate' to examine the process of inquiry and development of findings.

Conducted as a quality improvement activity during the course of routine business, the inquiry was exempt from formal ethical review, confirmed by the chair of a National Health and Medical Research Council-registered human research ethics committee. All activities were undertaken in a manner consistent with the 1995 Declaration of Helsinki (as revised in Tokyo, 2004), with full regard to the rights to dignity, privacy, and self-determination of all concerned. With the exception of the anonymous service users interviewed during their stay in hospital, all participants gave permission for publication.

RESULTS

Twenty interviews were completed with two consumer recovery workers, eight consumer companions and ten service users, hospitalized at the time of consultation. In addition to the authors, a further 12 stakeholders (six

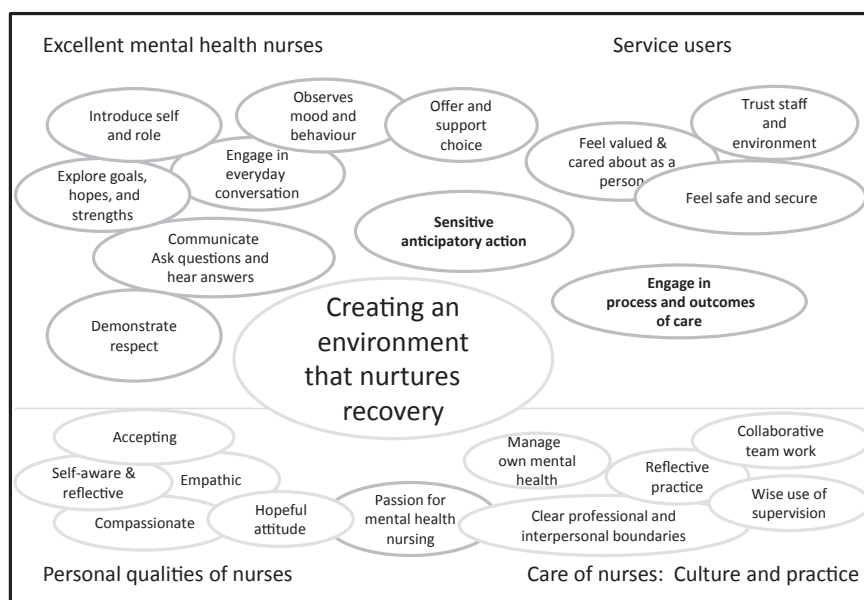


FIG. 2: *Creating a recovery-oriented environment.*

consumers and carer representatives and six mental health nurses) were involved in the analysis, development and interpretation findings which collectively represent the views of service users, carers and mental health nurses.

Analysis demonstrated that the 'excellent mental health nurse' is a complex construct. Inquiry participants agreed that personal qualities, interpersonal skills, professional resources and environmental factors all influence the delivery and experience of mental health nursing care. Best 'recovery oriented' practice mental health nursing, according to service users is grounded in an empathetic approach, underpinned by respect and a friendly demeanour. Senior nurses advised that diligent attention to self-care and reflexive practice, are essential to achieving this. Figure 2 is graphic representation of the findings of the inquiry articulated below.

Service users' perspectives

The messages from service users are simple and clear: people who are hospitalized for the treatment of mental illnesses want to feel cared about and be treated compassionately. Respect, manifest in the manner in which duties and interactions are enacted, is fundamental to optimizing the experience of hospitalization. Service users want to see and sense that mental health nurses are genuinely curious about their personal life stories and experiences; they want to be recognized and treated holistically (not as a collection of symptoms to be controlled). Excellent mental health nurses make it their business to learn

about each person's hopes, goals, strengths, and aspirations, and to do what they can to encourage progress along the 'recovery path'.

Simple things matter enormously to people who have (or perceive) little control over what is happening to and around them. Service users ask that nurses introduce themselves at the beginning of each shift, explain their role, and make time to talk with them during the shift. Service users want the opportunity to engage in general 'time-of-day' conversation while ward business continues. Service users say these things make a positive difference to their recovery journey, and build rapport and trust:

Let the patient know if you don't know the answer to a question, and tell them that you will get back to them when you find out the answer and get back to them.
(Service user)

Respect means refraining from inappropriate discussion about service users generally (negative talk is contagious), and particularly in corridors and lunch rooms where conversations might be overheard. Gossip is never OK but when 'debriefing' after a difficult or even amusing encounter is necessary this should be in a private space in a professional manner (using respectful language).

