Advanced Practice in Mental Health Nursing

A European Perspective

Agnes Higgins
Nina Kilkku
Gisli Kort Kristofersson
Editors

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Foreword

This textbook is very timely and very much needed to support the process of change within mental health policies and services.

The history of mental health care and psychiatry has been dramatic, with its pendulum-like shifts from theories and practices emphasizing certain elements of the bio-psycho-social model more than other ones. Recent decades were dominated by the biomedical model, which succeeded the previous dominance of psychoanalysis. Now there is increasing evidence pointing to the limited effectiveness and possible harm of mental health care that is over reliant on power asymmetries, coercion, and excessive use of biomedical interventions.

The bold promise, through several recent decades, has continually being that the systematic application of the biomedical paradigm would lead, through identification of biological markers, to effective treatment of mental health conditions, improved quality of life, and the end of stigma and discrimination. This did not happen. Despite new investments, huge numbers of people worldwide, including in Europe, continue to suffer from systemic human rights violations within mental healthcare facilities and services. Prevalence of non-consensual care is on the rise in all regions, including Europe. This is not surprising, as unlike the rest of medicine, the basic principles of informed consent and ‘first do no harm’ have been seriously undermined in psychiatry.

Change is urgently needed. In this process of change, creative solutions are emerging, as alternatives to the status quo, with attempts to prove that persons who experience mental health conditions can be effectively supported in ways that do not violate their human rights.

It is of crucial importance that the global mental health community creatively explores models of mental health service provision and ways of engaging with people that depart from the legacy of coercion, paternalism, discrimination, and excessive medicalization. At this moment in time, it is imperative that we strengthen the emerging view that psychiatry and psychiatric/mental health nursing can be empowering and respectful of people’s human rights.

The role of nurses is crucial in the process of providing mental health care to persons in need. Nurses as passionate carers are closest to everyday needs of persons with psychosocial disabilities and other mental health conditions. However, in mental health services, quite often nurses become hostages of coercive measures and paternalistic approaches. One of the observations by experts who are critical of the status quo is that not only users of services are disempowered by existing hierarchies and power asymmetries. Nurses may also be affected by the prevailing idea that only psychiatrists can be experts who make right decisions. In this regard, nurses should be supportive of change and indeed play a key role in democratizing services, as this needs to be the underpinning principle of all the needed change in mental health systems.

For the process of change to be smooth and effective, nurses, as well as other actors in the mental health scene, need to have the knowledge, skills and attitudes that represent and reflect the principles of a rights-based approach to care, principles that are aimed at empowerment, autonomy, and recovery. A human rights-based approach also includes focusing on important themes, such as therapeutic alliance, diversity, spirituality, and recovery-oriented care.

This textbook is about all these issues. By moving away from a medical way of framing peoples' distress, this textbook asks the reader to think differently and more creatively and is exactly what is needed now for European and global mental health.

The book will equip nurses with knowledge and practical understanding about how mental health services can be supporting, empowering, non-coercive and avoid hierarchical paternalistic approaches.

I strongly recommend this book to all nurses, but also to everyone who is related to or curious about mental health and mental health care.

Dainius Pūras
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Former UN Special Rapporteur on the
Right to Physical and Mental Health (2014-2020)

Preface

This genesis for this book was based on the willingness of Springer and Horatio, the European Psychiatric Nurses, to work together on a publication to strengthen advanced practice in mental health nursing in Europe. The idea behind the book was to fill a gap in the literature of advanced practice mental health nursing from a European perspective. Most of the available books, describing the work and philosophy of advanced practice mental health nursing, have been published in the USA. Although these books certainly contain valuable information for nurses working in Europe, the culture of caring, including the health services and education systems are so diverse, not only between Europe and the USA, but between countries within Europe, hence we considered that a textbook such as this was sorely needed.

While the field of mental health is without doubt a field of contestation and debate with various agendas and voices, the focus and tone of the book was strongly influenced by human rights and recovery approaches to mental health care. We are strongly of the view that the practice of advanced mental health nursing is, or should be, guided by a philosophy grounded in a humanistic approach, collaboration, coproduction, and inclusiveness. This approach is relational based and gives primacy to the voice and personal epistemology of the person seeking care and is one that challenges the privileging of one theoretical perspective over another, including the privileging of the biomedical model. Emphasis within the book is therefore on providing insights, from around Europe, on how to work ‘for’ and ‘with’ people with lived experiences and their families, while maintaining the rigorous and ethical standards advanced practice mental health nursing demands.

The period in which we edited this book became extraordinary in a way no one could have foretold. The worldwide pandemic and war in Europe affected us all, editors and authors, in different ways. Professionally, we all faced significant challenges at work, and personally many grieved the loss of loved ones without the usual support. On a positive note, we met many new people and developed new friendships and relationships in the process; and we all shared feelings in a way no one could have predicted.

Additionally as editors, hundreds of hours of discussions in online meetings about the text gave us a unique opportunity to work and learn from each other. We not only got an opportunity to share the challenges of teaching and practice during a pandemic, but we also got to discuss and debate the various aspects of advanced level mental health nursing in different countries. We told stories, compared traditions both within and outside of mental health nursing, found similarities and differences, agreed to disagree, and discovered the power of humour and laughter. During the shared enterprise of the book, we developed a sense of belonging and formed lifelong friendships, just like we see with nurses in mental health settings around Europe. The feeling of camaraderie and acceptance kept us going, while the world around felt like it was collapsing.

Completing this book was only made possible because of our excellent, committed colleagues who wanted to share their unique knowledge, strength, and experience by contributing to this book. We would like to thank them sincerely, as we know how hard it has been during these extraordinary times. We would also like to thank Professor Pūras, former UN Special Rapporteur on the Right to Physical and Mental Health (2014–2020), for writing the foreword for the book and for his strong human rights message to all of us who work in mental health.

To you the reader, irrespective of your role, position or discipline, we hope this book not only supports critical thinking and debate but is of practical relevance as you engage in your work alongside people with lived experiences and their families. Today more than ever, people require services that are underpinned by human rights and recovery principles, principles which we consider belong to the highest level of clinical competence.

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Acknowledgements

First and foremost, we, the editors, would like to acknowledge all of the people with lived experience of mental health problems and their family members who we have met throughout our journey in the mental health system and who have inspired and motivated us to strive to make a difference. It was out of this desire that the idea for this book was born.

We would like to extend a heartfelt thank you to the 25 people, from more than a dozen countries in Europe, who have authored or co-authored the various chapters. Your commitment to writing throughout all the challenges and demands of the Covid-19 pandemic is really appreciated. The rich text and analytic approach towards the writing of each chapter will be an invaluable source of information and learning for all mental health professionals, including Advanced Practice Mental Health Nurses.

A huge thank you to the people who generously provided case studies and exemplars to enrich the relevant chapters. These exemplars not only ground the material in the realities of everyday practice but help to remind us that the ultimate raison d'etre of mental health nursing is to support people's recovery journeys.

A sincere thanks goes to Professor Dainius Pūras, the Special Rapporteur of the United Nations (2014–2020), our foreword writer. We really appreciate the generosity of spirit in your comments and insights.

To Natalie and Siva at Springer, a big thank you for your patience and timely advice throughout the whole writing and production process, and to the Board of Horatio for their collaborative support. Finally, a huge thank you to our families and friends, who witnessed and supported us in the ups and downs involved in bringing this book into being.

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Editors and Contributors

About the Editors

Agnes Higgins, PhD, RPN, RGN, FTCD, FFNRCSI grew up in a small rural farming community in the west of Ireland, a middle child of seven, four sisters and two brothers. Today she lives with her husband Jim outside of Dublin and works as a professor in Mental Health at the School of Nursing and Midwifery, Trinity College Dublin, Ireland. Over the years she has worked in various aspects of nursing ranging from adult physical health to hospice/palliative care but has always returned to mental health nursing with new insights and enthusiasm to make a difference.

Her research in mental health is expansive and cross-disciplinary in scope. The central theme underpinning her research is on increasing understanding of service users' and family members' experience of mental health service provision and the development of psychosocial strategies that promote recovery and social inclusion. Agnes uses diverse research methodologies, all of which are underpinned by participatory and co-production approaches aimed at developing quality evidence to inform and transform practice and policy decisions. She has held numerous research grants from Irish and EU research bodies. As an educator, Agnes has led the development of numerous undergraduate and postgraduate programmes for mental health nurses, including online programmes. Agnes holds the Provost award for teaching excellence.

Agnes is a Fellow of Trinity College and a Fellow (Ad Eundem) of the Faculty of Nursing and Midwifery in the Royal College of Surgeons in Ireland and has been a chairperson or member of numerous policy, research, and advocacy committees/groups in the area of mental health. She is a reviewer of several international peer-reviewed journals and, to date, has published over 125 papers in peer-reviewed, high-impact journals, 2 books, and 13 book chapters.

Tá súil agam gur bhain tú taitneamh as an leabhar

Nina Kilkku, PhD, MNSc, RN, FFNRCSI Nina's home city is Tampere, a city located between two lakes in the inner land of Finland. Two adult daughters have already flown the nest and today she enjoys her life by one of the lakes as well as travelling with her boyfriend. Nina started her career as a psychiatric nurse more than 30 years ago in the acute admission ward in Tampere University Hospital District and later worked in different positions in the same organization before moving to the University of Applied Sciences where she currently works as a Principal Lecturer of Mental Health and Substance Abuse Care. Besides her daily work she has a private practice as a family and couple psychotherapist.

In the field of mental health her interests include therapeutic alliance with individuals, families, and networks as well as the different aspects of mental health, social inclusion, and human rights. She is also interested in mental health service systems, education, and competences, and more recently ecological and environmental changes as they relate to mental health. In the field of research, Nina's expertise is on qualitative research as well as participatory and action research methods.

During the years Nina has developed with her colleagues several mental health-related curricula in Finland. Today her focus is on master's degree education as well as specialized education on mental health and substance abuse care for social and healthcare professionals. Her work includes different development activities and co-operation at a regional, national, European, and international level. At the moment she is an editorial board member of two international scientific peer-reviewed journals.

Nina is the current president of European Psychiatric Nurses (Horatio), a member of the Advisory board in the European Centre of Excellence for Research in Continuing Professional Development, a member of ICN Mental Health Nursing Workgroup, and a proud Fellow (Ad Eundem) of the Faculty of Nursing and Midwifery in the Royal College of Surgeons in Ireland (FFNMRCSI).

Antoisia lukuhetkiä!

Gisli Kort Kristofersson, PhD, RN, PMHNP-BC was raised by a public health nurse and a single mom of four kids. Through his mom he was exposed to the wonders of the therapeutic alliance as he had to endure endless waiting each time they visited the neighbourhood grocery store as old and new clients would keep his mom chatting for hours. Gisli came to nursing in his early twenties through a calling after a tumultuous few years as an adolescent and young adult, and has never looked back.

Gisli worked as a Clinical Nurse Specialist in Adult Psychiatry in community mental health from 2008 to 2012 in an underserved neighbourhood in Minneapolis, MN, and in private practice from 2012 to 2014 in Minneapolis, MN. Upon his return to Iceland in August 2014 Gisli has practiced as a PMHCNS both in a hospital and private practice setting.

Gisli was awarded his PhD in Nursing from the University of Minnesota in August 2012. Both his research and clinical interests lie in the field of mental health nursing. His most recent research focuses on geriatric mental health in rural Iceland, and mental health of prisoners along with belonging to various national and international research groups related to different aspects of mental health care.

Gisli has been a member of various councils, boards, and committees, national and international, focusing on healthcare and mental healthcare policy, nursing education, and advanced practice nursing. Gisli is currently a board member of Horatio-European psychiatric nurses.

Njótið lestursins!

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Kirsi Hipp, PhD, MNSc, RN is a senior researcher at the Department of Nursing Science, University of Turku. She has a background as a registered nurse in community mental health care as well as a teacher of nursing students. Her primary research area is the realization of ethical values and rights in mental health care. She has studied patient participation in forensic psychiatric care and worked on an international research project focusing on preventive psychosocial interventions in vulnerable groups. Her current interest involves the potential of sensor technology in health care. Furthermore, she is interested in future learning needs, development, and leadership in health and social services.

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Diana Polhuis, MSc, MANP graduated in 1970 in (advanced) nursing, in Health Sciences and in Health Professions Education. Currently, she works as a dean and senior lecturer at GGZ-VS University of Applied Science in Advanced Mental Health Nursing. She developed and implemented the current curriculum and is a senior lecturer in assessment and clinical reasoning by AMHNPs. She combines her work in the academy with her role as an advanced mental health nurse practitioner in the Netherlands. She has a special interest in forensic mental health and trauma, and the impact on daily functioning. Finally, she is part of the Dutch Healthcare Disciplinary Board, where the quality of nursing treatment is assessed.

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Julian Raffay, BSc, BA, MTh, DThM Since 2020, Julian has been working as Director of Chaplaincy Studies at St Padarn's Institute in Cardiff where he heads up a master's programme and teaches on ethics. Prior to that, he worked with Mersey Care NHS Foundation Trust as Specialist Chaplain (Research, Education, and Development). He recently published *Coproduction: Towards Equality in Mental Healthcare*. He remains committed to coproduction as a way of reconceptualizing services, our understanding of professionalism, and indeed of care. His doctorate explored the relationship between mental health services and faith communities. He has spent 15 years working as a mental health chaplain and as many in parish ministry in the Church of England.

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Marc Verschueren, PhD, MSc, RN is a visiting professor at the faculty of medicine at the University of Leuven in Belgium. He teaches leadership for both nurses and physicians. He is head of Training and Development at the University Hospitals of Leuven, where he focuses on leadership development. 20 years ago, Marc started clinical leadership projects in more than 30 healthcare organizations. He is currently the coordinator of the Network for Leadership Development in Healthcare, a network that focuses on the promotion of sustainable and effective leadership.

Peter Wolfensberger, PhD, MScN, RN is an experienced mental health nurse who works as an expert, coach, and consultant in private practice in a rural community health centre. He is also a lecturer in Psychiatric Mental Health Nursing at the Department of Health in the School of Nursing and the Division of Applied Research and Development in Nursing at Bern University of Applied Sciences (Switzerland) and a visiting associate at Bournemouth University (England). Peter is particularly interested in the user perspective and their experiences and focuses mainly on disadvantaged people and minorities, such as LGBTIQ* people in his work.

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Part I

Theoretical and Historical Perspectives

Landscape of Advanced Practice Mental Health Nursing in Europe

Nina Kilkku, Gisli Kort Kristofersson, and Agnes Higgins

Learning Objectives
The objectives of this chapter are to enable you to:

- Locate mental health care and advanced level mental health nursing in a European context.
- Critically reflect on the education provided in Europe to mental health nurses as well as advanced practice mental health nurses.
- Collaborate with other professionals, people seeking help, their families, and communities to advance the human rights approach in all mental health care.

1 Introduction

The landscape of advanced practice mental health nursing in Europe is as interesting, varying, and intriguing as the area of Europe itself. With more than 50 countries, each with different geographical areas, histories, cultures, political, and economic backgrounds, the European perspective provides a rich and diverse perspective on the topic of this book. These different views and insights also influence

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and shape the ways mental health is understood and mental health care is organized in different European countries. Europe is a birthplace of many philosophers and theorists who have influenced and are still influencing research and practice in the area of mental health. Names like Hegel, Heidegger, Husserl, Merleau-Ponty, Ricœur, Levinas, and Gadamer are familiar to many researchers. From a psychoanalytic viewpoint, people like Sigmund Freud, Carl Gustav Jung, and Jacques Marie Èmile Lacan have, for decades, influenced mental health practice, research, and education in Europe. Other people like Michel Foucault [1], R. D. Laing [2], and Maxwell Jones [3] have provided critical viewpoints that are influencing our thinking on mental health and mental health service systems to the present day. In the field of mental health nursing, Annie Altschul [4] and Eileen Skellern [5] have been influential in the United Kingdom, while in some of the Nordic countries, ideas of the caring sciences, and especially the philosophy of caritative caring [6], have influenced the way people think about mental health and the education of mental health nurses [7]. The American nurse Hildegard Peplau and her theory of interpersonal relations in mental health nursing [8] not only highlighted the centrality of the therapeutic alliance, but over 70 years later, her theory is still the primary theory for many mental health nurses in several European countries. More recently, Phil Barker's thinking and the Tidal model have influenced mental health practice not only in the United Kingdom but has been highly influential in other countries within Europe and beyond [9, 10]. The list of people who have provided different perspectives is extensive; therefore, we have only mentioned some as examples to remind us of the rich tapestry of thinking and ideas that have challenged and continue to challenge our thinking in relation to mental health, mental distress, and mental health nursing.

As with all landscapes, the European landscape of mental health is a changing one. While reference was made to mental health within the Sustainable Development Goals (SDGs) (https://sdgs.un.org/goals), which recognized mental health as critical to sustainable development in all countries, the translation of aspirations into real-world impact is slow. Indeed, the latest Global Burden of Disease Study from 1990 to 2019 shows no decrease in the burden mental distress on individuals, families, networks, communities, and societies [11]. Instead, even before the COVID-19 pandemic, the prevalence of mental health problems in different age groups has been steadily rising in "all countries in the context of major demographic, environmental, and sociopolitical transitions" [12, p. 1553]. The COVID-19 pandemic has added to this increase, with its economic and health impacts accompanying us for many years to come [13, 14]. In recent years the number of forced migrants surprised many European countries, and 2022 brought another war that is forcing millions of traumatized people to abandon their homes and country to seek refuge. At the same time, worries related to climate change are burdening our mental health. All of these are not only challenging the mental health service provision but our understanding of mental health and trauma-related distress. It also brings into sharp relief the importance of human rights and human rights-based approaches to mental health care.

The European landscape in relation to the model of mental health care is also changing and varies between countries. Some countries or areas within a country may be well-resourced and well-funded, while underinvestment in mental health may be the hallmark of service development in other countries. What is frequently called the “postal-code lottery” also characterizes some people’s experience; depending on where you live, you may have access to well-developed community and early intervention services that are staffed by a multidisciplinary group of professionals and integrated with primary care, or the service offered may be more institutionalized. Depending on the role and position of psychiatry within the mental health system, mental health care in a country or service may be either biomedically focused or lean toward a broader psychosocial understanding of mental distress [15]. In addition, at a time when there is a need for more competent mental health nurses including advanced practice mental health nurses (APMHNs), many countries and services are struggling with a shortage of nurses, due to challenges with recruitment and retention [16]. This chapter, the first chapter of the book, is focused on mapping some parts of the European landscape as a way of contextualizing advanced practice mental health nursing.

2 Human Rights Agenda: Guiding the Way to Change

There is substantial international and European literature providing the rationale for prioritizing change toward a more “bio-psycho-socio-rights” and recovery approach in mental health care, with human rights seen as the essence or central pillar of all future mental health care [17]. Despite the Universal Declaration of Human Rights being launched in 1948 and several other Human Rights Council Resolutions, including the Convention on the Rights of Persons with Disabilities (https://www.ohchr.org/en/special-procedures/sr-health/right-mental-health) being released since then, many of the rights articulated in these documents have not become a reality.

The pressing need to adopt a human rights perspective has been highlighted by the Special Rapporteur of United Nations (UN) who not only reiterated the well-known slogan *“There is no health without mental health”* but expanded on it to incorporate the human rights perspective, by stating: *“There is no health without mental health and there is no good mental health and well-being without embracing a human rights-based approach*” [18, p. 18]. Indeed, the need to uphold the human rights perspective was illustrated in May 2021 when independent UN human rights experts had to raise their voice to avoid the Council of Europe Committee on Bioethics adopting an Additional Protocol which would have supported the use of coercive measures in mental health [19]. This example highlights the need for vigilance at all levels to ensure that human rights are respected and mental health services are developed based on human rights principles.

Throughout Europe many people have variable or limited access to quality mental health services that are accessible and affordable and provide a comprehensive range of effective psychosocial interventions that are evidence based and shown to have better outcomes than approaches that are purely focused on symptom reduction. What Pathare et al. [20] call the “psychosocial care gap” is a human rights issue, as access to timely and effective psychosocial care impacts health outcomes, which in turn impact access to other forms of health capital like education and employment. Today there is also a significant body of research about the physical health disadvantage people experiencing mental health problems experience. While the WHO in the Mental Health Action Plan 2013–2020 state: *"…health workers must not limit intervention to improving mental health but also attend to the physical health care needs of children, adolescents and adults with mental disorder"* (World Health Organization 2013, [21, p. 14]), a significant treatment gap in this area still exists.

Although the dark history of custodial, coercive, and inhuman care and treatments toward people seeking help for mental health care has been well documented (e.g., [22]), unfortunately the practices of involuntary detention and the use of coercive or restrictive treatment practices are still part of mental health care in several countries in Europe and even increasing in some countries (e.g., [23]). Indeed, 2 years ago, the UN stated that "*the combination of a dominant biomedical model, power asymmetries and the wide use of coercive practices together keep not only people with mental health conditions, but also the entire field of mental health, hostage to outdated and ineffective systems*" [18, p. 6].

There is also a long way to go to ensure that the mental health legislation required to support a human rights agenda within mental health services is in place. In the most recent Mental Health Atlas (World Health Organisation (WHO) [24]), 67% of responding countries, or 51% of WHO Member States, reported that their mental health policy or plan for mental health was in full alignment with international and regional human rights instruments. In the same report, 64% of responding countries, or just 39% of WHO Member States, reported full alignment of their mental health law with international and regional human rights instruments. Not surprisingly, the lack of attention to human rights and the many violations documented within the mental health system across different countries has been described as a "global emergency" and an "unresolved crisis" [17].

In response to these, there is an increasingly stronger voice that questions the dominance of the biomedical model as a way of framing mental distress as well as its influence on care and treatment approaches (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"). In addition to the United Nations [18] and the World Health Organization (WHO) [25], many others, including people using the mental health services, have critiqued the overreliance on biomedical explanations of emotional distress and mental health conditions and the dominance of the biomedical model within mental health services. People within the service user/survivor movement also see this as a human rights issue and are raising their voice, questioning "expert" opinion and rightly demanding a say in decisions that affect them, from policy to research to practice. Movements like Mad in America are spreading through Europe providing a critical viewpoint on mental health care, as well as asking searching questions about the primacy of the medical model and the uses of psychotropic medication to "treat" what many consider is a response to trauma and socio-/economic context [26]. There is also a growing number of people seeking to come off these medications and exercise their autonomy by discontinuing medication with or without support from mental health professionals

[27]. At the microlevel of service delivery, a consistent theme within service user and family research and feedback across services is the need for a more humane and person- and recovery-focused service; a service that acknowledges people's right to be involved in all aspects of their care, their right to information, and their right to have their voices listened to and respected [28, 29].

The roots of recovery as an approach and philosophy can be seen far in history—in the movements like moral treatment at the end of 1700s as well as within the later ideas of the therapeutic communities and the anti-psychiatric movement [30]. Since then, there is a vast amount of knowledge about recovery but also critical voices that challenges its individualism, stressing the importance of the need to emphasize the relational aspects of the recovery [31] as well as the social context [32]. Today there is not only a demand for more recovery-oriented service but a change in the culture of practice from one of compliance, risk adversity to one that is underpinned by the values of information sharing, positive risk taking, hope, and self-determination [33].

There are also less visible issues which the recovery approach is shedding light on and which should be critically reflected on from a human rights perspective, namely, the language and terms used by professionals. While language has important means of communicating understanding and perspective it is not a neutral vehicle for expressing thoughts and feelings, as words are a powerful medium for shape thinking and influencing behavior and actions. The words used can restrict or expand conceptualization of the world, include or exclude people, and can convey empathy and understanding or frame peoples as objects of mental distress and "pathology" [34]—hence the need to consider the language used to codify and categorize distress (see "Therapeutic Alliance"). Already the worldwide organizations are paying attention to the language used within mental health services and reminding stakeholders how language can exclude and stigmatize. For example, the Organization for Economic Co-operation and Development (OECD) recently described: Using appropriate language in the *field of mental health is important for at least two reasons: to align with rapid ongoing shifts in the use of language that go hand-in-hand with continuing efforts to raise awareness and address stigma; and to ensure clear communication of the population groups in focus. As much as possible, language should be person-centred, strengths-based, and recovery-focused*. [35, p. NA].

Outside the immediacy of the mental health services, people experiencing mental health problems are also more likely to be subjected to higher rates of stigma, discrimination, and violence in their everyday life compared to the general population [18]. The presence of a mental health problem is more likely to place an individual at risk for other aspects of their social and political rights being denied. For example, depending on where the person lives, they may be denied the opportunity to live in a place of their choosing, marry, have children, attend school, and seek employment.

Not surprisingly, Pathare et al. [20] remind us that these gaps negatively impact the exercise of a number of human rights, including the right to health which was enshrined as early as 1948 in the Universal Declaration of Human Rights, and reinforced in other conventions, including the UN Convention on the Rights of Persons with Disabilities (CRPD). They also impact the right to education (Art. 24), the right to habilitation and rehabilitation (Art. 26), the right to work and employment (Art. 27), and the right to adequate standard of living and social protection (Art. 28) (CRPD). While countries that have ratified the UN CRPD have an obligation to take steps to enable persons experiencing mental health problems exercise all of these rights, APMHNs as duty bearers also have an obligation to uphold the standards of the government under which they work (in public or private capacity), and people who use services as "rights-holders" have a legitimate claim to having their rights respected, or at least not have them violated or ignored.

There are already examples on how citizenship can be supported in service provision while respecting human rights [36, 37] as well as guidance and support toward human rights-based mental health. For example, the World Health Organization (WHO) [25] as part of their Quality Rights Initiative produced a comprehensive e-training program and guidance materials (https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools [25]). The materials are aimed at building capacity among mental health practitioners, people who use the mental health services, families, carers, and others on how to implement a human rights approach in line with the UN Convention on the Rights of Persons with Disabilities and other aforementioned international human rights instruments.

3 Reforming the Mental Health Services and Practices

A European mental health service model does not exist, with service systems and process differing between countries because of different historical, political, economic, and cultural factors (e.g., [38, 39]). In terms of deinstitutionalization and the transition from institutionalized care to community-based health care, the drivers also vary across Europe [40]. The most famous example is the reform in Trieste, Italy. In Italy, in 1978, Law 180 forbade the opening of any new mental health hospital, prioritized the care in the community, and ordered the existing hospitals to be emptied. This led to the closure of the asylum system and paved the way for the patient liberation movement in the country [41–43].

In other European countries, the reform has proceeded at a different pace [39]. While in the United Kingdom, deinstitutionalization started as early as the 1950s [44], in Ireland and Finland, it was only after institutionalization reached its peak in the 1970 that planning and development of a community-based services started [38]. Reform has only recently commenced in the Czech Republic [45]. In these developments there are often several factors enabling or hindering progress, including policy, economics, and strength of professional voices to name a few. For example, in Finland the progress of the reform of mental health services was negatively influenced by the economic recession. While the number of hospital beds were decreasing, due to limited resources, the number of staff in the outpatients services were also decreasing, leading to the situation in which outpatient services could not develop as planned [46]. Today, mental health services reform not only means moving from institutionalized services to community-based services, but it is about developing comprehensive, equitable, integrated, and specialist service that provides timely and accessible care to people across the life span, at the lowest level of complexity. In line with the human rights perspective, it is also about moving beyond individual causal models of mental distress to take a population-based approach, an approach that addresses the social and structural inequalities and conditions that negatively impact the determinants of mental health [25].

Today when following the principle of providing care where the people are, there are more and more mental health professionals, including APMHNs working in other, nontraditional mental health settings, like schools and in nongovernmental organizations. This not only requires a change in location but also a change in perspective. As it is no longer possible or desirable to "only" concentrate on mental health challenges, promotive and preventive practices need to be included [47] as well as the social factors [32].

4 The Establishment of the Advanced Practice Mental Health Nursing

There are several terms, like APN, ANP, APRN, CNS and NP, used sometimes interchangeably within the literature to describe specialized or advanced level nursing [48, 49]. As the titles of the advanced level nurses vary significantly between countries, organizations, and services, a number of writers comment on the confusion created not only within the service system but also for colleagues, the public, and recruitment activities [50, 51].

The International Council of Nurses [49, p. 9] defines advanced practice nurses as "*a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level*". In 2020 the ICN's Guidelines for Advanced Practice Nursing describes two types of advanced practice nursing, the clinical nurse specialists (CNS) and nurse practitioners (NP), and identified the direct or indirect activities (clinical or nonclinical activities) as the main difference between these two; CNS, in comparison to NPs are more involved with indirect activities (see more detailed "Role and Competencies of Advanced Practice Mental Health Nurses") [49]. However, how advanced practice nursing is defined also varies depending on the phase of the development of APN roles in different countries [52].

In different countries of Europe, the development pathway of advanced practice nursing (APN) and advanced practice mental health nursing varies greatly. In some countries the development of advanced roles is described as emerging in response to the lack of medical doctors in the field of mental health, this means the lack of psychiatrists. In a review by ter Maten-Speksnijder et al. [53] on the development of roles in the Netherlands, two discourses were identified relating to the development of advanced practice roles, namely, the efficacy discourse and development of the profession discourse. The efficacy discourse related to issues of shortages of both the doctors and nurses and included the idea of the attractiveness of the expanded role of a nurse as a career choice. This efficacy discourse also included economic aspects, such as how the role of the APN would be part of the solutions to the continuing growth of healthcare expenditure, as well as helping to address the fragmented service systems by providing more coordinated care. The development of profession discourse focused on the question of professional independency of APN and differences of responsibilities between professions [53].

While ter Maten-Speksnijder's et al. [53] review concentrates on the role of nurse practitioner (NP) in the Netherlands, different experiences and rational have been described in Sweden. In the Swedish context, the APNs are not seen as replacements of the general practitioners (GP), medical doctors, but as complimentary to the service systems [54]. In other words, APNs are not seen as mini-doctors or less expensive substitutes, but as maxi nurses or highly skilled nurses who provide holistic, effective, safe, and coordinated care to people seeking help [55]. Indeed given the nursing shortage that many countries are now facing, the substitute discourse is no longer a valid one.

Another example of a different development pathway is from Ireland. In the Republic of Ireland, the development of APN role arose from demands within the professions of nursing and midwifery as opposed to outside factors. As a result of industrial action (strike and withdraw of labor) by nurses and midwives in 1996, the Irish labor court, during its deliberations on the issues in dispute, recommended the establishment of a Commission on Nursing. Based on evidence reviews and discussion with international experts on role development, one of the recommendations made by the Commission was to expand the nurse's role and develop a clinical career pathway that progressed from staff nurse to clinical nurse/midwife specialist (CNS/CMS) to advanced nurse/midwife practitioner (ANP/AMP) [56]. Subsequently, in 1999, the National Council for the Professional Development of Nursing and Midwifery was formed, and this body developed the first Framework for the Establishment of advanced roles in Ireland, including definitions, approval, and accreditation guidelines. Since then, the respective frameworks [57, 58] have been revised in response to developments taking place in the Irish health system and the higher education sector [59]. Today the responsibility for the development of competences, accreditation, and registration of APNs lies with the Nursing and Midwifery Board of Ireland (NMBI) [60].

While the history and pathways to development may vary from country to country, several studies from different European countries demonstrate the benefits, such as improvement in the access to services, high patient satisfaction rates, and reduced waiting times, as a result of APNs working in different care contexts [52, 61, 62]. On the other hand, many studies also highlight the need to increase role visibility and strengthen the APN's position within services, especially in primary healthcare. In addition, APNs still encounter challenges from members to the multidisciplinary team that create an ongoing need to negotiate their scope of practice [63]. Similar challenges with role visibility and acceptance are found in the field of APMHNs.

In the systematic review on the tasks and activities of advanced practice nurses in the mental health care context, altogether 46 practice dimensions and 6 practice domains of the APMHN role were described and summarized as (1) clinical nursing and care practice; (2) care coordination and case management; (3) psychosocial health promotion and prevention; (4) consulting, education, and coaching; (5) leadership and public relations; and (6) research and practice development [64]. The core of mental health nursing, the therapeutic relationship [65], or as presented later in this book, the therapeutic alliance, is included in the first dimension. This dimension also included different psychosocial and psychotherapeutic activities, with the exception of German-speaking countries in which the psychotherapist has authority on the delivery of psychotherapeutic interventions [64]. This is one example showing the differences between European countries, differences which might be based on legislation, on historical tradition and on differences in the boundaries and positions of different professions. As the role, position, and education of nurses differ between the European countries, when developing and discussing advanced level mental health nursing, these differences need to be acknowledged, respected, and understood, not only as obstacles but as contextual factors influencing and defining the education and the scope of practice of APMHNs in Europe.

5 Advanced Level Mental Health Nursing Education

In the field of higher education, the Bologna Process has aimed to harmonize education to enable mobility and co-operation between European countries. With the development of the European Qualification Framework (EQF), which provides eight levels of learning outcomes, comparison of qualifications between countries became possible. Since its development in 2008 and revision in 2017, EU member states together with 11 non-EU countries have adapted the EQF. With the requirement for Master's level education, the advanced level mental health nursing is at level 7. However advanced level education for nurses is not available in all European countries, and there are many differences between the preregistration education of the nurses or the education required to achieve a license to practice [66, 67]. In some countries a "license to practice" can be achieved following a diploma, whereas in other countries a degree (level 6) is required. Differences are also evident in the length of education (e.g., [40]). Differences between countries are seen in the general education required before entering nursing education. The European Directive [68] gives an option of 10 years of general education, but most European countries require 12 years of general education before entering nursing education in higher education institutions. In the United Kingdom and Ireland, there is a direct entry to mental health nursing, with nurses registering (receiving a license to practice) as mental health nurses after undertaking their primary degree. In some countries there are studies as postgraduate level that specializes in psychiatric or mental health nursing, or in mental health and substance abuse care after first registration (see "Roles and Competencies").

In many countries the education of advanced level nursing is in the early phases, although growing. France, for example, aims to educate 3000 APNs by the year of 2022; this figure includes advanced mental health nursing together with three other specialized branches of nursing [69]. As the Master's level education is built on the competence gained in previous education levels, the diversity within and between preregistration and undergraduate education programs and the different entry requirements (e.g., in some countries work experience in nursing is requested before entering Master's level education) highlights the challenges of harmonization of programs across Europe. In addition to considering individual learners' differences, country-specific factors need to be acknowledged in the curriculum development process used [38]. Curricula for APMHNs need to support the development of competences in line with the changing need of populations and communities and informed by a human rights approach. As with the development of mental health practices, curricula also need to be co-created in collaboration with communities and citizens [70, 71].

Education at an advanced level is also seen as a career pathway supporting the recruitment and retention of nurses and providing one way to prevent attrition from the profession at a time of increasing shortage [72]. The APN role is also viewed as one way to increase job satisfaction as increased job satisfaction is thought to increase autonomy and sense of accomplishment [73]; which is emerging as an issue that impacts people's intentions to stay or leave the profession. While in many countries, there may be a desire to increase the numbers of APMHNs, this aspiration may be hampered long term by the nursing shortage, including the shortage of mental health nurses in all areas.

6 The Focus of Advanced Practice Mental Health Nursing

Despite the shortage of nurses and mental health nurses, the rationale and need for the development of APMHNs have not changed; the prevalence of mental health problems is still high worldwide, and the need to develop health promotion and preventions activities with citizens and communities is a priority [74]. The need to develop more community-based programs and people- and citizen-centered initiatives is still a challenge, as is the need to decrease the stigma affecting the everyday life and help-seeking behavior of people [75]. Moving to a recovery-oriented "bio-psycho-socio-rights" approach, also requires practitioners to understand the different factors related to mental health, like the societal factors that promote and support mental health, as well as recognizing and acknowledging P 31, P 98 the interdependent nature of these factors. Change toward right- and strength-based approaches to care also requires the strengthening and amplification of the persons and family voice within the entire mental health system.

Changes are also needed in everyday mental health nursing care. APMHNs need to ensure that the care and interventions they provide are not just evidence based but are based on ethical and human rights principles [76]. Although models like Safewards (https://www.safewards.net/; [77]) have been developed and widely implemented, there is still a long way to go, before coercive measures are a thing of the past worldwide. Similarly, while psychotropic medications may be effective in the short term, there is a growing concern about their long-term use and the impact of the many adverse side effects on people's quality of life [78]. As with all debates, there are grey areas and diverse viewpoints, but it could be argued that it is not a professions' mandate to decide on medication on behalf of the people seeking help, but an ethical imperative to respect their right to self-determination. From the viewpoint of APMHNs, this poses many challenges as in some countries prescribing authority seems to be one of the distinguishing features between the generalist or specialized mental health nurse and the APMHN.

APMHNs are ideally positioned to act as leaders and catalysts for change within the mental health system. APMHNs, like all professionals, have a double role as professionals and citizens, which give them more possibilities to use their influence in constructive ways to promote the development of bio-psycho-socio-rights-based models of care [79]. However, this requires APMHNs to listen to the person's voice, support informed decisions by moving beyond knowledge based or reductionistic or overly simplistic models of evidence-based practice, and include several other dimensions of knowledge, such as the person's own values and preferences (see "Educational aspects of Advanced Mental Health Nursing Practice"). APMHNs also have an important role and ethical requirement to lead and support this change by collaborating with other professionals, service users, families, and communities. To do this they must reflect on and recognize their own attitudes and carefully consider how they can make the change in themselves before they begin the process of supporting others to do the same. In other words, they must become the change they want to see in others and ensure that the care they provide is morally acceptable to the person using the service, the profession, and members of the public.

