Three issues for mental health nurse educators preparing new preregistration programmes

Ion, Robin
Patrick, Leanne
Chouliara, Zoe
Barlow, Emily-May

This is the Author Accepted Manuscript. The final published version is available in Mental Health Practice, published by RCNI. DOI: https://dx.doi.org/10.7748/mhp.2020.e1453

Ion, R., Patrick, L., Chouliara, Z., Barlow, E-M. (2020) Three issues for mental health nurse educators preparing new preregistration programmes. *Mental Health Practice*.

Implications and recommendations

The new NMC standards for education provide a rare opportunity for Universities to address some of the challenges facing mental health nurses in the UK.

We identify three areas where educators have an opportunity to make a significant difference to the student experience and, most importantly, to service user health.

In facing these challenges, educators can make a major contribution to the continued survival and relevance of the pre-registration specialty in the UK.

Abstract

Universities across the UK must develop and have in place new pre-registration programmes by 2020. Unlike in the rest of the world, where initial nurse preparation is generic, pre-registration education in the UK allows students to specialize in one of four specific fields of practice - adult, mental health, child or learning disability. To the relief of many , the new standards confirmed the continued survival of the specialist fields at undergraduate level. Educators across the UK now have an opportunity to fully review existing provision and address areas of significance. This paper explores three such issues. These are:

- How best to respond to adverse life experiences or trauma.
- The ethical tension which we believe is inherent in the use of coercive practice.
- The potential to make a difference to the appalling mortality statistics which indicate that people with long standing mental health problems die much younger than their contemporaries

In each case we make tentative suggestions for how they might be approached.

Keywords: Trauma informed, Mental Health Nursing, Curriculum, Ethical, Public Health, Education.

Introduction

Since 2010 all new entrants to pre-registration nursing in the UK have enrolled on undergraduate or masters level degrees (NMC 2010). Most of these require the completion of a three or four year programme, which includes a minimum of two thousand three hundred hours of practice learning and an equal amount of theoretical study . Those successfully exiting these courses may register with the NMC in one of the four fields of nursing .

Partly driven by demographic change, economic factors and the natural course of professional development, the NMC (2018) published new standards in May last year. There is much that is new

in these, including an enhanced emphasis on a broader and more complex set of physical skills and a stronger focus on medicines administration and pharmacology. Change, however, has not simply been a consequence of natural evolution . In part it also reflects concerns about the nursing profession as a whole with some arguing that, post Willis (2012) , and in light of recent high profile care failures (Ion et al 2019), it was time to abandon the traditional UK model in which students opt for a field specialism on programme entry. In its place, and in line with the rest if the world, a generic approach to nurse education, with field specialism only occurring post registration, was proposed. Following significant pressure from within the specialty (Butterworth and Shaw 2017) and to the relief of many mental health nurses, the pre – registration fields have survived. It would, however, be naïve to assume that this survival is permanently guaranteed – rather, it may need to earned on an ongoing basis. In our view, change on the scale outlined in the new standards provides an opportunity to ensure our programmes are fit for purpose and that the nurses who graduate from them are fully prepared for the challenges they will face going forward. Over the course of the coming months, educators have a chance to review, refresh and reconfigure their existing courses and in doing so make a major contribution to both the educational experience of students and, most importantly, to the lives of those who come into contact with services.

In this piece, we explore three challenges facing educators as they prepare their new mental health nursing courses. In each case we outline the problem and suggest tentative solutions.
First, we consider the issue of adverse life experiences or trauma; often, but not exclusively, occurring in childhood. Second, we examine an area of ethical tensions inherent in the role of the mental health nurse and which many face on a daily basis – the use of coercive practice.
Finally, we explore how mental health nursing could make a difference to the appalling mortality statistics which indicate that people with long standing mental health problems die much younger than their contemporaries who do not experience these difficulties.
Without doubt , some will see other areas which require attention - our focus is specifically on areas which we believe are significant for both patients and registrants and which we believe are amendable to change.

