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### Abstract

The purpose of this pilot study was to explore how best to prepare and support nursing undergraduate students learning in a community/primary care setting through a Student Managed Initiatives in Lifestyle Education (SMILE) project. Further to this our intention was to evaluate the ways in which students were able to apply nursing theory to the practice of identifying and responding to the health needs of vulnerable people through health promotion and creative arts activities. Using a collaborative approach and a qualitative method, this pilot study used focus group discussions to explore both the experiences of community participants and undergraduate nursing students. This project found that students were able to draw on theoretical understandings and their simulated learning experiences to support their learning in a complex, non-clinical practice setting. It also illustrates the way in which community centres and other naturalistic environments where individuals and groups meet, can provide spontaneous and rewarding opportunities for nursing students to develop and apply health promoting knowledge and skills. Shaping nursing curricula with this in mind, creates the potential for nurses to make a significant contribution to improved health outcomes for vulnerable and/or marginalised people.

<b>Keywords</b>	nurse education; primary care, mental health recovery, creative arts, arts for health, collaborative practice
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## Submission Files Included in this PDF

### File Name [File Type]

Cover Letter.docx [Cover Letter]

Table of Changes Learning how to SMILE LW\_ MC 29th July 2019.docx [Response to Reviewers (without Author Details)]

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## Research Data Related to this Submission

There are no linked research data sets for this submission. The following reason is given:  
Data will be made available on request

## Introduction

The physical health and wellbeing and life expectancy of individuals living with long-term mental illness is a cause of concern in most countries. The incidence of heart disease, cancer, diabetes along with many other long-term health conditions is documented as being well above the average and as such represents a significant challenge (Bahorik et al 2017, WHO 2016, 2017; Hardy et al, 2011). Moreover, it is being recognised that the personal and financial costs of this situation is unsustainable (Lawrence et al 2001, Jones et al 2004, Crotty et al 2015). It has been established that people living within communities of disadvantage, experience increased levels of mental illness, are stigmatised, have poorer physical health, and receive less health care than the rest of the population (Collins et al, 2012; Ohrnberger et al 2017; Crotty 2015, Bradshaw et al 2017). The range of care provision in many deprived communities is said to be limited and clinical evidence confirms that vulnerable populations have a lower life expectancy (Stanley and Laugharne 2011). The current approach to this challenge, in terms of increasing access to health services of marginalised populations and vulnerable individuals, and providing the comprehensive health care interventions and appropriate health advice needed, necessitates a radical approach by the health care service and its workforce. This approach needs to address both the continuing pervading stigma of people with mental illness and the structures that shape service delivery. These persistent health inequalities have been recognised in many countries including Australia and the United Kingdom. Nursing regulatory bodies have introduced Standards for Higher Education Institutions to equip graduates to be able to respond to the pressing health priorities including the needs of marginalised and disadvantaged groups (NMC 2018, ANMC 2012). The NMC's recently published standards for proficiency for example, has devoted a platform for 'Promoting health and preventing ill

health' but there is a real challenge in nurse education to translate this into meaningful practice learning experiences that both challenge and change the practice of the future nurse. Therefore in this paper we argue that the future nursing workforce has a significant role to play in this, given the scale of unmet need.

Higher Education Institutions (HEIs) and their health and social care partner organisations providing nurse education, need to recognise the way in which theory and practice needs to develop in order to equip graduates with the skills to be instrumental in bringing about change. This includes addressing the personal and institutional stigma and schema that act as barriers to engagement and accessing services, becoming knowledgeable about and skilled in advising on appropriate lifestyle education interventions and non-medical interventions. Above all, graduates need to be able to recognise presenting opportunities for appropriate interventions that will help vulnerable and isolated people who have mental illness both to maintain better physical health and to access health services and advice early when they become physically unwell.

## **Background**

To this end this project Student Managed Initiatives in Lifestyle Education (SMILE), was piloted within a Primary Health Care clinical placement for a group of final year Undergraduate Students in a University in Australia. Elements of this model for student learning had been developed and evaluated in previous placements in an ANMAC approved Bachelor of nursing programme (Ward and Barry, 2016) with a strong focus on enhancing communication and consumer health and wellbeing through the creative arts. Building on this model, this new project was designed to prepare and enable students to a greater initiative with opening discussions with consumers about their health and lifestyle factors.

Students had been prepared for the placement through theoretical and clinical nursing studies including learning about mental health and illness, national and local health inequalities and the social determinants of health and orientated to the contemporary context of primary health care provision. We had introduced students to the 'Peace and Power' approach to building communities in order to provide them with a 'tool kit' to use when opening and engaging conversations with vulnerable people (Chinn and Falk-Rafael 2015). The aim of this approach to professional and peer collaboration, allows the individual to lead discussions in identifying and exploring health needs and priorities in a way that encourages them to recognise and set aside personal prejudices, schema, priorities and intentions and by understanding the way in which power between client and professionals operate. This model also prepared students to understand the importance of critical reflection for example in building awareness of self and others through a collaborative approach to practice.

We argue that theoretical grounding is important for students. Research evidence and policy literature can orientate students to the significance of mental health and wellbeing and how lifestyle factors, alcohol and/or drug misuse, medication and psychosocial factors can impact quality of life. Further to this, students need to develop an understanding of how, in the broader scheme of things, nurses, and other health care professionals are already engaged in activities that make improvements in the general community, through education, health promotion, early intervention and prevention.

Students studying at this University are provided with extensive resources to support the theoretical component of their learning. However, working effectively in practice with this level of complexity is a daunting prospect for the student and achieving a level of

independence to make a difference requires an educational model that will optimise the learning experience, challenge the student and ensure appropriate levels of supervision and demonstrate the potential of Primary and Community Care for nursing careers. What is less well understood is the best way to prepare for the challenges of working with consumers closer to their homes and the power dynamics that operate within the professional/client relationships when health education or lifestyle change is required.

We are aware that future health care practice in Australia and the UK needs to be focussed on prevention and to be offered increasingly within the primary health care setting. The UK government for example is in the process of developing a national approach to 'Social Prescribing' (SP) as a means to address unmet health need in primary care, through non-pharmacological approaches (Department of Health and Social Care 2018, The Kings Fund 2017). Although this is a non-traditional health care setting it is one where there is a highly visible level of health care need and a large participating number of consumers, and we have found this to be an excellent environment for learning for final year students.

Through this project and its evaluation, we argue that:

1. Allowing students time to develop knowledge in primary health, mental health and wellbeing, therapeutic communication, and leadership skills in a community setting is invaluable to their learning and professional development.
2. Allowing students to engage in experiential learning in this way provides the community with a unique resource and provides the basis for partnerships and multidisciplinary working, we have found that the student contribution is important, even if on a small scale.

3. The approach illustrated in this project would sit well within newly developing approaches for the Social Prescribing model and other community development activities that seek to address ongoing mental health and other isolating long-term health conditions.

## **Research Design**

### **Setting**

This study took place in a non-clinical community setting where people were meeting to participate in adult educational activities within a local council neighbourhood house. The Neighbourhood House, funded by the local Council offers a meeting place for various groups, a community kitchen/restaurant and a rolling programme of adult learning activities.