7 Conclusion

This chapter provides a glimpse into the landscape of Europe from the viewpoint of advanced practice in mental health nursing. The human right-based approach is becoming increasingly influential in the international and European discussion and highlights the needed change in mental health practices and services. While in many European countries, positive developments are already a reality; however, there is still a need for improvement and change in many areas of mental health practice.

Although the idea of human rights may sound abstract, the human rights are actualized in all encounters, in the everyday practice of mental health care. Hence APMHNs are responsible to adopt a human rights approach in all their activities and in collaboration with people seeking help and their families support the development a bio-psycho-social-rights-based service. From an ethical viewpoint, the people-centered approach and collaborative practice should be part of everyday practice of mental health nursing. A human rights approach should also guide the development of curricula to ensure APMHNs have the competency in the future to sustain and enhance the change toward citizen-centered and community- and right-based mental health care.

Reflective Questions

- What development needs do you recognize from the human rights perspective in the unit/organization you are working or in your education as APMHN?
- What are the next steps you take as an APMHN to support the development of human rights approach?

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Role and Competencies of Advanced Practice Mental Health Nurses

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Learning Objectives
The objectives of this chapter are to enable you to:

- Articulate the context and development of the APMHN role from an international and European perspective.
- Identify and define the rationale and international trends behind the development of APMH nursing competencies.
- Compare the different competencies and roles for APMH nurses in Europe and apply them to your own context.

1 Introduction

Since this book is about advanced practice in mental health nursing in Europe, a discussion on the possible role of advanced practice mental health nurses (APMHNs) and what competencies underlie their work is clearly important. Articulating and discussing what APMHNs can do from a legal, practical, and ethical standpoint and what their role could be and should be are therefore the tasks of this specific chapter. There

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are other chapters later in this book that focus in more depth on all the key components of the APMHN role, such as clinical practice, education, research, and leadership. Using some chosen examples, the reader is given an insight into how the APMHN role is approached in Europe and internationally. As APMH nursing roles were created and developed in the wider context of advanced practice nursing, some discussion on trends regarding the advanced practice nursing (APN) role is also unavoidable.

In discussing the roles and competencies for APMHNs in Europe, there is great diversity to be kept in mind, as competencies, practice, clinical training, education, and legislation governing nursing and mental health services vary across different European countries (see "Landscape of Advanced Practice Mental Health Nursing in Europe") [1]. This diversity is one of the strengths of European APMHNs, as it opens the doors for creativity and innovation as well as creating opportunities to share knowledge and learn from each other. This chapter will offer different viewpoints on APMH nursing which will encourage the reader to reflect and ask the appropriate questions within the context of their own clinical practice.

Throughout the literature terms such as generalist nurse, specialized nurse, and advanced practice nurse are used, sometimes interchangeably about mental health nurses. A generalist nurse is a nurse that does not have any formal specialization beyond entry-level education into the profession and an advanced practice nurse (APN) is a nurse, who according to the International Council Of Nursing (ICN) *Guidelines on Advanced Practice Nursing 2020* "…has acquired, through additional graduate education (minimum of a master's degree), the expert knowledge base, complex decision-making skills and clinical competencies for Advanced Nursing Practice" [1, p. 6]. A specialized nurse is a nurse that has some preparation beyond the generalist nurse but may not have postgraduate education in the chosen specialty [1]. A good example of this can be found in the USA in the form of the psychiatric mental health (PMH) nurse [2] who has specialty certification without the expanded scope of practice nor a requirement for a graduate degree. Another example can be found in countries where there is direct entry education for mental health nursing or where nurses graduate with a primary degree in mental health nursing at the point of first registration or licensure. This can be seen in the United Kingdom (UK) and the Republic of Ireland (Ireland) [3] and was for many years the case in the Netherlands [4].

2 Differentiating Roles and Levels of APMHNs in the USA and Europe

The licensure, accreditation, certification, and education (LACE) model was developed in the USA as an attempt to standardize the education, licensure, and certification of advanced practice registered nurses (APRNs) [5]. In recent years, Australia and New Zealand and many European countries, such as the UK, Ireland, and the Netherlands, have made notable attempts to do the same [1, 6]. In general a Master's degree is required for advancement to advanced practice nursing, and there is even movement in the USA for a clinical doctorate (the Doctor of Nursing Practice or the DNP) as entry level to advanced practice [7].

As North America could be considered the birthplace of the APMHN role [8], it may make sense when discussing terms to start there. In the USA, the term advanced practice registered nurse (APRN) is used to refer to advanced practice nurses. It is important to differentiate between the American term APRN and the previously defined term of the APN endorsed by the International Council of Nursing (ICN). Within nursing in the USA, there are four main advanced practice registered nursing roles, namely, (1) the clinical nurse specialist (CNS); (2) the nurse practitioner (NP); (3) the certified registered nurse anesthetist (CRNA); and (4) the certified nurse midwife (CNM) [5]. For APMHNs it can be argued that only the first two are relevant, the CNS and the NP roles.

A CNS is defined by the ICN as an "advanced practice nurse who provides expert clinical advice and care based on established diagnoses in specialized clinical fields of practice along with a systems approach in practicing as a member of the healthcare team" [1, p. 6]. Although in certain countries the CNS title sometimes refers to a type of specialized nurse rather than an APN, such as in Ireland where a distinction is made between the APN role and the CNS role in this manner [9]. A nurse practitioner (NP) is defined by the ICN as "an advanced practice nurse who integrates clinical skills associated with nursing and medicine in order to assess, diagnose and manage patients in primary healthcare (PHC) settings and acute care populations as well as ongoing care for populations with chronic illness" [1, p. 6]. The NP often has an expanded scope of clinical practice especially related to having their own caseload and a higher level of clinical autonomy, such as through prescribing, diagnosing, and treating illnesses, often through interventions that are historically under the purview of the medical profession. The CNSs hold a more specific focus on indirect care, such as quality improvement tasks including development and implementation of new policies or quality control standards, scientific endeavors including research and its dissemination, and other kinds of professional leadership including but not limited to clinical supervision [1]. The roles of the CNS and NP have become somewhat distinct in certain countries, emphasizing the increased clinical autonomy of the NP versus the CNS although many exceptions to this exist [6, 8–10]. One example is that of Iceland where there are many specialized nurses, but only one type of APN, the clinical nurse specialist, which then branches off into different specialty areas of nursing [11]. Other examples of hybrid models of CNSs and NPs include the Netherlands and in some ways Germany, although the level of APN is quite different there with more focus on the specialized nurse. Some European countries that have a more developed NP-oriented system have developed an advanced practice tool kit for further delineation and development of different advanced practice roles such as the National Health Services in the UK [1, 12].

3 The APMHN Role

Certification, licensure, and scope of practice issues are very similar in APMH nursing as in advanced practice nursing in general, albeit with some exceptions [1, 4, 5, 7, 13, 14]. In examining the role of the APN and/or APMHN, some examples could be helpful to give the reader different viewpoints from different countries on this subject.

Since its inception the APN role in psychiatric mental health (PMH) nursing in the USA has been through many changes. The first APMHN program was founded in 1954 in Rutgers University in New York, which was inspired and deeply influenced by Peplau's work on the role of the psychiatric nurse [8]. The focus of this program was on organizational analysis, consultation, and systems approaches, but true to Peplau's vision, the greatest emphasis was placed on developing psychotherapeutic skills centered on the nurse-patient relationship [8]. In the 1990s, there was a shift toward a more biomedical approach for APMHNs in the USA, when the "three Ps," namely, pharmacology, physiology/pathophysiology, and physical assessment, became mandatory in psychiatric mental health clinical nurse specialist (PMHCNS) programs, although the "fourth P" of psychotherapy was forefronted in many APMHN programs as well. In the early 2000s, the psychiatric mental health nurse practitioner (PMHNP) role was created in the USA, and the focus became even more biomedically oriented, which created a differentiation between the CNS and NP roles within the specialty of mental health. However, over time many realized that the competencies of the two roles were more alike than different, and as more lifespan-related certifications were created, these designators started to create more confusion than clarity on the APMHN role in the USA [8]—a confusion that both the American Psychiatric Nursing Association (APNA) and the International Society of Psychiatric Nurses (ISPN) were eager to address [14]. In 2011, the decision was made that new graduates specializing in APMH nursing would bear only one designator, psychiatric mental health nurse practitioner (PMHNP). The PMHNP would be prepared to provide comprehensive mental health nursing services, across the lifespan to service users throughout different service levels and organizations [14]. The PMHNP needed competencies in various individual and group psychotherapy models, diagnosing and prescriptive practice. The target date for this transition was set for 2015. At the same time, the decision was made to grandfather in all preexisting licensures in APMH nursing. Grandfathering refers to the intention to include a provision in new laws and regulations exempting those already within the system from the requirements of the new laws and regulations. In other words, those APMHNs already practicing under older certifications could continue to do so regardless of newer provisions that would only apply to those not already within the system [14]. This means that in the USA the role of the PMHCNS and PMHNP have essentially been merged into one designation. At the same time, within the USA, a call has been made for benchmarking of existing competencies within APMHN education [15]. But in the USA, it can be said that the biomedical view has been more dominant in the competencies for APMHNs compared to traditional system-focused CNS competencies not to mention more recovery-oriented principles [16].

In 2006, the Doctorate of Nursing Practice (DNP) degree was introduced in the USA, but the DNP is not a certification or licensure title but an academic one, not unlike clinical doctorates in other professions [15]. The DNP is a 3-year graduate level program offering the time and space to combine the competencies from both the more biomedically oriented NP program and the more system- and quality-improvement-focused CNS program. It can also allow APMHNs more freedom to choose their emphasis and career trajectory based on system needs, the changing nature of service user need, and their own interests. Thus, enabling APMHNs to pivot between these areas of focus to achieve different set of competencies without having to reenlist in a new graduate program or recertify with a different licensure [7, 15, 17]. As the ICN indicated in its *Advanced Practice Guidelines 2020*, this may be a future step for APNs internationally which may bridge the gap between the two dominant APMHN roles, i.e., the CNS and the NP role [1]. The DNP has been suggested as entry level to practice for APMHNs as well as other NPs in the USA for 2025 [7].

3.1 Ireland and the APMHN Role

As noted in the opening chapter of this book, other notable work has been done in European countries to define and articulate the role and competencies of APNs including APMHNs. In 2017, The Nursing and Midwifery Board of Ireland (NMBI) published Advanced Practice (Nursing) Standards and Requirements where they outline five ethical principles, as well as domains of competence and standards of conduct which "guide each Registered Advanced Nurse Practitioners (RANPs) interaction with patients, colleagues and society" [18, p. 11]. This document is useful when looking at the APMHN role from a European perspective as the principles, competency domains, and accompanying standards of practice are echoed through the literature on APN competencies and includes items historically associated with both NP and CNS roles.

The five ethical principles include (1) respect for the dignity of the person; (2) professional responsibility and accountability; (3) quality of practice; (4) trust and confidentiality and finally; and (5) collaboration with others. Based on these principles, the NMBI divides the core competencies of APNs into six separate domains. The first competency domain is professional values and conduct, which includes the following standard of practice "The Registered Advanced Nurse Practitioner will apply ethically sound solutions to complex issues related to individuals and populations" (p. 16). The second domain is clinical decision-making which include utilizing "…advanced knowledge, skills, and abilities to engage in senior clinical decision making" (p. 17), a standard of practice which may or may not involve the prescribing of medications. The third domain is knowledge and cognitive competencies, to which the following standard of practice applies, "The Registered Advanced Nurse Practitioner will actively contribute to the professional body of knowledge related to his/her area of advanced practice" (p. 17). The fourth domain is communication and interpersonal competencies, which includes negotiating and advocating "…with other health professionals to ensure the beliefs, rights and wishes of the person are respected" (p. 18). This competency includes clinical supervision and mentorship, as well as other advocacy roles and factors. The fifth domain is management and team competencies, which includes managing "…risk to those who access the service through collaborative risk assessments and promotion of a safe environment" (p. 18). The sixth and final competency domain for RANPs is leadership and professional scholarship competences, where the RANP "…will lead in multidisciplinary team planning for transitions across the continuum of care" [18, p. 19].

This model entails competencies which the individual APMHN can use, based on service user and system need along with personal interest and passions, to guide their chosen career trajectory. In this document APNs, including APMHNs, are encouraged to "be proactive in identifying areas where expansion in their scope may lead to improved outcomes for patients" [18, p. 6]. This inclusive language indicates an expectation or perspective that is positive toward role expansion, if it is being done for the right reasons, i.e., contributing to holistic care and improved service user outcomes.

3.2 The UK and the APMHN Role

When it comes to mental health nursing, the UK has been at the forefront for many years producing many documents and position statements of interest [3]. A recent publication by the National Health Services (NHS) titled *The Advanced Practice Mental Health Curriculum and Capabilities Framework*, not only focuses on the core competencies or capabilities of APMHNs but of all advanced practice mental health practitioners, regardless of professional or educational background [19]. The main drive behind this publication "is to enable practitioners to practice to their full potential and to optimize their contribution to meeting individual, family and carer needs through different models of service delivery and multidisciplinary working" [19, p. 3]. The core capabilities outlined in the document are presented under the following six domains: (1) person-centered therapeutic alliance; (2) assessment and investigations; (3) formulation; (4) collaborative planning; (5) intervention and evaluation; and (6) leadership and management, education, and research. Despite the multidisciplinary approach and inclusive nature of the "capabilities," most of the domains outlined can be found in abundance in the literature on principles and competencies in relation to the role of APMHNs and APNs. Within this document the specific focus on the therapeutic alliance is strongly aligned with the core values of APMH nursing [16, 20, 21]. Given the current emphasis on interdisciplinary teamwork within the mental health sector, having such core competencies that reach across different mental health professions to inform curricula may prove useful to other European countries and become a boon for APHMNs in European countries where the APMHN role is still underdeveloped and/or uncertified.

In addition to *The Advanced Practice Mental Health Curriculum and Capabilities Framework*, work has been done in the UK to develop an Advanced Practice Tool Kit [12]. Within the tool kit, advanced practice is defined as practice that "…includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes" [12, p. 1. The four pillars of advanced practice, (1) clinical practice, (2) leadership and management, (3) education, and (4) research (sometimes referred to as evidence based practice or EBP), also reflect the four pillars of advanced practice nursing and thus APMH nursing as articulated by the Royal College of Nursing in the UK [12, 20].

The APN role of the nurse consultant was first introduced in 2000 in the UK and bears mentioning here. It was "related to three professional groups: nursing, midwifery and health visiting, allied healthcare professionals and pharmacists" [22, p. 820]. The consultant is an interdisciplinary role with four core functions: (1) expert practice; (2) professional leadership and consultancy; (3) education, training, and development; and finally, (4) practice and service development, research, and evaluation. The expectancy for nurses assuming this role was that they would have a minimum of a Master's degree education and extensive experience in all four functions [22]. This role has been found effective especially related to traditional CNS functions such as quality improvement, effectiveness of healthcare services, and productivity [23].

4 Netherlands and the APMHN Role

From 1921, the education of Dutch specialized psychiatric nurses was separate from generalist somatic nursing, but unlike in the UK and Ireland, it was merged again with generalist nursing in 1997 [4]. After an incubation period of over a decade, the Netherlands introduced the legal framework for the NP role in 2011. This had initially entailed informal role expansion into specific tasks belonging to the traditional realm of medicine but from 2012 became a more formal process [24]. However, similar to elsewhere, the debate about their role and competencies still rages as well as discussion on the difference between the new NP role and the older specialist nurse role [4, 25].

At a similar time, the difference between the competency and scope of practice of the generalist nurse and the "nurse specialist" (referred to here as NP) was further clarified with a professional Master's degree made an entry-level requirement into advanced practice, similar to requirements for the APN role around the world [1, 5, 24]. A competency framework based on the Canadian Medical Association Direction for Specialists was developed as well by the national professional organization of nurses [26]. This framework entails core competencies based on seven key roles, namely, communicator, collaborator, leader, health advocate, scholar, and professional. With the seventh and final role at its axis, the medical expert makes the biomedical associations hard to ignore [27]. This dramatically changed the landscape of Dutch APMHNs practice, both through role expansion but also through role recognition and legitimation [4, 24, 25].

5 APMHN Competencies

Competence has been described by the European Federation of Nurses Associations [28, p. 33] as "…the intersection between knowledge, skills, attitudes and values, as well as the mobilization of specific components in order to transfer them to a certain context or real situation, hence coming up with the best action/solution possible to address all different situations and problems that can emerge at any moment, making use of the available resources." For APMHNs competencies can be related to any of the following domains or pillars as previously reviewed: (1) clinical practice, (2) research, (3) management and leadership, and (4) education [20]. When looking at research on the roles, tasks and activities of APMHNs much similarity can be identified both within the general APN competencies and the more specific APMHN competencies indicating that these actually represent what APMHNs do in real-life clinical practice [21, 29]. The next section uses the four pillars to explore APMHN competencies, although it must be acknowledged that overlap does exist and cannot be avoided as practicing at an advanced practice level requires the integration of competencies across all pillars.

5.1 Advanced Clinical Practice

This is the first and most important part of the APMHN role and is where the heart of mental health nursing lies. For APMHNs the therapeutic relationship is the driving force behind all aspects of the clinical role and associated competencies. In advanced clinical practice, the APMHN not only focuses on the service user but also on the needs of the service users' family and significant others [30]. The APMHN needs to be especially mindful of the human rights principles and mental health promotion and recovery, when making complex ethical decisions and when cultivating the therapeutic relationship [31, 32]. Under this domain the competencies most specific to APMH nursing can be found, while in the other three domains, many of the competencies are in common with APNs in general. It is also under this domain the most variability can be found in the role of APMHNs between different countries, as rules and regulations that dictate the scope of practice determine to a certain extent the specific competencies of APMHNs in each country [1, 21]. For APMHNs some focal points belonging to this pillar are principles related to different models of care and interventions regarding the individual, families and groups, assessment and recovery planning, risk management and safety planning, and ethical decision-making processes, service user empowerment, and collaborative practice [13, 16, 21, 29]. In Table 1 the characteristics of the advanced clinical practice pillar according to the RCN can be found as well as the additional capabilities required for all advanced practice mental health practitioners identified by the Health Education England [19, p. 9, 20, p. 5]. The table illustrates well the core advanced clinical capabilities required to practice as an APMHN with fairly generic language accounting for the diverse landscape of APMH nursing found in Europe.

Expanding on the factors described in Table 1 involving a recovery-based approach, such as co-production and increasing service user and public involvement in their care, Stickley et al. [33] review the competencies (knowledge, skills, and attitudes) required in the advanced level education of mental health nurses related to recovery and social inclusion. Their findings suggest that the knowledge needed includes the CHIME framework, where the literature on recovery was synthesized revealing five themes, connectedness, hope and optimism about the future, identity, meaning in life, and empowerment [34] (see "Perspectives and Frameworks

Table 1 Clinical practice pillar

RCN (2018) characteristics of advanced clinical practice	Health Education England (2020)
1. Decision-making/clinical judgment and problem solving 2. Critical thinking and analytical skills incorporating critical reflection 3. Managing complexity 4. Clinical governance 5. Equality and diversity 6. Ethical decision-making 7. Assessment, diagnosis, referral, and discharge 8. Developing higher levels of autonomy 9. Assessing and managing risk 10. Nonmedical prescribing in line with legislation 11. Developing confidence 12. Developing therapeutic interventions to improve service user outcomes 13. Higher level communication skills 14. Service user/public involvement 15. Promoting and influencing others to incorporate values-based care into practice 16. Development of advanced psychomotor skills	1. Work autonomously within professional, ethical codes, and legal frameworks, being responsible and accountable for their decisions, actions, and omissions at this level of practice 2. Demonstrate the underpinning psychological, biological, and social knowledge required for advanced practice in mental health 3. Demonstrate comprehensive knowledge of, and skills in, systematic history taking and clinical examination of patients who are culturally diverse and/or have complex needs in challenging circumstances, to develop a co-produced management plan 4. Utilize clinical reasoning and decision-making skills to make a differential diagnosis and provide rationales for person-management plans, through critically reflecting on and evaluating their own role in relation to challenging traditional practices, new ways of working, and the impact upon the multidisciplinary team 5. Initiate, evaluate, and modify a range of interventions, which may include therapies, medicines, lifestyle advice, and care

Underpinning the Practice of Advanced Mental Health Nursing”). Other key concepts identified related to recovery, included knowledge on narrative theory and recovery as a journey or a process and tools to measure recovery process and outcomes. In addition, this review highlighted the importance of knowledge on diverse topics related to social inclusion and recovery, such as education on human rights, critical psychiatry, social model of disability, social inclusion, participatory models of shared decision-making and exploring the role of friendship, community, education, leisure, culture, arts and creativity in people’s recovery, to name a few [33]. The attitudes needed for the mental health nursing graduate programs according to Stickley et al. [33] need to be framed within a humanistic approach, attitudes such as treating people with dignity and respect as opposed to disorders, believing in the persons potential, unconditional positive attitude and developing self-awareness and emotional intelligence. The skills suggested belonging to such programs include various derivatives of the points reviewed already, such as collaborative work with service users and families, power sharing and management of self, counteracting social isolation and using interventions to cultivate strengths and recovery of service users such as motivational interviewing and compassion focused therapy [33].

Mental health promotion competencies which focus on promoting wellness from a holistic standpoint, and not just treating diseases, require some more specific attention from APMHNs (see "Advanced Practice Mental Health Nursing and Mental Health Promotion"). Knowledge, skills, and attitudes belonging to the advanced clinical practice pillar that can play a role here include a positive and hopeful attitude, focusing on strengths instead of deficits and knowledge about different evidence-based interventions and coping mechanisms that support general well-being and wellness [31]. Lahti et al. [35] identified key themes of knowledge needed for advanced level mental health nursing programs across the lifespan. For children and adolescents, these included (1) child and adolescent development such as normal development, the development of family process and the impact of trauma; (2) knowledge of mental health promotion and prevention programs in areas such as bullying and child abuse; (3) recognition of early signs of mental health challenges; and (4) care and treatment of specific mental health challenges. For adults they identified the following: (1) lifestyle, such as importance of having an active lifestyle and life and work-related interventions; (2) family and intimate relationships, such as normal family processes, couple counselling, and sex education; (3) nursing care, such as education on mental health problems, comorbidities, and long-term care; and (4) mental health prevention and promotion; for example, physical activity programs. And finally the themes identified on knowledge required regarding the older person for mental health nursing graduate programs included (1) the developmental processes, such as what transitions and changes are to be expected during this lifespan; (2) mental health prevention and promotion; (3) recognition of abuse and neurological status; (4) care and treatment, such as treatment and care related to nutrition; and (5) active lifestyle, such as healthy aging, social involvement, and retirement. The authors also identified skills such as assessment of distress and clinical decision-making skills, psychological support skills and interventions to name a few. Finally, the attitudes identified included advocating human rights values along with moral reasoning [35].

All these areas help further articulate competencies for lifespan-related issues for APMHNs and clarify both clinical and educational expectations on these issues [35]. The same group of authors also reviewed the literature for knowledge, skills, and attitudes required for APMHNs to work with families and identified numerous factors that have an impact in this area. These include but are not limited to having the ability to empower and provide appropriate and non-shaming and validating knowledge regarding the burden and complexity involved with being in the carer role, as well as working with the complex ethical issues APMHNs are faced with when working with service users and their families [30].

In their review on master's level mental health nursing competencies related to the physical health of mental health service users, Jormfeldt et al. [36] describe three essential domains of knowledge for APMHNs: (1) specific knowledge about physical health risks connected with mental illness; (2) detailed knowledge about mental illness stigma and its effects on physical health; and (3) extensive knowledge of mental health nurses' duty to promote mental and physical health in mental health service users. They further describe two main skills to ensure this: advanced therapeutic and pedagogical skills to motivate healthy living and teamwork and collaboration skills to counteract barriers to a healthy lifestyle among mental health service users [36]. In addition, they include two main attitudes that need to underlie in achieving equal health among mental health service users, namely, engagement in person-centered nursing practice to promote overall health and commitment to quality improvement in health promotion in mental health nursing. These domains of knowledge and accompanying skills and attitudes are a good example of ways to enhance and expand on clinical practice competences for APMHNs that, for example, can be found in Table 1. Identification of competencies such as these also help ensure proper training in undervalued or neglected areas of care for APMHNS such as can sometimes be found in the physical health area for mental health service users [36]. They can also be quite helpful in identifying competencies for the integration of mental health and physical health services and thus can facilitate the care coordination skills needed for APMHNs. Even though generalist nurses are more commonly in this role, such skills may be quite important for APMHNs as well [37].

The US-based National Organization of Nurse Practitioner Faculties (NONPF) has published specific competencies related to the APMHN role in the USA. These are not meant to substitute more generic APN competencies but rather expand on them for each subspecialty of APMH nursing [16]. The dimensions of practice are somewhat different to the pillars used to categorize competencies in this chapter, and a total of nine in number as opposed to four. For direct clinical care, there are at least 35 specific competencies that include generic APMHN competencies such as "Develops an age-appropriate treatment plan for mental health problems and psychiatric disorders based on biopsychosocial theories, evidence-based standards of care, and practice guidelines, includes differential diagnosis for mental health problems and psychiatric disorders and conducts individual and group psychotherapy." The more specific competencies include competencies such as "applies supportive, psychodynamic principles, cognitive-behavioral and other evidence-based psychotherapy/-ies to both brief and long term individual practice" and "uses self-reflective practice to improve care" [16, p. 69, 71]. NONPF also includes competencies related to building and maintaining the therapeutic alliance and recovery-oriented principles such as "applies recovery-oriented principles and trauma focused care to individuals" and "demonstrates best practices of family approaches to care" although more enhanced competencies on these issues are clearly needed for APMHNs and examples of which have already been reviewed previously in this chapter [16, p. 69, 71].

Combining work specifically focused on competencies, tasks, and activities of APMHNs with that which is focused more generically on APN practice, the reader should be able to construct a holistic picture of which of these may be applied in their respective country. But as previously stated, this domain of advanced clinical practice is most dependent on different rules and regulations that dictate APMHN and APN practice in each country, so which of these apply to the readers context will vary greatly on situation and context. But clearly further development in this area is required as while competencies do exist to guide APMHN practice a comprehensive and inclusive competence framework for APMHNs has not really been developed outside the USA, and certainly not with a focused human rights and recovery approach, although a promising start has certainly been made in this direction.

5.2 Leadership

The international literature is replete with commentary on the centrality of nursing leadership in advancing health care reform and creating a culture of innovation in the workplace. As far back as 2011, the Institute of Medicine with their report on *The Future of Nursing* supported nurses to take on leadership roles to address changes in healthcare [38]. For over a decade, the ICN has been delivering programs to nurses around the world, aimed at developing the leadership skills necessary to implement organizational change for the purpose of improving nursing practice and achieving better health outcomes [39]. Nursing leadership is also central to the agenda of professional bodies such as the Royal College of Nursing (RCN) in the UK. More recently the World Health Organization [40] identified investment in leadership skills development as one of its key priorities in the global strategic direction for nursing and midwifery for 2021–2025. While leadership is a shared responsibility of all nursing roles, it is a core competency of advanced practice nursing [1] and a central pillar of the role. Lamb et al. [41] note that the contribution that advanced practice nurses make to the healthcare reform and quality is frequently not recognized, because their leadership activities are so embedded in the complex actions of care delivery that it is frequently viewed through the lens of clinical practice and not leadership.

Heinen et al. [42] in a recent review synthesis the evidence from 15 international research studies and 7 competency frameworks on leadership and advanced practice nursing. As an outcome they identified 30 core leadership competencies that they classified into the following 7 domains: (1) clinical, (2) professional, (3) health systems, (4) health policy, (5) clinical and health systems, (6) professional and health systems, and (7) clinical/health system and health policy. Most of the competencies relate to the first four domains; however, as six competencies incorporated more than one domain, the latter three domains were created, which highlights the complex and interrelated nature of leadership activity at this level.

In the clinical leadership domain, eight competencies focused on providing leadership in the delivery of excellent care included items like being an expert clinician; implementing innovations; improving the quality of care through monitoring standards; collaborating with professionals and other health agencies; and aligning practice with organizational goals [42]. Although evidence-based practice (EBP) and research are often viewed as a stand-alone pillar, enhancing EBP is included within this domain as the authors viewed supportive leadership critical to the successful institutionalization of EBP. Similar to an earlier study by Elliott et al. [43], the competencies in the professional leadership domain ($n = 6$) focus on the development of the nursing profession through development and integration of APN roles into the healthcare system and participation in professional national and international organizations networks, working groups, committees, and peer-reviewed activities, all with a view to keeping up-to-date with changing evidence, technologies, and practices. The competencies within the health systems domain ($n = 8$) shift focus from direct care to leading and influencing at the strategic level, which is especially important for APMHNs, given how many professions are integral to the provision of high-quality services for mental health service users. Thus, the competencies in this domain focus on team working, delegation, creating a culture of ethical standards, and creating a shared organizational vision on quality including the implementation and monitoring of organization performance standards. The health policy domain has two competencies, to provide leadership in policy-related activities and the articulation of the values of nursing to key stakeholders and policy makers. The clinical and health systems domain includes competencies that are frequently omitted in other frameworks, such as competencies related to employing principles of business, finance, and economics to develop and implement quality initiatives at system-wide level, as well as creating positive, healthy working environments that supports safe care, collaboration, and professional growth. The professional and health systems domain had one competency that focuses on coaching and mentoring future generations. The one competency in the clinical/health system and health policy domain emphasizes providing leadership on evaluating and resolving ethical and legal issues that relate to information technology and communication networks [42].

Although this framework is not specific to APMHNs and some of the identified competencies need to be further refined, it does provide an understanding of the complexity of competencies required at this level. The framework also adds to the six characteristics of this pillar identified by the RCN [20, p. 5] and the additional capabilities required for all advanced practice mental health practitioners identified by the Health Education England (see Table 2) [19, p. 9]. In doing so it helps support the development of evidenced-based curricula and training programs on

Table 2 Leadership pillar

RCN (2018) characteristics of leadership	Health Education England (2020)
1. Identifying need for change 2. Leading innovation and managing change, including service development 3. Developing case for change 4. Negotiation and influencing skills 5. Networking 6. Team development	1. Identify, critically evaluate, and reformulate understanding of professional boundaries to support new ways of working within the context of organizational and service need 2. Exercise professional judgment and leadership to effectively promote safety in the presence of complexity and unpredictability 3. Demonstrate teamworking, leadership, resilience, and determination in managing situations that are unfamiliar, complex, or unpredictable

leadership for APMHNs. However, as the framework is not specific to APMHNs and while it does mention ethical standards and advocating "for" environments that promotes safety, it reads more within the paradigm of "doing for" people as opposed to doing "with." In this way it fails to make explicit that one of the critical leadership competencies of APMHNs is the ability to join forces with service users and carers to co-create the agenda for change, including the implementation and evaluation of all innovations. APMHNs have a critical role to play in promoting and supporting the development of service users' leadership while valuing the service user voice and their experiential knowledge and expertise [44]. As it is only through combining experiential and nursing knowledge will APMHNs be in a position to direct their leadership toward the human rights agenda (as discussed in chapter "Landscape of Advanced Practice Mental Health Nursing in Europe"), take on the advocacy dimension of their leadership role, and act to challenge and disrupt structures and process at the individual, team, service, systems, and policy level that continue to reproduce and widen divides that are the major determinants of poor mental health outcomes (see also "Advanced Practice Mental Health Nurses as Leaders" and "Advocacy and the Advanced Nurse Practitioner").

5.3 Research and Evidence-Based Practice

Although "research" is the third pillar of APN according to the RCN, we have chosen to add evidence-based practice not only because it is central to the practice and vocabulary of all nursing [45, 46], irrespective of position or role, but it is a more expansive and inclusive term. While some debate exists on what constitutes evidence, there is consensus that it incorporates the most valid and current evidence from primary research, systematic reviews, clinical guidelines, clinical expertise, and service user preferences [47, 48]. The ICN and various regulatory bodies for the nursing profession throughout Europe make it very explicit that nurses are expected to value research, use evidence-based knowledge, and apply best practice standards in their work, as the application of best evidence is central to quality care and enhanced outcomes for service users [1, 18, 20]. Furthermore, the importance of delivering evidence-based care to people experiencing mental health problems is reiterated in the guidelines published by organizations such as the National Institute of Health and Care Excellence (NICE https://www.nice.org.uk/). While specific research and evidence-based competencies have not been developed for APMHNs, the international literature on advanced practice roles identifies the need for all APNs to not only base their practice on the best evidence available but promote evidence-based nursing among other nursing staff through their clinical leadership role [49]. Gerrish et al. [49] in exploring the contribution of all advanced practice nurses to evidence-based care identifies five dimensions of what they term "evidence brokering" that can help APMHNs consider their role and competencies in the area of EBP, namely, (1) accumulating evidence which involves searching it out, networking, and acting as a conduit for organizational evidence; (2) synthesizing evidence, which involves bringing together different pieces and types of knowledge

Table 3 Melnyk et al.'s [50] evidence-based practice competencies for advanced practice nurses

1.	Systematically conducts an exhaustive search for external evidence to answer clinical questions (external evidence: evidence generated from research)
2.	Critically appraises relevant pre-appraised evidence (i.e., clinical guidelines, summaries, synopses, syntheses of relevant external evidence) and primary studies, including evaluation and synthesis
3.	Integrates a body of external evidence from nursing and related fields with internal evidence* in making decisions about patient care (internal evidence* = evidence generated internally within a clinical setting, such as patient assessment data, outcomes management, and quality improvement data)
4.	Leads transdisciplinary teams in applying synthesized evidence to initiate clinical decisions and practice changes to improve the health of individuals, groups, and populations
5.	Generates internal evidence through outcomes management and EBP implementation projects for the purpose of integrating best practices
6.	Measures processes and outcomes of evidence-based clinical decisions
7.	Formulates evidence-based policies and procedures
8.	Participates in the generation of external evidence with other healthcare professionals
9.	Mentors others in evidence-based decision-making and the EBP process
10.	Implements strategies to sustain an EBP culture
11.	Communicates best evidence to individuals, groups, colleagues, and policy makers

and aligning them with both service user and professional perspectives; (3) translating evidence which involves a number of processes including evaluating, distilling, and interpreting evidence to make it understandable to different audiences, including service users, family, public, and more junior colleagues with the mental health team; (4) generating evidence from research and audit; and finally (5) disseminating of evidence within and outside healthcare [49]. More recently in addition to EBP competencies required of all nurses, Melnyk et al. [50] identify 11 competencies (see Table 3) for advanced practice nurses, including APMHNs.

While Melnyk et al. [50] include skills such as critical appraisal and mentoring of others and highlights the importance of the APNs' role in integrating evidence from diverse sources, including the service users, and implementing strategies to sustain and EBP culture, the 11 competencies reflect Gerrish et al.'s [49] typology of accumulating, applying, translating, generating, and disseminating evidence. Although more expansive they also reflect some of the content of the RCN document (RCN [20, p. 5], and the additional capabilities required for all advanced practice mental health practitioners identified by the Health Education England (see Table 4) [19, p. 10]. However, like the leadership frameworks, competencies related to the coproduction of research agendas and the involvement of service users/family members/carers in all stages of the research or audit process are not made explicit. Yet patient and public involvement (PPI) in research from design to dissemination or thought to translation is core to all national and international research frameworks. Although the use of the term "patient" is contested in the mental health arena, ethically, PPI is advocated on the grounds that people have a right to have a say in decisions about research that may affect them and have a right to influence research that is paid for from public resources. Pragmatically, PPI is seen as benefitting the research process by enhancing the validity, design, applicability, or dissemination of the research. PPI is also considered important in ensuring the research

Table 4 Research pillar

RCN (2018) characteristics of research	Health Education England (2020)
1. Ability to access research/use information systems 2. Critical appraisal/evaluation skills 3. Involvement in research 4. Involvement in audit and service evaluation 5. Ability to implement research findings into practice—including the use of and development of policies/protocols and guidelines 6. Conference presentations 7. Publications	1. Critically appraise and apply the evidence base in influencing engagement, recovery, shared decision making, transference, and safeguarding 2. Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review 3. Demonstrate the application of quality improvement methodologies in improving service

questions, methods, and outcomes are relevant and appropriate to research participants and service users [51].

5.4 Education

This pillar includes education in a broad context, both as a part of clinical practice and also as part of larger educational systems. The European Federation of Nurses Associations (EFN) describes in the Workforce Matrix the Advanced Nurse Practitioner's (ANP) competence from the education viewpoint as competence to guide, counsel, and educate other health professionals about latest practice innovations, act as a mentor and role model, and actively engage in knowledge transfer with patient communities [28]. Similarly the Royal College of Nursing (RCN) [20, p. 5] in the UK describes the characteristics of the education competence of APNs which is compared to capabilities for the Health Education England's Advanced Practice Mental Health Curriculum and Capabilities Framework for the education pillar in Table 5 [19, p. 9].