Trauma informed education

Exposure to trauma of various forms, including sexual, physical and emotional abuse and neglect, is not only a statistical likelihood in the population using mental health services, but is also widely believed to be a causal and maintaining factor in poor mental and physical health (Moore et al. 2010). Trauma of this type has also been shown to have a significant impact on survivors' use of services and their ability to form trusting relationships (Reeves and Humphries 2018), and is likely to be implicated in the development, continuation and day-to-day experience of those who have been exposed to it. With this in mind, it is essential that mental health nurses have a well-devel-

oped understanding of trauma; equally, that they are able to use this knowledge to inform their interactions, care and support of survivors. Unfortunately, there is reason to think that trauma-informed nurse education may be inadequate (Zalm et al. 2015) and that many students are insufficiently equipped to work with this issue (Stokes et al. 2017). What then might a trauma informed curriculum look like?

Before discussing this it may be helpful to clarify that we do not propose that undergraduates be trained as psychotherapists, with the ability to directly treat trauma. This level of expertise is far beyond what can realistically be offered in first level nurse education. Rather, we argue for the development of competence in trauma informed care. By this, we mean the development of sensitivity to the fact that many service users will have experienced trauma, that this may well have impacted the development of their current presentation that it may colour their response to offers of help and that, in some cases, its effects may well require referral for specialist input. Awareness and understanding here are vital, but they are only a first step toward education which delivers trauma informed care.

We believe that a clearly articulated philosophy of trauma informed practice at programme level is required to maximise student understanding and competence. This is necessary to avoid the pitfalls associated with piecemeal implementation of concepts which require more substantial treatment.

In terms of content, Wilson et al. (2017) and Muskett's (2014) work suggest that education which recognises and respects individual experience, that emphasises the value of working in ways which encourages collaboration and choice, and conversely which minimises professional domination is likely to be helpful for this client group.

Programmes must also equip students with the high level interpersonal skills that are vital to skilled and effective mental health care of this population (Zalm et al. 2015). The ability to listen, to be present, to respond sensitively and to provide validation and comfort in the face of the most distressing stories are the fundamental skills required. Moreover, competence must be assessed and this assessment must explicitly address the needs of those who have experienced trauma - put bluntly, broad assessment of student interpersonal skill is not the same as the focused assessment of ability to provide support for someone who has taken the decision to reveal a history of domestic violence or sexual abuse.

Similarly, educators need to consider how best to develop personal awareness - we should not underestimate the complexity of what is meant here. Without a robust understanding of self and how this may impact on those in need of support, there is a distinct risk that we will perpetuate the distrust of others that can so often be a consequence of trauma and that, in our inability to moderate ourselves, we create the conditions for retraumatisation. In a recent paper, Bliss (2018) suggested that mandatory participation for students in psychotherapeutic group work might be a route to achieve the level of insight required to work effectively across a range of nursing settings. This is a

popular approach in counsellor training and it may be that mental health nurses should also consider its potential utility. By extension, this approach might also be useful as a way of helping those professionals whose own lives have been affected by abuse, neglect or mistreatment. It would, after all, be an outrage if the profession expected those on the front line of distress to provide support without also considering the psychological impact of this upon the nurse. An example of what a trauma informed curriculum might look like is provided by Young et al. (2019).

Ethical dilemmas: coercion

Mental health nursing is shot through with contradictions. On the one hand, its mission is to provide care for those distressed by psychological phenomena, while on the other and as part of this, the nurse has the power, under certain circumstances, to legally take away the liberty of the individual, to detain them against their will, to restrain them and enforce treatment. It is not the intention of this paper to create a position statement about whether forced treatment is ethical or unethical. Rather, we acknowledge its reality and note that few other professional groups have a level of power which equals that held by mental health nurses - where they do, for example, the police, and security services, their primary role is invariably accepted as authoritarian.

What then is the solution to this situation, where commonly used interventions provoke strong reactions (Kontio et al 2012) and where those who enforce them have another role whereby they are required to develop therapeutic relationships with the recipients of this enforced 'care'?

Several issues are worth exploring. First, although an aspiration to eradicate controlling aspects of care is laudable, a reduction in the use of such interventions is perhaps more achievable in the short term, while a better understanding of its potential impact when used after other options have been exhausted might mitigate some of the reported negative effects. For this to happen, students must be taught the knowledge and skills required to reduce the likelihood that coercion will be required. Emerging evidence around the Safewards model (Bowers et al 2015) provides an example that could be drawn on to help future registrants minimise the use of custodial approaches. When coercion is the only option, it is vital that those who take part are fully aware of the gravity of their decisions and that these are properly thought through before being enacted.