### **Participants**

The participants were Undergraduate nursing students of the bachelor program of study and local people who were engaged in the SMILE project in the Neighbourhood House. All the participants were recruited once the project had received ethical approval from the University and the partner institution, and informed consent to participate had been given. The key ethical concerns arose from the vulnerability of some of the participants. Our consent process was based on open discussion and written information explaining the purpose and design of the study, assuring anonymity for participants and ensuring those

who participated could withdraw at any time without question. Students were invited to participate in the SMILE placement program via an Expression of Interest. There were no exclusion criteria for consumer participants as we hoped to include as many individuals as possible reflecting the diversity of the local community. The program was facilitated for 8 x 2-week blocks, 4 student cohorts (32 students in total) and (65 community members) participated.

### **The SMILE Program**

The SMILE placement program facilitated student participation in the Neighbourhood House activities, such as conversational English, basic cooking class and a women's health and wellbeing group. A key element for the students was the development and leading of health promotion education sessions through a 'Kiosk' for Health Checks, student led community forums and health education delivery at what was known as the StARTalking creative arts workshop 1 day each week. The program of activities enabled an interprofessional approach to learning as provided an opportunity for the nursing students to learn alongside other undergraduate health care students about health and wellbeing in a number of ways and through the StARTalking activity, explore health topics and art-making in a relaxing, safe and informal environment (Ward and Barry, 2016). The key aims of StARTalking are to assist participants to develop social networks, build new skills and knowledge about maintaining their health, increase self-efficacy around creative activities and health literacy. The creative arts activities, ranged from traditional painting and drawing activities to, collage making, ceramics and mixed media (Ward and Barry, 2016).



## **The SMILE Clinical placement evaluation**

### **The students**

In all, thirty-two students, 2 nurse academics and sixty-five community members were invited to participate in the SMILE activities held during the student placement weeks. A qualitative method of enquiry was applied to the evaluation of the SMILE placement program. Focus groups were undertaken with student participants before the placement with four questions to prompt /provoke discussion with participants. The aim of the evaluation was to better understand to what extent students had been able to draw upon the theoretical learning that they had experienced to prepare them for this practice experience.

The following questions were used to prompt discussion and encourage reflective thought on student preparation:

1. Have you participated in a community arts/ mental health and wellbeing project or placement program before?
2. Have you practiced any art making before? What was your experience?
3. What do you understand by community mental health and wellbeing?
4. What do you do to manage your own mental health and wellbeing?

On completion of the placement, the student focus groups were reconvened, and the following questions were used again to encourage discussion about the experience:

1. Did you enjoy the mental health and wellbeing workshops and the SMILE placement program?
2. Did you learn anything new about yourself?
3. Did you learn anything about community mental health and wellbeing?
4. What did you learn from the SMILE placement program?
5. What do you think the community needs to support better mental health and wellbeing for community members?

### **The community members**

The 65 community members who participated in the SMILE program activities participated in a focus Group evaluation at the end of the SMILE program. All participants who had attended the focus group had attended the 'kiosk for Health Checks' 'StARTalking' and participated in a student led health care assessment. All participants (n=65) expressed benefit of the SMILE program and the SMILE Clinical placement. We have deidentified the participants here but have provided alternative names and included genuine biography to humanise the accounts. We used the following broad and open-ended questions to trigger discussion:

- Have you practiced any art making before? What was your experience?
- What do you know about your health / mental health and wellbeing?
- What do you think your community needs, to support better mental health and wellbeing?

### **Analysis**

The focus group data was audio recorded and transcribed verbatim. The data was deidentified and alternate names used to represent participants. The pre and post focus

group transcripts were analysed using a thematic approach (Hsieh and Shannon 2005). The transcripts were read and then re-read to identify any common themes, and or patterns. And a comprehensive immersion in the participant responses. To ensure an accurate representation of the themes the researchers analysed the data individually to identify key repetitions and subtext and then together to decide on emergent themes (Ward & Barry, 2016).

### **The student evaluation findings**

Students expressed feelings about the extent to which they felt prepared for the placement and drew upon theory and practice in their recognition of the significance of the social determinates of health to individual and population consumer health outcomes. The students identified the challenges associated with working across disciplines and organisations; the importance of cultural safety practices working with vulnerable people and students could articulate concerns related to the power and inequalities that exist in society. Three key themes emerged: **Ditching nursing routine, Insight and outcomes, Different strokes for different folks.**

### **Ditching nursing routine**

The perceived lack of routine, specific tasks to complete and the structure in the environment were highlighted as follows. Jenny (student) made a comment about their preparedness for the placement:

*.... I feel that I only was only moderately prepared coming in because we have (experienced) such different nursing, there's a lot more independence here, and talking to the health care team, you know, there's not someone right there letting*

*you know exactly what you should say. So, it's a bit different, because you are giving health advice and you have to sort of draw a little on the education which isn't clinical, non-clinical which is not something we have done before.*

**And Meg (student) responded saying:**

*.... I would have to agree, I didn't feel overly prepared coming into this placement I felt like most of the other placements were hospital based and very regimented on a ward routine, with a strong focus on the current primary diagnosis. Of course, in ward nursing you do have that discharge planning but it's not the same intensity as community based (practice).*

**This theme was reflected in many of the student's comments during the focus group discussion. The theme highlights the students common understanding of the nursing role as experienced on previous clinical placements. The hospital, acute ward perspective was referred to several times in relation the nursing tasks they were familiar with. The nursing tasks required on the SMILE placement however were noticeably different. The reference to working autonomously at SMILE was raised and there was acknowledgement that however daunting that was at first it represented great learning. This variance between what they were used to doing and what opportunities SMILE offered them was significant to the development of leadership skills and nursing competence.**

### **Insight and outcomes**

**Student participants were able to articulate their insight into the nursing approach necessary to work with communities of disadvantage.**

*(applying) knowledge of how to access healthcare and stuff and knowing what's available to them and even simple things like language barriers... they come to this facility but they may not be able to actually benefit from all the programmes because they don't fully understand what else there is here, they can't just read the brochures or things like that.*

The students discussed the way in which they adopted a different nursing approach when working with people of disadvantage. They spoke about how they actively engaged in conversation to develop rapport however how they were mindful that the people they were caring for were not patients. Elle said:

*you have to approach the person and be led by them, I felt I was following their lead, responding to their need'*

They reported that because of the various approaches they adopted in this community setting their learning was significantly different. They considered their learning was 'in action' 'happening in the moment' and this was in contrast with how they had learnt in the hospital environment. The students articulated that in the hospital environment they were working off theory, step by step skills and a very structured time management plan. Rosie said:

*In the hospital you have a very clear order of things you need to do and usually not enough time to do everything. And your work relates to a group of patients and the care they need on any one day.*

Lenny (student) said that learning was different because you the community environment required different knowledge therefore students were stretched to see health and illness from a different perspective:

*...I think that it's the health promotion, not the illness focus, you can't just fall back onto the idea of helping them recover you can't just be task orientated because, well you can't become complacent as you are about health promotion and providing, well I don't really know what I'm saying....*

### **Different stakes for different folks**

This theme recognised the different health beliefs arising from different cultural perspectives and how students were required to learn this information 'on the run':

*....if you have a patient from a different cultural background, the typical western/ Australian model of health , they just do what the doctors say, and someone may come in and their culture may not believe in a certain medication and a certain way of doing something they can say OK, can you explain to me why you are uncomfortable with this 'cos then that makes them feel respected and more comfortable and you can try and find out what their reasoning is and if there's a way you can work around that.*

Students shared their learning about the way that health care is organised and delivered and what that can mean for vulnerable people trying to access services. Amy said:

*I have found that I am more able to identify barriers to health for people, the things we are expected to do ....providing education and support and advocacy for our patients and think that part of that even we have patients*

*who are without healthcare we need to be effective in our job and identify ways to .....even those who don't speak the same language as us, to often I feel that nurses will not give....health education or work with the patient for them to become a partner in their health care and I think this placement has helped me to identify those skills an help me also address those barriers.*

Student expressed that they had to work with each individual and respond specifically to their needs. They had to acknowledge culture, age and respect a person's belief system and way of being in the world. The students referred to being non-judgemental and 'respecting everyone's differences' 'learning that 'people have had different life experience' and those experiences influence them when they interact with others.