When reflecting on these descriptions of the educational aspects of APNs in the context of APMHNs, notable differences exist. This is especially true regarding co-operation with service users and in the continuous development of APMHNs' own competence, which is an important part of the educational competence of APMHNs to guarantee the high-quality mental health care. These differences between APNs and APMHNs is understandable bearing in mind that the therapeutic alliance is the core of mental health nursing compared to other fields of nursing. In practice this means that in mental health care, collaboration with the service users, families, networks, and communities are based on the ideas of human rights and recovery which become a reality in the co-creation and co-production of knowledge. Therefore, the role of the APMHN is rather a facilitator and active partner than the traditional educator or teacher, where collaboration means respecting and valuing the different kinds of knowledge people have as well as a commitment to learn from each other (see "Educational Aspects in Advanced Mental Health Nursing Practice").

Table 5 Education pillar

RCN (2018) characteristics of education	Health Education England (2020)
1. Principles of teaching and learning, 2. Supporting others to develop knowledge and skills 3. Promotion of learning/creation of learning environment 4. Service user/carer teaching and information giving 5. Developing service user/carer education materials and teaching 6. Mentorship and coaching	1. Facilitate collaboration of the wider team to support individual or interprofessional learning and development 2. Critically assess and address individual learning needs that reflect the breadth of ongoing professional development across the four pillars of advanced clinical practice 3. Effectively utilize a range of evidence-based educational strategies/interventions to support person-centered care with individuals, their families and carers, and other healthcare colleagues

This approach, which is based on a human rights, social justice, and equality, is also important from the viewpoint of decreasing stigma where APMHNs have a key role to play [52].

The NONPF competencies that apply to education are distributed over all nine competency areas of the model but do include specifically for APMHNs competencies such as “providing psychoeducation to individuals, families, and groups regarding mental health problems and psychiatric disorders” [16, p. 66] and generically for all the NP specialty areas such as the following:

- Translates technical and scientific health information appropriate for various users’ needs
- Assesses the patient’s and caregiver’s educational needs to provide effective and personalized healthcare
- Coaches the patient and caregiver for positive behavioral change

The educator component of the role of the APMHN and related competencies are more often associated with the traditional CNS role than the NP role, although again overlap is noted in the literature [1, 21, 53].

When considering the education pillar, it is important also to be mindful of different types of learning. Although there are many different types of learning, most often the terms “formal” and “informal” learning are used. “Formal” is used to describe the organized and structured program or event, while the informal or nonformal learning refers to all other kinds of learning [54]. Formal educational practices of APMHNs can include different kinds of educational activities with service users, families, students, and other professionals. Educational activities with service users and family members may range from co-producing educational material to facilitating group discussion with service users or family members in-person or online. APMHNs having pedagogical competence to support these activities is important as well as understanding the pedagogical principles underpinning the process of translating knowledge into practice (see "Knowledge Translation and Linking Evidence to Practice" and "Enhancing the Quality of Care Through Participatory Generation of Evidence"). Informal learning is important as well, as often without being conscious about it; APMHNs are role models in practice not only for students, novice colleagues, and other professionals but also for service users and family members. In a similar way, APMHNs are themselves learning all the time; thus, the continuous professional development or continuous professional growth of the APMHN is a crucial part of quality mental health practice. Given that the therapeutic alliance and therapeutic use of self is core to mental health nursing, self-reflection on one's own inner processes as well as reflecting on the viewpoint of others is needed. Reflecting in and on practice and learning about the "self" with the support of the clinical supervision is a key competence (see "Maintaining Professional Competence"), which enables continuous professional development as well as role modelling to others the importance of continuous development.

Before concluding this section, it is important to note that in some countries a role called the clinical nurse educator exists, creating some confusion and overlap with APNs [53]. But as said about other competencies of APMHNs involving elements that do not entail direct care, the tasks, activities, and competencies related to educational aspects of the APMHN role need to be specifically guarded and cultivated, else they may start slowly disappearing from it.

6 Challenges Encountered by APNs in Enacting Their Role

When it comes to the role of the APN and APMHN in Europe and beyond, there are many lessons to be learned. Like in other places around the world, the NP role in Australia includes traditional medical roles on top of other advanced practice nursing and mental health professional roles, such as "prescribing medications, ordering of diagnostic tests, referral to specialists, admitting and discharging privileges, and the authorization of absence from work certificates" [55, p. 181]. In Australia some debate has taken place whether this constitutes role expansion or role extension for APMHNs. But in essence the difference between role expansion and role extension is that role expansion includes an expansion of skills and responsibilities already present in its essence, while role extension refers to functions traditionally belonging to another profession being assumed by the APN, e.g., prescribing medicine [55]. Both phenomena can be seen as role development based on the need of service users and/or healthcare services. Researchers have pointed out that there are many ways in which to perceive APMH nursing, either through competencies, role extension or expansion, or even the skill to effectively reflect on one's own practice [56]. But clearly opinion about the APMHN role varies greatly depending on context, access to care, and geographical settings. Elsom et al. [55] point out that the development of the APMHN role is often and will continue to be quite haphazard and coincidental, based on the need, rather than on intentional development—something that entails just as many risks as it entails opportunities.

However, equating expanded practice with advanced practice may indeed be quite damaging for the APMHN role. Although the role may include role extension and/or expansion, it certainly does not need to do so. Therefore, competencies may be an effective way to ensure that roles do indeed include the required advance practice nursing skills to become an advanced nurse practitioner [55].

Lowe et al. [57] make a further compelling point about role clarity of the NP and stress the importance of an international approach to the issue, such as the attempt by the ICN in 2020 already reviewed earlier in this chapter [1]. The therapeutic alliance is the heart of APMH nursing and studies on the efficacy of the APN role demonstrate that this may be the very key to the success of APNs [55]. So, in the final analysis, the need for constructing competencies with the therapeutic alliance at its core could be a first step in protecting APMH nursing practice from mindless extension and intentionally developing it based on advance practice nursing competencies to meet the need in each system, for the good of service users, families, and communities.

There is a growing concern in the international and European literature that direct patient care time for CNSs is decreasing over time, rendering the role of the CNS all but invisible [58]. This is relevant to APMHNs especially as direct clinical care lies at the very heart of mental health nursing especially, with the therapeutic alliance at its very core. If APMHNs wish to provide high-quality, advanced level mental health care to the service user and their family and significant others, time to cultivate the therapeutic alliance should be set aside and ensured.

There is also concern about the development of the leadership role for APNs including the lack of clarity on the leadership role, not enough time for leadership tasks, lack of leadership skills, and lack of support from nursing management and other staff [59]. As the demand for a bigger caseload increases with the greater focus on advanced clinical competencies of the NP role, more effort needs to be placed on maintaining and enabling leadership competencies [59]. For APMHNs to be able to fulfill their leadership role and the associated competencies, both healthcare leaders and managers as well as the APMHN need to place effort in cultivating and supporting these competencies. The barriers to APNs and APMHNs to conduct research and audit are myriad as well. Nurse consultants have been shown to spend the majority of their time on activities other than research, audit, and evaluation [22]. APNs also run into trouble with lack of time and confidence with research, which regardless of role, research confidence, and competencies should be a special focus of all APN programs, including APMHN programs [23].

For the education part, time constraints and lack of training, privacy, and managerial support are some of the main barriers to fulfilling this part of the APMHN role, despite evidence that education can lead to increased feelings of empowerment as well as positively impact various other factors for service users [60, 61]. For APMHNs setting aside time and space for collaboration with service users remains an essential component of their role. However to actualize this, educational programs for APMHNs need to include appropriate pedagogical competencies, and healthcare systems and organizations must provide APMHNs with the time and space to fulfill this aspect of their role [60].

7 Future Issues for the Role Development of the APMHN

Work needs to be done to clarify the APMHN role for individual service users and family members as well as healthcare organizations, policy makers, and other healthcare professionals. Without role clarity and well-defined but inclusive competencies that are centered around recovery and human rights of service users, the rationale for APMHNs will be hard to articulate and argue for, as the biomedical approach already has enough champions within the mental health services. This rationale could be achieved in part through frameworks such as the participatory, evidence-based, and patient-focused process for guiding the development, implementation, and evaluation of advanced practice nursing framework (PEPPA), with the combined efforts of individuals, professional organizations, and healthcare organizations [62]. The PEPPA framework emphasizes service user input and opinion, as well as taking into consideration the needs of the healthcare system in a given context and thus may be a good fit for APMHN role development [63]. As more and more European countries start to develop APMHN educational programs and establish clinical certifications, with clearly delineated roles and competencies, the question of maintaining the quality and safety of established APMHNs is raised. Recertification and demands for maintenance of competencies vary in Europe both for generalist, specialized, and advanced practice nurses [1]. But recertification is one way to ensure quality and safety of APMHNs for service users, ensuring that at least minimal competencies are maintained through various educational programs, scientific efforts or continuing professional development, and education activities. The models that dictate exactly how this is done are myriad and lie beyond the scope of this chapter, but it should be sufficient to say that many such models exist and could be applied in different countries if a regulatory body exists and APMHN certification is in place. But as in so many other issues, the diversity of APMHNs in Europe is great, and one single approach or generic solutions are unlikely, irrespective of how enticing they may seem on the surface (see “Maintaining Professional Competence for Further Discussion”).

As the role of the APMHN develops and rights-based, recovery-oriented, and community-based care become more common, the demand for a clear interdisciplinary role collaborating with service users, family, community, and networks will likely increase. As discussed, some countries have answered this call by creating competencies and tool kits for advanced practice mental health professionals regardless of clinical background [19]. If APMHNs want to impact mental health services, they will need to have competences in promotion, prevention, and rights-based and recovery-oriented care and be able to respectfully work in collaboration with the other professionals, with people seeking help, their families, communities, and networks. This requires clinical humility on the part of APMHNs, an understanding and acknowledgment that some competencies as advanced practice mental health practitioners are not theirs alone.

It may be that the future of APHMNs lie in one role that encompasses both the traditional CNS role and the role expansion often associated with the NP role. Regardless clarity is needed on what standards and competences dictate the work of APMHNs and models that take into account the diverse legal and clinical settings where APMHN practice internationally (e.g., [57]).

8 Conclusion

In this chapter the roles and competencies of APMHNs from various perspectives have been reviewed. The different roles within advanced practice nursing have been discussed including the difference between generalist nurse, specialized nurse, and APN, as well as the difference between the CNS and NP role and their similarities as well as the four pillars of advanced practice nursing and the accompanying competencies. Some pitfalls in the development of the APMHN role have been addressed, making sure role expansion takes place for the right reasons and in the right way, i.e., based on competencies, not tasks, and with the need of the service user as its driving force. Finally, some of the challenges and opportunities these bring are reviewed.

The role of the APMHN in Europe varies greatly depending on multiple factors. This does not necessarily constitute a weakness but rather is an expression of the diversity that may be the greatest strength of European APMHNs. This also applies to the competencies of APMHNs in Europe, which are often a part of the bigger picture of APN competencies in general. In some countries the role simply does not exist, and in others some could argue; it has drifted too far from the heart of mental health nursing, the therapeutic alliance, and thus lost its way. Moving forward and intentionally developing the APMHN role in Europe should be a focal point for mental health educationalists and healthcare leaders in conjunction with other stakeholders, such as service users and family member groups and organizations. It is only through the acknowledgment of the multiple voices and views that the development of the APMHN will be guided by service user need centered on their recovery and human rights.

Reflective Questions

- How do the four pillars of advanced practice as defined by the RCN resonate with your own view on the roles and competencies of APMH nursing?
- Contemplate some examples of competencies for each pillar that are of special importance to the APMHNs in your country.
- When comparing your own work as an APMHN or APMHN student, what similarities or differences with the competencies described in this chapter do you find?

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Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing

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Learning Objectives

The objectives of this chapter are to enable you to:

- Appreciate how the biomedical, psychological, socioecological, and recovery perspectives influence our understandings and approaches to care of people experiencing mental distress.
- Critically analyse the strengths and limitations of each framework, including the challenges created in terms of identities, power, positionality and stigma.
- Develop a sensitivity to how each model influences one's own practice and the practice of others, including their espoused theories and theories in use.
- Integrate the various frameworks into a relational and person-centred approach to care underpinned by recovery principles and nursing values.

1 Introduction

The field of mental health care is one of the competing discourses, paradigms and understandings about what constitutes mental health and illness. Ever since the beginning of time, people have used various ideas to explain anything they

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considered a deviation from the norm of emotions and behaviour. These ideas include supernatural theories of demonic possession or godly displeasure, somatogenic theory of humours, and more contemporary biological, psychological, and social discourses. Within the literature words such as ‘framework’, ‘theories’, ‘perspectives’, ‘approaches’ or ‘models’ are used, often interchangeably, to describe these ideas. Within this chapter we use the term ‘perspective’ to describe the way certain ideas and beliefs about mental distress are put together, in order to present an idea in a particular way.

Theoretical perspectives not only offer a way of seeing, thinking about and explaining the nature of mental health and distress, but they influence how we think about care and treatment, including issues of power, positionality and agency. By their very nature, they colour our epistemology of practice and shape what we value as knowledge and what we choose to see and not see. In addition, they limit the meaning assigned to a particular subject, by facilitating some things being said while ruling out or limiting other things.

Some of these perspectives have been developed by nurses for nurses, but many have been developed by people outside the discipline of nursing but are applied to mental health nursing. Consequently, members of the multidisciplinary team may demonstrate a preference for a theoretical perspective that corresponds to their discipline. In some cases, a service model, institutional practices or research agendas may be more aligned with one perspective than another, leading to tensions and challenges. The theoretical perspective one ascribes to can help promote access to mental health services and inclusion or serve to exacerbate stigma and loss of voice. The degree to which each perspective is promoted by the media also shapes and moulds the public’s views and perceptions about the nature of, and treatment required for, mental distress, including the views of the person experiencing mental health problems and their family members. Hence, they have very real consequences, as they are both a model of explanation about causal attributions and a model of action for mental health practice.

APMHNs work in key coordinating and enabling roles in a variety of team configurations, as well as in different service contexts (primary to specialist mental health services). They also work with people who experience a diversity of mental health challenges across the life span, as well as with family members, significant others and social networks. As no one theoretical perspective meets the needs of all people, APMHNs need to be mindful of various theoretical perspectives or frameworks, when thinking about the nature and cause of people’s distress, in order meet the World Health Organisation’s [1, p. 6] aspiration of providing ‘high-quality, person-centred, recovery-oriented mental health services that protect and promote people’s human rights and one which promotes autonomy, encourages healing, and creates a relationship of trust between the person providing and the person receiving the service’.

In a review of frameworks underpinning mental health nursing, authors identify over 20 different frameworks or perspectives [2, 3]. As it is beyond the scope of the chapter to explore every framework or every writer, our focus is on the major perspectives which have influenced mental health practice and which are relevant for contemporary practice. While each provides a lens of understanding and influences the care offered, they do have their limitations. APMHNs who can deconstruct and critique past and current perspectives and are aware of how a perspective constructs identity, and ways of being and relating, including expectations of power and control, are more likely to understand how their espoused theories of action may differ from the theories that govern their practice. They are also more likely to resist the privileging of one theoretical perspective as the primary explanation for, and treatment of, mental distress, and be aware of how wider political, disciplinary and institutional forces shape and govern mental health practice.

Hence, the focus in this chapter is on revealing how biomedical, psychological, socioecological, recovery and of course nursing perspectives not only shape our understanding of mental health and the causes of mental health problems but influence our interactions with, and the care or interventions offered to, people who are seeking help. The discussion, presented in this chapter, is not meant to suggest that one perspective holds ‘the truth’ of mental health problems or care. Neither is it our intention to position the perspectives in opposition to each other. Given the complex nature of the human being, we come from a position that mental health and distress is a complex issue that cannot adequately be conceptualised using one single lens of understanding, as there are multiple ways of viewing a problem and multiple ways of thinking about solutions. Some might argue that ideas frequently overlap and are interdependent, so it is impossible to demarcate ideas around mental health and distress into independent frameworks. While agreeing somewhat with this perspective, we do break ideas into well-recognised frameworks to explore the meaning and implications of each perspective. From the position that the APMHN needs to adopt a pluralistic stance, we see each perspective as having relevance and utility within an integrative relational-based approach to care underpinned by nursing values, including person centredness, respect for voice, dignity and human rights, compassionate witness, respectful curiosity and coproduction as portrayed in Fig. 1.

To help APMHNs critically reflect on the implications of viewing mental distress through any one particular lens, and how the foregrounding or privileging of one framework runs the risk of submerging and inhibiting other voices and ways of understanding from coming to the fore, we first outline some of the core epistemological characteristics underpinning each framework and discuss the manner in which identities are constructed and power manifested.

Fig. 1 Integrative relational-based mental health nursing

2 The Biomedical Perspective

The medical perspective is a ‘style of thought’ that conceptualises and understands a problem through a medical framework and treats it using a medical solution. Within mental health the medical perspective, or what is now frequently referred to as the biomedical or biopsychiatric model, frames human experiences (thoughts and feelings) that deviate from ‘normative standards’ as mental illnesses or disorders. Historians suggest that as an outcome of the modernist ‘scientific’ agenda, and in an attempt to enhance its professionalisation, psychiatry drew on a biomedical model of illness to explain mental distress. Emphasis, therefore, was placed on constructing mental distress as ‘illness’ and locating its cause within the physical body. In keeping with the epistemology of the positivist and post-positivist paradigm, people became objects of study and classification, a collection of symptoms or signs that had to be known about so one could observe, detect, control and treat. This epistemology is given contemporary expression in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the International Classification of Diseases [4]. In a desire to produce knowledge or truths that could be considered as value neutral, objective and universal and premised on the belief that mental distress is akin to physical health problems, aetiological theorists gave primacy to the brain-disease model of mental illness and searched for solutions within the person's anatomical, biochemical and genetic structure.

While this may be an oversimplified characterization of the biomedical model, and few practitioners, including APMHNs would exclusively support a purely biological or somatic approach to care, evidence from research, including service users' accounts, indicate that although practitioners espouse a more holistic biopsychosocial approach, the majority of institutional mental health practice is infused with the belief system of the biomedical framework [5]. In many contexts, the language of diagnosis and symptoms remains central to communication between practitioners, including APMHNs, service users and family members, and the use of psychotropic medication (antipsychotics, anti-depressants, mood stabilisers and anxiolytics) is a central part of treatment guidelines for many people experiencing mental health difficulties [6, 7]. Having a diagnostic framework is important from the perspective of communication, research and the opportunities it affords the person to access services and other entitlements, such as social welfare or disability payments. Equally, prescribed medication may play a role in reducing distress, improving coping ability and enhancing social and occupational functioning. In addition, some people experiencing mental health problems, including family, find the biomedical framework a useful way of conceptualising their distressing experience and value the validation that a diagnosis may bring. An illness diagnosis also adds legitimacy to demands for increases in services and research funding as well as parity in health insurance cover. There is no doubt that advances in neuroimaging technology, molecular biology and epigenetics (interactions of genes with their environment) have increased our understanding of the bidirectional nature of biology and environment (see [8, 9]) as well as opening up debate and discussion around the exciting area of brain plasticity and the role of trauma and chronic stress [10]; however, these insights haven't always translated into improvements in care.

Consequently, the hegemonic position of the biomedical model is increasingly being the subject of much critique from people using mental health services (for example the consumers/survivor movement, Mad Pride movement) and from mental health professionals themselves. Some of this critical commentary includes the rising trend towards the 'pathologizing' of everyday life, the over 'pharmaceuticalisation' of emotional, social and behavioural conditions, as evidenced by the growing number of disorders included in the classification systems, and the increasing debate around the influence of the pharmaceutical industry on the practice of psychiatry, as well as the efficacy of many of the medications used [11, 12]. Commenting on both, Gardner and Kleinman [13] recently noted that, despite the proliferation of both diagnoses and medications, no comprehensive theoretical model for the cause or treatment of 'psychiatric disorders' has emerged.

This positivist model of diagnosis has also engendered much commentary for its ‘sterile’, mechanistic, detached approach to examining human distress, an approach that has led to a monopoly on ‘truth’. While the main objective of a classification system is to bring consistency or inter-rater reliability to the diagnostic process, especially in a world of increasing pharmacological treatments, critics question the validity or factual soundness of the system [14, 15], with many commenting on the epistemic injustice perpetuated by the biomedical framework [16, 17]. Within this system knowledge production is located within the hands of the medical experts, with their narrative deemed to hold greater truth and considered higher in the hierarchy of knowledge. As a result, the need to be attentive to and respectfully explore the embodied experiences of those who experience mental distress is assumed as unnecessary, as mental distress is considered a constant that is not influenced by history, culture or individual biography. This assumption not only perpetuates the belief that mental illness is similar throughout the world, but the person experiencing a mental health issue is constructed as the ‘passive object of care’, and their experiential knowledge, accrued through lived experience, is discounted and marginalised. In addition, the assumptions of universality reproduce numerous other forms of inequality and fails to challenge the social inequalities and political structures that influence and impact people’s journeys into, and experiences of, the mental health system, including racial, economic, educational, cultural and gender bias [16, 18].

Notwithstanding the fact that conceiving mental distress as an ‘illness’ located within biology was seen as an important stigma reduction strategy in the move away from causal ideas of demonic possessions, character flaws or moral/ethical transgressions, the medical lens is being challenged for contributing to the very stigma it purports to undermine [19]. While stigma reduction is still a noble aspiration, some people view the language of psychopathology as oppressive, with recent studies indicating that the biomedical approach and diagnostic labelling in fact increases stigma, especially for people who receive a diagnosis of schizophrenia or personality disorder [20]. As the stigmatizing process is distinctly ‘a relational’ one, once a label is applied, the label assumes a life of its own, with the person being burdened with the cultural connotation of the label, including the societal reaction of stigma, discrimination, and rejection. Johnstone [21, p. 31] also argues ‘that the single most damaging effect of psychiatric diagnosis is loss of meaning. By divesting people’s experiences of their personal, social, and cultural significance, diagnosis turns “people with problems” into “patients with illnesses.” [As a consequence] “stories of trauma, abuse, discrimination, and deprivation are sealed off behind a label as the individual is launched on what is often a lifelong journey of disability, exclusion, and despair”’.

The impact of diagnosis and the separation of the knower from the known is also felt within the healthcare system and among those who provide care. For example, sometimes once the diagnostic label or category is applied, it becomes the person’s ‘master status’ [22], resulting in other health concerns going unheard or discounted as a ‘symptom of mental illness’. In this context it is not surprising that the World

Health Organisation [1], among many others, urge the mental health systems and practitioners to widen their focus beyond the biomedical model and consider all aspects of a person's life.

3 Psychological Perspective

The psychological perspective, which Wittchen et al. [23, p. 98] suggest is the 'mother sciences' of mental health and mental disorders, has a long history dating back to Sigmund Freud (1856–1939). Over the years, this perspective has undergone several theoretical paradigm shifts (e.g. structuralism, psychoanalysis, behaviourism, cognitivism, humanistic); hence, it offers a large spectrum of theories, principles and methodological approaches to understanding mental health problems. In summarising this approach, Kinderman [24, p. 206] states 'by contrast [to biomedical theories which focus on synaptic or intercellular processes] psychological approaches focus on associated networks based in the neural substrate but developed through learning, and rely on theories of conditioning, perception, appraisal and belief formation, on propositional and implicational encoding, on mental models of the world and internalises schemas of relationships, and so forth'. In other words, the focus within this perspective is on how cognitive, emotional, motivational, attitudinal and behavioural processes give rise to mental health problems. In making a case for the importance of a psychological perspective, Kinderman does not disagree that biological factors (genetics, biochemical/neuroanatomical abnormalities), social circumstances (poverty, unemployment) and significant life-shaping events or experiences (trauma such as bereavement, violence, bullying and other interpersonal experiences) give rise to mental health problems, but they do so through 'disrupting or disturbing psychological processes' [24, p. 208]. Within this perspective, it is the 'disruption or perturbation of psychological processes', be they cognitive, psychodynamic, interpretative or appraisal processes, that is the 'final element [or pathway] in the origins of mental disorders' p. 208 (see Kinderman for a more expansive explanation).

Over the years, research arising from the psychological perspective has explored the relationship between a variety of psychological theories to explore mental health problems, such as attachment, behaviour, interpersonal and cognitive theories (see Bernaras et al. [25], Pienkos [26] for some review articles). In addition, various social-psychology models or theories associated with health behaviours and behaviour change such as the Health Belief Model, Theory of Reasoned Action and Self-Regulating Model (see [27, 28]) have been applied in the various aspects of mental health. We are also seeing an expanding body of diagnostic and transdiagnostic research and systematic reviews exploring the causal relationship and impact of multiple cognitive and metacognitive variables on human distress and mental health problems as well as interactions between the variables such as cognitive dissonance [29], illness beliefs or schemas [28], insight [30], coping/emotional regulation [31], hope [32] and identity [33], to name but a few. The impact of social processes such as stigma and discrimination on self-appraisal and internalised stigma has also been explored [34, 35]. In the last number of years, positive psychology has drawn attention to the limitations of focusing on mental disorders and the deficit way of thinking, to highlight the importance of understanding the factors and processes that promote positive development among individuals exposed to high levels of stress or adversity, including protective factors such as resilience [36].

In addition, in the last 20 years, we have also witnessed an explosion of psychological-based interventions as well as research into psychological processes that may impact outcomes, such as psychoeducation, cognitive behavioural therapy (CBT), behavioural activation therapy, interpersonal therapy (IPT), solution-focused therapy, mindfulness, motivational interviewing and so on. Today some of these interventions such as CBT and psychoeducation are recommended within clinical guidelines [6, 7] and are part of the skill base of APMHNs. In addition to interventions aimed at the individual, there has been an increase in interventions focusing on the person's family [37] and an explosion of multilevel interventions which highlight the positive impact of contact interventions and educational interventions upon stigma [38].

While it is beyond the scope of this section of the chapter to do a comprehensive review, and although we still lack answers to many critical questions into the cognitive, emotional and motivational mechanisms that give rise to mental health problems, it is fair to say that the psychological perspective has offered valuable insights into individual level factors that impact mental health and influence outcomes for people experiencing mental distress. It has also provided much needed insights into socio-relational dynamics associated with issues such as social isolation, stigma and harmful psychological scripts which limit social participation, as well as providing various psychological-based interventions to support the person and their family, as well as interventions which target the wider community.

Although these are all necessary steps towards establishing well-being and supporting people experiencing mental health problems, the psychological perspective has been critiqued for its epistemological alignment with the post-positivist research paradigm and for largely sticking with traditional orthodoxies of diagnostic criteria and syndromes that pathologise psychological difficulties and downplay or ignore subjective experiences of human suffering [23, 39]. It has also been critiqued for its tendency to privilege individual- and interpersonal-level interventions, which remain insufficient in the face of the wider social-structural factors that impact mental health. There is now global evidence that mental health problems are strongly determined by the social and economic circumstances of a person's life [40]. These determinants include the conditions in which people are born, live, work and age, including the health systems they can access. Hence, APMHNs need to move beyond the level of the individual and consider their role in the context of forces within the person's socio-ecological system.

In the recent years, there has also been ongoing debate, within the field of clinical psychology on the need to move away from the disease-based model that has underpinned much of the research and practice in this area. This debate culminated with the publication by the British Psychological Society's Division of Clinical Psychology of the document called *The Power Threat Meaning Framework:*

Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis [21]. In summarising this framework, the authors write:

> "Unlike the more traditional biopsychosocial model of mental distress, there is no assumption of pathology and the "biological" aspects are not privileged, but constitute one level of explanation, inextricably linked to all the others…The individual does not exist, and cannot be understood, separately from his/her relationships, community and culture; meaning only arises when social, cultural and biological elements combine; and biological capacities cannot be separated from the social and interpersonal environment. Within this, "meaning" is intrinsic to the expression and experience of all forms of emotional distress, giving unique shape to the individual's personal responses" [21, p. 9].

4 Socioecological Perspective

While recognising that individual characteristics are only one part of the puzzle, the socio-ecological perspective (SEP) moves beyond the person's internal processes, be they biological or psychological, to provide a more multifaceted and nuanced understanding of mental health problems. The SEP focuses on the dynamic reciprocal interactions between individuals and their environment as determinants of health-related behaviour. This perspective, which is often excluded from mental health discourse and practice [1], acknowledges that an individual's mental health is shaped through multilevel structural factors and conditions of daily life. In other words, in addition to individual level factors (for example biological vulnerabilities and psychological processes, there are many 'social-produced' societal factors that underpin and drive an individual's risk for poor mental health, many of which are 'shaped by the distribution of money, power and resources' [41, p. 24].

Over the years authors and institutions have mapped these determinants using various models and frameworks [40, 42, 43]. Bronfenbrenner's [44] ecological approach is a useful way to think about the relationships between a person, their microsystem and the environment in which they live (Fig. 2). Similar to Russian dolls, the framework conceptualises the individual at the centre of ever-increasing spheres of social influence, which Bronfenbrenner terms micro-, meso-, exo- and macro-systems. These interconnecting nesting systems simultaneously combine, interact and intersect to support mental health or produce poor mental health outcomes. In other words, it is within these social and institutional systems or 'habitus' that the person's life chances are determined (see Fig. 2).

The **microsystem** closest to the individual contains the strongest influences and encompasses the interactions and relationships the person has with their immediate surroundings, such as parents, siblings, partner or peer group. The importance of early experiences, including safe, nurturing relationships within the family unit, in the promotion of mental health and emotional well-being is without question. The microsystem is also the place where socialisation takes place and, with it, moral development. Over the years studies have clearly highlighted the negative impact of adverse experiences in early life, including unsupportive, neglectful or abusive

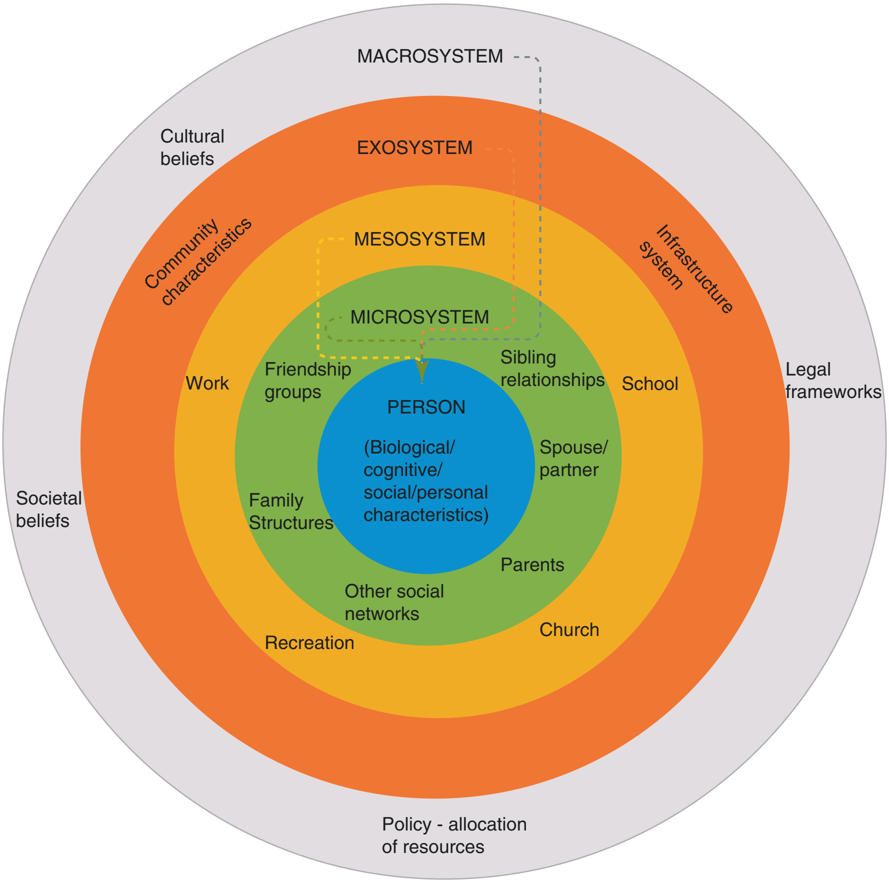

Fig. 2 Persons in context of ecological systems

family relationships, as well as growing up or living in the presence of unpredictable home environments, involving domestic violence, intimate partner violence and other forms of trauma (see "Trauma and Trauma-Informed Care"). Poor family cohesion not only affects the person's long-term physical and emotional well-being but negatively impacts other aspects of life including educational outcomes.

The second level is the **mesosystem** and refers to the interaction the individual has with structures and institutions such as school, work and church. Houston [45, p. 57] describes this system as a 'rich soup of interaction that provides stimulation, structure, purposive action and meaning'. The importance of social connection and community participation, including positive school relationships, employment and housing stability has been well proven to have a positive impact on mental health. It is interactions with institutions within this system that frequently determines the person's position on the social hierarchy as well as their level of educational, social and economic capital (see [46]), which in turn creates opportunities to maximise personal goals and aspirations and enhances one's power to access further resources/

capital. In contrast, those lower on the social hierarchy with less access to power and resources are more likely to experience less favourable economic and social conditions, and therefore, experience much more accumulative stressors. There is now an increasing body of research highlighting how exposure to a wide range of social stressors plays an important role in the aetiology and the course of mental health problems. Higher rates of mental health problems are associated with low educational attainment, material and social disadvantage, irregular or poor-quality employment, unemployment, low income, financial strain and family poverty [42]. Inadequate housing, overcrowding and homelessness in all its forms are also consistently associated with increased risks of mental health problems [43].

The **exosystem** includes the contexts in which the person lives, including the natural and built environment. Although the person may not be directly part of the system, they nevertheless are affected by the knock-on effect it has on their micro- and mesosystems. Analysis that has focused on community characteristics suggest that satisfaction with living environment, including housing quality, infrastructural systems (water, sanitation, transport), green spaces and neighbourhood safety, is linked to lower levels of mental health problems. In contrast poor-quality housing, overcrowding, area level poverty and neighbourhoods that have high rates of community violence [47] are associated with poorer mental health outcomes, many of which are products of the person's social position and capital.

The **macrosystem** is the all-encompassing sphere that includes societal, religious and cultural values but also embraces the polity and economy. Numerous studies highlight the negative impact of societal, religious and cultural beliefs that increase people's exposure to stigma, social exclusion, isolation and discrimination. Contemporary research has repeatedly shown the relationship between oppression, discrimination and exclusion and negative mental health outcomes, whether related to gender, sexual orientation, ethnicity/race, refugee and migrant status, age or disability. In addition, it is within this system that social and political policy is formed and where the allocation of resources is controlled. How a state deals with inequality and the distribution of resources (such as housing, health, education, transport, environmental hazards, climate change) through public policies and legislative frameworks can either promote positive mental health or reproduce and widen economic, social, educational and resource divides that are the major determinants of mental health outcomes. In addition, countries with few political freedoms or where legislation to protect human rights is limited create vulnerabilities which negatively impact mental health.

Although this perspective aids understanding of how individual, interpersonal, institutional, and societal level factors may impact mental health outcomes, giving rise to mental health problems, less frequently considered is the bidirectional impact. While factors in the wider socioeconomic ecosystem can negatively impact the person's mental health, having a mental health problem can also impact social determinants. Poor mental health can limit opportunities and, without timely intervention and support, can adversely influence educational performance and employment capacity, as well as increase the risks of becoming involved in the judicial system [40]. These in turn, over time, can impede access to a range of material and social resources such as employment and earning potential, which further exacerbates barriers to various types of capital, such as access to stable housing in safe neighbourhoods, social status and strong community connections; thus, in a cyclical manner, further social drift is created, which in turn may exacerbate people's mental health problems.

From a life course perspective, people will also have particular stressors at different times of their life, such as pregnancy and perinatal period, during adolescence, building family years, working and retirement year, all which change dynamics within each of the aforementioned systems. In addition to the temporal challenges throughout the life course, significant changes within society, such as war, pandemics or natural disasters, create greater challenges across multiple levels. People also have multiple identities or social positions such as age, gender, race, sexual orientation, education level, employment status and financial stability which may simultaneously combine to produce more additive disadvantage in terms of health inequities and poorer health outcomes.

While biomedical and psychological theories have their place, it is to the 'social' that the APMHN must look in order to truly develop an understanding of the person's life and the context of their mental distress. The SEP reminds practitioners that mental health problems are not just located with the person but reflect a symbiotic relationship between the individual and the wider social and physical environment in which they live, including the cultural and political context. The APMHN can use the four levels as a schematic focus to examine the interplay between the internal world (thought and perception) of the person and external social dimensions/determinants. The model can also be used to consider how interactions which take place at individual, group or community levels can be both a source of weakness and strength and how the person's access to various forms of capital (educational, economic, social) may impact their recovery journey. In addition to providing a way of considering the bidirectional relationship between mental health and social determinants, the framework is also a means of considering what actions/interventions the APMHN needs to take to support the person strengthen social and community connections at each level. It is also a reminder of the political advocacy dimension of the APMHN role (see "Advocacy and the Advanced Nurse Practitioner") in terms of empowering individuals to access education, employment opportunities as well as becoming public mental health advocates. The public advocacy role involves making the case for investment in national and local policies that directly target the social roots of mental ill health and working upstream to change structures and policies that perpetuate inequalities and exclusion.