While much is made of the potential for reflection to change practice, there is also a recognition that it is sometimes approached in an instrumental fashion, as a task to achieve in order to meet a learning outcome or to please a marker (Murdoch-Eaton & Sanders 2014) To promote deep, personal learning, academic staff might therefore wish to look beyond the standard models of reflection to approaches which encourage a more rigorous internal, ethical dialogue in which the individual examines their personal and professional ethical position and values, their motivations and thoughts, and evaluates these in relation to particular courses of action. The development of this capacity is essential if we are to produce registrants who can reflect in and on action with regard to their impact on those vulnerable others for whom they provide care (Roberts and Ion 2014).

The physical health of people with enduring mental health problems

There is now a growing acceptance across the profession that mental health nurses must respond to the very clear and significant differences in morbidity and mortality which exist between those who live with severe mental health problems and those who do not. The evidence that physical health is poorer in this group and that they are more likely to die earlier than their peers is now unequivocal (WHO 2018). The great majority of this reduced life expectancy is accounted for by cardiovascular and respiratory illness, infectious disease, diabetes and hypertension (Dickens et al. 2019). Often lifestyle related - linked to obesity, smoking and substance misuse - and exacerbated by social exclusion, difficulty accessing services, poverty, stigma and long-term use of psychotropic medication, this is an area where mental health nurses can and must make a real difference. The evidence suggests that while many practitioners share this view, they often lack the confidence and skill to provide the required care (Bressington el al. 2018). The new programmes must ensure that all newly qualified nurses are properly prepared to deliver evidence-based interventions which effectively support behaviour change, for example smoking cessation for those who are open to giving up smoking, harm reduction in those who are considering changing their relationship with substances, and weight management for the obese.

There is also an urgent need to address the sexual health needs of those with mental health problems. It is a matter of fact that there are higher rates of unwanted pregnancy, sexual violence and coercion, unprotected sex and associated disease in this group (Quinn et al 2018). While there may be uncertainty about the most effective ways to address these matters, there can be little doubt that we must raise awareness of them among future mental health nurses and ensure they have the confidence, skill and knowledge to address the sexual health needs of service users and be able to signpost sources of more specialist help - to remain quiet as a result of embarrassment or lack of knowledge is simply not acceptable.

Programmes must also consider how to prepare students to offer practical help, for example, with the completion of benefit forms and housing applications - without money, food and a safe place to live, efforts to promote smoking cessation , improve eating patterns and influence other aspects of behaviour are unlikely to yield long term benefit.

Upskilling the workforce to deliver interventions has the potential to make a difference, however on its own it will not be enough. To realise the full potential offered by grasping the public health agenda, mental health nurse education must engage its students in a meaningful discussion of the social and political environment, which frames health care and within which inequality is played out. If we are to avoid the simplistic neoliberal solutions which promote self-help and resilience building at the expense of a strong and supportive welfare system, then the version of public health which we deliver must be a critical one which not only recognises the pivotal role played by social

determinants and intervenes to mitigate the impact of these, but which also actively challenges the legitimacy of a system which perpetuates them.

Conclusion

We have outlined three challenging areas and possible solutions which educators might wish to consider when developing their new undergraduate programmes. Each presents a significant opportunity to make a difference. Others may see different problems and other possible solutions. If we are to make a real difference, we need to systematically address each of these across our new mental health nursing courses. The degree to which we are successful in doing this will impact the lives of service users, their families and friends and those who provide nursing care. It may also determine the future of the specialty in the UK.

References

Bliss, S. (2018). Could we remedy the 'crisis of care' by incorporating mandatory group psychotherapy in nurse education? Nurse Education Today, 61, 25-27. doi:10.1016/j.nedt.2017.11.001

Bowers, L., James, K., Quirk, A., Simpson, A., SUGAR, Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The safewards cluster randomised controlled trial. International Journal of Nursing Studies, 52(9), 1412-1422. doi:10.1016/j.ijnurstu.2015.05.001

Butterworh, T & Shaw, T. (2017) Playing our part. London, Foundation of Nursing Studies.