### **The consumer participant evaluation findings**

The consumer participants shared their experience in one or more of the SMILE activities: The Kiosk for Health Checks, StARTalking- creative arts activities, the relaxation sessions, and the health education information. The two themes to emerge included **One Stop Shop** and **Connecting**.

### **One stop shop**

The Kiosk for Health Checks were considered a One stop shop. The participants referred to them as an opportunity to ask questions and reflect on their health and wellbeing.

Gwen (67-year-old woman) made comment on the positive impact of SMILE on her health and wellbeing:

*I realised I didn't know much about my health and I have diabetes so I should know more. One thing I realised is that it's my mental state that I need to manage so I can*

*manage my health. I get stressed about things and going to the doctors because I worry about getting sicker or having cancer. Going to the kiosk was great because I talked to the students and they told me where I can go to for free and how I can manage my health better.*

Gwen had attended the Kiosk for Health Checks several times and felt that she learnt something new at each visit. Gwen expressed feeling very comfortable to ask students questions about her health and to enquire about local service providers.

Troy (a 33-year-old homeless man) said he too felt comfortable with the students. Troy spoke about the way in which students communicated. He considered them non-judgmental and caring. He said:

*I have been able to learn a lot about my health. The students presented it in a way I could really understand'.*

Marion (73-year-old woman) said that attending the SMILE Kiosk for Health Checks and education session provided her with a greater sense of awareness about her health and with this knowledge she was able to formulate a plan to take care of herself. Marion spoke about attending the kiosk and StARTalking. She said the two activities complemented each other. She said:

*I have trouble with weight, but I didn't understand how that might affect my other health issues.*

Joy a 74-year-old woman with a diagnosis of type 1 diabetes shared with the focus group that SMILE had provided education that was having a direct impact on her physical wellbeing. She said:



*The one thing I want in my life is good health, but I have never had it. SMILE has taught me more about how to get it.*

Mary (53-year-old woman) shared the following experience.

*I am on a lot of medication so when the students had the kiosk, I told one about them all. They got the teacher because they didn't know all of them. The teacher then talked to us all about what they do and why I take them and then I understood more about them too. I didn't know I could ask the doctor to maybe change them if they didn't work. I then went to my doctor and I am going back to what I was on before. So that was good and wouldn't have happened without SMILE.*

Mary was convinced that without SMILE she may not have followed up with her doctor. SMILE had offered opportunity to reflect on her current medication regime. This small intervention may have been lifesaving.

## **Connected**

The theme of being Connected emerged as participant data continually referred to 'making friends' 'connecting to others' 'being heard' and 'having purpose'.

In reflection of the StARTalking workshops participants spoke about connecting, being part of something and they were clear that this group was positive to their health and wellbeing.

Mark (47-year-old male) shared he had a long-term mental health problem that had a huge impact on his life. He expressed a great appreciation of the SMILE program and in particular the StARTalking program:

*I always wish to be healthy. I have schizophrenia. You can't get rid of that. My general health suffers and all I want to be is loved with luck, safe and successful. The students have given me friendships I don't have.*

Dianne (45-year-old woman) attended StARTalking. Dianne shared in the focus group that StARTalking and the education provided by students had a direct impact on her life choices and her health:

*I need to quit smoking and need to lose weight and exercise more. SMILE taught me to look at what to eat and how to eat better.*

Dianne said:

*Learning about how my heart works and then doing relaxation makes me understand how to be in control. It makes me want to stop smoking now so my heart can be healthier.*

The participants spoke about the relaxation sessions and the theme of Connected was again apparent as discussion involve comments such as May's comment:

*I feel welcome to be a part of the SMILE program and that feels good*

Dianne (45-year-old woman) told us:

*I want to be a loving mother. I don't want to be stressed and uptight because I am worrying all the time. The stress management I learned in SMILE has taught me how to take time out and breath. Be more mindful. The kiosk with the students was good and my blood pressure was good so I felt like there was less to worry about with my health. They also told me about the health coaches we can go to for more help.*

Dianne made mention that being able to access the SMILE resource, and most importantly the relaxation sessions and the student assessment made them feel connected to others, which in turn resulted in good health. The other participants used words such as 'I've made friends at SMILE' and 'I feel good that I know SMILE is around the corner'.

Cindy (32-year-old woman) shared with the group that she had trouble managing her emotions and in turn her behaviour. She said that being connected to the SMILE program and attending StARTalking has meant she had to reflect on how she interacted with others. She said she was aware she needed to take responsibility for her behavior. She said:

*I feel anxious all the time. I feel like I stuff up all of the time and end up hurting people. I need to stop stressing and consider other people more.*

Cindy spoke further to the group about the positive impact meditation in StARTalking had on her life and that it was a practice she would continue to use to manage her anxiety.

Connecting to the SMILE program had enriched her life:

*I need to control my anxiety. The students taught me how to breath and be more mindful. I want to keep coming to SMILE so that I can learn more about my health.*

Susana (29-year-old woman) talked about being connected to SMILE and the benefit that health information she received from students had on her wellbeing and outlook on life.

Susana had disclosed a long history with depression. Susana said:

*I am on a lot of medication and I hate taking it. It makes me feel sad that I have to do it for the rest of my life because I am young but in SMILE, we talked about what people took and other people are on lots of pills too, so I don't feel as bad. The students talked about health and I understood what they said because they spoke slow, and we could ask questions. When I go to the doctors it is always so quick and sometimes, I forget why I went in the first place and then I get home and think I should have asked that question.*

The theme **Connected** represents the participants appreciation of being 'apart of something', 'in relationship with others', 'feeling safe to speak' and knowing they are 'being listened to'.

## **Discussion**

The students who participated in the study reported a positive but challenging experience in this placement overall. The students spoke about the challenges of working in this non-clinical environment, and how they had to take the initiative and opportunities as and when they presented. They also recognised the language and other cultural barriers to beginning conversations about health and well-being and that sufficient time was needed to listen as well as talk and to find new ways to explain or provided information to people with very different needs and expectations.

The Focus Group discussions illustrated the students struggles to express and articulate the scale of the challenge of assisting vulnerable individuals to both recognise poor health and take steps to make even small changes. There was reference to 'thinking on your feet', 'you have to problem solve and find solutions-pretty quick'.

It was clear however, from the student discussions, that they were beginning to understand the challenge and that one of the key steps they had to make themselves was improving their own ability to listen and communicate with individuals whose health literacy was poor and who had many other priorities.

Chinn's ideas are powerful in that they remind students that this environment is not a health professional's domain. The priorities and preoccupations of health care services and professionals have to give way to the issues that are foremost in the mind of the individuals who are seeking help. This requires a reflexive, responsive and highly adaptable approach as well as a skill set that can be transferred to complex and challenging situations and experiences. Exploring these ideas through the Peace and Power model has helped students to recognize the power dynamics in professional/client relationships. Moreover, it has allowed them to think more critically about what empowers and disempowers individuals, what builds community and how they can contribute. The theoretical learning that preceded the placement, applying the Peace and Power approach and the academic teacher support were important dimensions and reference points for teachers and students. This is important when learning or working in a non-institutional health setting where the framework, routines and model of care is otherwise fluid or undefined and the people using this local service are marginalised and otherwise vulnerable. An important dimension of the student feedback was the account they gave of their improved understanding of why those

who experience mental health issues or live in poverty may not seek out health care and in turn limit their social interactions due to negative attitudes toward mental illness and ongoing associated stigma.