5 The Recovery Perspective

While the three previous perspectives discussed are driven by an epistemology that privileges professional expertise and knowledge, recovery perspectives are underpinned by an epistemology that focuses on the lived experience. Thus, the service user voice is centre stage, challenging some of the epistemic injustice of previous discourses. Primarily arising from the narratives of people who experienced mental health problems, and in response to their dissatisfaction with the disease-diagnosis-deficit model of traditional mental health services, the concept of recovery is now an underpinning principle of mental health and social care policy, including the WHO [1] guidance document on the development of community mental health services.

The contemporary model of recovery differs in significant ways from the more traditional biomedical view of 'clinical or functional recovery' which is defined and measured by health professionals based on a reduction, remission or elimination of clinical symptoms. While the recovery perspective may include clinical recovery, it centres on personal recovery or what is sometimes called user-based recovery (people's personal experiences or journeys of recovery), and, as such, it provides 'ecologically valid pointers to what recovery looks and feels like from the inside' [48, p. 2]. These personal autobiographical accounts acknowledge that although recovery is a complex journey characterised by achievements and setbacks, people have the potential to live meaningful lives despite the presence of challenges or the ongoing limitations caused by mental health problems. It is now more than 15 years since Anthony [49, p. 11] defined recovery as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles…a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness'. More recently Watts and Higgins [50, p. 136], following their narrative study of recovery through peer support, with 26 people, define recovery as 'a dynamic and ongoing educative process of personal transformation, effected through reciprocal relationships with compassionate but honest others. It involves self-activation, the taking of personal responsibility, and the development of personal resources and support systems, which enable people to flourish, and have a zest for living, even when life becomes challenging'. While this definition has similarities to Anthony's and many others, it does draw attention to the fact that while recovery is an individual process, it is also a relational process that takes place within a social milieu—a milieu that may or may not include the mental health system [51]. It is within and through interdependent relationships with others that the 'nutrients of recovery, such as hope, courage, acceptance, warmth and compassionate witness and understanding are available' [50, p. 81]. It is also within this milieu that the person becomes an active participant in shaping their own life by rebuilding connections with self and others, redefining their experiences, discovering their sense of self and self-worth and learning to embrace the challenges and risks of life.

Recovery is also a narrative that is endeavouring to transform the mental health services by calling for a fundamental shift in the way mental distress is conceptualised and responded to, including the colonisation of people's experiences and voices by framing their distress within the biomedical perspective. As Watts and Higgins [50, p. 25] point out 'within a recovery paradigm the person experiencing a mental health problem is considered the "expert" in their own lives and as such develops their own epistemology, explanatory framework or meaning, setting forth their own criteria for recovery and mapping their own recovery journey'. Thus, practitioners, including APMHNs, seeking to engage in recovery practices are challenged to rethink the manner in which the biomedical perspective is privileged and 'truly engage in dialogue with service users and families so that understandings, solutions, and plans are co-constructed, and a "consensus reality" of what is 'real' is continually produced' [52, p. 69].

The recovery perspective also calls for a deep analysis of the way mental health services are organised and implemented, including a critique of how power is distributed and shared within services [52]. In so doing it challenges practitioners to move away from the coercive, oppressive, disempowering and paternalistic practices that diminish autonomy, agency and power. Recovery also mandates practitioners to truly engage in co-production by involving service users and family members in all aspects of shared decision-making around service planning, design, delivery, evaluation/research and the education of practitioners [53]. Practitioners are also challenged to embrace concepts such 'dignity of failure' and 'positive risk taking' [54], as well as to move away from 'professional centric' services to embrace the role of peer support and peer support workers [55].

The recovery perspective is also marked by political and social justice goals, as it recognises that for many people, recovery is also a process that involves recovering from the social, political, cultural and economic consequences of being labelled 'mentally ill' and from the consequences of societal stigma, social exclusion and discrimination. Hence, the need to address the inequalities, injustice and oppression, as discussed in the socioecological perspective, that prevent people labelled 'mentally ill' from leading socially integrated and inclusive lives.

In the last number of years, numerous typologies or frameworks synthesising service users' experiences of recovery have been developed. One of the most rigorous and frequently cited is the CHIME framework, which is based on a systematic review of recovery studies and is an acronym for five recovery processes (i.e. connectedness, hope and optimism, identity, meaning and empowerment) [56]. Connectedness emphasises the centrality of people connecting with others and developing meaningful relationships with family, friends, peers, faith-based organisations and the wider community. Harnessing positive aspects from the social environment, such as positive interpersonal interactions and relationships, is central to many people's recovery [57]. Hope, sometimes described as the 'vital ingredient' and 'cornerstone' of recovery or the 'emotional essence of recovery' [52], refers to the importance of people believing in themselves and their capacity to overcome obstacles, as well as other people believing in their recovery potential [58]. Identity focuses on the process of developing, defining and reconstructing a positive sense of self and personal identity, through the learning of new perspectives about oneself, one's experience of mental distress and the world. This may involve transformation from an illness dominated identity or 'master status' [22] to one that encompasses personal agency and competence. Meaning refers to the process of discovering purpose and direction in one's life. Meaning may arise from paid or unpaid work, or it may be derived from advocacy, political action or from social relationships or spiritual connections. Empowerment, which has been central within recovery narratives since the beginning, emphasises the criticality of the person taking control and responsibility for their own life and recovering a sense of personal resourcefulness and agency.

Since its development, CHIME has been used and adapted by various organisations and services. It has also been reworked and applied to family members by Wyder and Bland [59]. In their work, they recognise that while family members are valuable interdependent partners and supporters in a person's recovery journey, they have their own experiences of recovery as they navigate their own distress—hence, the need for services and practitioners to consider the relevance and application of the CHIME processes to family members (see chapter Collaboration with Families, Networks and Communities).

While the recovery perspective has immense support from service users, family members, practitioners and policymakers and is considered the gold standard to which mental health services currently aspire, similar to other perspectives, the concept of recovery is not without critique. Some of the main critiques focus on the manner in which the radical intent of the original concept has been subverted and co-opted by Neoliberal ideology which uses it 'as cover for coercion, victim blaming, disability denial and removal of services' (see Recovery in the Bin https://recoveryinthebin.org/ritbkeyprinciples/). Recovery is also critiqued on the grounds that the human rights, citizenship and democratising agenda that was central to earlier recovery proponents are being submerged and corrupted by professionals, who through the development of scales, measures and typologies which ultimately align with traditional medical frameworks are using the banner of recovery as a means of preserving power imbalances [60]. Researchers and activists have also expressed concern about recovery's 'normalising individualism' [61, p. 6], thus disregarding and deflecting attention from the wider cultural inequalities and discriminations that are systemically embedded within social, political and economic systems, which, as discussed previously, have been consistently identified as among the strongest predictors of mental health outcomes. Those writing in the field of cultural diversity also express concern about the assumption of generalisability, especially in relation to how an individualistic recovery framework transfers to cultures and groups with strong collectivist orientations [62] (see "Diversity and Culturally Responsive Mental Health Practice").

6 Mental Health Nursing Perspective

While recovery-focused care is now considered best practice within mental health care, relational-based care and human connection also feature heavily in the remit of European and Australasian nursing associations, who highlight the need for nurses to demonstrate effective therapeutic relationships requiring skilful use of the self [63–65]. Indeed, the therapeutic relationship has been a defining element of psychiatric/mental health nursing practice since Hildegard Peplau published her seminal text on the *Interpersonal Relations Theory of Mental Health Nursing* [66]. Considered the founding mother of psychiatric/mental health nursing, Peplau defined nursing as 'a significant therapeutic interpersonal process [that] functions co-operatively with other human processes that make health possible for individuals and communities' [66, p. 52]. For Peplau, the core of psychiatric/mental health

Table 1 Overview of Peplau's phases of nurse-client relationship

Orientation	Identification	Exploration	Resolution/ termination
• Becoming acquainted • Building trust • Engaging in non-directive listening • Exploring by asking who, why, and when type of questions • Discussing roles • Finding common ground	• Clarifying expectations and perceptions • Identifying strengths, needs and issues to be addressed • Identifying mutually agreed goals • Developing a plan towards achieving goals	• Facilitate person to increase awareness of feelings/ emotions • Support person to see patterns in experiences and behaviour • Support person to develop coping skills • Provide reflective non-judgemental feedback	• Evaluate goals and interventions • Explore impact of the relationships on outcomes • Prepare plan for the future

nursing is about forming and maintaining therapeutic relationships, as, in her view, it is within the context of the relationship that the 'work' of mental health nursing takes place. In her view, presence, congruency, respect, empathy, trust, hope, unconditional positive regard and shared decision-making are central values underpinning effective nursing. In explicating the specific phases of a successful therapeutic relationship as orientation, working (identification and exploration), and resolution (see Table 1), and describing the various roles nurses transition through (stranger, teacher, resource person, counselor, surrogate and leader), Peplau not only provided mental health nursing with a midrange theory that continues to inform nursing practice and research to the present day (see, e.g. [67, 68]), but she also highlighted the need for nurses to remain firmly focused on the person in distress.

Commenting on the needs of service users and importance of the interpersonal relationship, Peplau wrote 'Despite our current emphasis on medical diagnoses, sophisticated technology, economic cutbacks and "quick fixes", what patients need most in the midst of this health care maze is sensitive and caring individuals who are willing to enter into interpersonal relationships that foster hope and prevent hopelessness' [69, p. x]. Although written over 25 years ago, the statement has resonance for the APMHN today as more and more service users continue to voice the need for practitioners to engage with them as whole human beings, as opposed to viewing them as a case, diagnosis or collection of symptoms.

Since Peplau, many other researchers and nurses have emphasised the therapeutic value of the nurse-patient relationship [70, 71], including the authors of the Tidal model of mental health recovery and reclamation [72, 73]. Although the model has moved beyond nursing and is used in a range of disciplines across the mental health spectrum including social work, occupational therapy and psychiatric medicine [74], it is frequently cited as the first recovery model or philosophical approach to be developed by and for mental health nurses in practice. The Tidal model is a way of thinking about how people might reclaim their personal story, as a first step towards recovering their lives. Young [75] describes the model as 'a paradigm for giving person-centered care that is strength-based, empowering, and relational'

Table 2 Tidal's ten core values or commitments

1.	Value the person's voice
2.	Respect the language of the person
3.	Become the apprentice
4.	Use the persons available toolkit
5.	Craft the steps forward
6.	Give the gift of time
7.	Develop genuine curiosity
8.	Know change is constant
9.	Reveal personal wisdom
10.	Be transparent

For fuller explanation and resources, see https://www.tidal-model.com/index.html

(p. 574). The authors of the Tidal model start from the premise that power and professional expertise is problematic, noting how psy-disciplines, including nursing, frequently submerge 'the person's story in a sea of professional theorising, interpretation and observation' [73, p. 7]. Hence, in keeping with the recovery ethos, rather than being paternalistic, the Tidal model, which is underpinned by a set of essential values or the "ten essential shared commitments" (see Table 2), views the person in distress as the authority on their life.

The APMHN working with the Tidal model is encouraged to form genuine, meaningful and collaborative relationships that move away from a detached style of interaction where the person is a passive recipient of the nurse's wisdom to one that locates the person's narrative or 'story' at the heart of the caring process. Core to this is valuing and actively listening to the person's story as well as viewing the person as the expert in their life story. By focusing on personal experience, the APMHN gains an appreciation of who the person is, their 'personal aetiology' and the meaning they attach to their experience, as well as their needs, wants and dreams, and in so doing, facilitates the person to re-author the story of their lives. In this context, the APMHN engages in a 'relational narrative' or dialogue with the person, facilitating the person to tell their story and talk frankly about feelings and experiences, while creating a context for telling, through 'natural curiosity' and the asking of 'interesting questions' [76, p. 100].

The Tidal model also emphasises the importance of supporting the person to take greater control over their lives. Consequently, APMHNs need to be mindful of how they exercise power within the relationship, supporting autonomous decision-making, self-determination and personal responsibility. Other writers, including service users, highlight the importance of nurses moving away from relationships characterized by neutrality and distance to ones that are more personal, reciprocal and equal [77]. Rather than focusing on problems, deficits and inabilities, Barker also emphasises the importance of nurses seeking to reveal the person's many resources, strengths and abilities, which are hidden in the person's own life story. In other words, instead of being the expert 'nurse-diagnostician-therapist' on the stage, the APMHN becomes the 'apprentice', learning 'from and with' the person what needs to be done in their voyage to recovery [73]. Indeed, a collaborative approach to care has been shown to lead to a range of positive outcomes for service users and family members, including better quality of health care, higher levels of satisfaction and engagement with services and practitioners, and improved health outcomes for both the person and family members. Barker and Buchanan-Barker [73] also remind nurses, including APMHNs, that while there is no right or correct way to recover, as each person's journey is unique, some of the most important things they do with people 'is imbued with the perfume of ordinariness' (p. 35).

The authors of Tidal also emphasise the difference between 'being with', 'caring with' and 'connecting with' as opposed to 'doing to' and 'caring for' the person. Caring with the person experiencing distress in a way that nurtures growth, development and potential also calls for the APMHN to create a supportive environment that is challenging and stretching of the person's ability and one that promotes and supports positive risk taking. In this context, the APMHN needs to view setbacks as opportunities for growth and learning as opposed to failures [54] and reflectively guard against their desire and need to take back control. 'Caring with' also challenges nurses and APMHNs to support the person, if they wish, to use their experience as a source of positive inspiration and resource for others, including becoming involved in peer or advocacy activities. Involvement in such activities have been shown to help develop positive and empowering identities [50]. More recently, Gabrielsson et al. [78] urge mental health nurses to stay focused on the caring aspect of nursing and argue that by doing so 'psychiatric and mental health nursing constitutes a transformative force for good in health care by applying a holistic view to health and recovery, challenging the false and problematic division of human needs of body and mind and the notion that the only outcomes of care that matter are only those readily defined and measurable' (p. 978).

Developing an integrative nursing care approach is more than adjusting services or assimilating recovery principles into the current paradigm of care. Research suggests that one of the core ingredient in people's recovery journey is the personal qualities of the person they meet [50]—people who work from a stance that enables the person to develop and hold hope for the future; find meaning and purpose in their experience; promote a positive sense of self and identity beyond the label of 'mental illness'; become involved in meaningful roles and social activities and develop a sense of personal control, resourcefulness and agency. Ultimately it is the feeling of control and responsibility that increases people's confidence and self-belief, which in turn enhance their willingness and capacity to trust their voice and ability to overcome obstacles. For APMHNs to be in a position to 'compassionately witness', on an ongoing basis, the lived reality of people's distress and move to a position of emotional connectedness and interpersonal presence, nurses need space to attend to their own internal life world; this includes fine-tuning their self-reflective skills and addressing their own distress and feelings of guilt or professional hopelessness when people continue to experience distress and require emotional and practical support on an ongoing basis. Notwithstanding the fact that therapeutic nursing is not an objective action that nurses perform on another person but is an embodied way of thinking about and relating to another human being in distress, Table 3 uses CHIME as a touchstone for thinking about how services and APMHNs might give expression to some of the principles discussed in this chapter.

Table 3 How APMHNs might give expression to some of ideas in this chapter

Connection	Support the person to develop meaningful relationships with family, friends, social, cultural and communities Actively engage with family, friends, peers and wider networks/community groups according with the person's own choices and preferences Challenge one's own and others' professional centric views, and support the person to engage with peer support/community networks Work collaboratively to put in place meaningful supports to enable the person to fulfil education and work aspirations as well as gain access to appropriate accommodation/housing Support the development and inclusion of peer-led services and the involvement of peers in the development, delivery and evaluation of services and educational programmes Take on an advocacy position to challenge the wider social, economic, structural and attitudinal barriers to social integration
Hope	Acknowledge the common humanity that exists between practitioners, service users and family members Believe in the person's capacity to recover irrespective of 'medical diagnosis' or symptoms View the person as having the right to the same pleasures, passions, dreams, hopes and aspirations as the rest of society Support the therapeutic alliance by developing an attitude of 'being with' and 'caring with' the person as opposed to 'doing to' Develop a hope-inspiring relationship with the person and their family, and affirm that living a full life in the presence or absence of 'symptoms' is possible Adopt a rights- and strengths-based approach, acknowledging and mobilising the person's abilities, achievements, resources and potential
Identity	Respect the person's unique identity and context (ethnic, cultural, religious, sexual, etc.) Support the person to appreciate their sense of self and self-worth Respect the person's capacity for self-determination by enabling them to exercise autonomy and choice Acknowledge, through action, that the person is the expert on their own life Strengthen the person's ability to overcome stigma and external prejudices as well as self-oppression and self-stigma
Meaning	Give primacy to the person's voice and narrative by foregrounding the meaning the person gives to their mental health experience in interactions and care Recognize that the person exists in a fluid web of relationships and sociocultural contexts that shapes the meaning they attach to their experiences, preferences and desires Embrace and respect the experiential knowledge that the person and family bring to the relationship, and use that knowledge to coproduce a recovery plan Resist the privileging of any one perspective on the nature and cause of mental distress, and commence a dialogue with the person on the many and different ways of understanding mental distress Support the person to rebuild their life though purposeful and meaningful activities that accord with their choices and preferences

(continued)

Table 3 (continued)

Empowerment	Value the person as an active participant in their own care with the right to self-determination Support the person to develop confidence and trust in their abilities and voice by fostering self-determination, control and choice in all aspects of care Maximise the therapeutic alliance with the person and family, by becoming skilled in recovery-oriented practices, such as wellness recovery action planning, trauma-informed care, crisis planning, safety planning and co-facilitated models of education Engage in shared decision-making or, where not possible, put strategies in place for supportive decision-making Support the person to develop strategies to scaffold, and manage their distress and embrace challenges and positive risk taking Be proactive in providing information based on the best evidence available, including information on the pros and cons of all options available Consider that the family, in many situations, is the unit of care, and engage with and support family to support the person experiencing distress Support family members in their own recovery journey so they develop a life and identity that moves beyond the caring role Involve service users and family members in the design, delivery and evaluation of services Reflectively explore the implications of professional positions of power and privilege on the relationship with the person and family Consider how the language of ‘psychiatry’ and ‘nursing’ can be a tool that enables the exercise of power, perpetuating traditional power relationships between the nurse, the person in distress and their family Adopt a proactive stance in identifying difficulties the person may experience with treatments, including prescribed medication, and be willing to explore the possibility of people living a medication free life Create safe spaces where the person feel contained in mind and body Review own practice and avoid the use of restrictions that are experienced by service users as retraumatising, paternalistic and disempowering Cultivate the moral courage to challenge institutional, professional and personal systems, procedures and practices that work against the development of person centred, rights-based and recovery-oriented nursing practice

7 Conclusion

APMHNs work in a variety of roles with people who experience a diversity of mental health challenges and need to work collaboratively with service users and family members in a way that is informed by multiple perspectives and frameworks. As there are multiple ways of viewing and thinking about problems and solutions, this chapter focused on exploring how biomedical, psychological, socioecological, recovery and nursing perspectives frame thinking and action in relation to mental health and mental health distress. The discussion within the chapter highlights the limitations of privileging any one theoretical perspective as holding ‘the truth’ of mental health problems or care. Hence, it argues for the APMHN to adopt a pluralistic, integrative stance that gives primacy to the voice and personal epistemology of the person seeking care and one that is underpinned by values such as person centredness, caring with, respect for voice, dignity and human rights, compassionate witness, respectful curiosity and coproduction. The importance of relational-based nursing care that enables the person to develop and hold hope for the future; find meaning and purpose in life and develop a sense of personal control, resourcefulness and agency is emphasised.

Reflective Questions

- How would you open a space within the multidisciplinary theme to explore what theoretical frameworks are guiding practice?
- How might you ensure that the service users personal meaning and experiential knowledge are not submerged by professional discourses with mental health care?
- How might you as APMHNs support the development of and inclusion of peer-led services and the involvement of service users and family members in the development, delivery and evaluation of services, including educational programmes for nurses?

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Part II

Foundations for Collaborative Working

Therapeutic Alliance

Nina Kilkku and Gisli Kort Kristofersson

Learning Objectives
After reading this chapter you will be able to:

- Value therapeutic alliance as the core of advanced practice mental health nursing.
- Enhance practices that enable and support the therapeutic alliance in different mental health settings.
- Reflect on the different aspects of the therapeutic alliance, both from a personal viewpoint and from the viewpoint of service users, with professional curiosity, humility and a willingness to understand and learn more about the therapeutic alliance.

1 Introduction

The core of the mental health nursing is the patient-nurse relationship—the therapeutic alliance, in which the 'patient' could be an individual, family, group, network or a community. In this chapter we consider the importance of this alliance as a focal point of all the mental health nursing practice regardless of clinical setting. This relationship is different from the relationships we have with our peers, families, friends or other persons in our social network. But there are also similarities, as all connections are based on an interest towards other human beings, on an ability to be present with and for another human being and on attempts to understand the

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other. Communication in all its forms, as well as self-reflection skills, are always there regardless of the type of relationship, although in informal relations we do not use them as consciously as in a professional mental health setting. It is often said that relational and communication skills can be developed, learned and taught, but without a proper foundation, including a positive regard towards the other person, a genuine interest in and willingness to understand the other person and ourselves, learned communication skills will remain technical and superficial, lacking the proper depth to create a meaningful and resilient therapeutic alliance.

With the demands for efficacy and effectiveness that is omnipresent in modern healthcare delivery, there is a danger that nursing's focus will remain on issues which are more easily measurable than the therapeutic alliance. These demands often come from outside mental health nursing and are based on another set of priorities. As these demands are often strong and loud, they might even confuse and/or create uncertainty on what is helpful in mental health nursing and what is the underpinning philosophy and basis of practice. Therefore, it is important that as mental health nurses, and especially APMHNs, we remind ourselves and others that the most important thing in our profession and in our practice is the human encounter: the relationship between two (and sometimes more) human beings, which we refer to in this chapter as the therapeutic alliance. Without the understanding and appreciation of this therapeutic alliance, there is a risk that mental health nursing is reduced to a set of measurable, detached procedures and interventions.

The nature of APMHN education and training varies greatly from one country and school to another, and some APMHNs may have training to deliver specific psychotherapy interventions or be educated as psychotherapists. Our understanding is that the therapeutic alliance is not limited only to those APMHNs with psychotherapy education or only takes place when the APMHN is delivering psychotherapy. As part of care, APMHNs engage in may tasks besides therapeutic encounters with service users, such as care co-ordination, medication administration, education and collaboration with families, to name only a few. All of these activities are also built on, and happening within, the therapeutic alliance, and therefore the alliance is the core in all encounters with the person seeking help. In other words, the therapeutic alliance does not happen only in some pre-arranged formal meeting, but it is a foundation of every encounter with the person in mental health care, as described in the case vignettes in the end of this chapter.

In addition to what some call the clinical role, APMHNs have an important role as educators, researchers and leaders [1, 2]. However, we see these roles are interlinked. As described later in this chapter, the therapeutic alliance is not an intervention, but it is a way of being with people who are seeking help. In this sense APMHNs are educators and role models to other staff members and students with their ways of engaging and being with other people. It is important that APMHNs support and enhance a working environment where the therapeutic alliance is enabled and respected as the most important helping element of mental health nursing practice, an element that is given space in staff education, clinical supervision and practice. APMHNs are also role models in this context in taking care of their own professional, therapeutic capabilities with self-reflection and through supporting reflective actions of others, e.g. through clinical supervision. As educators they can highlight the importance of the therapeutic alliance and enable situations where more and diverse experiences of the therapeutic alliance could be gained. But their role is also to increase understanding of different forms and levels of knowledge especially from the viewpoint of the therapeutic alliance through further development of the concept through research. Educational aspects can't be seen as a separate part of the therapeutic alliance, or mental health nursing, and therefore we recommend the reader to also visit the chapter on educational aspects in advanced mental health nursing practice. Hopefully this chapter on the therapeutic alliance will encourage all readers, and especially APMHNs, to reflect and recognize their ways of being in the therapeutic alliance and value the alliance as the core of mental health nursing. From our viewpoint mental health nursing does not exist without the therapeutic alliance.

2 The Legacy of Hildegard Peplau

When describing the therapeutic alliance in mental health nursing, the legacy of Hildegard Peplau (1909–1999) and her focus on interpersonal relationships, especially the nurse-patient relationship, can't be overemphasized. With her middle-range theory, she made mental health nursing visible from a theoretical viewpoint and thus provided a major contribution to developing the very foundations of mental health nursing. Her legacy is still seen in the everyday practice of mental health nursing, even thought we might not always acknowledge it. Her studies were grounded in clinical practice and used knowledge and influences from other influential thinkers of that time, such as Harry Stack Sullivan, Eric Fromm and Frieda Fromm-Reichmann [3]. Her book on *Interpersonal Relations in Nursing* [4] together with several other publications by her and her successors has developed and nurtured our thinking on the therapeutic alliance as a shared experience of the nurse and the patient, or service user, which is the more commonly used term today within the mental health literature.

The nurse-patient relationship is at the core of her work on psychiatric/mental health nursing, thus clearly setting the stage for future generations of mental health nurses to view the service user and the relationship as central, as everything else is a secondary derivative of that relationship. In other words, without the therapeutic alliance, or what Peplau referred to as the nurse-patient relationship, nothing of real value can be gained in mental health care. Besides the work of Hildegard Peplau, Annie Altschul's [5] and Eileen Skellern's [6] work has also advanced our understanding of the importance of developing therapeutic communication as well as developing interpersonal relationships. Their work also paved the way to today's emphasis on user-involvement, social inclusion and recovery in mental health nursing [7].

In her theory, Peplau [4, 8] described the phases of the nurse patient relationship as orientation, identification, exploitation and resolution, together with the different roles of the nurse. Barker [9, 10] has expanded this relationship further in his Tidal model, in which there are three dimensions as a means of representing personhood: world, self and others. According to the Tidal model, the experience and relation of health and illness can be explored by service user and the nurse together, to find the kind of support needed in the time of crisis or in helping the person back to the life course.

Besides Peplau, several other authors and researchers have defined or conceptualized the therapeutic alliance. According to Lundh [11], the therapeutic relationship or alliance is a special form of human relationship which is designed for the purpose of helping another person to reach some personal goals. Some more structural viewpoints on therapeutic alliance have been provided by Zugai et al. [12] in their concept analysis. They describe the attributes or core features of the therapeutic alliance as 'partnership', 'consumer focus' and 'empowerment', while the antecedents were a 'collaborative and interpersonal healthcare culture and organization', 'bilateral participation', 'interpersonal engagement', 'self-awareness', 'nursing support and education' and 'equality, being the balance between autonomy and support'. The consequences or outcomes of the therapeutic alliance were identified as 'enhanced health' and 'enhanced care experiences' [12]. As the therapeutic alliance is a relationship between two, or more, people, it is not stable or fixed but dynamic in nature [13]. As such, it is a delicate relationship, which needs to be negotiated again and again, and will change over time. Indeed the ideas of 'patient-centredness' or 'person-centredness' demands this flexibility as the therapeutic alliance is not a step-by-step intervention, but is always anew, with every encounter being unique in this context.

3 Therapeutic Alliance and Common Factors

The therapeutic alliance has also been an interest of psychotherapy and psychotherapy research for a long time, especially from the viewpoint of common factors. The idea of common factors was first introduced by Saul Rosenzweing in 1936 [14]. In his publication he referred to the importance of unrecognized factors in all psychotherapies, factors which could be even more important than those which are purposefully used. Today these factors are named common factors as they are often common across different psychotherapy approaches that impact change. In other words, they are the factors that *collectively shape a theoretical model about the mechanisms of change in psychotherapy* [15, p. 270]. From the viewpoint of this chapter, the most interesting finding is the precedence and impact of the therapeutic alliance over other factors on outcomes [15]. While the distinction between common factors and factors that are specific to the psychotherapy model in use is not always clear, as they are dynamically affecting each other through complex interactions in therapeutic encounters [16], it is recognised that without a trustful, safe therapeutic alliance, interventions have no meaning and are unlikely to yield any beneficial results for the service user [17]. In a study by Cahill et al. [18] on mental health nurses delivering psychotherapy, service users reported very little differences between the type of psychotherapy that helped them but reported the therapeutic relationship as the most important and helpful factor. Similar results have been reported in several other studies in the last few years (e.g. McAndrew et al. [19]; Newman et al. [20]; McAllister et al. [21]).

4 The Therapeutic Alliance as a Safe Base

The relevance and centrality of the therapeutic alliance or the therapeutic interaction between a person or persons seeking help and the person or persons trying to provide help is based on the importance of social interaction between human beings. Our mental health does not develop in a vacuum but develops and is maintained through social interactions. It is important for our development to have positive relationships, in which we encounter a positive, accepting manner, with 'loving eyes', also described by Rogers [22] as 'unconditional positive regard'. People need human relationships for development [23, 24], not only as children but throughout the life course.

Opposite to this, we know that social isolation and perceived loneliness are risk factors for poor mental health [25]. The impact of social isolation has become unfortunately more evident in the time of the pandemic [26]. People who experience mental health problems are also at increased risk of social isolation and loneliness and need to experience examples of safe and secure social interactions. The therapeutic alliance can provide this space and increase peoples' sense of social competence, which in turn can be transferred to other meaningful relationships. We know that many people seeking help from mental health services have traumatic experiences in their past. In some studies of persons with severe mental health problems, the prevalence rate for previous experiences of emotional or physical neglect or physical abuse is as high as 82% [27]. While we know that psychological traumas lead to experiences of disempowerment and disconnection from others, through the therapeutic alliance, people can be enabled to experience empowerment and social/emotional connection. It is through these connections that the healing process becomes possible [28].

Bolsover ([29], p. 12) describes talking as a safe base: 'Putting what he wants help with into words may be a secure base experience, as what might seem vague and threatening becomes clearer when spoken'. Similarly, the nurse can create another secure base by responding in a way that makes the service user feels listened to and understood. Bolsover also describes the importance of talking, noting that it is part of our history from the time of the writings of the Icelandic Sagas to Freud. He refers to the open dialogue approach ([30], see also other references by Seikkula in this chapter), in which the aim of the dialogue is not to interpret what the person means but to listen, accept and engage in a quest to understand together [29].

5 The Core Characteristics of the Therapeutic Alliance

In the following paragraphs, we try to describe some of the content of the therapeutic alliance, but it should be remembered that despite the well-known and recognised importance of the therapeutic alliance, there is still a need for more research on the topic, to provide evidence, especially within nursing and specifically within mental health nursing [31]. The following discussion and categorization should be considered as a theoretical attempt to describe some characteristics of the therapeutic alliance. However, in practice it is an everchanging and developing relationship with a variety of moving parts, such as thoughts and feelings that are happening, affecting, overlapping and being experienced together and separately. Several different descriptions and categorizations of the characteristics can be found in the research literature, but here we concentrate on the two we think catches the very essence of this phenomenon, namely, trust and empathy.

5.1 Trust

The idea of the therapeutic alliance as a safe base is important if we think about the situation from the viewpoint of the person seeking help. There are several factors which could affect how this alliance begins and flourishes from the first encounter. At times it has been assumed that the person who seeks help from the mental health care services is willing to open up and disclose her/his whole story to a stranger, 'the professional'. But of course, we all choose what we disclose, how we disclose and to whom. Self-disclosing as well as stepping into the therapeutic alliance demands trust. Wampold emphasizes [15, p. 270] the importance of the first meeting and trust in the following way: 'The initial meeting of patient and therapist is essentially the meeting of two strangers, with the patient making a determination of whether the therapist is trustworthy, has the necessary expertise, and will take the time and effort to understand both the problem and the context in which the patient and the problem are situated'. This description resonates with Peplau's [8] ideas of the nurse being a stranger in the initial phase of the relationship. It is also similar to Johns' [32] analysis of trust, in which she describes the ongoing process of assessing and deciding whether to trust or not. All encounters between nurse and service user are important from the viewpoint of trust, as the process of assessing and deciding whether to trust continues all the time, but the first encounter is especially significant [33].

Trasmundi and Philipsen [13] describe trust as an expression of good therapeutic alliance, a successful human interaction in general. In mental health nursing, we know that many service users have had traumatic experiences in their past—times when it has not been wise or possible for them to trust another person or develop a secure attachment, such as living in an environment or family context which is unsafe (e.g., [34]). Previous negative experiences in social and healthcare services, including the mental health services, might also have corroded trust, and therefore it takes time to reconstruct and regain the trust via new positive experiences [33]. Sometimes the difficulties of trusting become visible in avoidant behaviours, like no-shows or arriving late to prearranged appointments or in difficulties with sharing personal information. Sometimes these kind of challenges with trust could have shadowed many relationships of the service user. These occurrences should make practitioners and nurses stop, think and question what is happening in these situations. What history and story might this behaviour be reflecting? Is it a sign of uncertainty and the service user not being able to trust? Is it even safe for them to trust in this situation? Is the service user unsure if I will be truly there for him/her? Am I worthy of being trusted? How have I treated service users who trusted me in the past? How have I listened and responded? In contrast to times when the person experienced distrust and lack of safety, the therapeutic alliance can be a safe base. When we as professionals are reliable and trustworthy, in our talks and actions, we give the service user another kind of an experience.

If as mental health nurses we look at trust from the viewpoint of psychotherapy research, some notions on attachment styles might also inform our practice. Some connections are described with different attachment styles and readiness for psychotherapy, such as connection between the avoidant attachment style and trepidation towards relational aspects of psychotherapy [35] and on the outcomes of psychotherapy [36]. Adult attachment styles might also be connected to the manner in which people use mental health services; persons with insecure attachment are more likely to use a wide range of mental health services, while persons with anxious attachment preferred to use chat rooms or internet support groups [37]. In practice APMHNs can use this information when working with the service user to decide together on the type of a connection that would be most helpful and the type of help that might best suit the person needs.

5.2 Empathy

Empathy is considered another key characteristic of the therapeutic alliance, a prerequisite for attempts to understand the other persons experiences and a necessary part of the nurse's competence to work therapeutically in mental health (e.g. [38]). Van Dijke et al. [39, p. 7] view empathy as relational, and therefore they suggest four different but interrelated perspectives on empathy: '(a) A co-creative practice of both the empathizer and the empathee; (b) An experience that is fundamentally other directed without losing the connection with oneself; (c) An interpersonal process that is bi-directional, interactive and dynamic and that requires continuous attunement and responsivity; and (d) A quality of a relationship in which empathy can flourish based on qualities such as openness, relatability and trust'. Wu [40] describes four types of empathic interactional sequences, discovered by conversation analysis, namely, cognitive, affective, sharing and nurturant empathy. Wu concludes that empathy establishes a caring environment in which nurses aligns with service users, and this is more than expressing understanding. Wu's [40] conclusion reflects the perspective of Rogers [22] on empathy being an attitude rather than a set of techniques and empathy also having a connection with 'unconditional positive regard' mentioned earlier in this chapter. The amount of literature on empathy is extensive, and often it is mentioned that no consensus has been reached on what exactly it entails, but Eklund and Meranius [41, p. 306] in their review conclude with the definition: 'Empathy is to understand, feel, and share what someone else feels, with self-other differentiation'. Self-other differentiation is an important part of empathy. While empathy provides us with a possibility to understand, feel and share experiences with another and to experience compassion satisfaction, it also exposes us to the risk of compassion stress, compassion fatigue and vicarious traumatization [42].

6 Communication as a Key of Therapeutic Alliance

The therapeutic alliance is developed and nourished in the relationship through various forms of interaction and communication. As Transmundi and Philipsen [13, p. 24] suggest therapeutic alliance is 'intertwined with interaction and develops with changes in interaction'. A person-centred interaction style, incorporating listening with the asking of questions focusing on emotions, strengthens the therapeutic alliance [43]. Communication is easily thought of as synonymous with speaking, but it also includes non-verbal communication. Gestures, positions, utterances and facial expressions support communication; however, they can also be in contradiction or incongruent with what is being said or signalled to the other person. Our attitudes, values and emotions are reflected in our talk and in non-verbal forms of communication. And again, this applies for all persons involved in the therapeutic alliance, the services user/s and the nurse, or if the client is a family or a group, there are several relationships with various forms of communication occurring at the same time. We are often not conscious about our own communication or the communication of others, and we can also misinterpret 'the message'. However, as professionals we have an ethical responsibility to educate ourselves to be more conscious on what is happening to, and in, us and to enable the development of our personal and professional knowledge as well as communication skills.