Bressington, D., Badnapurkar, A., Inoue, S., Ma, H.Y., Chien, W.T., Nelson, D., Gray, R. (2018). Physical health care for people with severe mental illness. : International Journal of Environmental Research and Public Health, 15(2) doi: 10.3390/ijerph15020343

Dickens, G.L., Ion, R, Waters, C, Atlantis, E, & Everett, B. (2019) Mental health nurses' attitudes, experience, and knowledge regarding routine physical healthcare: systematic, integrative review of studies involving 7,549 nurses working in mental health settings. BMC Nursing, 18:16 https://doi.org/10.1186/s12912-019-0339-x

Ion, R, Olivier, S, & Darbyshire, P. (2019) Failure to report poor care as a breach of moral and professional expectation. Nursing Inquiry. 26:e12299. https://doi.org/10.1111/nin.12299

Kontio, R., Joffe, G., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M., & Välimäki, M. (2012). Seclusion and restraint in psychiatry: Patients' experiences and practical suggestions on how to improve practices and use alternatives. Perspectives in Psychiatric Care, 48(1), 16-24. doi:10.1111/j.1744-6163.2010.00301.x

Moore, E,E, Romanuik, H, & Olsson, C,A, Jayasinghe, Y, Carlin, J,B. (2010) The prevalence of childhood sexual abuse and adolescent unwanted sexual contact among boys and girls living in victoria, australia. Child Abuse and Neglect, 34(5), 379-385.

Murdoch-Eaton, D., & Sandars, J. (2014). Reflection: Moving from a mandatory ritual to meaningful professional development. Archives of Disease in Childhood, 99(3), 279-283. doi:10.1136/archdischild-2013-303948

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. International Journal of Mental Health Nursing, 23(1), 51-59. doi:10.1111/inm.12012

Nursing and Midwifery Council (2010) Standards for pre-registration nursing education. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf

Nursing and Midwifery Council. (2018). Standards of proficiency for registered nurses. (). London: NMC. Retrieved from https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/

Reeves, E. A., & Humphreys, J. C. (2018). Describing the healthcare experiences and strategies of women survivors of violence. Journal of Clinical Nursing, 27(5-6), 1170-1182. doi:10.1111/jocn.14152

Roberts, M & Ion, R (2014) 'Preventing moral catastrophes in modern health care systems by facilitating the development of a Socratic ethos: A big idea from an Arendtian perspective', Nurse Education Today 34(12), pp. 1411–1413. doi: 10.1016/j.nedt.2014.08.010.

Quinn, C., Platania-Phung, C., Bale, C., Happell, B. and Hughes, E. (2018) 'Understanding the current sexual health service provision for mental health consumers by nurses in mental health settings: Findings from a Survey in Australia and England', International Journal of Mental Health Nursing, 27(5), pp. 1522-1534. doi: 10.1111/inm.12452.

Stokes, Y., Jacob, J., Gifford, W., Squires, J., & Vandyk, A. (2017). Exploring nurses' knowledge and experiences related to trauma-informed care. Global Qualitative Nursing Research, 4, 2333393617734510. doi:10.1177/2333393617734510

Willis, P. (2012) Raising the Bar. Shape of Caring : A Review of the Future Education and Training of Registered Nurses and Care Assistants. Health Education England.

Wilson, A., Hutchinson, M., & Hurley, J. (2017). Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia. International Journal of Mental Health Nursing, 26(4), 326-343. doi:10.1111/inm.12344

World Health Organisation. (2018). Management of physical health conditions in adults with severe mental disorders. (). Switzerland: WHO. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/275718/9789241550383-eng.pdf?ua=1

Young J, Taylor J, Paterson B et al (2019) Trauma-informed practice: a paradigm shift in the education of mental health nurses. Mental Health Practice. doi: 10.7748/mhp.2019.e1359

Zalm, Y. C., Nugteren, W. A., Hafsteinsdóttir, T. B., Venne, Cokky G. J. M., Kool, N., & Meijel, B. (2015). Psychiatric nursing care for adult survivors of child maltreatment: A systematic review of the literature. Perspectives in Psychiatric Care, 51(1), 71-78. doi:10.1111/ppc.12059