From the consumer perspective, their contribution to this study confirms the potential of programmes like this in their recovery and in their coping. Having the students and academics bring such a rich programme of activities and health care skill to an accessible place is clearly valuable to them. Based on the findings from the student learning evaluation process and SMILE participant focus groups, a risk and resilience framework that identifies protective factors will be introduced in the next SMILE clinical placement program.

### **Limitations**

As a pilot study with a small number of overall participants and the localised (single centre) approach do limit wider application of the findings but we consider with some modifications to the design this study might be repeated in other settings where students are learning about Primary Care and health improvement. Other methods including interviews may also be appropriate and enable us to look more closely at individual case studies and narratives of experience. We are aware of a burgeoning interest in collaborative approaches to improving health and in new methodological approaches that may be helpful including co-creative community-based health research (Daykin et al 2017, Greenhalgh et al 2016). The insights this study provides, should assist those engaged in similar work or exploring its potential, to consider applying elements of the SMILE model in preparing students, supporting them in practice and helping them to analyse and evaluate their learning through critical reflection on their practice experiences. It may also provide encouragement to create partnerships with stakeholders to generate new knowledge both about how students learn but also how professionals can support consumers to make the lifestyle changes that will improve their health and wellbeing.

## **Conclusion**

The SMILE clinical placement aimed to provide nursing students with an opportunity to offer nursing care to diverse community populations and gain insight into the way in which social and economic factors can affect mental health and wellbeing. The findings of the pilot study encourage us to continue with this collaborative approach both in its value to learning in primary care but also because of the way it has strengthened our community health partnerships. We identified that the participating students were able to recognise the way in which nursing interventions can help to overcome issues of disadvantage by engaging

potentially vulnerable people in a program that can contribute directly and indirectly to their mental and physical health and wellbeing. Hearing from the users of SMILE added to our understanding of the student contribution's value to them. The students were able to both recognise and discuss the different ways in which they can apply their knowledge and skills to support consumers to access health services, helping them to understand the ways in which lifestyle and socioeconomic circumstances can worsen or improve health and, through wider knowledge and understanding of the organisation and delivery of health services, help to increase the community's health literacy overall.

We are aware that government health departments in many countries are looking to address rising medical costs and unmet need through restructuring services, for example through community (or socially) based schemes and consequently making a significant health impact. We would argue that these schemes should not just seek to occupy participants in creative and other recreational activities (which are important ends in themselves) but should also seek to widen access to appropriate health care support and advice through new community partnerships and this we suggest, is especially important for vulnerable individuals with mental health care needs if health outcomes are to be improved. Making changes to the way that health practitioners (including the large nursing workforce) learn how to contribute to these efforts through theory and practice, is an important way to begin to realise these goals.



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StARTalking <http://startalking.blogs.latrobe.edu.au/>

**Title: Learning how to SMILE. improving physical and mental health through nurse education and creative practice.**

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4 **Learning how to SMILE: improving physical and mental health through nurse education**  
5 **and creative practice**  
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8  
9  
10 **Abstract**  
11

12 The purpose of this pilot study was to explore how best to prepare and support nursing  
13 undergraduate students learning in a community/primary care setting through a Student  
14 Managed Initiatives in Lifestyle Education (SMILE) project. Further to this our intention was  
15 to evaluate the ways in which students were able to apply nursing theory to the practice of  
16 identifying and responding to the health needs of vulnerable people.  
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19 Using a collaborative approach and a qualitative method, this pilot study used focus group  
20 discussions to explore both the experiences of community participants and undergraduate  
21 nursing students.  
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23

24 This project found that students were able to draw on theoretical understandings and their  
25 simulated learning experiences to support their learning in a complex, non- clinical practice  
26 setting. It also illustrates the way in which community centres and other naturalistic  
27 environments where individuals and groups meet, can provide spontaneous and rewarding  
28 opportunities for nursing students to develop and apply health promoting knowledge and  
29 skills. Shaping nursing curricula with this in mind, creates the potential for nurses to make a  
30 significant contribution to improved health outcomes for vulnerable and/or marginalised  
31 people.  
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62 Introduction  
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64 The physical health and wellbeing and life expectancy of individuals living with long-term  
65 mental illness is a cause of concern in most countries. The incidence of heart disease,  
66 cancer, diabetes along with many other long-term health conditions is documented as being  
67 well above the average and as such represents a significant challenge (Bahorik et al 2017,  
68 WHO 2016, 2017; Hardy et al, 2011). Moreover, it is being recognised that the personal and  
69 financial costs of this situation is unsustainable (Lawrence et al 2001, Jones et al 2004,  
70 Crotty et al 2015). It has been established that people living within communities of  
71 disadvantage, experience increased levels of mental illness, are stigmatised, have poorer  
72 physical health, and receive less health care than the rest of the population (Collins et al,  
73 2012; Ohrnberger et al 2017; Crotty 2015, Bradshaw et al 2017). The range of care provision  
74 in many deprived communities is said to be limited and clinical evidence confirms that  
75 vulnerable populations have a lower life expectancy (Stanley and Laugharne 2011). The  
76 current approach to this challenge, in terms of increasing access to health services of  
77 marginalised populations and vulnerable individuals, and providing the comprehensive  
78 health care interventions and appropriate health advice needed, necessitates a radical  
79 approach by the health care service and its workforce. This approach needs to address both  
80 the continuing pervading stigma of people with mental illness and the structures that shape  
81 service delivery. These persistent health inequalities have been recognised in many  
82 countries including Australia and the United Kingdom. Nursing regulatory bodies have  
83 introduced Standards for Higher Education Institutions to equip graduates to be able to  
84 respond to the pressing health priorities including the needs of marginalised and  
85 disadvantaged groups (NMC 2018, ANMC 2012). The NMC's recently published standards  
86 for proficiency for example, has devoted a platform for 'Promoting health and preventing ill  
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121 health' but there is a real challenge in nurse education to translate this into meaningful  
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123 practice learning experiences that both challenge and change the practice of the future  
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125 nurse. Therefore in this paper we argue that the future nursing workforce has a significant  
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127 role to play in this, given the scale of unmet need.  
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131 Higher Education Institutions (HEIs) and their health and social care partner organisations  
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133 providing nurse education, need to recognise the way in which theory and practice needs to  
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135 develop in order to equip graduates with the skills to be instrumental in bringing about  
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137 change. This includes addressing the personal and institutional stigma and schema that act  
138  
139 as barriers to engagement and accessing services, becoming knowledgeable about and  
140  
141 skilled in advising on appropriate lifestyle education interventions and non-medical  
142  
143 interventions. Above all, graduates need to be able to recognise presenting opportunities  
144  
145 for appropriate interventions that will help vulnerable and isolated people who have mental  
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147 illness both to maintain better physical health and to access health services and advice early  
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149 when they become physically unwell.  
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## 153 **Background**