From the viewpoint of verbal communication, Pinto et al. [43] described factors that are positively associated with the therapeutic alliance; these are the ability to discuss options with the service users, ask their opinion, a willingness to encourage them to ask questions and an ability to answer service users' questions clearly and explain what service users need to know. All these factors seem to be very self-evident, as parts of any well-structured communication, but in reality, it is often not so simple. For example, from the viewpoint of language, Bertelsen and Boe [44] describe the risk associate with professionals not using the language of the service users, but teaching their therapeutic language to them. They introduce the terms 'rational community' and 'the community of those with nothing in common' (p. 368). If we borrow this idea and apply it in the context of mental health nursing, our professional community with its language, ways of working and practices could be referred to as a 'rational community'. And the non-predictable, unique moments with service user forming 'the community of those with nothing in common', a community in which something new can emerge with time and space. When we speak with our professional terms, regardless of how well meaning it may be, we are inviting service users to a 'rational community', to a community which is familiar to us, but maybe not to them. In doing so we run the risk of losing something important that exists outside the professional framework that we use. These two communities are not completely separated, neither are they options that we can choose from, but they are different ways of being connected [44]. Bertelsen and Boe's [44] ideas raise many questions about whose language and communication is heard in the therapeutic alliance, while Anderson [45] reminds us that professionals should at all times enter the therapeutic relationship as learners, giving the service user's language and meanings primacy at all times.

We mentioned earlier in this chapter that the therapeutic alliance is not a stable phenomenon, but rather a living, dynamic process involving two or more persons. From the viewpoint of non-verbal communication, there are several issues to address. The main principle to keep in mind is the uniqueness of the participants and the situation. There is not, nor should there be, a cookbook to tell us how to provide 'positive facial expressions' or 'trustful body-language' [13, p. 24]. 'Little things', such as micro-affirmations, matter as they have an important role in improving the sense of self in recovery processes, for example, by supporting the person's feeling of being like others [46]. Arnold [47] describes the meaning of *mm-hmm*, an utterance we often use in therapeutic communication without even noticing. This utterance has its role in maintaining the structure in the communication of the relationship, while it could also be considered as stereotypical. He describes how his writing about the issue decreased his own use of this utterance in practice after becoming more self-conscious about it [47]. This is a good example of how our awareness of our communication patterns give us an opportunity to make changes, if needed, and the importance of reflection in developing our communication.

In developing a therapeutic alliance, the participants, as in all human encounters, are present, as a whole person, and therefore we also need to understand therapeutic alliance as a profoundly embodied phenomenon. The body-mind division based on the cartesian ideas of dualism should not guide our thinking but rather the more holistic viewpoints and understanding of the intercorporeal experience of the therapeutic encounters. French philosopher Merleau-Ponty (1908–1961) is often mentioned as the most influential existential-phenomenologist bringing the meaning and importance of the body forward [48]. Jensen et al. [49] followed the ideas of Merleau-Ponty in their study on we-ness, the 'we experience' in the context of psychotherapy. They describe this experience as 'the notion of we-experience rests on the assumption that we develop an interpersonal self in which we not only experience ourselves in our interaction with others, but also experience the other's perspective on ourselves as part of our own experience' [49, p. 4]. Thomas [50] suggests that the philosophy of Merleau-Ponty is something mental health nurses could examine more as it could give new inspiration for their clinical practice because of its connection with today's humanistic- and recovery-oriented thinking.

There is extensive literature on the concept of dialogue (which could be also considered as a part of the therapeutic alliance), so we provide a short glimpse into some aspects. Guilfoyle [51] suggests that for a dialogue to occur. There must be a true commitment to engage in joint discussion and willingness to hear all parties' perspectives, with a view to collaborative decision-making. Dialogue is not only about spoken language, and turn taking, but it is a wider phenomenon including the abovementioned concept of embodiment and 'being at the present moment' [52]. It is a condition for understanding [53]. Together with the idea of dialogue, the concept of voices is often presented, following the ideas of Bakhtin [54]. The 'inner' and 'outer voices' of participants are all the time present in the dialogue, and together they create a polyphony of voices [55]. All the participants of the therapeutic alliance, whether it is an individual, family or group, participate to this polyphony of voices. Polyphony is both horizontal and vertical; it is horizontal between participants and between their outer voices and at the same vertical from the viewpoint of each one's inner voices [56]. For example, from the viewpoint of the professional, there is not only his or her professional voice but also the personal, more intimate, inner voice present in dialogue. The inner voice is not spoken aloud but it enables adaptation to the present moment [52]. This understanding of dialogue with many voices leaves space for professionals 'not knowing' [45] and enables different voices to be respected, listened to and heard in an equal manner, thus strengthening the therapeutic alliance. Reflection enables the awareness of our vertical polyphony, the inner voices [57], the co-creation of knowledge as well as the emergence of new understandings [58]. We will return to the importance of reflection, from the viewpoint of self-reflection and professional practice, after describing some possible pitfalls within therapeutic alliance.

7 "Mind the Gap": Some Possible Pitfalls and Challenges

In mental health nursing, the issue of power is always involved as one person is seeking help and the other one is trying to provide it. Unfortunately, power remains often invisible in mental health care [59]. But power can be experienced in many ways, via language or nonverbally [60]. It could be argued that the more competent we are, the more knowledgeable we should be about the language, words and terms we use in our work with service users. For example, if we refer to the service users by their diagnoses, using categories such as 'schizophrenics', we are not only supporting the use of a stigmatizing term, but we are also defining that person by their diagnosis, which prevents us even "seeing" the person we are working with, the whole person behind and beyond the diagnosis. Language such as this might prevent us from seeing the daughter or son; the mother or father; the person who might be worried about his/her income, employment or health or the avid supporter of the local sports team. If a diagnosis-based approach guides our thinking towards the biomedical model and framework (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"), there is a risk that this reductionistic view of the person becomes overly dominant and we fail to look beyond a diagnosis; as a result we stop addressing the individual persons needs and start 'treating' their problems as they are defined by us. It is our ethical duty to use power in a positive way, to support the service users' recovery journeys, with a collaborative therapeutic alliance at its core, not the opposite.

As said power is ever present in communication. Many individuals seeking help in the mental health services have traumatic experiences in their past. As the core of our work as mental health nurses is based on listening and empathy, listening to traumatic experiences also increases our risk of compassion fatigue and silencing responses. Baranowsky [61, p. 156] writing on compassion fatigue and working with trauma survivors describes silencing responses as the times 'when the stories are overwhelming, beyond our scope of comprehension and desire to know, or simply spiralling past our sense of competency. That is the point at which we may notice our ability to listen becomes compromised'. Sadly, this is also reflected in our communication and leads us to 'redirect, shutdown, minimize, or neglect the traumatic material brought by another'. To provide good-quality care in this and other contexts, it is important to pay attention to our internal processes and notice with self-reflection this risk [61]. It is through reflection-in-action and on action that we will enhance our skills to minimize such missteps.

In the chapter on "Diversity and Culturally Responsive Mental Health Practice", the term cultural humility is used to increase the understanding of ways of being with other human beings and thus enabling health equalities. In that chapter the term microaggressions is described, a term which again increases our understanding on those issues in communication, e.g. previously mentioned silencing response and other prejudicial occurrences that may take place during an encounter. Additionally, Topor et al. [46] reminds us about the risks of invoking service users' experiences of microaggressions even though our purpose might have been rather to be positive and micro-affirmative.

From the service system viewpoint, practices based on the therapeutic alliance might be difficult to actualize if we do not share an understanding on its importance to every dimension of mental health care. This also challenges people in management and leadership positions to understand the value of the therapeutic alliance as core to the provision of high-quality mental health care [62]. Unfortunately, today there are sometimes care models with limited number of appointments and with highly manualized content that might not allow for the true person-centred approach—models which could therefore be criticized as lacking awareness regarding the centrality of the therapeutic alliance.

From the individual viewpoint, we can stop and think about therapeutic contexts from several different viewpoints. Within the therapeutic alliance, things like the life situation of both the service user and the nurse, previous experiences in the healthcare services and specifically in mental health care settings and other outside factors might influence the present encounter. Previous experiences might increase or decrease trust towards the help received from nurses or other professionals, and therefore every appointment or every encounter is important and might affect later help-seeking [33]. Previous experiences are also important for the nurse as his/her experiences might increase or decrease personal trust around his/her professional competence, which again could be affected or is affecting at the private, personal level. Therefore, self-reflection, support from colleagues and clinical supervision are highly important in enabling us to learn more about ourselves as part of our never-ending personal and professional growth journey, which at the same time is critical to enhancing the quality of care we provide [63–65].

8 The Importance of Self-reflection

Reflection is an extensively studied concept, but there is no consensus on what exactly it entails. The most known are Schön's [66] ideas of 'reflection-in-action' and 'reflection-on-action'. Reflection-in-action refers to reflection that occurs simultaneously to action, while reflection-on-action refers to reflection after the action or incident takes place. Reflection-on-action is often considered the basis of reflection in clinical supervision. However according to Rolfe [67], there is place for both retrospective reflection-on-action and reflection-in-action in mental health nursing. In his view reflection-in-action enables service users to be active and autonomous partners in the therapeutic alliance.

For example, our own experiences in caring and/of prior therapeutic relationships might have played a part when we chose our profession, especially in mental health nursing or as APMHNs. The prerequisite for a career in mental health nursing, especially as an APMHN, is to be interested in people and relationships. Of course, we are oversimplifying here; there are as many reasons to become an APMHN as there are nurses, but to be engaged in the therapeutic alliance with another requires us to retrospectively reflect and journey through our own history, our own 'emotional backyard'. We need to understand how difficult it may be for ourselves to engage in the therapeutic relationship, to trust and be trustworthy with the persons coming to us for help [34]. 'The backyard' in this context also includes the not-so-nice parts, the not-so-flattering aspects of our personalities, the shadow side which needs to be recognized, acknowledged, processed and understood. This is an area where we need to grow continually as humans and as professionals, and in the clinical setting, we need to comprehend how it affects our ways of working in the therapeutic alliances. When we acknowledge and familiarize ourselves with our dark sides, we also make it possible for service users to reveal theirs to us. In any given therapeutic alliance, we are then able to signal our willingness to listen and our ability to be present and to address even very difficult issues with and for the service user and/or ourselves [68].

In the professional settings, it is our responsibility to reflect, explore and try to understand what prevents the formation of the therapeutic alliance. It is much easier to assume that anything that hinders the development of the alliance has to do with issues from the service user's backyard, rather than our own. However reflecting on the barriers within ourselves that affect the development of the therapeutic alliance is central. These barriers could be several, and although it might be very hard to have an open and curious mind, recognizing, accepting and addressing our own barriers over time is necessary. At all times we should strive to have a "professionally curious mind" and reflect on the situation from different perspectives without searching for someone to blame [69]. Sometimes we work with service users who have done things we cannot approve of, but as APMHNs we need to be ready to work on the therapeutic alliance together regardless of this. We need to see the human being despite the things he/she has done and to differentiate between the action and the person or the 'sin' and the 'sinner' to use language that may be familiar to some. And if we are not able to work with an individual for some reason, then it is our professional and ethical responsibility to make sure someone else works with the service user, as he/she is still entitled to the best possible care available.

While reflection-in- and reflection-on-action may sound easy in theory, it is not something that we do once and then just continue to practice automatically. From the perspective of the therapeutic alliance, it is an area, like other aspects of practice, that we have a professional requirement to update our knowledge, to develop our skills, recognize and challenge our attitudes again and again and learn more about the service user and ourself in each encounter. While reflection can be very rewarding, it demands courage [70]—courage to look at the self in a critical yet compassionate manner and courage to seek and honestly look at and accept feedback.

9 Therapeutic Alliance and Y Model

In 2009, Plakun, Sudak and Goldberg published an article on the Y model. The authors' goal was to '…develop an integrated model for teaching psychotherapy competencies across schools of therapy' [71, p. 5]. The model is born out of an effort to organize psychiatric residency training in diverse psychotherapy models in North America. It is based on the letter Y with the stem representing core features and common factors from different schools of therapies, such as represented by fairly generic interventions and approaches, such as supportive psychotherapy and motivational interviewing. One of the main ingredients of the stem of the model is the therapeutic alliance, the foundation which all other therapeutic work rests on. The two 'branches' or 'arms' of the Y represent cognitive behavioural therapy (CBT) on the one hand and psychodynamic therapy (PDT) on the other hand. But numerous studies have found that even very different schools of thought within psychotherapy can give similar results, one example being the similar efficacy of interpersonal psychotherapy (IPT) and CBT when treating adult depression [72]. The Y model based its premise on various aspects of the comparative psychotherapy process literature, but studies have found that very different psychotherapeutic approaches have a great deal of factors in common [15]. For APMHNs the Y model could prove extremely useful from a practice and educational standpoint as the stem of the model mainly focuses on what different approaches have in common, and how they can be integrated within the therapeutic alliance. The Y model could also possibly prove itself useful for the APMHN for professional career planning and educational development.

10 Challenges to Researching the Therapeutic Alliance

Our understanding today about learning goes beyond formal learning, as we learn all the time; each encounter and every therapeutic alliance we form teaches us more. When we consider the therapeutic alliance between the service user and the nurse, we can study this setting from the viewpoint of both individuals and the relationship between them. In this sense there are three things to focus on: two persons and the therapeutic alliance. However, this is a simplistic picture from the research viewpoint as the therapeutic alliance does not occur in a vacuum, but unfolds in a real-life context. Interestingly Peplau also had a wider, societal viewpoint in her theory of interpersonal relations in nursing [3]. There are several contexts of therapeutic alliance, e.g. the societal, cultural and political context in which service systems operate. Other contexts, such as the philosophical and theoretical approaches adapted and governing the service provision, as well as the individual contexts of both the service user and the nurse, their families and networks in which they are part of, all play a part. They are all present in the therapeutic alliance, although we do not always consciously think of them. Therefore, from the research viewpoint, the therapeutic alliance is an interesting but challenging concept to study, as it is reborn in each therapeutic encounter and thus forms a multilayered, amoebic phenomenon, which is hard to capture, especially from the viewpoint of effectiveness or efficacy. It could be argued that the value of the therapeutic alliance is not counted in measurable quantities, such as the number of meetings, length of time or other measures, but its value lies in the quality, the value given to it by those involved and thus making the research on it even more challenging. The therapeutic alliance is after all a process, and a process is always challenging to study as Bøe et al. [73, p. 76] indicates; 'yet a result is never finished, because life never slows down or takes a break'.

Case Vignettes. The Bubbling Body and the Hot Shower

Several years ago, I decided that all my research should be done together with the people the research was about, so I engaged with patients in a Psychiatric Intensive Care Unit and involved them as co-researchers. The patients knew why I was in the unit, and one afternoon, when I was sitting in the dining room, Sandra came and asked me: 'are you the one doing research about mechanical restraints?' I replied: 'I am'. Sandra continued: 'You know what, yesterday I got very upset, I just felt my body was bubbling, and I thought, they might put me into mechanical restraints, and then everything turned black. You know, I have been in mechanical restraint many times, but something new happened yesterday. Yesterday was a nice day, because instead of using a belt, Ingrid, the nurse, whom I know very well, we resonate, she said: you know what Sandra, you look very sweaty, maybe you need a hot shower?'

I kept silent while I was listening to her story. Then I thanked her for telling me about her experience and told her that I would be in the unit every day for the next period if she wanted to talk to me again. When I arrived the next morning, she was waiting for me in the dining room. She asked me: 'do you think my story was alright?' I replied that this was an important story, especially the part about how the nurse suggested a shower.

Sandra continued: 'I had not thought about it (a hot shower) at all, my body was bubbling, but the shower was nice, and I avoided mechanical restraint, but do you think Ingrid is angry at me?'

I have recalled this dialogue many times, and the role of the professionals when patient's share their history. Firstly, the patient told me about a professional and caring person, whom she trusted, 'who resonated' and who helped her regain self-control by suggesting a hot shower. This illustrated an authentic nurse, who intervened positively and professionally and looked beyond the persons behaviour addressing the persons personal needs. Secondly, by allowing me to listen to the story several times, the patient showed confidence and trust in me, which thirdly, might support the patient's personal recovery journey, as recovery is supported when patients tell their story to someone who listens. It also underlines how important it is to return to the patient in order to re-establish the mutual relationship and the therapeutic alliance, as the patient will worry about the caring persons feelings.

This incident was a crucial moment in my professional life, and always reminds me that apparently small interactions with patients can have large and important impacts.

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Clinical Vignette for Therapeutic Relationship

Ellen is 14 years old with a 6-month history of anorexia nervosa and has arrived for her initial assessment. The nurse opens by explaining that many people are secretive about their intake and activity levels because everyone they tell says it is bad for them and they should give it up. However, this interaction is different. The nurse begins with the opening line ‘I think I know why you do this?’, ‘It’s because it helps doesn’t it’. This surprises Ellen and she listens. The nurse goes on to explain that when our lives feel overwhelmed and out of control, we all cling to something that we can exercise some control over, as it makes us feel better. The nurse hypothesises that Ellen’s life may have felt overwhelming and therefore turning to anorexia for containment was understandable. The nurse explains that at the start when anorexia is coaching us to eat less and move more, it is very pleased with us when we do. This positive reassurance is very nice when we feel alone and helps us to feel better. But then the support becomes more hostile, doesn’t it? Then anorexia is no longer coaching us to feel in more control, it is controlling us now, and that feels less safe. Ellen nods her head and agrees.

The purpose of this engagement is therapeutic buy-in. Ellen thinks the nurse is going to criticise her and tell her to eat more and gain weight. After all that’s what everyone else has said. But he doesn’t tell her that he knows something about what she feels. He acknowledges how seductive anorexia can be, and most importantly he explains how it might make her feel. This feeling of being heard and understood allows Ellen to feel safe. She knows now someone understands what life is like for her. They are not demanding change or being nagging. They are showing empathy, understanding and a willingness to listen. This allows Ellen to feel understood and heard. These are the two foundational blocks of any therapeutic relationship, particularly in adolescence where they have a preconceived idea that adults just don’t get it.

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11 Conclusion

In this chapter we have described the therapeutic alliance from different viewpoints, acknowledging that much has been left unsaid given the enormity of the subject within mental health nursing. At the same time, the writing process has been a learning process, an attempt to develop shared understanding from both of our viewpoints on what the therapeutic alliance means for different people, with different educational backgrounds and different personal histories.

For APMHNs and future APMHNs, this chapter hopefully enhances and increases understanding of the importance of the therapeutic alliance, so that they integrate some of the thinking it to their practice with service users and families, as well as educating and supporting colleagues in this effort. Demands of professional and ethical competence are high, and at the same time there is a great opportunity to learn more by self-reflection and, hopefully, with the help of clinical supervision. If an APMHN is trained in clinical supervision (this depends on the country and education systems), they can also provide clinical supervision to others to enhance the quality of their therapeutic alliance in future encounters.

In many European countries, there seems to be a strengthening voice of psychotherapy as the primary choice in psychosocial care, although it is at the same time recognized that psychotherapy is not an answer for everything. In this chapter we endeavoured to highlight some aspects of the therapeutic alliance to encourage and remind APMHNs about the priority of the therapeutic alliance in mental health care, as a core competence of their clinical practice.

Reflective Questions

- What kind of experiences do you find together about the therapeutic alliance, from both the service user's and your standpoint?
- What feelings and emotions do you experience during the therapeutic alliance and what aspects of your personal or professional life do they resonate with?

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Advanced Mental Health Nursing Assessment, Formulation and Decision-Making

Diana Polhuis and Annmarie Grealish

Learning Objectives
The objectives of this chapter are to enable you to:

- Discuss how recovery, trauma-informed care and strengths-based approaches influence your assessment, formulation and collaborative care and treatment plan.
- Explore the use of interview methods, observations, frameworks, symptom inventories, and tools in terms of reliability, validity, specificity and appropriateness for assessment.
- Develop a critical awareness of when and how to employ psychological formulation and its relationship to the person's presented problem.
- Explore how advanced mental health nursing assessment, also called intuitive and analytic clinical reasoning, in combination with collaborative approach and critical thinking leads to good clinical decision-making or clinical judgement.

1 Introduction

(Self)-management of strengths and resilience is a necessary foundation of physical, social, and mental well-being. When a person experiencing a mental health problem calls upon an advanced practice mental health nurse (APMHN) to support their recovery, understanding what happened to the person and how their strengths

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and resilience can be regained or improved is crucial. In the field of mental health, assessment permeates all aspects of nursing care and is considered a central activity and a high priority for APMHNs' clinical practice. APMHNs are therefore expected to be competent in their holistic assessment and decision-making. Conducting a holistic assessment is, therefore, crucial for good clinical decision-making, the foundation of effective mental health care, treatment and a recovery plan. An essential part of the assessment is to collect good information as it is not possible to understand the person's experiences or problem(s) without good information. As assessment typically leads to a formulation of a plan, developing a collaborative individualised treatment plan is not possible without a detailed and shared formulation of the person's presented problem(s) and a discussion on goals of treatment. Communication is a key element of the assessment and represents the bridge between the person's perspective and the APMHN's theoretical framework and professional perspective. This chapter aims to provide information on the communication skills as well as assessment frameworks and tools that can be helpful to APMHNs in assessing people's mental health and well-being. Some practical suggestions and examples that can make interactions with people more effective and efficient are also provided. Within the chapter, clinical assessment and decision-making are divided into three different stages:

- In the first stage, we describe the methods of advanced clinical assessment in mental health practice and how the APMHN helps the person to explore, define and clarify their problem(s). This also includes communication skills that enables collaboration with the person.
- In the second stage, we discuss why we should use existing classification models to support clinical reasoning.
- In the third stage, we focus on collaborative formulation and goal settings and decide how to achieve these goals.

These stages seldom occur all together or in one encounter or session, and as an assessment is an ongoing process, the APMHN needs several encounters to assess the person before commencing the more specific therapeutic phase. This awareness helps to give clarity and assists the APMHN in organising the sessions according to the specific aims that need to be achieved.

2 Advanced Mental Health Nursing Assessment

Advanced mental health nursing assessment and decision-making is understood as systematic evaluation of relevant information to determine what happened, how a person (and family) is functioning in relation to their (mental) health status and why and what can be done to improve functioning, strengths, resilience, (mental) health status and recovery. It is a process by which an APMHN engages and interacts with the person and their significant others; collects, selects and weights information; comes to a contextual understanding of the situation and makes collaborative clinical decisions, the so-called clinical reasoning [1]. These clinical decision-making or clinical judgements are about recognizing patterns and choosing between alternatives, based on knowledge gained from clinical practice, the expertise of the person experiencing the distress and scientific knowledge [2]. 'It is the depth of decision-making and critical thinking associated with clinical reasoning that distinguishes the advanced practice nurse from the generalist nurse and the registered nurse specialist' [3, pp. 75] or the specialized nurse.

3 Some Core Principles Underpinning Assessment

Quality assessment and clinical decision-making go hand in hand with the principles of recovery, trauma-informed care and strengths-based approaches which are now enshrined in most government policy internationally [4–6]. Recovery-orientated care recognises the person as the 'expert' through their own experience and supports autonomy, independence, collaboration, hope and attaining a meaningful life beyond the constraints of diagnosis [7]. A recovery approach also gives space to the persons voice and experiential knowledge [8]. Merging the experiential knowledge of the person or family with professional/practitioner knowledge helps the APMHN to understand complex situations [8] (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing").

Trauma-informed care recognises the high prevalence of historical trauma and adversity experienced by people accessing mental health services and the strong association this has with mental ill health [9]. This concept also recognises that people who have experienced trauma are more likely to experience distress and re-traumatization as a result of encountering the healthcare system [10] (see "Trauma and Trauma-Informed Care").

Good assessment and practice imply focusing on individual strengths, resilience and understanding the person as is described in the strength model of Rapp and Goscha (2014) [11]. A strengths-based assessment seeks a more balanced stance to assessment and moves away from traditional mental health assessment formats which are primarily structured to seek out deficits, problems and pathology and are not considered 'comprehensive,' instead a strengths-based assessment focuses on the resources of the person. Strengths-based approaches encourage exploration of the person's attributes, assets, abilities, resources, coping skills, past successes, goals and future hopes [12], which are also essential components for the recovery process [11]. Therefore, questioning styles concentrate, for example, on what the individual does well, what helped the person in the past, how the person coped through adversity and how the person envisages their life beyond their mental ill health [13].

The therapeutic relationship and alliance between the APMHN and the person are also primary and essential (see "Therapeutic Alliance"). Therefore, good communication skills are critical for the building of trust and an in-depth collaborative assessment. Using good communication skills in conjunction with models/frameworks allows the APMHN to obtain in-depth information on the persons experience and presented problem, signals an interest in the views and experiences of the person, stimulates the person's participation and collaboration, increases the reliability of the collected information and, finally, makes the consultation more effective. The communication style (both verbal and nonverbal behaviours) of the APMHN is one of the strongest criteria through which a person experiencing a mental health problem judges the nurses' attitude towards listening and their ability to understand their problems and provide help and support.

Shared decision-making is an important value. Shared decision-making is about introducing choices, describing options and helping persons with mental ill health explore preferences to make joint decisions [14] and is associated with a better quality of clinical reasoning and clinical decision-making [15]. Elwyn et al. offer three key steps for shared decision-making, namely, (1) choice talk, (2) option talk and (3) decision talk [14]. Through shared decision-making, uncertainties about treatment options can be addressed and the persons' ability to truly participate in treatment decisions enhanced [16]. Shared decision-making also contributes to person-centred care and meaningful goals by addressing the persons' needs, experiences, preferences and life purposes. In addition, shared decision-making supports the persons' recovery process by promoting their engagement and responsibility for their own care, treatment and health [17]. Although professionals sometimes think the opposite, impaired insight is not a limitation to shared decision-making. However, it requires more competences of professionals in engaging, communication and motivation [18]. For example, engaging may require more time spent on demonstrating possible benefits of a particular approach, or not giving up on someone.

Involving family or significant others in the assessment process can improve the quality of contact with the person and the support provided to the person during the recovery process. When families are involved, communication and decision-making improve [19, 20]. Families can act as a social support network for the person by providing positive expectations and hope, as well as being a close partner with the APMHN in achieving the recovery goals [19].

Assessment also requires clear communication between the multidisciplinary team members and clarity about roles and responsibilities [21]. In addition, due to the relevance and value of experiential knowledge, support from peer workers in mental health care is increasing [22], and they are also becoming part of the multidisciplinary team.

4 Types of Information or Data Collected

In assessment several kinds of data are collected. If collected and used in a fluid manner during the whole process, it makes subtle and continual adjustments possible. Whilst the following types of data are recommended, the information should be always validated by the person and when appropriate by the family or supporters.

1. Previously *known data*. We often use data from early assessments, reports or summaries of former treatments. Using this data can misrepresent the current situation. People, circumstances and insights can and do change. And, if not verified, there is a risk that some older misinterpretations keep circulating unduly.
2. *Psychiatric and medical data*. This includes review of psychiatric symptoms, trauma history, development and life history and psychiatric treatment history;

substance use assessment; risk assessment of suicide and aggressive behaviours; assessment of cultural factors and social context; assessment of physical health (including physical examination) and use of medication as well as a comprehensive mental status examination (cognitive, affective and conative functioning).

3. *Nursing data*. Nursing data provide information about the pattern in a persons' daily functioning related to health condition and well-being [1]. This includes review of feeling safe, stable and secure and satisfaction about health, living, leisure, education, work, meaningful daily activities, maintaining meaningful relationships, sexuality and intimacy, self-development and spirituality. Specific knowledge about aspects such as, coping resources, strengths, resilience and experiential knowledge, in combination with knowledge about psychopathology (including somatic functioning and psychopharmaceutic therapy), self-efficacy and self-management, is a necessary foundation for the APMHN.
4. *Routine outcome monitoring data*. This is data systematically collected by validated questionnaires about health problems, daily functioning and needs, risks and quality of life. Routine outcome monitoring data can also be collected by using questionnaires to focus on specific aspects, like trauma-related symptoms or forensic risk assessments. Routine outcome monitoring data may help evaluate the progression of care and treatment.
5. *Additional data*. Sometimes more in-depth information is needed for a good understanding of the situation, for example, an intelligence or personality assessment, psychological tests or information about the social-emotional development.

5 Methods of Advanced Clinical Assessment in Mental Health Practice

This section describes some strategies or methods to enable the person to tell their story and support the collaborative process. Across clinical and research domains, methods of mental health assessment and diagnosis are carried out using clinical interviews, observation and questionnaires.

5.1 Clinical Interview

An essential part of any assessment is the data gathering process; without good information it will not be possible to understand the person's problem(s). The key aims of the clinical interview are as follows:

- Build the therapeutic relationship and respond appropriately to the person's emotions (relational skills).
- Develop an insight and understanding of the persons story or problem (data gathering skills, see Box 1).
- Support the person to explore their experience, develop an understanding of their experience and develop strategies to enhance and maintain wellness (information-giving skills, negotiating and motivating strategies).

The best way to support the person to tell their story and elicit information is by asking 'careful' questions and using reflective listening. Box 1 outlines some useful communication skills which are fundamental tenets of the therapeutic alliance. Used capably in assessment by APMHNs, they can enhance the quality of the assessment and interactions (Box 1 and Fig. 1).

Box 1 Core Communication Techniques Required for APMHNs for Good Interviewing or for Gathering Data Effectively

- **Open-ended questions**: Using open broad questions particularly in the early stage of the assessment encourages the person to freely tell their story and gives the APMHNs time and space to listen and think about the person's problem and story rather than thinking of what to ask or explore next (e.g. 'can you *tell me more about the*…'). Thinking about the five Ws is a useful framework for questioning (see Fig. 1): *What*, *Where*, *When*, *Why* and *With whom* supports the person to answer questions in an open way.
- **Closed questions:** Imply a yes or no answer or a forced choice between two or more options. These are useful, if skilfully used, to investigate specific areas and to analyse issues in detail. Closed questions can discourage the person from talking and can be traumatizing if paced incorrectly. Therefore they should be well balanced and used in the interview only after the person's presented problem(s) has been explored and a good relationship established.
- **Verbal and non-verbal cues:** Observing verbal and non-verbal cues help the APMHN to pick up the person's body language, facial expression and vocal cues and allows the APMHN to acknowledge appropriately and check out their possible meaning.
- **Listening (active, reflective)**: These are skills for information gathering but also for building and reinforcing the therapeutic engagement. Listening is more important than speaking especially when trying to give the person space to think about things that they may have not been previously disclosed. Listening attentively allows the person to complete statements without interruption and leaves space for the person to think before answering or proceed after pausing. Therefore, listening carefully is an essential skill to guide the person through their storytelling. There is little benefit in asking questions if you are unable to listen properly to the answers.
- **Passive listening (non-verbal responses)**: Passive listening includes the appropriate use of silence and use of non-verbal and verbal facilitation such as nodding, use of eye contact, adopting attentive posture, shaking your head and facial expressions. The use of pauses, brief silence and waiting time helps the person to express thoughts or feelings that are occurring inside their mind at that time and can also facilitate the person to tell you more.
- **Clarification**: A simple verbal skill (e.g. 'Could you explain what you mean by…') can help you fully understand what the person is telling you as it is important to check the person's choice of words or expression which often can be vague or have different meanings or need amplification.

- **Paraphrasing**: Listen to what the person is telling you, interpreting the meaning into your own words, and repeat this back to the person, for example, 'It sounds as if you're worried that you won't be able to cope on our own'. This is an important skill as not only does it ensure you are interpreting correctly, but it gives the person further opportunity to clarify.
- **Reflecting**: This encourages the person to clarify further or expand on the information and enables you to check that you have accurately understood what the person said (e.g. 'I'd like to sum up with you what you said so far…'). Here you are letting the person know that you are listening by reflecting what they have just said (content and emotional tone). Using reflection can also encourage the person to reflect on their feelings or experiences.
- **Summarising**: This is the deliberate step of making an explicit verbal summary of the information gathered so far and to verify one's own understanding of what the person has said. This invites the person to correct interpretation, provide further information, facilitate the comprehension and improve the relationship. This strategy is useful if used periodically during a session or at the end of a session as a way of ensuring the accuracy of the information gathered. It also communicates that you have listened and fully understood the issues that are important to the person.
- **Facilitating:** Facilitating the person's responses verbally and non-verbally indicates to the person that you are interested in what they are saying (e.g. 'Hmm', 'ah', 'I see,' 'yes', facial expressions such as nodding and smiling, silence, paraphrasing) and can make them feel listened to, understood and supported. It also encourages the person to say more about the topic and let them continue freely in their narrative, for example, 'Can I just see if I've got this right? You've had thoughts about…is that right?'
- **Language (avoid jargon)**: Using concise easily understood questions/statements and the avoidance of, or if used the explaining of healthcare terminology/jargon is important. Try to make the person feel at ease, for example, by making empathic comments when the person is worried about their ability to clearly explain the problem(s) (e.g. 'It can be difficult to talk freely about our feelings but every word coming up in your mind may be useful and important to help me better understand what you are feeling in this situation').
- **Reformulation**: This strategy lies between data gathering and information giving. Reformulation is mostly related to the content expressed and combines elements of clarification, facilitation, summarising and reflections. Here you are adding something new or some educational or therapeutic messages, for example, showing the linkage between events and emotions, for example:

  Client: *I am so worried...what happens if I can't breathe on the bus…or get another panic attack on the bus…*

  APMHN: *What you are telling me is that you are worried that you might experience another panic attack if you go on the bus again…*

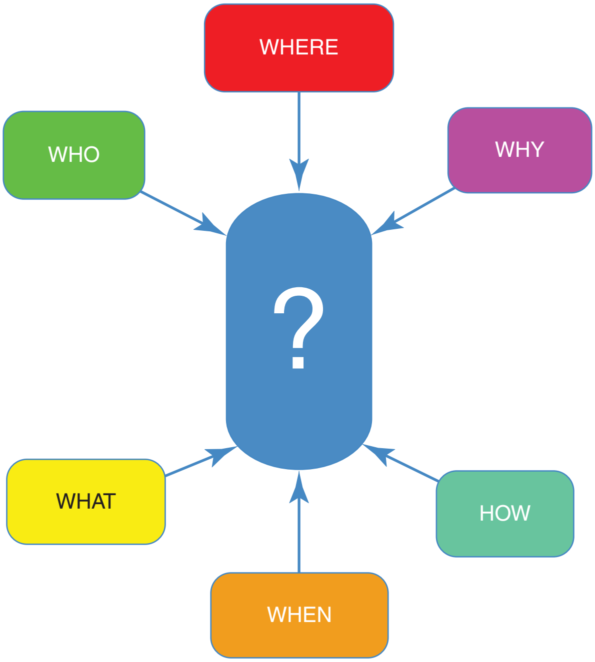


Fig. 1 The Six Ws

Table 1 Four-step model of relationship-building communication

PEARLS	SOLER
Partnership	**S: Sit squarely** to the person
Empathy	**O: Open posture**, not crossing your arms or legs
Acknowledgement	**L: Lean** slightly forward
Respect	**E:** Maintain **eye contact** without staring
Legitimization	**R: Relax**

These specific interpersonal skills need to be combined with the four-step model of relationship-building communication using the acronym PEARLS [23] and non-verbal communication cues [24] and awareness of these cues using the acronym SOLER [25], see Table 1. Where possible, an assessment interview should be conducted in a private room, with both the person and the APMHN comfortably seated in chairs of equal height, without being separated by a desk or table. In some situations, interviews may occur in the living environment of the person, especially in community or primary care. The needs of the person to feel as comfortable and equal as possible should be paramount.

5.2 Mental Health and Distress Assessment Tools (Questionnaires, Rating Scales)

Across the landscape of mental health practice, questionnaires and rating scales are widely used in routine clinical practice, clinical trials and research studies (see, e.g. Table 2). These tools are used to assess the presence, severity, frequency, duration and treatment outcomes for specific mental ill health and reflect the dominant prevalence of self-report tools in the mental health assessment literature [26, 27]. There is a diversity of choice when searching for questionnaires and rating scales to suit the needs for mental health assessment, and it can be challenging on deciding which tool to select for clinical diagnosis or evaluation or act as a guide for planning care [26, 28]. These tools must be assessed for their validity and reliability with which they measure a concept of interest, but they do not replace clinical decision-making. These tools generate quantifiable measures of human experiences and can build up a picture of the

Table 2 Some specific self-reported questionnaires commonly used in mental health assessment

Subject	Most commonly self-evaluation questionnaires in mental health practice
Psychosocial functioning and recovery	• Recovery Assessment Scale – Domains and Stages (RAS-DS • WHO Disability Assessment Schedule (WHODAS 2.0) • Dysfunctional Attitude scale (DAS) • Social Performance Scale (SPS)
Depression	• Beck Depression Inventory (BDI) • Hamilton Rating Scale for Depression (HRSD) • Patient Health Questionnaire (PHQ-9) • Beck's Hopelessness Scale (BHS)
Anxiety	• Beck Anxiety Inventory (BAI) • Generalized Anxiety Disorder (GAD-7) • Zung Self-Rating Anxiety Scale
Psychosis	• Positive and Negative Syndrome Scale (PANSS) • Psychotic Symptom Rating Scales (PSYRATS)
Bipolar disorder	• Mania Rating Scale (MRS) • Mood Disorder Questionnaire (MDQ) • Composite International Diagnostic Interview (CIDI) • Bipolar Spectrum Diagnostic Scale (BSDS)
Addiction screening tools	• Michigan Alcohol Screening Tool (MAST 25) • CAGE Questions for Alcohol Use (CAGE) • CAGE Adapted to Include Drugs (CAGE-AID)
Suicide risk assessment	• Suicide Behaviors Questionnaire-Revised (SBQ-R) • Suicidal Ideation Questionnaire (SIQ)
PTSD and trauma	• Clinical-Administered PTSD Scale for DSM-5 (CAPS-5) • PTSD Checklist for DSM-5 (PCL-5) • Impact of Event Scale-Revised (IES-R) • International Trauma Questionnaire (ITQ)
Eating disorders	• Eating Attitude Test (EAT-12; EAT-26) • Eating Disorder Inventory (EDI-1, EDI-2, EDI-3) • Yale-Brown-Cornell Eating Disorders Scale (YBC-EDS)

psychological problems and concerns faced by the persons with mental ill health so that the APMHN can in collaboration determine a diagnosis or problem formulation that will then determine a treatment or intervention regime. Questionnaires and rating scales have the advantage of being relatively quick to deliver and review the characteristics and severity of a person's thoughts, feelings and actions. However, when different APMHNs use different assessment tools during treatment evaluations, this practice has the potential to introduce variability and inconsistency in diagnosis or problem formulation. Similarly, when researchers use different questionnaires and rating scales in the assessment of symptom severity in studies or evaluating the effectiveness of new treatment or intervention, it has the potential to introduce variability which impedes attempts to demonstrate the validity and reliability of results across studies [26, 27]. Despite the large variety of assessment tools, mental ill health is reliant, first and foremost, on the way that a person's symptoms are assessed.