Service users want to know what you know about them – communication about the process of care should be clear, honest and frequent. Service users ask that nurses explain clearly what will be happening during the day/shift and what longer term plans are. Because nurses are

seen as the link to doctors and other allied health professionals on whom treatment and potentially discharge may be dependent, service users expect them to know what is going on and to share that information freely. This matters both because the content is important and because communication represents being cared about. Nurses who listen carefully and check for shared understanding are highly regarded.

Service users want nurses to be attentive. Acknowledging that frustration was often evoked when apparently simple (or basic) needs were not met, service users agreed that sensitivity to mood (of service users and the ward) and anticipating service user's needs and meeting them or explaining why particular needs could not be met could avert difficult interactions and potentially episodes of seclusion. Excellent mental health nurses acknowledge service users promptly:

... no-one likes to be ignored. Please speak to someone waiting at the nurses' station, even if they are not your patient. (Service user)

Service users asked that even when busy, nurses take a few moments to explain why a request could not be actioned and arrange to follow up.

Carers' perspectives

Please listen to us. Carers can make an invaluable contribution to care. Communication is the key. (TP)

Carers are impacted in diverse and complex ways by hospitalization, and should be involved in care wherever possible. Carers can contribute substantially to inpatient care, easing the burden on nursing staff and hastening recovery of service users if they are appropriately supported and engaged. Carers can provide important information about service users and their circumstances, enabling appreciation of the whole person:

Like consumers, carers should also be treated with compassion and respect and to feel they are being heard. (TR)

While permission should be sought before sharing personal details, carers have a right to general information about services and treatment of particular conditions. Meeting carers' personal needs for information and/or support will promote engagement in care and better outcomes.

Mental health nurses' perspectives

Nurses affirmed the views of service users, as set out above, and provided guidance to made recommendations to support nurses practicing in the way desired by service users.

From the nurses' perspectives, being clear about and promoting the rights and responsibilities of service users was considered crucial to establishing the relationship that is fundamental to effective practice. Nurses need to provide sufficient guidance to enable service users to negotiate ward routine and practices, such that they know what is not negotiable and are not left wondering what is acceptable. Being explicit about what speech and behaviour are acceptable in which circumstances is vital to avoid inadvertent boundary transgressions or anxiety, either of which might precipitate conflict situations.

Nurses emphasized the centrality of collaborative teamwork to effective, empathetic nursing practice. Because receiving mixed or conflicting messages about care and boundaries creates confusion and frustration for service users, the care team should ensure clear communication. Importantly, professional differences of opinion about care processes should be managed sensitively, and the service user provided with all information needed to play an active role in care planning. Handovers need to be comprehensive. They should encompass discussion of the service users' goals, strengths, and aspirations; engagement with family; and include details of any agreements made in relation to care. Best practice might require a nurse to advocate on behalf of a service user, for example about medication or leave, with other team members, and this might involve critical reflection on care.

Best practice is possible only when nurses are self-aware and manage their own mental health well. Nurses stated that maintaining hope and compassion in what can be challenging circumstances requires effort; celebration of the intangible rewards inherent in mental health practice is crucial:

Remember what inspired you to choose this career, and find some joy in your practice every day. (Mental health nurse)

Reflective practice incorporating critical examination of personal assumptions, thoughts, actions, and interactions with colleagues and service users *in situ* (Somerville & Keeling 2004), and wise use of supervision, are crucial to ensuring that care remains person centred. Dynamic self-awareness was in turn considered fundamental to each of these and crucial to management of interpersonal and professional boundaries. If (when) problematic encounters occur, these are best viewed as learning experiences:

Nurses should make time to debrief, to express frustrations, and explore the circumstances surrounding the incident so it doesn't negatively impact them or practice. (IG)

Ultimately, consensus among all involved in this process was that having a passion for mental health nursing and a genuine commitment to helping others were crucial to nurses' well-being and the quality and experience of care.

DISCUSSION

Research demonstrates that people hospitalized for the treatment of mental illnesses have inconsistent experiences of service, and are often dissatisfied with process and/or outcome of admission. Given the crucial roles inpatient care plays within a mental health system, typically supporting service users at their most vulnerable, targeted quality improvement activities are essential (MIND 2004).