154  
155 To this end this project Student Managed Initiatives in Lifestyle Education (SMILE), was  
156  
157 piloted within a Primary Health Care clinical placement for a group of final year  
158  
159 Undergraduate Students in a University in Australia. Elements of this model for student  
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161 learning had been developed and evaluated in previous placements in an ANMAC approved  
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163 Bachelor of nursing programme (Ward and Barry, 2016) with a strong focus on enhancing  
164  
165 communication and consumer health and wellbeing through the creative arts. Building on  
166  
167 this model, this new project was designed to prepare and enable students to a greater  
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169 initiative with opening discussions with consumers about their health and lifestyle factors.  
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180 Students had been prepared for the placement through theoretical and clinical nursing  
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182 studies including learning about mental health and illness, national and local health  
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184 inequalities and the social determinants of health and orientated to the contemporary  
185  
186 context of primary health care provision. We had introduced students to the 'Peace and  
187  
188 Power' approach to building communities in order to provide them with a 'tool kit' to use  
189  
190 when opening and engaging conversations with vulnerable people (Chinn and Falk-Rafael  
191  
192 2015). The aim of this approach to professional and peer collaboration, allows the individual  
193  
194 to lead discussions in identifying and exploring health needs and priorities in a way that  
195  
196 encourages them to recognise and set aside personal prejudices, schema, priorities and  
197  
198 intentions and by understanding the way in which power between client and professionals  
199  
200 operate. This model also prepared students to understand the importance of critical  
201  
202 reflection for example in building awareness of self and others through a collaborative  
203  
204 approach to practice.  
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209  
210 We argue that theoretical grounding is important for students. Research evidence and  
211  
212 policy literature can orientate students to the significance of mental health and wellbeing  
213  
214 and how lifestyle factors, alcohol and/or drug misuse, medication and psychosocial factors  
215  
216 can impact quality of life. Further to this, students need to develop an understanding of  
217  
218 how, in the broader scheme of things, nurses, and other health care professionals are  
219  
220 already engaged in activities that make improvements in the general community, through  
221  
222 education, health promotion, early intervention and prevention.  
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226  
227 Students studying at this University are provided with extensive resources to support the  
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229 theoretical component of their learning. However, working effectively in practice with this  
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231 level of complexity is a daunting prospect for the student and achieving a level of  
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239 independence to make a difference requires an educational model that will optimise the  
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241 learning experience, challenge the student and ensure appropriate levels of supervision and  
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243 demonstrate the potential of Primary and Community Care for nursing careers. What is less  
244  
245 well understood is the best way to prepare for the challenges of working with consumers  
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247 closer to their homes and the power dynamics that operate within the professional/client  
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249 relationships when health education or lifestyle change is required.  
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253 We are aware that future health care practice in Australia and the UK needs to be focussed  
254  
255 on prevention and to be offered increasingly within the primary health care setting. The UK  
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257 government for example is in the process of developing a national approach to 'Social  
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259 Prescribing' (SP) as a means to address unmet health need in primary care, through non-  
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261 pharmacological approaches (Department of Health and Social Care 2018, The Kings Fund  
262  
263 2017). Although this is a non-traditional health care setting it is one where there is a highly  
264  
265 visible level of health care need and a large participating number of consumers, and we  
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267 have found this to be an excellent environment for learning for final year students.  
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272 Through this project and its evaluation, we argue that:  
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278 1. Allowing students time to develop knowledge in primary health, mental health and  
279  
280 wellbeing, therapeutic communication, and leadership skills in a community setting  
281  
282 is invaluable to their learning and professional development.  
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- 284  
285 2. Allowing students to engage in experiential learning in this way provides the  
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287 community with a unique resource and provides the basis for partnerships and  
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289 multidisciplinary working, we have found that the student contribution is important,  
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291 even if on a small scale.  
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3. The approach illustrated in this project would sit well within newly developing approaches for the Social Prescribing model and other community development activities that seek to address ongoing mental health and other isolating long-term health conditions.

## 310 **Research Design**

### 314 **Setting**

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This study took place in a non-clinical community setting where people were meeting to participate in adult educational activities within a local council neighbourhood house. The Neighbourhood House, funded by the local Council offers a meeting place for various groups, a community kitchen/restaurant and a rolling programme of adult learning activities.

### 332 **Participants**

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The participants were Undergraduate nursing students of the bachelor program of study and local people who were engaged in the SMILE project in the Neighbourhood House. All the participants were recruited once the project had received ethical approval from the University and the partner institution, and informed consent to participate had been given. The key ethical concerns arose from the vulnerability of some of the participants. Our consent process was based on open discussion and written information explaining the purpose and design of the study, assuring anonymity for participants and ensuring those

355  
356  
357 who participated could withdraw at any time without question. Students were invited to  
358  
359 participate in the SMILE placement program via an Expression of Interest. There were no  
360  
361 exclusion criteria for consumer participants as we hoped to include as many individuals as  
362  
363 possible reflecting the diversity of the local community. The program was facilitated for 8 x  
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365 2-week blocks, 4 student cohorts (32 students in total) and (65 community members)  
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367 participated.  
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### 371 **The SMILE Program**

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377 The SMILE placement program facilitated student participation in the Neighbourhood House  
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379 activities, such as conversational English, basic cooking class and a women's health and  
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381 wellbeing group. A key element for the students was the development and leading of  
382  
383 health promotion education sessions through a 'Kiosk' for Health Checks, student led  
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385 community forums and health education delivery at what was known as the StARTalking  
386  
387 creative arts workshop 1 day each week. The program of activities enabled an  
388  
389 interprofessional approach to learning as provided an opportunity for the nursing students  
390  
391 to learn alongside other undergraduate health care students about health and wellbeing in a  
392  
393 number of ways and through the StARTalking activity, explore health topics and art-making  
394  
395 in a relaxing, safe and informal environment (Ward and Barry, 2016). The key aims of  
396  
397 StARTalking are to assist participants to develop social networks, build new skills and  
398  
399 knowledge about maintaining their health, increase self-efficacy around creative activities  
400  
401 and health literacy. The creative arts activities, ranged from traditional painting and drawing  
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403 activities to, collage making, ceramics and mixed media (Ward and Barry, 2016).  
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416 **The SMILE Clinical placement evaluation**  
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421 **The students**  
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424 In all, thirty-two students, 2 nurse academics and sixty-five community members were  
425 invited to participate in the SMILE activities held during the student placement weeks. A  
426  
427 qualitative method of enquiry was applied to the evaluation of the SMILE placement  
428  
429 qualitative method of enquiry was applied to the evaluation of the SMILE placement  
430 program. Focus groups were undertaken with student participants before the placement  
431 with four questions to prompt /provoke discussion with participants. The aim of the  
432  
433 evaluation was to better understand to what extent students had been able to draw upon  
434  
435 the theoretical learning that they had experienced to prepare them for this practice  
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437 experience.  
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442 The following questions were used to prompt discussion and encourage reflective thought  
443  
444 on student preparation:  
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- 446  
447 1. Have you participated in a community arts/ mental health and wellbeing project or  
448  
449 placement program before?  
450  
451 2. Have you practiced any art making before? What was your experience?  
452  
453 3. What do you understand by community mental health and wellbeing?  
454  
455 4. What do you do to manage your own mental health and wellbeing?  
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461 On completion of the placement, the student focus groups were reconvened, and the  
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463 following questions were used again to encourage discussion about the experience:  
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490
1. Did you enjoy the mental health and wellbeing workshops and the SMILE placement program?
  2. Did you learn anything new about yourself?
  3. Did you learn anything about community mental health and wellbeing?
  4. What did you learn from the SMILE placement program?
  5. What do you think the community needs to support better mental health and wellbeing for community members?