In addition to the assessment tools just described, there are other tools we can use to measure other outcomes related to health and well-being, needs, symptoms or quality-of-life aspects.

- The Manchester short assessment of quality of life (MANSA)
- The Manchester short assessment of quality of life (MANSA) shows outcomes in persons' satisfaction on several life areas about life in general, employment/retirement, financial situation, friendships, leisure, accommodation, personal safety, people living with, sex life, relationship with family, physical health and mental health [29].
- Gordon's Functional Health Patterns (FHP)
- Gordon's 11 FHP [1, 30] are related to nursing theories and provide a more concrete tool for assessing and organizing data about human functioning related to health and well-being. Gordon identified the following 11 FHP which can be impacted and dysfunctional in relation to the health and well-being situations:

    1. Health perception—health management
    2. Nutritional—metabolic
    3. Elimination
    4. Activity—exercise
    5. Cognitive—perceptual
    6. Sleep—rest
    7. Self-perception—self-concept
    8. Role—relationship
    9. Sexuality—reproductive
    10. Coping—stress tolerance
    11. Value—belief

The benefit of using the FHP is that data can be collected in an analytic and intuitive way. By asking themselves which health patterns are dysfunctional, APMHNs take their intuitive cues and pattern recognition into account [1, 30].

6 Mental Health Assessment and Decision-Making: Classification Models

There are many classification models available to support clinical reasoning. Some of these are nursing focused, and other are more aligned with the medical paradigm. Although not without critique, classification models/diagnostic categories in mental health practice are regarded by some as helpful for clinical practice and research as they offer a guide for treatment options and allow for outcomes to be quantified. In addition, they provide uniform language and can help in exchanging and collecting information at the level of the person experiencing the mental health problem, as well as at a policy or research level. In some countries, APMHNs prescribe psychiatric medications [31–33] which enables them to provide integrated diagnostics, care and treatment based on a strong therapeutic alliance [31, 32]. To do so, it is necessary that they formulate a psychiatric diagnosis, using medical frameworks, or be supervised for some years by a psychiatrist or an experienced APMHN. If classification models are used flexibly and carefully, they improve the assessment, enhance the analytic clinical reasoning process and help with focusing the conversation and decision-making. However, flexibility is necessary to prevent a narrowing of vision. Too much rigidity and focus on the models can lead to the person's problems being classified in a narrow way, instead of viewing their experiences, needs, desires and recovery goals in a broad integrative way. To prevent this narrowing of vision, it helps to understand that taxonomy models are not set in stone and are developing over time due to new insights. A narrow vision can also be avoided and a more holistic and individual tailor-made process made possible by the APMHN working with the multidisciplinary team to incorporate different views and contributions in the assessment and diagnosis process. Classification models can be nursing orientated, medically orientated or more in general focused on human functioning related to health conditions. The following are some examples.

- **NANDA-International (NANDA-I)**
  NANDA-I initially started in 1982 as the North American Nursing Diagnosis Association. The organization developed the earliest nursing diagnoses, primarily with nurses in the United States and Canada. Nowadays, NANDA-I is a global organization. Derived from research around the world, the NANDA-I taxonomy is a broadly accepted classification model for nursing diagnoses [1]. It is not by chance that it also uses a similar classification to Gordon's FHP, as Marjory Gordon was part of the original NANDA group that formulated the domains. Currently the taxonomy contains the following 13 domains:

  1. Health promotion
  2. Nutrition
  3. Elimination and exchange
  4. Activity/rest

5. Perception/cognition
6. Self-perception
7. Role relationships
8. Sexuality
9. Coping/stress tolerance
10. Life principles
11. Safety/protection
12. Comfort
13. Growth/development

- **Nursing Outcomes Classification (NOC)**
  The Nursing Outcomes Classification (NOC) identifies over 540 research-based results from nursing interventions [34]. The NOC can help APMHNs operationalise treatment goals by using specific measurable indicators. For example, if 'coping' is a desired outcome for a person, it can be operationalised by one or more of the indicators provided, such as 'verbalise sense of control'. For each indicator it is possible to decide together with the person which extent improvement is possible and needed.

- **Nursing Intervention Classification (NIC)**
  The Nursing Intervention Classification provides a taxonomy of research-based nursing interventions [35]. Every intervention includes a definition and a list of activities. These activities may be especially helpful to be more specific about what to do in each situation [36]. There is also a need for further development of the NIC to be supportive in systematic documentation of nursing interventions [37]. The NIC can be used complementary to other evidence-based interventions. Decisions about effective interventions are based on research evidence, guidelines, service user's experiences and professional knowledge as solely relying on the NIC for this purpose may prove overly restrictive.

- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases (ICD-11)**
  The *DSM*, fifth edition (*DSM-5*) [38], is one of the taxonomic and diagnostic tools that conceptualizes and operationalizes mental disorders. It is widely used in practice and in research, especially in the United States. The other more widely used classification model is the International Classification of Diseases (ICD-11), produced by the World Health Organization (WHO) in 2019. Both classification models provide common language to communicate about persons' possible symptoms in relation to medical conditions or mental disorders. They also offer consistent language for research purposes. The primary intention of the DSM-5 was to make it clinically useful for professionals and secondary to align the DSM-5 with the International Classification of Diseases (ICD-9 at that time, currently ICD-11) [39]. The WHO had the same intention with the ICD-11, to align it with the DSM-5, and to improve diagnostic accuracy [40]. As the development of DSM-5 was influenced by political, social, legal and cultural aspects [39], it has been criticized from several perspectives. For example, labels may stigmatize persons with mental ill health, and environment and personal factors are less likely to be taken in consideration [41]. Another concern is that classification

models like *DSM-5* or ICD-11 may have the potential for misuse, for example, by health insurance and pharmaceutical companies [39]. And finally, the models don't provide information about related causes or treatment needed. Today the cultural interview, which is now included in the *DSM-5*, is meant to address the social and cultural influences when assessing and diagnosing (see Diversity and Culturally Responsive Mental Health Practice). Both classification models can be used as an 'addition in the diagnostic toolbox' [41] that should be used in context to support the collaborative process of assessment and diagnosing.

- **International Classification of Functioning, Disability and Health (ICF)**
  The International Classification of Functioning, Disability and Health (ICF), also produced by the WHO [42], classifies human functioning related to health condition in four domains: (1) body functions (physiological and psychological functions of body systems), (2) body structures (anatomical parts of the body), (3) activity (tasks or actions by an individual) and (4) participation (involvement in a life situation). In these domains disability and functioning are viewed as outcomes of interactions between health conditions (disorder, disease or injury) and contextual factors, including environmental and personal factors. For example, a person who had a car accident and suffers from brain trauma experiences this in his daily functioning. Mental functions like attention or memory (as part of the body functions) may be altered. Also, there can be a change in the brain as an organ itself (part of the body structure). Because of the brain trauma, tasks or actions by the person can be affected. It may be the person had more difficulties in communicating, part of the activity domain. Keeping a job may also be a problem in participation. When the person has a supportive family, the burden of the consequences may be decreased. This can be seen as an environmental factor. Because ICF is focusing on human functioning related to health condition, it can be a very helpful component of the nursing assessment.

Whilst diagnosis is an important tool for defining a problem and for guiding medical decisions regarding treatment, for APMHNs trying to understand the impact of diagnosis on the individual, the reductionism of the diagnostic process is less helpful. The intention is to provide a holistic view of the persons' functioning, in which it partly succeeds, as it looks beyond medical health conditions. However, like *DSM-5* and ICD-11 frameworks, there are concerns that professionals may marginalize people with disabilities, by not taking their strengths and potentials into account [43] and codifying their distress using professional or medical language and interpretations. Using the ICF as one part of the assessment and diagnosing toolbox may prevent these risks.

7 Collaborative Formulation and Goal Settings: Decision-Making

Diagnoses using classification models are based on selecting symptoms from a list; some items may be present and others not. Two people can have the same medical diagnosis with few or no symptoms in common. In addition, diagnosis alone may tell us little about causation of mental health problems and nothing about the impacts on daily functioning [44]. In recent years case formulation has attracted a lot of interest. It is now a tool used by many mental health clinicians to relate theory to practice as it integrates a broad range of biopsychosocial causal factors and is based on personal meaning and constructed collaboratively with the person and members of the multidisciplinary team. Taking formulation into the APMHN setting can be a powerful way of shifting cultures towards a more psychosocial and recovery-oriented perspective, and it is particularly useful in situations where comorbidity clouds perceptions of what interventions should be prioritised [45].

There is no single definition of 'formulation', but it can be considered as a provisional explanation or hypothesis of how an individual comes to present with a certain mental health problem or circumstance at a particular point in time, and as an integration of a wide range of biopsychosocial factors. Formulation is built collaboratively and based upon personal meaning [46]. Collaboration is key to formulation because it allows the APMHN to gather the persons personal experience [47]. Formulation is linked to but distinct from assessment and diagnosis. It is the bridge between assessment and treatment as it brings together the persons' problems, the persons understanding of the problem(s) and the APMHNs' understanding of the problem(s) and the taking of action [47]. Case formulation, also referred to as conceptualisation, can be quite challenging for both novice and experienced APMHNs. Formulation is considered a core skill for APMHNs; they must be able to formulate a person's problem(s) within chosen therapeutic models and implement appropriate therapeutic or evidence-based interventions [48]. In several qualitative studies exploring service users experience of formulation, many describe how formulation helped them to increase their understanding of mental health difficulties, with a particular focus on how the difficulty links to experience, how it developed and what is maintaining the mental health difficulty [48]. Therefore, using a framework to assist in case formulation can help the APMHN to address anticipated challenges, develop active partnerships and better engage with an individualised and flexible intervention.

For the APMHN, how the person explains the nature and possible causes of their problem provides the APMHN with good information for the psychological formulation. It is common to give meaning to what happened in our life, both to events and to distressful experiences, and therefore it is important to be aware that people tend to search for meaning even when no causal events seem to have occurred. The biological, psychological, emotional and relational aspects need to be considered all together as different parts of the same problem and need to be fully explored, understood and appropriately managed.

7.1 ABC-E Model of Emotion

There are several frameworks that can assist the APMHN to conceptualise the person's presenting problem(s). The ABC-E model of emotion [49] is a biopsychosocial model of mental health care that embeds a person's emotional well-being and the contexts of their lives. The ABC model (A: activating events; B:

beliefs; C: consequences), which was first described by Ellis in 1962 and later adapted at the University of Manchester in 2002 [49], is underpinned by cognitive and behaviour models of emotional disorder to enhance the provision of facilitated self-help [49]. The ABC-E model (see Fig. 2) is particularly useful when trying to understand the person's mental health problem and is divided into the following components:

- **A**utonomic: relates to the physical effects of the problem or distress
- **B**ehaviour: relates to changes in behaviour and things people do to cope with the problem or distress
- **C**ognition: relates to changes to thoughts or images
- **E**nvironment: refers to the environmental triggers, maintain factors and social impact

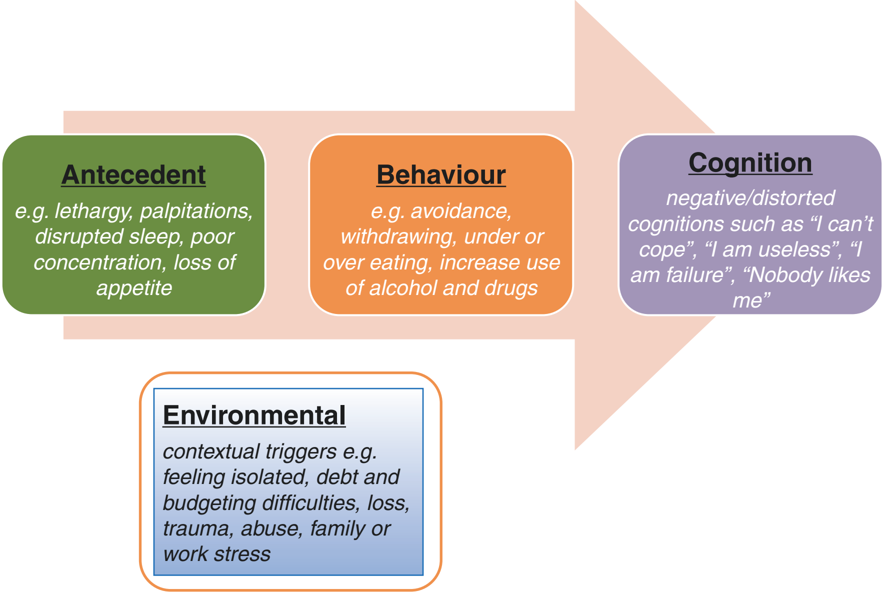


Fig. 2 ABC-E model of emotion

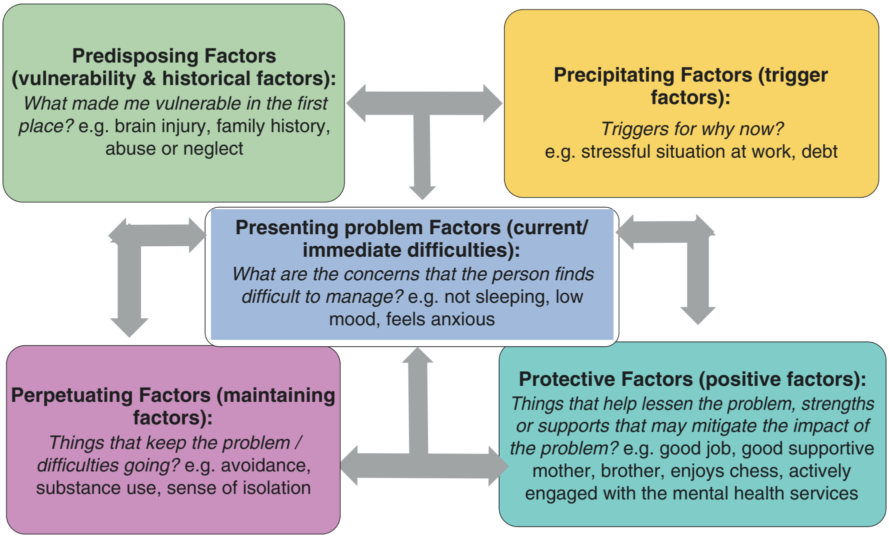
The ABC-E model is not in itself a formal model of assessment, instead it is an aid that can generate shared decision-making, goal setting and the application of interventions to promote recovery. It helps to formulate a problem statement. The problem statement is a summary of the all the elements of the assessment (interview, observation, assessment tools). An example of a problem statement by using the ACB-E model of emotion is contained in the Box 2. Now that you have read the example of the problem statement, consider how you might map Ingo's experience onto the elements of ABC-E model in Fig. 2. The resulting formulation will inform the management and support plan, which needs to be developed collaboratively, and when appropriate involving family and/or paid carers.

Box 2 An Example of Mapping the ABC-E Model

Ingo is a 19-year-old student who finds it difficult to talk in front of his peers. When Ingo is asked a question in class, he feels tense, unable to speak, his heart is racing, sweaty, shakes and cannot catch his breath and leave the class. This is always worse when he is not with people he knows. He feels his tutors and fellow students thinks he is stupid and that they will laugh at him if he speaks. Ingo struggles to concentrate in class and feels tired and lethargic. He is missing his old friends from his old school and is finding it hard to make new friends at college. He also misses his paternal grandfather who he spent a lot of time with and found the talks they had helpful and supportive. Since starting at the new college, concerns have been raised by Ingo's personal tutor that he has been absent a lot lately and when he is asked a question, he leaves the room abruptly. Ingo visited his GP with complaints of stomach ache, headache and chest pain, whilst appearing to be quite breathless and sweaty. He admitted that it had gotten worse since he started college 6 months ago and is struggling to settle into the routine of his new environment.

7.2 The Five Ps of Formulation

The five Ps framework [44] is another formulation tool that can help the APMHN to link the person's problems by using the five areas (Fig. 3).



Predisposing Factors (vulnerability & historical factors): *What made me vulnerable in the first place?* e.g. brain injury, family history, abuse or neglect

Precipitating Factors (trigger factors): *Triggers for why now?* e.g. stressful situation at work, debt

Presenting problem Factors (current/ immediate difficulties): *What are the concerns that the person finds difficult to manage?* e.g. not sleeping, low mood, feels anxious

Perpetuating Factors (maintaining factors): *Things that keep the problem / difficulties going?* e.g. avoidance, substance use, sense of isolation

Protective Factors (positive factors): *Things that help lessen the problem, strengths or supports that may mitigate the impact of the problem?* e.g. good job, good supportive mother, brother, enjoys chess, actively engaged with the mental health services

Fig. 3 The five Ps formulation

1. **Presenting problem**: the concerns that the person finds difficult to manage, for example, problems attending work, worrying, rumination and not sleeping.
2. **Predisposing factors**: what makes the person vulnerable in the first place, identify possible contributing factors that may put a person at risk: biological, genetic/vulnerability, environmental or personality considerations, for example, brain injury, adverse childhood experiences (ACEs) and poverty
3. **Precipitating factors**: triggers for why now, identify significant events preceding the onset of the episode/disorder/illness, for example, stress, debt, unlovable and ineffectual
4. **Perpetuating factors or maintaining factors**: things that keep the problem going, identify factors that sustain and possibly reinforce persons' current difficulties, for example, avoidance and substance use
5. **Protective or positive factors**: in keeping with a strengths-based approach, this P includes things that help lessen the problem, strengths or supports that may mitigate the impact of the disorder/illness, for example, good job, good supportive mother, and brother and enjoys chess

These five areas can help the APMHN and the team to make sense of the difficulties the person is experiencing, why the difficulties started and what is keeping them going as it looks at: what is happening now, what happened in the past, what triggers the problem/difficulties, what keeps it going and what helps to mitigate or reduce the problem [44, 50].

Box 3 using an example of Susan, demonstrate how the five Ps may be helpful in formulating and engaging with a person. Consider how you might map the elements of the five Ps in collaboration with Susan

Box 3 Illustrative Example and Mapping the Five Ps Formulation

Susan is 32-year-old White German woman, who lives with her husband Bruce and their three children aged 12, 10 and 6 years of age. Susan has a history of experiencing anxiety symptoms related to her executive position in a law firm, where she has worked for the last 5 years. Susan was promoted to senior position 12 weeks ago and made the decision to go off sick for the time being. On reflection, Susan admits she had an idealised view of having a great career whilst having a family and wanted to put on a perfect successful image for others.

Since her promotion, Susan said that she felt completely overwhelmed by the responsibility and became very anxious that she would do something wrong, cost the company money and would stay in the office after hours checking everything obsessively. She also reported feelings of low mood and that she was a fake and a failure. Susan feels she cannot work because she is unable to concentrate, feels lethargic all the time, not sleeping and is always worried that her manager will walk in and tell her that they made a mistake in hiring her and dismiss her. Susan said that, if she was honest, she would tell her manager that she was not the 'right person' but was embarrassed and scared to tell them including her husband. Susan often found herself turning down offers to meet colleagues outside work, fearing they would pick up how useless she is. She also stopped seeing her friends and engaging with the children's activities and would get her husband to take them to avoid talking to other parents. Lately she started to go out less and less and, on some days, struggled to even open the curtains or get dressed; some days she forgets to brush her hair or teeth and has started drinking alcohol to help her sleep.

Susan said she feels guilty and ashamed that she could not 'snap out of it' and for wishing that she had her old life back. She would then tell herself that her husband and the children deserved a better mother. Finally, she broke down in front of her husband and told him he had to stay at home from work because she could no longer cope and couldn't see herself ever going back to work.

Bruce reports that he often finds his wife crying. He could see that Susan was having difficulty sleeping and concentrating and would get angry if he tried to talk to her. Bruce admitted that he saw her like this before, after their second child Mia was born, and she received professional help from the local mental health services. He reported that she had endless worries about Mia's feeding and safety and was often exhausted. He often found her sitting by the cot as she slept to make sure she was still breathing and would not let her friends or family visit the house, fearing Mia would pick up germs. He says that his wife has always been a sociable person, but now she makes every excuse not to see friends and family. Instead, he notices that she spends her time worrying excessively that something is wrong with her. He also says that he has noticed his wife neglecting herself by not washing every day and not changing her clothes. He says that she appears tired, exhausted and worried all the time and complains of having no energy.

8 Mental Health Nursing Assessment and Clinical Decision-Making: A Complex Advanced Nursing Competency

Advanced mental health nursing assessment and clinical decision-making is a complex competency that requires good clinical reasoning and clinical decision-making, which involves several different processes [2, 36, 51, 52] that lead to clinical judgement. Tanner describes clinical judgement as 'an interpretation or conclusion about a person's needs, concerns, or health problems, and/or the decision to act (or not), use, or modify standard approaches, or improvise new ones as deemed appropriate by the person's response' [2, pp. 204].

Clinical reasoning in advanced nursing practice is not just a step-by-step process but more a cognitive process on a continuum from analytical to intuitive thinking [2, 53]. Analytical thinking relates to the conscious deliberate weighing up of factors to make carefully considered choices. Analytic clinical reasoning implies a step-by-step systematic and analytic assessment of cues, with conscious use of reason. It is considered explicit and takes time. In contrast, intuitive thinking is more experiential, heuristic and associative (reacting on various cues and impressions). It is fast, automatic, holistic and related to unconscious and implicit pattern recognition. It implies listening to your gut feeling, which helps to address the pattern recognition.

Research shows that intuitive thinking led to more accurate judgements, whereas analytical thinking led to more coherence in thinking. Therefore, a combination of analytical and intuitive thinking is very useful in decision-making [54]. The more experienced a nurse is, the more they use intuitive clinical reasoning skills and their clinical perspective [51, 52]. Hence circumstances determine which cognitive process is the most appropriate, and the amount of, and balance between intuitive and analytical thinking used.

Critical thinking is a way of reflection on the assessment process. It provides opportunities to challenge assumptions, to gain more insight, to create flexibility and creativity and to reconsider and reflect on clinical decision-making. Critical thinking can help professionals to challenge their biases, instead of relying on their experience and intuitive decision-making. Therefore, it requires open-mindedness, empathy, holism and reflection on presuppositions [51]. A systematic review about accurate and coherent decision-making showed some evidence for a positive relationship between higher levels of critical thinking and improved clinical decision-making in nursing [52], although the evidence was not strong, probably due to the generally poor methodological quality of studies. van Graan et al. on the other hand argued in their qualitative study that critical thinking was needed to develop a good clinical judgement [55].

Figure 4 outlines eight steps in the assessment and clinical decision-making process used by APMHNs and shows the integration of critical thinking and the continuum of analytical and intuitive thinking during the process.

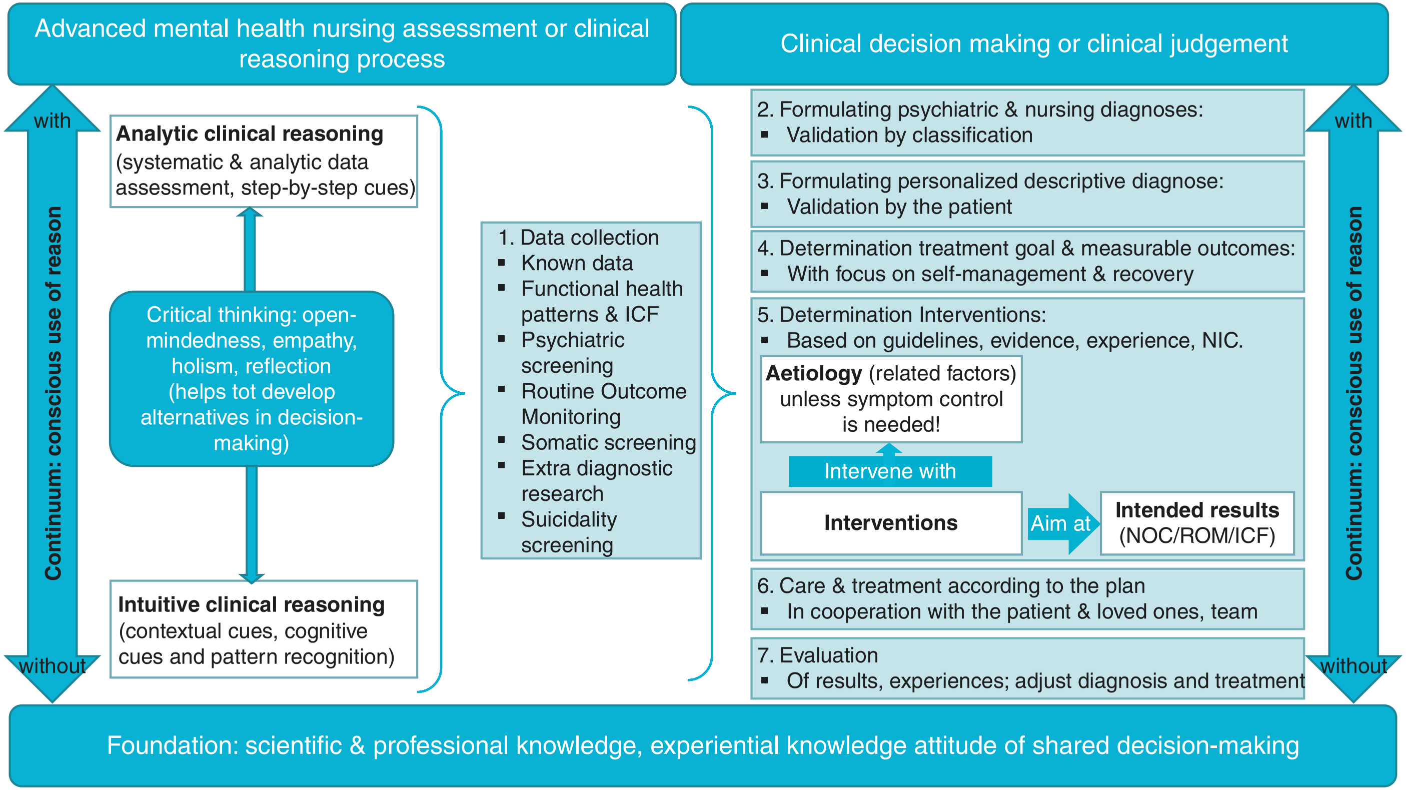


Fig. 4 Assessment and clinical decision-making by the APMHN

To illustrate the eight steps of assessment and clinical decision-making, they are applied to the example of Mrs. Khan (Boxes 4–12).

Box 4 Introducing Mrs. Khan

Mrs. Khan is a 58-year-old divorced woman. She divorced her second husband. She lives alone and loves her 23-year-old son (she had with her first husband) and her mother. She loves to play music, and she values a strong opinion on several social issues. She also had ambivalent experiences with health professionals and really wants to be taken seriously.

Step 1: Shared Decision-Making and Validation, Involving Family and Significant Others

Shared decision-making is about validation of the values, experiences, preferences and decisions of the person. Shared decision-making and validation are needed during the whole assessment process. Box 5 illustrates shared decision-making with Mrs. Khan.

Box 5 Shared Decision-Making with Mrs. Khan

The APMHN asks Mrs. Khan if she wants to bring a family or significant others to the first appointment. She does not want that, because she needs her privacy, she says. She has been invited by the APMHN to discuss every step during the assessment and treatment process. She feels taken seriously.

Step 2 Referral (Reason and Urgency)

This step is about the way a person experiencing a mental health problem is referred. The referral and the person who refers give important indications about the reason and urgency. This information is helpful in focusing on the immediate nature of the assessment and possible priorities for the immediate plan. In very urgent situations, the focus of data collection will be narrower and aimed more at crisis management and safety planning. However, caution is needed because assuming the referral is focusing on the essential aspects may cause bias in thinking. Box 6 shows an example of the referral of Mrs. Khan.

Box 6 The Referral of Mrs. Khan

Mrs. Khan has been referred by her general practitioner to an APMHN who works in a multidisciplinary mental health team. The reason for referral is deep sadness, feelings of worthlessness, loss of interest in her music, sleep disturbances, a feeling of being slowed down, feelings of anxiety and hyper arousal and changes in weight. She is continuously alert, afraid to walk the streets and feels afraid and responsible for her son and mother. Her former husband was abusing her. He still lives nearby.

The content of the referral indicates several possible problems. In the assessment depression, anxiety disorders or a trauma disorder need to be considered. Many of the health complaints of Mrs. Khan are pointing to this. To prevent bias, the APMHN also needs to take possible somatic causes into account (like menopause or thyroid problems). The APMHN also needs to take a closer look at the self-perception and the coping responses Mrs. Khan has developed during her life. The sleeping disorders and changes in weight, in combination with the mood problems, can also point to a stress response problem. The APMHN interviews Mrs. Khan and assesses the needed information. To validate the information, she checks if Mrs. Khan agrees.

Step 3 The Assessment Process

During assessment the APMHN gathers several kinds of data, including known data, psychiatric and medical data, nursing data, routine outcome data or additional needed data. Box 7 shows the collected data of Mrs. Khan.

Box 7 The Data Assessment of Mrs. Khan

The known data received say Mrs. Khan suffers from fibromyalgia for 10 years. Her general practitioner sent recent blood levels; there was no indication for thyroid problems. She also had her menopause 8 years ago.

Psychiatric and *medical data* showed dysphoria, feelings of worthlessness, loss of interests, sleeping very lightly and waking up after nightmares, a feeling of being slowed down in thinking, less concentration, hyper-alertness and feelings of anxiety regarding her husband. She uses oxazepam 10 mg before she goes to sleep. She never had thoughts about her death. There was no history of treatment. The APMHN asks Mrs. Khan what happened to her. She told her that her husband started to abuse her (physically, verbally and sexually) after she developed her fibromyalgia. Mrs. Khan says her ex-husband is narcissistic. She left him after he raped her for the first time. She flew with her son to a secret address following the assault. Mrs. Khan grew up in a small family. Her mother and brother said she used to be insubordinate during her youth, but recently she has less strong opinions about things, as she feels more unworthy than before…Upon review there are more indications for a post-traumatic stress disorder, than for a mood or anxiety disorder.

The nursing data show dysfunctional health patterns in self-perception and in coping and stress-tolerance. Her resilience seems low. Her functioning, according to the ICF, reflected in her self-perception pattern that she is dependent on others' opinions (ICF: severe disability in forming interpersonal relationships; d7200.3), exaggerates negative feedback, feels guilty and ashamed, is indecisive and feels unable to deal with the current situation (ICF: serious disorder in psychological stability; b1263.3). Her history shows she has great difficulty coping with loss (ICF: severe disability in dealing with loss; d2408.3), does not feel she belongs somewhere and she receives repeated negative reinforcement through her family. She had a long-lasting exposure to trauma with her ex-husband. This could result in chronic low self-esteem (00119, NANDA-I, domain self-perception).

Her coping and stress-tolerance pattern also has indications it is dysfunctional. She shows mood and concentration changes in several situations (ICF: severe disorders in regulating mood; b1521.3, and in attentions; b1402.3), flashback of the physical and verbal abuse, panic attacks when in stress (ICF: mild disability in dealing with stress; d2401.2), hypervigilance (ICF: severe disorder in auditive and visual perception; b1560.3 and b1561.3) and feeling numb. In combination of her history of abuse, this perhaps indicates a post-trauma syndrome (00141, NANDA-I, domain coping/stress tolerance).

Her social well-being is disturbed. She is unable to join the music association (ICF: severe disability in leisure; d9202.3). She feels very supported by her mother and son (ICF: positive supporting by close family; e310+3).

Routine outcome data were used to test the hypothesis of a post-traumatic stress disorder and of depression. The Clinical-Administered PTSD Scale for DSM-5 (CAPS-5) was used. It is a structured interview to assess PTSD symptoms. Mrs. Khan had a score of 54, which indicates severe symptoms of PTSD. Mrs. Khan scored 15 points on the Hamilton Rating Scale of Depression, which indicates a mild depression.

Additional data was not needed at the time.

Step 4 Validating the Personalised Descriptive Diagnosis

In this step the APMHN is looking for patterns; hence, all the collected data need to be judged and combined to form a conclusion. By formulating the complete personalised descriptive diagnosis, the APMHN will have a rather complete picture of the person with mental ill health, and the person with mental ill health will feel recognized and validated. It also gives direction to the treatment plan. A nursing diagnosis is in a sense a conclusion about the current health situation of a person with mental ill health. Before deciding about the diagnosis, the psychiatric diagnosis should be validated both with the person with mental ill health as to the *DSM-5* taxonomy. The nursing diagnoses should be validated both with the person with mental ill health as with the NANDA-I taxonomy. To improve internalization, it helps to use a template for formulating the personalised descriptive diagnoses, and it helps to use the ABC-E model of emotion and the five Ps previously reviewed. The template is used in the example of Mrs. Khan. The ICF and routine outcome monitoring data can be used to fill in characteristics, factors and signs and symptoms. Box 8 shows the validated personalised descriptive diagnosis of Mrs. Khan.

Box 8 The Validated Personalised Descriptive Diagnosis of Mrs. Khan

Reviewing all the data, Mrs. Khan was diagnosed with a psychiatric diagnosis of posttraumatic stress disorder (PTSD), validated to the *DSM-5*, where it met the criteria of the PTSD (symptoms in four criteria). She was also diagnosed with the nursing diagnosis of a chronic low self-esteem, validated with the NANDA-I. The post-trauma syndrome, also a nursing diagnosis, was rejected because of the PTSD. The mood and anxiety problems are closely related to the PTSD and will probably decrease when the PTSD and the low self-esteem diminish or are less severe. To avoid bias, the results and diagnoses are discussed in the multidisciplinary team and with Mrs. Khan. Mrs. Khan says they are representative of her situation, and she felt heard and seen. The multidisciplinary team confirmed the conclusions.

Mrs. Khan recognized herself in the following personalised descriptive diagnosis. This was an important step in the establishment of the therapeutic relationship.

Mrs. Khan, born on the 10th of December 1962, has been referred to the centre of mental health by her general practitioner Mrs. Steward, because of feelings of deep sadness, of worthlessness, loss of interest in her music, sleep disturbances, a feeling of being slowed down, feelings of anxiety and hyper arousal and changes in weight. She is continuously alert, afraid to walk the streets and she feels responsible for her son and mother.

Mrs. Khan divorced her second husband, who abused her, and is living on her own now. Her mother and adult son (she had with her first husband) are living nearby.

Mrs. Khan does not have a previous psychiatric history.

Psychiatrically Mrs. Khan suffers from a severe post-traumatic stress disorder (score 54 on CAPS-5) characterized by dysphoria, changes in mood and concentration, feelings of worthlessness, loss of interest, sleep disturbances and waking up after nightmares, flashbacks of physical and verbal abuse, a feeling of being slowed down in thinking, hypervigilance, hyper-alertness and panic attacks when under stress and feelings of anxiety towards her ex-husband. Physically Mrs. Khan's current physical health is mildly disturbed. She feels tired and filled with pain every day, partly due to the fibromyalgia she is known to have since 2011. There are no indications for menopause (already had) or thyroid problems.

The nursing diagnosis of chronic low self-esteem (00119) is defined by the following characteristics: dependent on others' opinions, exaggerating negative feedback, feeling guilty and ashamed, being indecisive and feeling unable to deal with the current situation. This is related to her history that shows she has difficulty coping with loss, she doesn't feel she belongs somewhere and she receives repeated negative reinforcement in her family. She had a long-lasting exposure to trauma with her ex-husband.

These vulnerabilities disable Mrs. Khan in a severe way in participating in her music association that she used to love. She also avoids going out of her house. Positive factors are that Mrs. Khan feels supported by her mother and son. Obstructive is that her ex-husband is living nearby. There is a certain risk she meets him in the supermarket or on the street. Mrs. Khan describes herself as 'a warm, helpful and a socially just woman. She loves music!'. She is motivated for treatment and describes her needs as 'I want to live without fear, join the music association and visit my son and mother without looking over my shoulder. I want my life back, without him controlling it'.