Statement of key findings

Drawing on the complementary expertise of people with experience providing and receiving inpatient care for mental illnesses, we have described the qualities and actions of an excellent mental health nurse and (some of) the support needed to enable the development of an environment that nurtures recovery. Interviews with people with experience of hospitalization demonstrated a desire to be treated holistically, with regards to personal needs, with a 'human touch'. Clinical knowledge, technical skill, and textbook communication techniques were not spontaneously discussed by any of our participants. Perhaps this is because such things are taken for granted, or perhaps it is because what matters most is being treated kindly and feeling respected. Carers want to be involved and have much to offer when appropriately supported to engage with the care team; they also have needs that should be addressed so that they are enabled to contribute. The excellent mental health nurse is compassionate, attentive, and engaged in his or her work. Such qualities support the development of a culture that is conducive to sensitive anticipatory action, described by Weaver *et al.* (2003) as an approach to service delivery that is likely to optimize outcomes. Reflexivity and appropriate supervision are essential to the maintenance of the hope that must be shared with service users if recovery is to be nurtured.

Our findings are not novel; rather they reinforce messages that 'how' care is delivered is at least as important as 'what' care is delivered, which have long been articulated. As proposed by Hansson *et al.* (1993) 20 years ago, 'Patients put the highest emphasis on staff empathetic qualities: being caring, interested and understanding, respecting patients, devoting time to patients, and creating a safe treatment environment'. People admitted to

hospital for care due to mental illnesses are not seeking costly or extravagant therapies, but positive interpersonal relationships and relevant compassionate support (Borg & Kristiansen 2004; Bowers *et al.* 2009a; Edwards 2000; McIntyre *et al.* 1989).

This work is novel, however, in its origins and conduct. As Ning (2010) argues, 'It is rare that there is an effective structure within a mental health service to systematically gather consumers' and carers' experiences . . . it is even rarer for the service to use this type of information to redesign and improve quality of services collaboratively with their consumers and carers' (p. 113). The inquiry described was instigated when feedback routinely gathered demonstrated room for improvement. The process was designed and led by a service user employed by a service, and has supported implementation of training to improve services.

Given the concordance with existing literature and its grounding in the real-life experience of a variety of stakeholders, we consider the 'findings' of this inquiry valid and credible. However, caution must be exercised in generalizing. Information was gathered in a particular context with a particular group of stakeholders for a particular purpose. The question, 'What makes an excellent mental health nurse?' framed the inquiry, necessarily shaping the information provided. Moreover, the inquiry was practically constrained by various factors, including resources. It is entirely possible that posing a similar question to different stakeholders or framing the inquiry differently would support the development of alternate understandings. We also note that we are not independent observers; each of us is embedded, albeit in different ways, in the organization within which the inquiry was undertaken, and we have a commitment to improvement of the care provided. Our personal characteristics, professional training, and predilections have necessarily shaped the representation of views of informants. Mindful of this, we put our account forward, not as 'the truth', but as a contextually-situated understanding of what matters to people hospitalized for the treatment of mental illnesses.

We urge mental health nurses to be cognizant of the influence of their interactions with people hospitalized for the treatment of mental illnesses on the experience and process of care. As noted by Borg & Kristiansen (2004), 'Little things can have a great meaning and impact' (2004; 499), particularly on someone who is 'vulnerable' to the control of others. We invite nurses to consider whether their ways of interacting reflect a person-centred ethos and the compassion, courage, and respectfulness considered role virtues in nursing practice (Armstrong 2007). In contexts where people might not be free to choose to

leave, where they are subject to institutional rules, and diverse other influences shape their daily lives, great care must be taken to promote autonomous decision-making and action wherever possible. Making time to work therapeutically in an acute care setting might require nurses to challenge bureaucratic administrative processes and engage in robust discussion with team members. It will certainly require passion, empathy, talking with and listening to people hospitalized for the treatment of mental illnesses, and self-care.

Although mental health nursing is recognized as a specialized field of practice, many nurses employed in psychiatric units do not have specialist training, and many experience frustration at not being able to work therapeutically (Cleary 2004). In these circumstances, we consider it particularly important that robust mechanisms be established to ensure that nurses are appropriately socialized to recovery-oriented practice and supported to enact person-centred care. Establishing and maintaining a culture that promotes recovery takes time, commitment vigilance, and partnership among diverse stakeholders.

We recognize this as a beginning, and will continue to monitor service user feedback and work with nurses and other staff to improve care as indicated. Our next step will be to conduct a similar exercise with doctors.

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