### 491 **The community members**

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The 65 community members who participated in the SMILE program activities participated in a focus Group evaluation at the end of the SMILE program. All participants who had attended the focus group had attended the 'kiosk for Health Checks' 'StARTalking' and participated in a student led health care assessment. All participants (n=65) expressed benefit of the SMILE program and the SMILE Clinical placement. We have deidentified the participants here but have provided alternative names and included genuine biography to humanise the accounts. We used the following broad and open-ended questions to trigger discussion:

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- Have you practiced any art making before? What was your experience?
  - What do you know about your health / mental health and wellbeing?
  - What do you think your community needs, to support better mental health and wellbeing?

### 522 **Analysis**

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The focus group data was audio recorded and transcribed verbatim. The data was deidentified and alternate names used to represent participants. The pre and post focus

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534 group transcripts were analysed using a thematic approach (Hsieh and Shannon 2005). The  
535  
536 transcripts were read and then re-read to identify any common themes, and or patterns.  
537  
538 And a comprehensive immersion in the participant responses. To ensure an accurate  
539  
540 representation of the themes the researchers analysed the data individually to identify key  
541  
542 repetitions and subtext and then together to decide on emergent themes (Ward & Barry,  
543  
544 2016).  
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### 548 **The student evaluation findings**

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551 Students expressed feelings about the extent to which they felt prepared for the placement  
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553 and drew upon theory and practice in their recognition of the significance of the social  
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555 determinates of health to individual and population consumer health outcomes. The  
556  
557 students identified the challenges associated with working across disciplines and  
558  
559 organisations; the importance of cultural safety practices working with vulnerable people  
560  
561 and students could articulate concerns related to the power and inequalities that exist in  
562  
563 society. Three key themes emerged: **Ditching nursing routine, Insight and outcomes,**  
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565  
566  
567 **Different strokes for different folks.**

#### 568 569 **Ditching nursing routine**

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572 The perceived lack of routine, specific tasks to complete and the structure in the  
573  
574 environment were highlighted as follows. Jenny (student) made a comment about their  
575  
576 preparedness for the placement:  
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579  
580 *.... I feel that I only was only moderately prepared coming in because we have*  
581  
582 *(experienced) such different nursing, there's a lot more independence here, and*  
583  
584 *talking to the health care team, you know, there's not someone right there letting*  
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593           *you know exactly what you should say. So, it's a bit different, because you are giving*  
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595           *health advice and you have to sort of draw a little on the education which isn't*  
596  
597           *clinical, non-clinical which is not something we have done before.*  
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600  
601 And Meg (student) responded saying:

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603           *.... I would have to agree, I didn't feel overly prepared coming into this placement I*  
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605           *felt like most of the other placements were hospital based and very regimented on a*  
606  
607           *ward routine, with a strong focus on the current primary diagnosis. Of course, in*  
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609           *ward nursing you do have that discharge planning but it's not the same intensity as*  
610  
611           *community based (practice).*  
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613

614  
615 This theme was reflected in many of the student's comments during the focus group  
616  
617 discussion. The theme highlights the students common understanding of the nursing role as  
618  
619 experienced on previous clinical placements. The hospital, acute ward perspective was  
620  
621 referred to several times in relation the nursing tasks they were familiar with. The nursing  
622  
623 tasks required on the SMILE placement however were noticeably different. The reference to  
624  
625 working autonomously at SMILE was raised and there was acknowledgement that however  
626  
627 daunting that was at first it represented great learning. This variance between what they  
628  
629 were used to doing and what opportunities SMILE offered them was significant to the  
630  
631 development of leadership skills and nursing competence.  
632  
633

### 634 635 **Insight and outcomes**

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638 Student participants were able to articulate their insight into the nursing approach  
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640 necessary to work with communities of disadvantage.  
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652 *(applying) knowledge of how to access healthcare and stuff and knowing what's*  
653 *available to them and even simple things like language barriers... they come to this*  
654 *facility but they may not able to actually benefit from all the programmes because*  
655 *they don't fully understand what else there is here, they can't just read the brochures*  
656 *or things like that.*  
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663  
664 The students discussed the way in which they adopted a different nursing approach when  
665 working with people of disadvantage. They spoke about how they actively engaged in  
666 conversation to develop rapport however how they were mindful that the people they were  
667 caring for were not patients. Elle said:  
668

669 *you have to approach the person and be led by them, I felt I was following their lead,*  
670 *responding to their need'*  
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678  
679 They reported that because of the various approaches they adopted in this community  
680 setting their learning was significantly different. They considered their learning was 'in  
681 action' 'happening in the moment' and this was in contrast with how they had learnt in the  
682 hospital environment. The students articulated that in the hospital environment they were  
683 working off theory, step by step skills and a very structured time management plan. Rosie  
684 said:  
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692 *In the hospital you have a very clear order of things you need to do and usually not*  
693 *enough time to do everything. And your work relates to a group of patients and the*  
694 *care they need on any one day.*  
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710  
711 Lenny (student) said that learning was different because you the community environment  
712 required different knowledge therefore students were stretched to see health and illness  
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715  
716 from a different perspective:  
717

718  
719 *...I think that it's the health promotion, not the illness focus, you can't just fall back*  
720  
721 *onto the idea of helping them recover you can't just be task orientated because, well*  
722  
723 *you can't become complacent as you are about health promotion and providing, well*  
724  
725 *I don't really know what I'm saying....*  
726

### 727 728 **Different stakes for different folks** 729

730  
731 This theme recognised the different health beliefs arising from different cultural  
732 perspectives and how students were required to learn this information 'on the run':  
733

734  
735  
736 *....if you have a patient from a different cultural background, the typical*  
737  
738 *western/ Australian model of health , they just do what the doctors say, and*  
739  
740 *someone may come in and their culture may not believe in a certain*  
741  
742 *medication and a certain way of doing something they can say OK, can you*  
743  
744 *explain to me why you are uncomfortable with this 'cos then that makes them*  
745  
746 *feel respected and more comfortable and you can try and find out what their*  
747  
748 *reasoning is and if there's a way you can work around that.*  
749  
750

751  
752  
753 Students shared their learning about the way that health care is organised and delivered  
754 and what that can mean for vulnerable people trying to access services. Amy said:  
755

756  
757  
758 *I have found that I am more able to identify barriers to health for people, the*  
759  
760 *things we are expected to do ....providing education and support and*  
761  
762 *advocacy for our patients and think that part of that even we have patients*  
763  
764  
765  
766  
767

768  
769  
770 *who are without healthcare we need to be effective in our job and identify*  
771  
772 *ways to .....even those who don't speak the same language as us, to often I*  
773  
774  
775 *feel that nurses will not give....health education or work with the patient for*  
776  
777 *them to become a partner in their health care and I think this placement has*  
778  
779 *helped me to identify those skills an help me also address those barriers.*  
780

781  
782 Student expressed that they had to work with each individual and respond specifically to  
783  
784 their needs. They had to acknowledge culture, age and respect a person's belief system and  
785  
786 way of being in the world. The students referred to being non-judgemental and 'respecting  
787  
788 everyone's differences' 'learning that 'people have had different life experience' and those  
789  
790 experiences influence them when they interact with others.  
791  
792

### 793 794 **The consumer participant evaluation findings**

795  
796  
797 The consumer participants shared their experience in one or more of the SMILE activities:  
798  
799 The Kiosk for Health Checks, StARTalking- creative arts activities, the relaxation sessions,  
800  
801 and the health education information. The two themes to emerge included **One Stop Shop**  
802  
803 and **Connecting**.  
804