Step 5 Recovery and Treatment Goals and Measurable Outcome

Step 5 is an essential step before deciding on interventions. Treatment goals are established in close cooperation with the person and if appropriate with the family to meet their needs. It helps to formulate the goals in a measurable way by using intended results. These results or measurable outcomes can be retrieved from aspects of functioning (ICF), ROM and/or the nursing outcome classification (NOC).

Treatment goals are also needed for evaluating the progress of the treatment. Box 9 shows the recovery and treatment goals and measurable outcomes in the treatment plan of Mrs. Khan.

Box 9 Recovery and Treatment Goals and Measurable Outcomes for Mrs. Khan

Mrs. Khan decides together with the APMHN what her treatment goal will be and what measurable outcome is intended. She agrees with the goal of her treatment plan that has been documented in her file.

Her treatment goal is described as 'Within half a year, Mrs. Khan can go to her former residential neighbourhood to visit her mother and son and to join the music association weekly. The measurable outcomes needed are being able to control her panic attacks by working on her fear self-control (NOC: uses effective coping strategies 140406; uses relaxation exercises to decrease fear 140407), a stable and qualitative good sleeping pattern (NOC: amount of sleep of a minimum of 8 h 000401; the quality is high 000404 and she sleeps all night 000418, feels rested 000408 and no more nightmares 000422). She increases her resilience (NOC: using effective coping strategies 130902; positive self-esteem 130907; shows self-efficacy 130909). She shows no scores on the CAPS-5 indicating symptoms of PTSD (which includes no more flashbacks, hypervigilance and feeling confident about herself in relation to others).

The outcomes are related to the symptoms in the personalized descriptive diagnosis. They have been operationalised.

Step 6 Interventions

This step is about decision-making in interventions. For this clinical reasoning, the personalised descriptive diagnosis is needed as well as the measurable outcomes of the recovery and treatment goal. On the one hand, interventions are focusing on reaching the intended outcomes. On the other hand, interventions primarily are targeting the aetiology, causative factors or related factors as described in the diagnosis unless symptomatic treatment is necessary. A psychiatric diagnosis may in some cases be an indication for medication treatment. The treatment plan is formed by the personalised descriptive diagnosis, the goal(s) and measurable outcomes and the interventions. In selecting interventions, the APMHN considers evidence-based interventions, guidelines and research findings but always with the service users 'preference central'. The nursing intervention classification (NIC) can be used complementary and be very helpful in describing separate actions for the interventions. For example, the nursing intervention 'suicide prevention' contains activities as 'instruct person in coping strategies' or 'use direct, non-judgemental approach in discussing suicide'. Box 10 shows the interventions the APMHN and Mrs. Khan decided to use. (see "Integrative Care Planning" for a more detailed overview).

Box 10 The Interventions for Mrs. Khan

Together with the APMHN, Mrs. Khan decides to choose the following interventions in symptom reduction. To improve her sleep, she stops taking the oxazepam. Instead, she starts to regulate her sleep by a regular rhythm and exercises she can perform despite her fibromyalgia. By improving her sleep, she will be able to reduce her stress responses.

To control her panic attacks, she learns to use breathing exercises (when having an attack) and mindfulness exercises (to prevent an attack).

Key elements in the treatment of Mrs. Khan are the interventions that intervene in the aetiology to establish a permanent change. These interventions are focusing on trauma treatment and coping strategies. The trauma of Mrs. Khan is treated with eye movement and desensitization and reprocessing (EMDR) therapy because the intended outcome is to reduce hypervigilance, flashbacks and nightmares [56].

Mrs. Khan is treated by Schema- Focused Therapy (SFT) to identify and change specific unhealthy ways of thinking and unhealthy coping strategies. Although the therapy initially is meant for people with borderline personality disorder, it can also be very helpful in traumatised people with unhealthy coping strategies [57]. It helps to increase Mrs. Khan's resilience.

Step 7 Providing Treatment

Treatment is provided according to the care/treatment plan and in cooperation with person and family. The APMHN can oversee the treatment plan and is therefore responsible to be clear about who is responsible for what and who is providing (parts of) the interventions. Box 11 shows how treatment is provided to Mrs. Khan.

Box 11 Treatment Provided to Mrs. Khan

Mrs. Khan is very well committed to the treatment. She joins every appointment, and she practices relaxation exercises at home. During the treatment, the EMDR interventions are expended with exercises in exposure, like driving to her former residence neighbourhood. During these exposure exercises, she uses her breathing and mindfulness techniques. The treatment is given by the APMHN, except for the SFT. In the multidisciplinary team, one of the team members is a psychologist trained in SFT. She provides this treatment to Mrs. Khan and informs the APMHN about the progress of the SFT.

Step 8 Evaluate

The personalised descriptive diagnosis and the treatment plan form also the base of evaluating the treatment provided. Together with person and family, progress is evaluated by looking back on the initial diagnosis and the intended outcomes. The assessment skills can also be used to evaluate the diagnosis and intended outcomes. Diagnoses do change, and if they do it is important to document this. It also validates the person's efforts. Also, treatment can help achieve goals and be successful. But despite this, a person may not be satisfied, for example, because their experience with the treatment or medication was not what they expected. These situations may mean that the diagnosis and the treatment plan needs to be reconsidered. Box 12 demonstrates the evaluation of the treatment plan with Mrs. Khan.

Box 12 Evaluation of the Treatment Plan with Mrs. Khan

Mrs. Khan and the APMHN evaluate the progress in the treatment and in the daily functioning of Mrs. Khan every 3 months. She doesn't want her son or mother to join. But she does ask them what they experience in relation to her.

Evaluation takes place about the interventions. Mrs. Khan is content with the way the treatment is given and how she can do exercises herself. She says it improves her self-management.

The evaluation is also about the results achieved. All the intended NOC-outcomes are achieved. Mrs. Khan scores 15 on the CAPS-5, which means there are no more symptoms of PTSD. She can control her panic attacks; they are also decreasing in frequency and severeness. She sleeps 8 h at night, feels rested and does not wake up with nightmares. During the daytime she does not experience any flashbacks or hypervigilance. She did join a music association and visits her mother and son every week. She was very proud to mention she even forgot to lock her car whilst driving through her former husbands residential street. And finally, she feels confident about herself now. She learned to see herself as a strong woman, able to meet her needs without giving in to others.

9 Conclusion

This chapter is about the process of advanced mental health assessment and clinical decision-making by the APMHN. This process is a combination of intuitive and analytic clinical reasoning, which requires open-mindedness, empathy, holism and reflection on presuppositions. The process of assessment and clinical decision-making by an APMHN requires a foundation of specific and professional knowledge and shared decision-making as an underpinning value for the professional approach. A therapeutic validating relationship with the person is essential. Therefore, specific communication skills are needed.

The process of assessment consists of elements from both psychiatric evaluation and the process from nursing assessment to a personalized descriptive diagnosis, including the ABC-E model of emotion, five Ps, the strengths, needs, wishes and the person with mental ill health's motivation. Of course, other viewpoints are helpful in developing the professional knowledge of the APMHN. Coaching new practitioners to learn and internalize clinical reasoning and clinical decision-making is hard work. The experienced APMHN is an important role model for them by showing how they use their firm base of specific knowledge and showing a recognizable clinical reasoning process in several contexts.

Reflective Questions

- How can APMHNs improve work in cooperation with the person experiencing a mental health problem and family to improve assessment, clinical reasoning and decision-making?
- How may APMHNs use technology to support assessment and clinical decision-making without impacting negatively on the therapeutic relationship and shared decision-making?

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Integrative Care Planning

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Learning Objectives
After reading this chapter, the reader will be able to:

- Describe the rationale and principles underlying shared decision-making in APMH nursing practice.
- Compare different types of care plans, including recovery care planning, joint crisis planning, and advanced mental health directives in relation to shared decision-making, collaboration, and treatment components.
- Examine the eight components of the integrated treatment plan (ITP) model for advanced practice mental health nurses (APMHNs) and its application in clinical practice.

1 Introduction

As the number of advanced practice nurses (APNs) increases globally, so has the role and scope of their practice evolved. The role of the advanced practice mental health nurse (APMHN) was initially developed over 60 years ago in the USA to provide increased access to primary healthcare, and now APMHNs are an integral part of many healthcare systems to improve the quality of care [1]. With increasing need for APMHNs and fast changes in their role in different contexts and countries,

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including in Europe [2], it is more critical than ever for APMHNs to incorporate evidence-based care planning practices that are firmly grounded in careful assessment (see "Advanced Mental Health Nursing Assessment, Formulation and Decision-Making") collaborative practice and shared decision-making. As APMHN prescribing becomes more acceptable and widespread, the risk of medications becoming the focus of care plans increases as well [3].

Various models, care pathways, and/or principles have been developed to guide mental health practitioners in making good clinical decisions regarding the most appropriate care and treatment plan for each service user. Each of these models has its strengths and limitations in terms of teaching and guiding clinical decision-making. Along with different types of care plans, a new model, the integrative treatment plan (ITP) model will be described as a guide to clinical decision-making. Integrative care planning is a whole-system, whole-person, shared decision-making approach to care planning. In presenting the ITP model, it is assumed that at the advanced level of practice, the model is an especially good fit for both APMHNs and APMHN students.

2 Shared Decision-Making and Care Planning

Helping people to realize what options they have in addressing their mental health challenges is one of the many tasks of the APMHN. Regrettably advanced mental health practitioners, including APMHNs, have a long and rather bleak history of paternalistic approaches as opposed to advocating with service users [4]. With the supremacy of the biomedical approach, there is also a trend to ignore the voice of the service user by not implementing shared decision-making principles within routine practice [5]. In recent years researchers and clinicians have attempted to rectify this by focusing on a human rights approach to mental health care, including shared decision-making, leading to increased self-determination [6, 7].

Shared decision-making (SDM) has been defined as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options to achieve informed preferences" [7, p. 1]. The service user's life experiences and the process of SDM should be integrally associated with evidence-based practice (EBP). Often the literature about EBP focuses on the pyramid of evidence in which randomized trials are the most valued evidence for making clinical decisions, while the lived experiences of the service user are the least valued and placed at the bottom of the evidence pyramid [8]. It remains essential not to get caught up in false dichotomies as EBP models are of limited use if the service user context is not kept at their center (see chapters "Advanced Mental Health Nursing Assessment, Formulation and Decision Making" and "Enhancing the Quality of Care Through Participatory Generation of Evidence"). One EBP model where shared decision-making between the service user and the practitioner is clearly at the forefront is Satterfield et al.'s [8] work on an interdisciplinary approach to EBP. This model integrates three factors: (1) best available research evidence; (2) client's/population's characteristics, state, needs, values, and preferences; and (3) resources, including practitioner's expertise. The process of making-decisions about care is located at the intersection of these three factors, with reference to the environment and organizational context in which all these things take place.

There is much work underway to implement SDM in various healthcare settings and systems around the world [6], but regrettably there seems to be some difficulty in associating SDM with improved treatment outcomes [9]. There are indications that the use of tools and aids (practitioner and service user training, pamphlets, videos, presentations, etc.) for SDM may be helpful in some contexts, such as depression and anxiety, while it has been more difficult to verify the efficacy of these in other areas [6].

Makoul and Clayman [10] identified over 20 distinct elements of SDM which were commonly emphasized during physician/service user encounters. The review revealed that many common elements of the SDM models included in the study focused on principles of recovery, such as mutual respect, presenting different options, partnership, and an individualized approach to care planning.

Notwithstanding the importance of SDM, Bee et al. [11] in their study on participation of service users in care planning in diverse care settings report barriers and facilitators to SDM that were categorized into five different dimensions. These are important to APMHNs as they reveal what factors to be aware of when trying to implement SDM in their practice setting. Facilitator and barrier categories are (1) relational influences; (2) organizational influences; (3) service user/carer buy-in; (4) meaningful information exchange; and (5) participatory deliberation and decision-making. The barriers in the category relational influences included such factors as perceived lack of service user/carer capacity for involvement, perceived lack of service user/carer interest, perceptions of professionals as "experts" in care and responsibilities, and stigmatization of service users/carers. The facilitators included professional respect for service user autonomy and expertise and staff empathy for service users/carers. Barriers under organizational influences included unpredictable, task-oriented environments, and lack of interagency communication/coordination, while the facilitator identified included validation of time spent with service users. In the service user/carer buy-in category, the barriers included medically/diagnostically led care plans, illness and dependency-focused dialogue, and previous negative service user/carer experience. Facilitators included items such as sufficient service user/carer motivation and care plans founded on a strengths-based approach. In the meaningful information exchange category, barriers included inadequate/inconsistent staff-service user communication and lack of service user/carer feedback mechanisms. In this category, examples of facilitators were staff competency in service user-centered needs assessments and transparent/open documentation and materials written by/with service users. Finally in the participatory deliberation and decision-making category, examples of barriers were lack of service user/carer confidence, perceived provider-consumer power differential, lack of advocacy/carer inclusion, and insufficient time dedicated to service users. Facilitators in this final category included, but were not limited to, informal, creative, and flexible consultation approaches; staff-service user agreement on recovery priorities; and inclusion/recognition of service user-identified needs [11]. As can be seen by this extensive list of facilitators and barriers of SDM, there is much that can prevent or promote the implementation of SDM. Bee et al. recommend practitioners, users, and carers participate in SDM training to facilitate the implementation of the principles underlying SDM into clinical practice (2015). Slade [9] further identified important elements which enable successful SDM processes such as creating access to high-quality SDM support tools, integrating SDM with other recovery-supporting interventions and responding to cultural changes as service users develop the normal expectations of citizenship.

Researchers have also pointed out that there are both clinical and ethical reasons for implementing SDM [5]. While the clinical reasons are important, the ethical importance of SDM should be reason enough to apply such principles into APMHN care planning routines [12]. Based on the ethical principle of autonomy, it clearly is not ethical to exclude service users from decisions that affect their life and death [6]. Indeed, in 2011 the National Institute for Health and Care Excellence [12] published guidelines on *Service user experience in adult mental health services*. In this document eight quality statements are identified of which two are especially important to the content of this chapter. Quality statement number two reads “People using mental health services are supported in shared decision-making” [12, p. 10], and number six reads “People using mental health services jointly agree a care plan with health and social care professionals, including a crisis plan if they may be at risk of crisis” [12, p. 21]. The latter statement refers to the importance of having review dates on the care plan and updating the care plan based on these review dates. In addition, it emphasizes the need to have a written crisis plan in place of which the service user has a copy should they need it. This crisis plan can include possible warning signs of relapse, positive coping skills that fit the individual service users’ preferences, and information on how to get support to prevent a crisis. If a person needs to be admitted to the hospital, it can also contain what their needs and preferences are in that context [12].

For several reasons, some people may require help and support with decision-making. Supported decision-making has been defined as “the process of supporting people, whose decision-making ability may be impaired, to make decisions and so promote autonomy and prevent the need for substitute decision-making” [13, p. 61]. There are many variations of supported decision-making, and it can refer to either legal or more informal processes. One common form of care planning, advanced mental health directives, which will be reviewed later in this chapter, is a good example of supported decision-making. Although not legally binding, they can inform future care decisions of service users with present-day input [13].

3 Recovery Care Planning

Care planning is the process between practitioners and service users where they discuss concerns, review options for treatment, and agree on a plan of care. The care plan is the outcome of this process and is usually a written document [14]. Many models of the care planning process have been described in the literature for nearly every health profession. These models begin with assessment and end with a plan for care and treatment and are based on the scientific evidence and standards of practice of the discipline [15].

Recover-focused care planning is simply the implementation of a mental health care plan which is based on the philosophy of recovery. Recovery care planning is a collaborative and individualized process grounded in SDM with aims of supporting people to live meaningful and productive lives [16, 17] (see also "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"). Simpson et al. in talking about recovery state that "The written care plan lies at the heart of the care planning process and should be collaboratively developed by professionals working in partnership with individual service users and their significant carers. It should include details on goals or intended outcomes, on services to be provided, on plans to be followed in the event of a crisis and on the maintenance of safety" [17, p. xv]. Thus, a recovery care plan is a care plan that moves beyond various mental health interventions and looks at supporting peoples' strengths, helping people connect with family and the community, and engage with meaningful activates, be it work, education, or leisure. It is more than symptom reduction but a plan that acknowledges people can live meaningful and productive lives even though experiencing symptoms, sometimes grave, of their mental health challenges.

In their study on recovery-focused mental health care planning, Coffey et al. [16] found factors that both facilitated and hindered recovery-focused individualized care planning in acute inpatient mental health settings. Some of the barriers experienced by staff were the perceived difficulty of working with service users with impaired insight or in severe mental distress and lack of time. Service users experienced barriers to recovery-focused care planning such as the rigid and overly generic electronic health record used to document the care plan as well as lack of time [16]. Service users who perceived receiving recovery-focused care also perceived having a strong therapeutic alliance with the staff and a higher quality of care. APMHNs need to be aware of this association in their clinical practice, especially given the time constraints they operate within which may not always support devoting time to cultivating strong therapeutic relationships and personalized care planning, the hallmarks of recovery care planning [16, 17].

4 Collaborative Care Models

In their review of collaborative care models (CCMs) for mental health conditions, Woltmann et al. [18] synthesized the results of 57 trials on collaborative care models in various mental health settings. The following elements were found to be core elements of CCMs: (1) patient self-management support, with focus on coaching, problem solving, or skills-focused psychotherapy or psychoeducation-targeting the persons ability to self-manage symptoms and participate more effectively in clinical care and decision-making; (2) clinical information systems use, with a focus on facilitation of information flow from relevant clinical sources to treating clinicians for optimal management of individuals, panels, or populations; (3) delivery system redesign with a focus on redefinition of work roles for physicians and support staff to facilitate anticipatory or preventive rather than reactive care and allocation of staff to implement other CCM elements, such as self-management support and information flow; (4) provider decision support focusing on facilitated provision of expert-level input to generalist clinicians managing cases without need for specialty consultation separated in time and space from clinical needs; (5) community resource linkage with a focus on clinical and nonclinical needs from resources outside the health care organization proper; and finally, (6) healthcare organization support, focusing on organization-level leadership and tangible resources to support CCM goals and practices [18].

These elements could be of use to APMHNs because these describe core features of care planning from a broad and holistic viewpoint and illustrate how important it is to approach the issue of care planning from a whole systems and integrative viewpoint.

Woltmann et al. also highlighted numerous versions of CCMs which have been used over the years for various mental health conditions, often with very promising results. The results of the synthesis showed mixed results across people with multiple disorders, symptoms, and quality of life, but CCMs also did not increase healthcare costs [18]. The strongest effects of CCMs were found in primary care settings with people experiencing less complex mental health challenges such as depression and anxiety compared to less robust effect sizes with people experiencing more complex challenges and long-term conditions like substance use disorders, schizophrenia, and bipolar disorder [18]. However, there were fewer trials that involved people with these illnesses. This indicates that current CCMs may work better with less severe and long-term conditions but perhaps lack breadth and depth to be applied directly to more complex service users and mental health settings associated with long-term mental health problems. Models to be used in such complex situations need more holistic and integrative approaches, especially since SDM and true collaborative practice can be fairly difficult to demonstrate given the growing emphasis on preset care plans and treatment pathways which at times can lack the individualization needed for meaningful engagement with people experiencing more complex mental health problems [19].

More inclusive integrative care planning models for mental health have also been designed that may provide direction for SDM and collaborative care planning in more complex situations. Three of them, the biopsychopharmacosocial (BPPS) model, the integrative model of healthcare (IMHC), and the integrative treatment planning (ITP) model, will be discussed later in the chapter. The use of the ITP model will be demonstrated through a case vignette as an example of how such integrative models can be utilized by practitioners and service users to collaboratively approach complex life situations.

5 Joint Crisis Planning

Joint crisis planning has been defined as “a plan for use during a future mental health crisis or relapse. Its distinguishing feature is facilitation by a mental health professional external to the treatment team, who engages a mental health service user and members of his/her treatment team in a process of shared decision-making" [20, p. 281]. During a mental health crisis, planning becomes paramount to ensure the safety and well-being of the service user. The joint crisis plan is developed when the person is not in crisis so that they have it ready when needed. A well-defined and articulated written crisis plan may at times make the difference between life and death. It provides service users with a structured multistep approach in managing their crisis and guides them and/or their carers through temporary periods of mental unrest and instability [12]. Although a written crisis plan is a standard of care, regrettably few crisis plans are individualized. In joint crisis planning, the mental health professional and the service user recruit the aid of an outside facilitator in creating the joint crisis plan [20]. Joint crisis plans have been shown to have positive effects on the therapeutic alliance and service users reported that the aid and presence of the facilitator as a part of the joint crisis plan appeared to help adjust inherent power imbalances in the therapeutic alliance [20]. This is as opposed to routine care where service users have less tendency to receive individualized crisis plans. Joint crisis plans are ethical and appear superior to routine care, especially related to service user satisfaction and positive effect on the therapeutic alliance. This should lead APMHNs to consider their use when indicated and devote both time and resources to integrate them into their practice [20].

6 Advanced Mental Health Directives

Advanced mental health directives or psychiatric advanced directives (PADs) are "written documents or oral statements that allow adults with decision-making capacity to declare their treatment preferences and/ or to designate proxy decision-makers to act on their behalf should they be deemed incapable in the future of making informed choices on their own" [21, p. 278]. PADs are gaining traction internationally as recovery-oriented principles, and practices become more mainstream and can be viewed as a part of joint crisis planning or separate from it. Advanced mental health directives outline what to do if a service user becomes severely ill. Multiple guidelines for developing PADs are available and can be found through various international organizations and agencies [22], such as from the Substance Abuse and Mental Health Services Administration in the USA [23]. PADs could include various provisions on what action to take should a service user experience a worsening of their mental health challenge, whether a service user would like to be admitted to hospital or not, be involuntary detained or not, what medications they prefer to receive, what persons to contact, and even what to do with their pets and finances, as well as what carers and mental health practitioners should be involved in the process [22]. PADs have been shown to increase the quality of the therapeutic alliance, autonomy, empowerment, and self-determination. Most importantly PADs may also reduce the likelihood of service user experiencing negative coercive treatments in a mental health crisis [21]. APMHNs should be agents of the mental health advanced directive. It would be wise to keep in mind, however, that multiple barriers to their use and application exist such as lack of use in crisis and lack of healthcare provider's partnership [22]. PADs contain some elements of joint crisis planning such as provisions for what do to when mental distress and illness exacerbates, although in joint crisis planning a greater emphasis is often placed on practitioner involvement [24]. The evidence for the use of PADs appears strongest for their positive effect on the therapeutic alliance, and their use may be more effective when facilitated by outside third parties such as peer consultants [22].

7 Discharge Care Planning

Comprehensive discharge planning remains standard of care and is an essential component of mental health services [12]. Like other care plans, discharge plans should be an individualized collaborative effort [12, 25]. In a scoping review of the use of discharge plans, Nurjannah et al. [25] examined studies on discharge planning over a 20-year period. Although efficacy outcomes show promise, they are not as robust as hoped for with conflicting reports regarding the impact of discharge planning on readmission rates and treatment outcomes. Research also suggests that during the discharge planning process, there is a mismatch between service user and carer needs on the one hand and the information provided by mental health professionals on the other hand [25]. Like other types of care plans, there are indications that comprehensive discharge planning has a positive effect on the therapeutic alliance and service user and carer experience of healthcare services. APMHNs should look at discharge planning as a process that takes place during comprehensive dialogue with service users and their supporters and ends with a written care plan for service user as well as providing opportunities for psychoeducation regarding triggers, flags, and resources after discharge.

Overall different kinds of care plans should have one thing in common. They should be centered on the needs and preferences of the service user. Any model that APMHNs use for this purpose needs to be holistic, collaborative, focused on shared decision-making, easy to write, and given to service users after each appointment. It should also be time efficient and integrative in nature, with a balanced approach to evidence informed decision-making, considering the reality and preferences of the service user.

8 Integrative Mental Health Care Planning

The increasing demand by people for more holistic, personalized mental health care is changing our understanding of the relationship between mental and physical health and expanding options for more integrative approaches to care. In a landmark article, Lake et al. [26] describe the integrative mental health (IMH) paradigm of mental health care as a bio-psycho-social-spiritual approach to understanding and caring for people with mental health issues, which is in sharp contrast to the current allopathic biomedical treatment approaches. IMH focuses on the reciprocal relationship

Table 1 The tenets of integrative mental health

• Adoption of a bio-psycho-socio-spiritual framework
• Compassionate, unconditional person-centered clinical approach
• An individualized, whole-person approach to treatment
• Consideration of the psychological, social, and spiritual narrative of the service user
• Understanding the root cause(s) of mental distress/illness
• Emphasis on the prevention of illness and promotion of mental wellness
• Integrated use of allopathic and homeopathic or complementary/alternative therapies
• Judicious use of psychopharmacotherapies
• Emphasis on education, self-empowerment, and capacity of the service user

Adapted from Lake et al. [26]

between mental health and physical health (for further discussion on importance of this relationship, see "Interface Between Physical and Mental Health"). The tenets of IMH are found in Table 1.

The most extensive theoretical work and clinical practice applications of integrative health and mental health have arguably come from nursing. Nursing leaders in integrative nursing, Kreitzer and Koithan introduced the six concepts and principles of integrative nursing in their textbook, *Integrative Nursing* [27]. These principles both support and challenge our current nursing theoretical models of healthcare. Individuals/service users and their relationships to nurses are at the heart of integrative nursing. The focus of integrative care is on healing using a broad range of therapies depending on the service user's preferences, needs, and abilities, with a focus on the natural capacity for a human to heal. A unique perspective of integrative nursing is focused on the health of caregivers.

The six principles of integrative nursing are (1) human beings are inseparable from their environment; (2) human beings have the innate capacity for health and well-being; (3) nature has healing and restorative properties that contribute to health and well-being; (4) integrative nursing is person-centered and relationship based; (5) integrative nursing practice is informed by evidence and uses the full range of therapeutic modalities to support/augment the healing process, moving from the least intensive/invasive to more, depending on need and context; and (6) integrative nursing focuses on the health and well-being of caregivers as well as those they serve [28, p. 3–5]. These principles are outlined here because they encompass nursing values and beliefs. They are the foundation for integrative mental health nursing practice and incorporated into the ITP model described later in this chapter.

Other health specialties have also taken up the cause for a more integrated, mind-body approach to mental health. Ross describes [29] an emerging framework in nutritional psychiatry for integrated mental health care which includes nutritional and lifestyle therapies. Kassis and Papps [30] describe the paradigm shift in psychology from emphasizing just the treatment of the mind to the diversification of clinical practices by incorporating complementary and alternative therapies to treat psychological issues. Integrative pharmacology uses pharmacokinetic and pharmacodynamic research to determine the pharmacological effects of complementary/

alternative medicines such as traditional Chinese medicine [31] for clinical practice use.

Recent integrative care planning models have been developed to describe person-centered, collaborative approaches to mental health care. Clark and Clarke [32] propose a multimodal, biopsychopharmacosocial (BPPS) approach for APMHNs to use in assessment, problem formulation, care planning, and implementation. These authors contend that their model moves beyond the more traditional biopsychosocial nursing model by recognizing the importance of medication in the advanced nursing assessment and treatment of mental health problems and therefore should be seen as a separate domain in advanced practice nursing instead of being considered under the usual biological domain. Their BPPS model describes a comprehensive, biopsychopharmacosocial inquiry into the service users' circumstances, including predisposing (historical), precipitating (current), perpetuating (ongoing), and protective factors (strengths). The understanding and problem formulation of the service user's mental health challenge is based on advanced clinical reasoning. While authors of the BPPS model support interdisciplinary teamwork for mental health care including APMHNs, there is less emphasis in their model on collaborative approaches with the service user [32].

Another model of integrative, collaborative mental health care is one proposed by Ee et al. [33], the integrative model of healthcare. Like the BPPS model, Ee et al. [33] describe a model of mental health care which integrates evidence-based lifestyle interventions such as diet, exercise, sleep hygiene, mind-body interventions (meditation and yoga), and nutraceutical interventions (vitamins, plant-based medicines, and amino and fatty acids) with conventional pharmacologic and psychotherapy treatments. This model also proposes collaboration between members of "a treating team" whose members are involved in providing care to the service user in primary and secondary healthcare settings. While informed decision-making is described in the model, its basis is risk assessment of treatment options rather than a focus on collaboration between the service user and clinician for the purpose of developing a service user-specific plan of care. In fact, the authors are explicit in their recommendation for including the following in the treatment plan: "advice given, treatments that were agreed upon, the duration and frequency of treatments, and details of follow up and review" [33, p. 9].

To summarize, the integrative mental health nursing paradigm "...is a holistic practice that addresses the interactive systems of persons to promote their wellbeing within the context of their environment through the intentional use of the nurse/patient relationship as the vehicle to provide person-centered care based on existing and emerging evidence for the prevention and treatment of mental health challenges" [34, p. 465]. Current models of integrative mental health care stop at the point of explicating the clinical decision-making process and SDM in planning integrated treatment. APMH nursing lies at the very crux of integrative mental health care [35] because their focus is on collaboratively addressing mental wellness/health and preventing illness, empowering the service users' to make choices about care, and providing holistic options for care that are personalized and individualized.

9 Integrative Treatment Planning Model for APMHN Practice

The psychopharmacotherapeutic management (PPT) model was developed in 1996 to teach APMH nursing students a clinical decision-making model for prescribing psychotropic medications. Over the last 20 years, this prescribing model has evolved from a medication-prescribing model to the current ITP model with an integrative mental health nursing focus (see Fig. 1). The ITP model incorporates broader, service user-centered advanced clinical assessment, a shared decision-making process for care planning, and a written care plan map (see Fig. 2) to be used collaboratively by service users and/or families/carers and APMHNs to clearly describe the intervention plans. For each component of the ITP model, critical questions are asked to guide the APMHN's clinical decision-making process. The interaction among the components of the ITP model is depicted in Fig. 1 by the arrows.

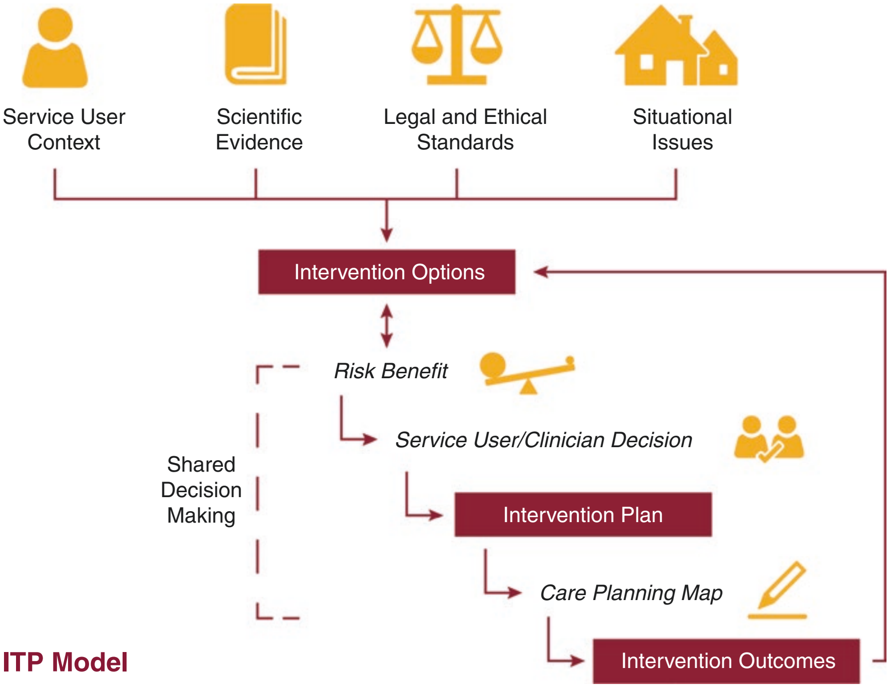

Fig. 1 The ITP model

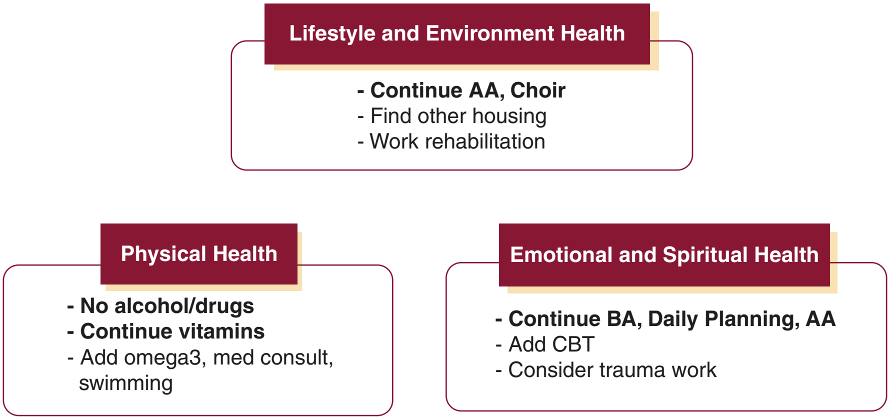

Fig. 2 Example of the use of the ITP care planning map

9.1 Service User Context

The start of this decision-making model after careful assessment (see “Advanced Mental Health Nursing Assessment, Formulation and Decision-Making” for further discussion on this) is with the **service user context** and voice because the service user is central in the care planning process and is the person who is seeking help and support with a mental health challenge. APMHNs need to understand the context of the service user’s life; what has happened to them; how it is experienced; how they define the problem; and what they have tried to do to mitigate or minimize their distress, including what has worked or not, what their history and current circumstances tell us, how their recovery plan has worked or not, and what their goals are for seeking help. An assessment is a first step in articulating how the person conceptualizes their experience. Specific questions aimed at hearing the service user’s voice and understanding the context of their request for help begin the assessment and are listed in Table 2, while Table 3 holds the case vignette of Jon to help us place the ITP model in context with real-life situations.

Table 2 Questions for service user context

What is the service user’s age, gender and pronouns, culture or ethnicity, language, and educational level?
How does the service user learn best?
How does the service user describe their current problem/difficulties/diagnoses?
How would the service user like their life to be different?
How have these difficulties impacted the life of the service user?
What is the psychiatric formulation/diagnosis and any nursing diagnoses?
What has the service user done so far to address the problem? What has worked? What has not worked?
How does the service user describe “normal”?
What are the service user’s goals for treatment and recovery? What is important to the service user’s quality of life?
Are reports from family/carers needed to assist in the description of the problem?
What medications is the service user currently taking, including prescribed, over-the-counter, and herbal/vitamin supplements?
What does the service user describe as their main strengths?
What do the service users’ loved ones describe as their main strength?

Table 3 The case vignette of Jon

Jon is a 36-year-old male who is 2 years sober from the use of alcohol. He lives in a rural town of about 20,000 people in the northeast of Iceland. Jon presents to the outpatient clinic because of increasing symptoms of anxiety and poor sleep. He is having more trouble falling asleep because he cannot stop his worrying about money and whether he will be able to pay his share of the rent. Jon is currently underemployed working part time as a housepainter. He feels his anxiety prevents him from seeking full-time employment. Jon lives with a roommate, Peter, whom he met in alcohol treatment. Regrettably, Peter has recently relapsed, and Jon is also anxious and worried about relapsing

Jon has been singing in a male choir for the last few months and feels this is “healing” and enjoys the company as there are some other sober men in the choir, which he feels is “very supportive.” Jon is quite active in AA and attends his homegroup every week, has a sponsor, is active in step work, and attends additional AA meetings 3–4 times a week as needed. Jon enjoys using the swimming found widely in the town he lives in and swims about three times a week. He takes vitamins D and B but no other supplements or vitamins and no other prescribed medications. In substance use treatment, Jon was taught mindful breathing which he continues to do most days, but since his anxiety has gotten worse, the mindful breathing has not worked to help him relax or sleep. Jon reports that he does not have a structured sleep routine now and he drinks caffeinated beverages, up to eight cans or cups a day. Jon was also taught daily planning in substance use treatment, like can be found in many behavioral activation programs (BA), but because of his anxiety, Jon has not been using the daily planning activities regularly

Jon describes a history of growing up with an abusive and alcoholic stepmother but denies having indications of post-traumatic stress disorder

Jon scored high on the Generalized Anxiety Scale 7 (GAD-7), or 17, indicating severe generalized anxiety

Jon’s goals are he wants to get good sleep again and be less anxious. He thinks he may have to move again

He is meeting with Olga today an APMHN working at the primary healthcare clinic in his neighborhood

9.2 Scientific Evidence

In addition to validating the service user's voice, APMHNs need to consider the best scientific evidence available to help the service user make safe, effective, and cost-effective treatment decisions as possible based on their preferences. This component of the ITP model focuses on using the scientific literature, practice guidelines, and formularies to aid the service user in choosing the best lifestyle, psychotherapy, dietary, pharmacological, and/or integrative approaches, always considering the service user context. Table 4 identifies questions to consider in this component of the ITP model.

Olga, the APMHN, understands the interplay between anxiety, sleep, and alcohol use/relapse. She refers to practice guidelines for guidance in the assessment and available options to address Jon's issues (see Table 5 as an example of this.)

Table 4 Questions for scientific evidence

What practice guidelines and scientific evidence support the treatment for the illness and/or specific symptoms and for recovery?
What are the most evidence validated interventions for the illness/symptom/problem?
Are there relevant medication formularies to be consulted/used?