### 805 806 **One stop shop**

807  
808  
809 The Kiosk for Health Checks were considered a One stop shop. The participants referred to  
810  
811 them as an opportunity to ask questions and reflect on their health and wellbeing.  
812  
813

814  
815 Gwen (67-year-old woman) made comment on the positive impact of SMILE on her health  
816  
817 and wellbeing:  
818

819  
820 *I realised I didn't know much about my health and I have diabetes so I should know*  
821  
822 *more. One thing I realised is that it's my mental state that I need to manage so I can*  
823  
824

827  
828  
829 *manage my health. I get stressed about things and going to the doctors because I*  
830  
831 *worry about getting sicker or having cancer. Going to the kiosk was great because I*  
832  
833 *talked to the students and they told me where I can go to for free and how I can*  
834  
835 *manage my health better.*  
836  
837

838  
839 Gwen had attended the Kiosk for Health Checks several times and felt that she learnt  
840  
841 something new at each visit. Gwen expressed feeling very comfortable to ask students  
842  
843 questions about her health and to enquire about local service providers.  
844  
845

846 Troy (a 33-year-old homeless man) said he too felt comfortable with the students. Troy  
847  
848 spoke about the way in which students communicated. He considered them non-judgmental  
849  
850 and caring. He said:  
851

852  
853 *I have been able to learn a lot about my health. The students presented it in a way I*  
854  
855 *could really understand’.*  
856  
857

858  
859 Marion (73-year-old woman) said that attending the SMILE Kiosk for Health Checks and  
860  
861 education session provided her with a greater sense of awareness about her health and with  
862  
863 this knowledge she was able to formulate a plan to take care of herself. Marion spoke about  
864  
865 attending the kiosk and StARTalking. She said the two activities complemented each other.  
866  
867

868 She said:

869  
870 *I have trouble with weight, but I didn’t understand how that might affect my other*  
871  
872 *health issues.*  
873  
874

875  
876 Joy a 74-year-old woman with a diagnosis of type 1 diabetes shared with the focus group  
877  
878 that SMILE had provided education that was having a direct impact on her physical  
879  
880 wellbeing. She said:  
881  
882  
883  
884  
885

886  
887  
888 *The one thing I want in my life is good health, but I have never had it. SMILE has*  
889  
890 *taught me more about how to get it.*  
891  
892

893 Mary (53-year-old woman) shared the following experience.  
894  
895

896  
897  
898 *I am on a lot of medication so when the students had the kiosk, I told one about them*  
899  
900 *all. They got the teacher because they didn't know all of them. The teacher then*  
901  
902 *talked to us all about what they do and why I take them and then I understood more*  
903  
904 *about them too. I didn't know I could ask the doctor to maybe change them if they*  
905  
906 *didn't work. I then went to my doctor and I am going back to what I was on before.*  
907  
908  
909 *So that was good and wouldn't have happened without SMILE.*  
910  
911

912  
913  
914 Mary was convinced that without SMILE she may not have followed up with her doctor.  
915  
916 SMILE had offered opportunity to reflect on her current medication regime. This small  
917  
918 intervention may have been lifesaving.  
919  
920

## 921 922 923 **Connected** 924

925  
926 The theme of being Connect emerged as participant data continually referred to 'making  
927  
928 friends' 'connecting to others' 'being heard' and 'having purpose'.  
929

930  
931 In reflection of the StARTalking workshops participants spoke about connecting, being part  
932  
933 of something and they were clear that this group was positive to their health and wellbeing.  
934  
935

945  
946  
947 Mark (47-year-old male) shared he had a long-term mental health problem that had a huge  
948 impact on his life. He expressed a great appreciation of the SMILE program and in particular  
949 the StARTalking program:  
950  
951  
952  
953

954  
955 *I always wish to be healthy. I have schizophrenia. You can't get rid of that. My*  
956  
957 *general health suffers and all I want to be is loved with luck, safe and successful. The*  
958  
959 *students have given me friendships I don't have.*  
960  
961  
962

963 Dianne (45-year-old woman) attended StARTalking. Dianne shared in the focus group that  
964 StARTalking and the education provided by students had a direct impact on her life choices  
965 and her health:  
966  
967  
968  
969

970  
971 *I need to quit smoking and need to lose weight and exercise more. SMILE taught me*  
972  
973 *to look at what to eat and how to eat better.*  
974  
975  
976

977 Dianne said:  
978  
979  
980  
981

982 *Learning about how my heart works and then doing relaxation makes me understand*  
983  
984 *how to be in control. It makes me want to stop smoking now so my heart can be*  
985  
986 *healthier.*  
987  
988  
989  
990

991 The participants spoke about the relaxation sessions and the theme of Connected was again  
992 apparent as discussion involve comments such as May's comment:  
993  
994  
995

996 *I feel welcome to be a part of the SMILE program and that feels good*  
997  
998

999 Dianne (45-year-old woman) told us:  
1000  
1001  
1002  
1003

1004  
1005  
1006 *I want to be a loving mother. I don't want to be stressed and uptight because I am*  
1007  
1008 *worrying all the time. The stress management I learned in SMILE has taught me how*  
1009  
1010 *to take time out and breath. Be more mindful. The kiosk with the students was good*  
1011  
1012 *and my blood pressure was good so I felt like there was less to worry about with my*  
1013  
1014 *health. They also told me about the health coaches we can go to for more help.*  
1015  
1016

1017  
1018 Dianne made mention that being able to access the SMILE resource, and most importantly  
1019  
1020 the relaxation sessions and the student assessment made them feel connected to others,  
1021  
1022 which in turn resulted in good health. The other participants used words such as 'I've made  
1023  
1024 friends at SMILE' and 'I feel good that I know SMILE is around the corner'.  
1025  
1026

1027  
1028  
1029 Cindy (32-year-old woman) shared with the group that she had trouble managing her  
1030  
1031 emotions and in turn her behaviour. She said that being connected to the SMILE program  
1032  
1033 and attending StARTalking has meant she had to reflect on how she interacted with others.  
1034  
1035 She said she was aware she needed to take responsibility for her behavior. She said:  
1036  
1037

1038  
1039  
1040 *I feel anxious all the time. I feel like I stuff up all of the time and end up hurting*  
1041  
1042 *people. I need to stop stressing and consider other people more.*  
1043  
1044

1045  
1046  
1047 Cindy spoke further to the group about the positive impact meditation in StARTalking had  
1048  
1049 on her life and that it was a practice she would continue to use to manage her anxiety.  
1050

1051 Connecting to the SMILE program had enriched her life:  
1052  
1053

1054  
1055  
1056 *I need to control my anxiety. The students taught me how to breath and be more*  
1057  
1058 *mindful. I want to keep coming to SMILE so that I can learn more about my health.*  
1059  
1060

1063  
1064  
1065  
1066  
1067  
1068 Susana (29-year-old woman) talked about being connected to SMILE and the benefit that  
1069  
1070 health information she received from students had on her wellbeing and outlook on life.  
1071

1072 Susana had disclosed a long history with depression. Susana said:

1073  
1074 *I am on a lot of medication and I hate taking it. It makes me feel sad that I have to do*  
1075  
1076 *it for the rest of my life because I am young but in SMILE, we talked about what*  
1077  
1078 *people took and other people are on lots of pills too, so I don't feel as bad. The*  
1079  
1080 *students talked about health and I understood what they said because they spoke*  
1081  
1082 *slow, and we could ask questions. When I go to the doctors it is always so quick and*  
1083  
1084 *sometimes, I forget why I went in the first place and then I get home and think I*  
1085  
1086 *should have asked that question.*  
1087  
1088  
1089

1090 The theme **Connected** represents the participants appreciation of being 'apart of  
1091  
1092 something', 'in relationship with others', 'feeling safe to speak' and knowing they are 'being  
1093  
1094 listened to'.  
1095  
1096

## 1097 **Discussion**

1098  
1099 The students who participated in the study reported a positive but challenging experience in  
1100  
1101 this placement overall. The students spoke about the challenges of working in this non-  
1102  
1103 clinical environment, and how they had to take the initiative and opportunities as and when  
1104  
1105 they presented. They also recognised the language and other cultural barriers to beginning  
1106  
1107 conversations about health and well-being and that sufficient time was needed to listen as  
1108  
1109 well as talk and to find new ways to explain or provided information to people with very  
1110  
1111 different needs and expectations.  
1112  
1113  
1114  
1115  
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1121



1122  
1123  
1124 The Focus Group discussions illustrated the students struggles to express and articulate the  
1125  
1126 scale of the challenge of assisting vulnerable individuals to both recognise poor health and  
1127  
1128 take steps to make even small changes. There was reference to 'thinking on your feet', 'you  
1129  
1130 have to problem solve and find solutions-pretty quick'.  
1131  
1132

1133  
1134 It was clear however, from the student discussions, that they were beginning to understand  
1135  
1136 the challenge and that one of the key steps they had to make themselves was improving  
1137  
1138 their own ability to listen and communicate with individuals whose health literacy was poor  
1139  
1140 and who had many other priorities.  
1141  
1142

1143  
1144 Chinn's ideas are powerful in that they remind students that this environment is not a  
1145  
1146 health professional's domain. The priorities and preoccupations of health care services and  
1147  
1148 professionals have to give way to the issues that are foremost in the mind of the individuals  
1149  
1150 who are seeking help. This requires a reflexive, responsive and highly adaptable approach as  
1151  
1152 well as a skill set that can be transferred to complex and challenging situations and  
1153  
1154 experiences. Exploring these ideas through the Peace and Power model has helped  
1155  
1156 students to recognize the power dynamics in professional/client relationships. Moreover, it  
1157  
1158 has allowed them to think more critically about what empowers and disempowers  
1159  
1160 individuals, what builds community and how they can contribute. The theoretical learning  
1161  
1162 that preceded the placement, applying the Peace and Power approach and the academic  
1163  
1164 teacher support were important dimensions and reference points for teachers and students.  
1165  
1166 This is important when learning or working in a non-institutional health setting where the  
1167  
1168 framework, routines and model of care is otherwise fluid or undefined and the people using  
1169  
1170 this local service are marginalised and otherwise vulnerable. An important dimension of the  
1171  
1172 student feedback was the account they gave of their improved understanding of why those  
1173  
1174  
1175  
1176  
1177  
1178  
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1180

1181  
1182  
1183 who experience mental health issues or live in poverty may not seek out health care and in  
1184  
1185  
1186 turn limit their social interactions due to negative attitudes toward mental illness and  
1187  
1188 ongoing associated stigma.  
1189

1190  
1191 From the consumer perspective, their contribution to this study confirms the potential of  
1192  
1193 programmes like this in their recovery and in their coping. Having the students and  
1194  
1195 academics bring such a rich programme of activities and health care skill to an accessible  
1196  
1197 place is clearly valuable to them. Based on the findings from the student learning evaluation  
1198  
1199 process and SMILE participant focus groups, a risk and resilience framework that identifies  
1200  
1201 protective factors will be introduced in the next SMILE clinical placement program.  
1202  
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#### 1204 **Limitations**

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1241  
1242 As a pilot study with a small number of overall participants and the localised (single centre)  
1243  
1244 approach do limit wider application of the findings but we consider with some modifications  
1245  
1246 to the design this study might be repeated in other settings where students are learning  
1247  
1248 about Primary Care and health improvement. Other methods including interviews may also  
1249  
1250 be appropriate and enable us to look more closely at individual case studies and narratives  
1251  
1252 of experience. We are aware of a burgeoning interest in collaborative approaches to  
1253  
1254 improving health and in new methodological approaches that may be helpful including co-  
1255  
1256 creative community-based health research (Daykin et al 2017, Greenhalgh et al 2016). The  
1257  
1258 insights this study provides, should assist those engaged in similar work or exploring its  
1259  
1260 potential, to consider applying elements of the SMILE model in preparing students,  
1261  
1262 supporting them in practice and helping them to analyse and evaluate their learning  
1263  
1264 through critical reflection on their practice experiences. It may also provide encouragement  
1265  
1266 to create partnerships with stakeholders to generate new knowledge both about how  
1267  
1268 students learn but also how professionals can support consumers to make the lifestyle  
1269  
1270 changes that will improve their health and wellbeing.  
1271  
1272  
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1278

## 1279 **Conclusion**

1280  
1281 The SMILE clinical placement aimed to provide nursing students with an opportunity to offer  
1282  
1283 nursing care to diverse community populations and gain insight into the way in which social  
1284  
1285 and economic factors can affect mental health and wellbeing. The findings of the pilot study  
1286  
1287 encourage us to continue with this collaborative approach both in its value to learning in  
1288  
1289 primary care but also because of the way it has strengthened our community health  
1290  
1291 partnerships. We identified that the participating students were able to recognise the way  
1292  
1293 in which nursing interventions can help to overcome issues of disadvantage by engaging  
1294  
1295  
1296  
1297  
1298

1299  
1300  
1301 potentially vulnerable people in a program that can contribute directly and indirectly to  
1302  
1303 their mental and physical health and wellbeing. Hearing from the users of SMILE added to  
1304  
1305 our understanding of the student contribution's value to them. The students were able to  
1306  
1307 both recognise and discuss the different ways in which they can apply their knowledge and  
1308  
1309 skills to support consumers to access health services, helping them to understand the ways  
1310  
1311 in which lifestyle and socioeconomic circumstances can worsen or improve health and,  
1312  
1313 through wider knowledge and understanding of the organisation and delivery of health  
1314  
1315 services, help to increase the community's health literacy overall.  
1316  
1317  
1318  
1319

1320 We are aware that government health departments in many countries are looking to  
1321  
1322 address rising medical costs and unmet need through restructuring services, for example  
1323  
1324 through community (or socially) based schemes and consequently making a significant  
1325  
1326 health impact. We would argue that these schemes should not just seek to occupy  
1327  
1328 participants in creative and other recreational activities (which are important ends in  
1329  
1330 themselves) but should also seek to widen access to appropriate health care support and  
1331  
1332 advice through new community partnerships and this we suggest, is especially important for  
1333  
1334 vulnerable individuals with mental health care needs if health outcomes are to be improved.  
1335  
1336 Making changes to the way that health practitioners (including the large nursing workforce)  
1337  
1338 learn how to contribute to these efforts through theory and practice, is an important way to  
1339  
1340 begin to realise these goals.  
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Dear Editor

Please find our research paper:

**Learning how to SMILE: improving physical and mental health through nurse education and creative practice**

which we submit for review. We declare as follows:

- 1) Conflict of Interest: none
- 2) Funding Sources: not applicable
- 3) Ethical approval details: La Trobe University Ethics Committee approval and written permissions from the local partner organisation)

Yours faithfully

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