Table 5 Examples of supportive evidence for Jon

Gautam, S., Akhilesh, J., Gautam, M., Vahia, VN., & Gautam, A. (2017). Clinical practice guidelines for the management of generalized anxiety disorder (GAD) and panic disorder (PD). Indian Journal of Psychiatry, 59 (Suppl 1), S67–S73
Lusk, P., & Kahn-John, M. (2019). Integrative nursing management of anxiety. In Kreitzer, M.J. & Koithan, M. Integrative Nursing (2nd Ed). Oxford, UK: Oxford Press
American Academy of Sleep Medicine, Practice Guidelines, (2022). https://aasm.org/clinical-resources/practice-standards/practice-guidelines/
Cueller, NG. (2019). Integrative nursing management of sleep. In Kreitzer, MJ & Koithan, M. Integrative Nursing (2nd Ed). Oxford, UK: Oxford Press
National Institute on Alcohol Abuse and Alcoholism. Treatment for alcohol problems: Finding and getting help. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/treatment-alcohol-problems-finding-and-getting-help

9.3 Legal and Ethical Standards

All practitioners need to understand and work within the professional legal and ethical standards which guide their scope of clinical practice including national standards and regulations for professional practice, mental health legislation, documentation standards, consents for treatment, and ethical concerns regarding specific treatment choices such as service user competence and pharmaceutical company persuasion. If Olga is to work with Jon to help him manage his anxiety, she needs to be aware of the professional standards of practice and determine if she is legally and ethically able to provide the interventions proposed in the guidelines. For example, if Olga were to prescribe a medication for Jon's anxiety, is she legally permitted to do so? If Olga was considering providing therapy for both Jon and his girlfriend separately, is there an ethical principle to guide her? Table 6 lists some of the major questions to ask when considering the legal and ethical guidelines for care planning. Many of these legal and ethical standards are found within various APMHN and APN professional guidelines and standards of practice (e.g., [36–38]). In addition, some healthcare organizations may also have formularies which APMHNs need to follow for recommending medications.

9.4 Situational Issues

In the ITP model, situational issues are described as those issues the APMHN and service user face in context of the acceptability, availability, and affordability of interventions and the resources needed to assist the service user to meet their goals. Jon has not been successful in using mindful breathing to help him sleep because he says he gets too distracted by the noises in the upstairs apartment. Jon tells Olga he was using noise-cancelling earphones, but he lost them. He would like to try this again. Olga determines that using earphones again is useful for Jon and he knows where to buy them. The cost however may be a concern because of his part-time work and anxiety about money. Jon tells Olga that he is working extra hours over the next month and may be able to afford new earphones to help him sleep. Table 7 holds the relevant questions to ask here.

Table 6 Questions for legal and ethical standards

Are there regulations related to prescribing or providing the interventions, for example, legal scope of clinical practice and professional standards?
Are there ethical concerns about an intervention, for example, service user competence?
Can the service user, family, and carer provide consent for the intervention?
Could prescribed interventions/medications be misused?

Table 7 Questions for situational issues

Are the proposed interventions available to the service user?
Is the service user able to pay and/or access the interventions?
Is there environmental support for the service user to use the interventions?
Do the proposed interventions work well together, for example, time, cost, and food/drug interactions?

9.5 Risk-Benefit Analysis

This component of the ITP model considers the risks and benefits of using or not using potential interventions. This usually entails a discussion with the service user about the goals for care. The APMHN's knowledge of the best research-based evidence for interventions and the potential positive and negative outcomes of these interventions needs to be discussed with the service user and their stated desires and goals. As part of the informed consent process, people have the right to make decisions which may not agree with the APMHN's. In other situations, a recommendation might not be available to the service user, for example, using a gym for exercise. The APMHN needs to be aware of issues that may function as a barrier to the service user accessing interventions. Understandably there are times when the service user cannot decide or participate equally in this shared decision-making process because of physical or cognitive impairments and the APMHN may need to consider supportive decision-making. At other times, the service user may not be their own decision-maker, and care planning discussions may need to be done with the family and/or legal guardian. When possible, the information about treatment options and the risk/benefits of each should be in writing, dated, and reviewed with the service-user and/or family/guardian prior to intervening. Table 8 identifies questions to consider in this component of the ITP model.

Table 8 Questions for risk-benefit analysis

What are the potential positive effects of the interventions?
What are the potential side effects or risks?
Is the service user aware of these?
Does the benefit of this intervention outweigh the risks?
How are risks of treatment minimized and side effects monitored?
Do the proposed interventions match the service user's preferences, values, and beliefs?
Do the proposed interventions fit with other activities the service user is engaged in?
Based on experience, what would be the intervention preferences of the APMHN?
Are there other care team members with whom to consult?
Are the interventions effective, appropriate, safe, cost-effective, and easy?
Have the service user/family/carer and APMHN co-produced a description/formulation of the problem/difficulty and decided about treatment?
How would the service user like their life to be different?

9.6 Service User/Clinician Decision

Once the risks and benefits of the possible interventions have been discussed, the service user and APMHN decide on the specific interventions. In some situations, the decision is to watch and wait without recommending specific treatment but support the positive actions of the service user to manage their own mental health challenges. It is during this process when the APMHN provides to the service user education about the selected intervention(s) and the expected positive and potential negative benefits of the selected interventions. The APMHN and the service user discuss directions and/or education about the intervention and document decisions including any referrals and future appointments. After receiving this information, it is the service user's right not to follow the recommendations and/or engage in further discussions about what is possible for them to do next. Table 9 provides discussion of intervention options for Jon to consider during this stage, and Table 10 identifies questions to contemplate in this component of the model.

Table 9 Examples of intervention options for Jon to consider

Interventions which Olga could do with Jon during this initial visit include reinforcing Jon's ability to do mindful breathing and planning his day. Olga could also teach him progressive muscle relaxation exercises and other types of breathing to relax
Another possible intervention to help Jon alleviate his anxiety is cognitive behavioral therapy. Cognitive behavioral therapy (CBT) has strong evidence for helping anxious people to stop the negative thinking and rumination [39]. If Olga were prepared in CBT, she could teach him how to challenge his negative thinking and change the distortions in his thinking, thereby helping him feel better and able to problem-solve more efficiently. Usually, CBT therapy is conducted over 12–16 weekly sessions, possibly lasting 3–4 months. The positive aspects of CBT are skill-building so Jon develops an understanding about his anxiety and the cognitive skills to manage it. The potential negative aspect is the length of time to learn these new skills and the need to practice them. Olga would review with Jon the advantages and disadvantages of CBT at this time [40]
The use of medication to help Jon manage the anxiety quickly is another intervention option. Because Jon's GAD-7 score of 17 suggests high anxiety at the present time, medications may be useful to help him decrease his anxiety to sleep better and feel less anxious and then be able to focus more to learn CBT interventions. If Olga was prepared to prescribe medications, she might consider several different medications which have solid evidence for managing symptoms of anxiety such as beta blockers, short-term use of benzodiazepines, or antidepressants, such as selective serotonin reuptake inhibitors (SSRIs). Each of these has its own risks and benefits which Olga would then discuss with Jon [39]

Table 10 Questions for service user/clinician decision

If the service user is not ready for treatment, can the service user and APMHN engage in watchful waiting and reassess need for treatment later?
What interventions has the service user already used that have made a positive difference?
Can the service user continue these interventions?
What expectations does the service user/family/carer have of the APMHN?
What expectations does the APMHN have of the service user/family/carer?
What are the goals for treatment and how can these goals be reasonably monitored?
What support does the service user/family/carer need, if any, to follow through with treatment plan?
What other health team members need to participate in the care planning process?
Who is responsible for implementing the parts of the treatment plan?
Who will be coordinating the care plan?

9.7 Intervention Planning

Intervention planning is the next step of the ITP model and is the culmination of the preceding steps. Here advanced mental health directives would be created as well as joint crisis planning with outside facilitation as needed. In this phase the APMHN addresses the care plan decisions and writes them into the care planning map so that the service user can use this map to guide their recovery planning. The care planning map can be given to other care providers (with service user's consent) or could be reviewed verbally. The major reason for using the care planning map is to provide a tool for ongoing collaboration about care options and/or decisions. For ease of understanding, the care planning map is divided into three components. These are (1) *emotional and spiritual health* that may include such activities as psychotherapy modalities like cognitive behavioral therapy or motivational interviewing, stress management techniques, education, advocacy, and spiritual or meditative practices, peer support along with secular philosophies such as stoic philosophy; (2) *lifestyle and environmental health* that may include social activities and support, including support from friends and family; nurturing activities such gardening; or other activities that may be pleasurable to the service user and support the service user to manage stress on a micro- and macro level, and pursue school work, training, or courses for growth and/development, as well as help with occupational rehabilitation, financial stability, and/or helping to secure housing or accommodation; (3) *physical health* may include exercise habits related to physical health, use of vitamins and supplements, dietary habits, sleep and sleep hygiene, medications, advice on the use of drugs or alcohol including caffeine, recent laboratory test and primary care clinic visits, and integrated care for various physical health problems. Table 11 contains key points in the care planning discussion with Jon.

Table 11 Care planning with Jon

There are many interventions Jon is already doing to help manage his anxiety, such as swimming, singing in the choir, and participating in AA activities. But sometimes these activities are not enough. During the discussions with Olga about what he could do, Jon decided to increase his swimming to daily to help him sleep better. Jon also decided to set his morning alarm so he could get up earlier and practice his mindfulness breathing before going to work. He will also continue to take his vitamins and try to reduce his caffeine intake, replacing coffee and Coke with more water and non-caffeinated beverages [39, 41]
Jon also decided he wanted to join a cognitive behaviour therapy (CBT) group so he can learn new strategies for managing his worries and anxiety and meet new people. Olga provided Jon with a list of CBT groups in the community, including the hospital outpatient department. Olga also reviewed the possible medication options with Jon and discussed these options with Jon's primary care provider (PCP). After selecting a selective serotonin reuptake inhibitor (SSRI) medication, Olga educated Jon about when to take the medication and what outcomes he might expect. Olga and Jon reviewed the ITP care plan map (see Fig. 2). Olga used the care plan map to depict the care plan and gave Jon a written copy of this

Jon's care planning map (see Fig. 2) is developed after using the ITP model questions to guide the collaborative decision-making process. Highlighted in **bold** are examples of the things Jon is already doing to as a part of his recovery. This is an extremely important part of the ITP model: coming from a strengths perspective, it acknowledges all the work Jon is doing and has already done for his mental well-being. Seeing this ITP care planning map with the positive activities he is already doing challenges the pervasive ideas often found with service users experiencing anxiety and depression that "nothing has been done" or "I have not done anything to get better." The ITP care planning map shows that no one starts to get better with a blank slate. Everyone is doing something. As can be seen by the **bolded** activities, Jon certainly is doing quite a few things for his recovery. However, this can also mean there are more activities and interventions that Jon can do to feel less anxious and sleep better (some of his goals). After a careful discussion with Jon, Olga adds some suggestions (in regular font) based on the ITP model as to what Jon could add to his care planning map, starting with his **physical health**. Olga and Jon decide to add omega 3 and probiotics to his dietary intake, which they deem an inexpensive, and safe intervention in his context [42]. Jon has not seen a primary care provider (PCP) for 8 years, and Olga recommends a PCP visit to rule out physical etiologies for his symptoms [39]. Jon scored high (17) on the Generalized Anxiety Disorder Scale 7 (GAD-7), indicating severe generalized anxiety. As Jon drinks caffeinated beverages in great excess, up to eight cups/cans per day, Olga will support him with a plan to taper down the caffeinated beverages to improve his sleep and anxiety [39, 41]. Additionally, because Olga does not have prescribing privileges in her country, she and Jon will consult with the PCP about the possibility of the prescribing an SSRI, used for the treatment of anxiety [39].

Next Olga and Jon considers his **lifestyle and environmental health** and recommends continuing his 12-step activity and choir participation as this supports his social connections and social support [43, 44]. Olga suggests to Jon that he consider looking for alternative housing because his current situation is a potential trigger for a relapse of his substance use disorder as well as increasing his anxiety and reducing his quality of life. Olga also recommends a comprehensive and holistic work rehabilitation program where Jon could get support over 12–36 weeks to get back into the labor market full time. Finally looking at Jon's **emotional and spiritual health**, Olga encourages Jon to continue his basic behavioral activation (BA) work with his daily activity planning and his 12-step work and mindfulness practice. In addition, Olga recommends CBT and to consider future trauma work, as this can sometimes prove useful in recovery from substance use disorders [45]. All these activities and recommendations are discussed between Olga and Jon and are written on the care planning map. Jon takes the care planning map home to use as a reference for planning his daily structure.

Table 12 Questions for intervention planning

Does the integrative treatment plan include specific interventions for reducing symptoms and maintaining and/or improving physical, emotional, spiritual, and social functioning?
Do these interventions include conventional medications, complementary/alternative techniques, psychotherapy and/or mindfulness interventions, lifestyle modifications and support of social networks, and strategies for strengthening a personal sense of spirituality?
Do these interventions address the service user's personal description of the problems, values, beliefs, and preferences?
Do the interventions help to meet the service user's goals?
What education does the user/family/carer need to be comfortable and/or successful with the plan?
Does the integrated treatment plan include interventions for the initiation, stabilization, maintenance, and recovery phases of treatment? Crisis/emergency plans? Referrals to other health team members?
Are the follow-up visits noted on the care planning map?
Does the written care planning map include what the service user is already doing as well as new interventions?
Who receives a copy of the written care plan? Service user? Family/carer? Health record? Health team members?

There are many things to add to the care planning map, but Olga emphasizes Jon's strengths and preferences and is careful not to overwhelm Jon with more things he "should" do, as this runs the risk of adding to his stress instead of alleviating it as well as being an overly paternalistic approach to care planning. Olga and Jon would adjust the care planning map as needed over time based on Jon's preference and changes in his mental health. Over time Olga and Jon will build up an interactive and collaborative care map that will function as a blueprint for Jon's path to recovery, helping him to eventually manage his own recovery independently (see Table 12 for questions to consider in this phase of the model).

10 Intervention Outcomes

Determining realistic outcomes with the service user and APMHN together is the final piece of the ITP model. Monitoring and evaluating the effects of the interventions is essential for quality care and a key component of the competencies for APNs and APMHNs [38, 46]. Intervention outcomes inform APMHN practice and as can be seen in Fig. 1; at this point the ITP model circles back to interventions the service user utilizes and informs the next step in the care planning process. Table 13 outlines some essential questions to help with this final phase of the model.

Table 13 Questions for intervention outcomes

Are the expected treatment/intervention results clearly and specifically noted on the integrative treatment plan with a process for evaluation?
Does the service user/family/carer need coaching as to how to evaluate progress?
How should behavior/feelings/thinking/function be assessed?
What is the service user's personal definition of recovery?
Is there a process for ongoing review of the integrative treatment plan?

11 Future Directions

For APMHNs a recovery-oriented approach becomes meaningless if not actualized through concrete actions manifested through their delivery of care. Shared decision-making (SDM) lies at the very core of integrative care planning as little can be achieved without applying the principles of SDM to any care planning model. Although guidelines, pathways, and collaborative care models are helpful in guiding treatment, they require a more holistic and integrative approach to ensure they truly encompass a shared decision-making process between the APMHN and the service user to meet the service user's needs.

The ITP model supports the APMHNs complex decision-making process of creating a comprehensive integrative care plan, through a step-by-step process founded in SDM and integrative nursing. The model also helps the APMHNs apply critical thinking skills to each service users' unique needs while keeping a collaborative focus. But it is in emphasizing this collaborative effort that the future direction of mental health care planning lies.

12 Summary

Clinical decision-making and care planning for APMHNs need to be based on the unique philosophy of integrative nursing and the philosophy of recovery-oriented care including SDM. This chapter introduces various care planning models, the concept of shared decision-making and introduces a model for integrative mental health nursing care planning, the ITP model. The model includes eight distinct steps of care planning based on SDM and an interactive Care Planning Map for a visual, dynamic, and collaborative approach with the service user and/or carers. A case vignette demonstrates how the ITP model and care planning map can be utilized to create a truly integrative treatment plan with service users and illustrates the role of the APMHN in this collaborative process.

Reflective Questions

- What do you think are, or will be, the challenges and opportunities of shared decision making in your own practice as an APMHN?
- Why may advanced mental health directives prove important for service users, practitioners, and family members?
- Consider the ITP Care Planning Map. How would you create a care map for yourself? What are you already doing in each of the three components? What would you add for yourself and why?

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Part III

Therapeutic Engagement in Different Contexts

Collaboration with Families, Networks and Communities

Eydís Kristín Sveinbjarnardóttir and Nina Kilkku

Learning Objectives

The objective of this chapter is to enable you to:

- Understand the history, the different developments and the importance of family-focused care in mental health to encourage you to work with families and networks in an inclusive and active manner whenever it is appropriate and possible.
- Understand how a mental health crisis challenges and impacts not only on the individual but also family members and other social networks.
- Integrate family-focused approaches in your own practice by establishing therapeutic alliances with family members and other members of the social networks and motivate others in your work environment to work in a family-inclusive manner by providing role modelling and clinical support.
- Reflect on and critically assess your own practices in family-focused care from the viewpoint of competencies of the advanced level mental health nursing.

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1 Introduction

In this chapter, our aim is to encourage and support mental health nurses and especially the advanced practice mental health nurses (APMHNs) to work in a family- and network-inclusive manner, whenever that is possible. Moreover, even in a therapeutic alliance with individual clients, APMHNs need to discuss and consider the persons' background and possibilities of support from their family and/or social networks in a challenging life situation. If there is a need for community or hospital care, it is important to remember that the individual's length of stay in these settings is most often only a small part of the persons' whole life. Furthermore, as helping professionals, we should make ourselves unnecessary as soon as there is no need for professional help and support. Other people, usually family members and significant others in the clients' life, are often providing continuous and necessary support. In addition, family members and others within the persons' social network may also be in need and entitled to support and knowledge to ensure their own well-being. The more understanding APMHNs and all health professionals have from the prevention viewpoint, the more important family- and network-based practices become.

The APMHN needs to be aware that mental health or substance abuse problems contribute to 10–13% of the global burden of disease and this is expected to increase in the next decade, the most common being anxiety and depression. Before the age of 14, half of all mental problems will have occurred for the first time. A suicide occurs every 40 seconds somewhere in the world. Despite these facts, countries do not spend enough of their health budget on mental health, on the prevention on mental health problems or on taking the responsibility in creating policies that guarantee the welfare of families. Instead, families are filling the gaps in caring because of lack of support to persons with mental health problems within the mental health service system – often creating a burdensome situation for the entire family [1, 2].

Several international policy strategies and statements are encouraging and supporting the family-focused care. In a recent guidance document by the WHO (World Health Organisation), the importance of person-centred and right-based approaches together with an emphasis on families is highlighted at the policy level. The WHO notes that "Countries with a strong and sustained political commitment to continuous development of community-based mental health services that respect human rights and adopt a recovery approach will vastly improve not only the lives of people with mental health conditions and psychosocial disabilities, but also their families, communities and societies as a whole" [3, p. xviii]. This supports the further development of the family-inclusive mental health practices in communities, where APMHNs have an important role to play.

In the 2020 International Council of Nurses (ICN) Position Statement on Mental Health Nursing relational interventions were recognised as the foundation for effective nursing service not only with individuals but with families and communities [2]. Moreover, the International Family Nursing Association (IFNA) Position Statement on Advanced Practice recognises a similar vision and framework on advanced practice as the ICN [2, 4, 5]. The ICN monograph from 2002 on family nursing, emphasised that caring for families is a central focus of nursing, to reduce the factors that damage health, to enhance good health and well-being and to strengthen self-care and coping skills. In the ICN documentation, they recommend using approaches with theoretical foundations and underpinnings [4], similar to those we emphasise in this chapter.

This chapter on working with families and networks starts with exploring and defining the concept of family and family-focused care. A brief summary is given on the history and developments of the family-focused care in the mental health settings and on the impact of the mental health challenges or problems on the family. Advanced practice competencies in family nursing are introduced, five family-focused care frameworks or approaches are presented and finally family collaboration with networks is emphasised.

2 What Is Family?

Family has been defined in various ways as it has been difficult to reach a consensus on a unified concept [6]. Wright and Bell [7] defined a family as a “group of individuals who are bound by strong emotional ties, a sense of belonging, and a passion for being involved in one another’s lives” (p. 72). Families have a variety of subfamily systems, that is, spouses, siblings, parents, children and adult children. Families can be formed by procreation, blood related, blended or a family of choice—with preferences who is included in the family; hence, families themselves define who they are [7]. In many Western countries, the traditional idea of family has included the so-called nuclear family with two parents and children, although this description has also been challenged [8]. As the concept of family is also a culturally and historically defined construct, it varies between countries, some being more individually focused and some more family-centred. Therefore, the idea of family as persons who are part of the same household might be too simplistic. For these reasons, we invite you, the APMHN, to be open minded when reading this chapter and when applying this knowledge in practice with different families, irrespective of age, gender or any other diversity which might define them (see also “Diversity and Culturally Responsive Mental Health Practice”).

In this sense, we can also talk about networks, the different social networks persons are part of and which might provide support and help in the times of mental health distress and problems. These social networks could include people from other networks besides family, like people from the workplace, leisure activities or peers. So, networks go beyond the traditional ideas of family, and they incorporate people who might be worried about the person or the situation and who could be invited to dialogical meetings in the time of crisis (e.g. Seikkula and Arnkil [9]).

3 What Is Family-Focused Care?

There are many kinds of terms for family-focused care or family-centred practices used in the literature [10]. In this chapter, we will use both the terms of family-focused care and family nursing, in the context of the mental health-care settings.

Foster et al. [10] found, in their systematic review from 1994 to 2014, six core mental health practices underpinning family-focused practice with clients of mental health services and their families. Those included family care planning, liaison between the family and services, support, assessment of the family, psycho-education and a coordinated system of care for families.

Family-focused care becomes actualised when families are invited and involved in the care of their family member. Family members and their support play an important role in the recovery process [7]. When family-focused care is implemented into routine acute clinical mental health nursing practice, family members reported significantly more cognitive and emotional support compared to a control group that received traditional care. Family members receiving family-focused care reported receiving more information and knowledge from the nurses (cognitive support) and in sharing their experiences with the nurses (emotional support). However, in the same study, the clients reported receiving less cognitive and emotional support from the nurses compared to their family members—measured with a perceived family support questionnaire [11, 12]. There are several explanations for the difference in perception of the nurses' support, but one could be that service users are in an acute mental health state and are possibly not as open and receptive to the support as their family members. Therefore, it is important to remember that the service users who are dealing with mental health challenges are on a different recovery journey than their family members who are on their own separate recovery journey [7, 13].

Advanced level family-focused care in mental health means that evidence-based family assessment and interventions are integrated into the practice [14]. While family-focused care builds on family therapy theories and principles, it is not the same as family therapy. Family therapy or family psychotherapy demands specific education which varies between different countries and which some APMNHs may be skilled in, following further education. In this chapter, however, we focus on family-focused care, which could be implemented by the APMHN without further education as a family therapist or a psychotherapist.

4 Brief History of Family-Focused Care

4.1 The Blaming and Suffering of Families

The emphasis on psychiatric-mental health nursing, from the mid-nineteenth century until the time after World War II, was on institutional care. Theories and literature on families of people with mental health problems in that time period described families as negative and pathological. Families' feelings of guilt because of mental health problems have also a historical background as they have found themselves blamed as primary sources of mental health problems in the family. This was reflected especially in the term of the 'schizophrenogenic mother' introduced by Frieda Fromm-Reichmann in 1948 and used in the psychiatric literature until the 1970s [15, 16]. The focus on family communication and especially towards the mother as the 'most disordered member of the family' was seen also in Bateson's double bind theory of schizophrenia [17]. Although research does not support the idea that the mother is the cause of schizophrenia in her child and ideas around the 'schizophrenogenic mother' were challenged by the organisation of parents of people with a diagnosis of schizophrenia [18], this thinking caused considerable damage which created much sadness, worry, shame and guilt for the families, which in turn increased their suffering [16]. Criticism towards institutional care was growing in the 1950s at the same time when new medications were invented. After World War II, the pioneers in family therapy and the first generation of family therapists emerged who deviated from conventional practice. Murray Bowen, one of these pioneers, established a family systems theory, seeing the family as an emotional unit where illness in one family member affected the entire unit. He is said to be the father of the generational transition idea in families [19].

4.2 Expressed Emotions, the Knowledge of Attachment Styles and Intergenerational Influence

Brown et al. [20] reported differences on relapses between male clients returning home or to some other housing environment after hospitalisation. The clients who return home were more likely to relapse if they return to live with their parents or wives [20]. This finding was followed by several studies concentrating on so-called expressed emotions, a term used to describe the emotional atmosphere with the family unit [21]. Expressed emotions put again the focus on families, this time focusing on the families' emotional environment, although it is now recognised that the difficulties in families' emotional atmosphere might be caused by the burdening life situation.

A theory on attachment styles has provided knowledge, not only from the individual but also from the family's viewpoint [22]. Although the mother-infant relationship is often the primary relationship in families, there could be also other caregivers, father, grandparent or other relatives, to provide secure attachment to an infant, especially if the mother is not able of providing this by herself. One important aspect to understand is the effect of the intergenerational, unresolved traumas [23], for example, it might be difficult for the mother to adapt her behaviour according to the infant's needs, if she has not experienced safe relationship as a child herself. Similar behaviour might also be evident in previous generations. A sense of insecurity could also be reflected in difficulties in trusting mental health professionals and the help they provide, making co-operation sometimes challenging if this is not recognised [24]. This intergenerational understanding can help the family and the professionals to see patterns in difficulties and the importance of considering different options in care.

4.3 Objective and Subjective Burden

Research for decades repeatedly shows that families, including one or more family members with serious mental health problems, have to cope with stressful and emotional situations. Experiences of both objective and subjective burdens of families have been researched and described in the literature [25]. Objective burden includes negative experiences on all aspects of family life activities and the burden of instrumental (practical) caring of the person with the mental health problem. Subjective or emotional burden on the other hand includes the internal impact on family members and feelings of stigma and embarrassment in social situations.

The various aspects associated with mental health problems like challenging behaviour, mood swings and sleep reversal patterns, to name only a few, have been reported as burdensome for families and family members to cope with, especially from the social and emotional viewpoints. Part of the burden families reported in the 1990s was based on their negative experiences with mental health service system, the blaming attitude they felt and the deficit view of the family, that is, describing and emphasising only the burden and the stress of caring for the family member with mental health problems [25]. Rose et al. [26] in 2006 described how the family caregivers experienced emotions of grief, sadness and worries about the future of their family member with mental health problems. They emphasised how these emotions could contribute to the risk for family members having mental health problems themselves because of their burdensome caregiving situation. In their study, family members reported experiencing the instrumental burden, in relation to financial problems, missing work and frictions with friends, being perceived as smaller than the emotional burden because of their caregiving role [26].

The burden studies emphasize the negative aspects of the caregiving experience and omitted to look comprehensively on the diverse experiences of being a caregiver. Recent studies of family members of people with mental health problems describe and give more positive meaning to the social support experiences of caregiving. These studies emphasise supportive conditions of deepening the understanding of the mental health problem to increase the attitude of endurance of acceptance and affection. This attitude buffers the impact of stressors from the mental health challenge for the entire family. Moreover, it makes room for endurance of attitudes like respect, worth and value towards the person experiencing the mental health problem. These supportive conditions increase acceptance and decrease stigma which gives more space for hope, growth and recovery [27].

4.4 Intervention Programmes for Families

In the 1980s' and 1990s' evaluations of family intervention programmes, with emphasis on psycho-education, stress management and support showed promising results [28]. Studies found that the families' feeling of support, ability to cope with stress and problems related to their family members' mental health problems and recovery and feelings of burden and distress significantly improved because of a family intervention programme. Since then, a number of comprehensive reviews and meta-analyses have supported the effectiveness of these types of interventions [29]. However, many of these studies were not concerned with the well-being of the family but rather the decrease in service user relapse rate, which was one of the key outcome variables [10]. The interest has gone beyond the relapse agenda, with the families' perspective being emphasised more, but further development in family-focused care is still needed [30].

4.5 The Stigma of Mental Health Problems

Mental health problems still carry stigma, which affects not only the person experiencing the mental health problem but also the family (e.g. Reupert et al. [31]). Besides the burdensome life situation, as has been mentioned before, the courtesy stigma experiences can raise feelings of guilt and shame and lead to family members withdrawing from social relationships which can exacerbate their sense of isolation and loneliness. Moreover, several studies have shown that family members themselves are at an increased risk for mental health problems, such as stress, anxiety and depression, due to the emotional, social and economic pressures of their caring role. While these risks are widely known, family members are often marginalised by the mental health system; hence, family-focused care could also be considered as preventive [10].

5 Why Family-Focused Care?

In this section, we emphasise the importance of involving family members in advanced mental health nursing practice when caring for persons (older person, adult, children, youth) experiencing mental health problems. Mental health problems affect the entire family, and each person in the family deals with the situation in their own way. Moreover, as already stated, each person in the family has his/her own separate recovery journey, and each family, family members and persons with mental health challenges have their own different narratives and stories to tell [7, 13].

5.1 Benefits and Barriers of Family-Focused Care

In mental health settings, the benefits of the family approach are based on wide understanding and research on the importance of family involvement and participation in care both for the person experiencing mental health issues and family members, parents, siblings or children of someone with mental health problems [10, 30, 32, 33]. An additional benefit is preventing family members from being at risk of developing their own mental problems [34]. APMHNs are in the ideal position to work simultaneously with the client and the client's family members [35], and they usually have a positive attitude towards working and collaborating with families [14, 36]. It is important that the APMHNs recognize the potential positive influence of families in shaping the course of their family members' mental health problems and recovery. Some care models have been developed since the importance of family-focused work has been acknowledged, but still there seems to be paucity of evidence-based knowledge on how, and if, these models have been adapted and implemented into practice (e.g. Vermeulen et al. [37]). There is a need to increase the advanced practice competencies in family-focused care to enhance recovery and wellness within the family [13, 38].

Besides the studies showing the importance of family work, during the recent decades, the reform of mental health services has impacted strongly on the role of the family. In line with the deinstitutionalisation process and more progressive mental health policies, community-based services have been developed, although European countries are in very different phases in this process [39]. With the community-based and low threshold mental health services, everyday support provided by family members and other close ones is highly important. From the family member's viewpoint, this might cause burden, but from the viewpoint of the individual, it is more human if hospitalisations could be avoided or the length of stay in institutional care could be as short as possible, because of stigma. Community-based care models demand informal support if needed, and often this means support provided by the family [37].

In a study published in 2015 by the European Federation of Associations of Families of People with Mental Illness (Eufami) and University of Leuven (KU Leuven, LUCAS), with 1111 family members from 22 countries as participants, both the country-based information and overall information were described showing the experiences of family members in their caring role with their family member with severe mental health problems. The study reveals several risks in different life domains for the family members as carers, including high level of burden on the social relationships as well as on their physical and mental well-being. But at the same time, there are also positive experiences, like love and compassion, and the balance between these two is crucial. However, over a third of the family members indicated that they were near breaking point, which emphasises the need for more support [37]. Other researches involving eight European countries have also shown the economic importance of the carers' work to societies [40]. Family members' expectations towards the professionals included the need to be listened to, taken seriously and recognised as full partners in care [37].

With an EU-funded eMenthe project (2013–2016), open access e-learning materials were developed to support the advanced level mental health nurses' competence also in family-focused care. Competence of working with families included knowledge of the family system and the impact of mental health distress on the family, valuing the role of the family and working with the family by providing support and education [41]. The theme of working with families also included competence to interact with the family and an ability to identify individual and family's needs. In addition, competence for collaborative knowledge development as well as competence to address the ethical and legal issues around involvement is required [38].

Besides practitioner competence, the challenges of integrating family-focused care into mental health practice are often related to constraining factors in organisational structure and culture. Systematic barriers such as lack of time [42] and a strong culture and tradition of focusing on the individual client as well as an emphasis on the biomedical model of care may prevent many professionals from collaborating and working with families [43]. Professionals have also referred to the clients' reluctance to include family members in care and decision-making, pointing towards legal issues and challenges of knowing what information could be shared safely with the family [38]. Moreover, it is important to mention that within the family, there can be systematic or social barriers connected to availability of family members themselves in supporting the person, that is, work commitments, childcare issues and demands of modern-day life.

Sometimes there are situations in which the family's involvement should be critically evaluated and refused (e.g. in case of history of abuse). If the client refuses to give consent to contact family members, it is still important to talk with the client about the worries other people might have in the situation and to discuss together what are the reasons for not having a family member or other persons from the social network included. Keeping this conversation open and ongoing is important, as sometimes clients may change their mind.

6 Approaches in Family-Focused Care

APMHNs are in a leadership position to include and advance family-focused care, that is, to look at the person in relation to family and social context. In this respect, it is important to emphasise that we all come from a family; we all have social networks and backgrounds which may help or hinder our understanding of the persons' family and social networks. Our own unique experiences might resonate with the experiences of the family, but we need to understand and recognize the uniqueness of each individual and each family from the viewpoint of their world view. The experiences family have and the meaning they give to those experiences are primary. The collaborative development of knowledge becomes possible in a respectful and trusting relationship when the knowledge can be discussed and shared together.

However, this does not mean that mental health professionals should disclose their experiences when working with families or that they should only have positive experiences in their past. Instead, it urges mental health professionals to reflect on their own family and other networks' experiences to help them to understand the other's experiences. As human beings, we all have different shadows in our life; we need to become familiar with these and develop an awareness, acceptance and understanding about ourselves and others by self-reflection. This knowledge can help us to understand the clients and their families in times of crisis [44]. Personal experiences that have been reflected upon and integrated with knowledge of family theories provide the APMHNs with tools to address family-focused care within their practice. When APMHNs integrate family care into their practice, it is important that they 'think family', meaning that in all meetings with clients, the APMHN uses therapeutic curiosity and enquires about close family members, family environment and the client's family attachments [45].

Systems theories have provided the background for family work for decades. Individuals are thought to be best understood in the context of their families, the family is a system and, moreover, everyone in the family is a system as well. At the same time, the family is a part of a larger environment. Each system affects other systems, and systems have inner movements too, meaning there are changes within the family system and the family system is affected by outside systems. Other background theories commonly presented with family interventions are based on theories of communication, cybernetics, postmodernism and change [14]. In the family assessment, different tools are often used when exploring the structures, relationships and attachments of the family. Ecomaps and genograms are popular tools in clinical practice in conducting a family assessment with service users and family members [14]. However, these tools are not only for assessment as they also support ongoing therapeutic discussion and analysis. Furthermore, they provide narratives and common understanding among clients and family members as well as sometimes bringing the forgotten or not spoken issues to the joint discussion. In this sense, they are not only professionals' tools but tools for all the participants within the collaboration.

When working with families, the verbal and non-verbal communications between family members are the most easily recognised, but over-interpretations should be avoided. Active listening and true and authentic interest towards everyone's concerns are the keys to understand the families' situation and the viewpoints of all individual family members. This means involving family members in all age groups, including children. In exploring issues with families, the APMHN should acknowledge the burdening and risk factors but also the strengths of the family. Especially in times of crisis, like when someone in the family is experiencing mental health problems, the person's viewpoint can often narrow and focus only on the problems. As there are always things that work well, these could be highlighted as strengths for the family to focus on and to support coping. These could be small, everyday matters or the help-seeking that has already taken place. For example, when family members come together to discuss the situation, they are showing compassion and willingness to support the person who is having problems at that time [7].

The co-operation with the family is based on the therapeutic alliance with the whole family and with all the family members. In the highly emotional or conflict situations, it might be challenging to join with all family members equally. Therefore, it is of importance to inquire of clients and family members about their personal lived experiences on the challenges facing the family when offering the family conversations. Their feedback can strengthen the therapeutic alliance and, moreover, the quality of the family intervention [46].

It is possible to work in a family-oriented way without meeting everybody in the family and even when having an individual therapeutic conversation [14, 45]. Personal protection of the person and family (e.g. suicidality or risk of violence) as well as confidentiality issues must be discussed openly and respected with family members. For example, when a young adult client rejects a meeting with parents, it does not mean that the parents should not receive support—but it means that the professional who supports the parents cannot disclose information about the young adult. Working with families is always built on the principles of dignity, openness and equality.

The next section presents five possible approaches that may support APMHNs to work in a family-focused way. The first one is collaborative development of knowledge which is an undivided part of the family-focused care. As a second approach, the Family Strength-Oriented Therapeutic Conversations (Fam-SOTC) is introduced as a structured approach towards giving cognitive (information and knowledge) and emotional support to families. The Open Dialogue approach and two preventive approaches for families with children are also introduced, that is, Let's Talk about Children and the Solihull approach. Two clinical vignettes are used to give deeper meanings and understanding into the Fam-SOTC and Open Dialogue approaches.

6.1 Collaborative Development of Knowledge

We have previously stated the importance of families supporting the person who is experiencing mental health problems as well as the support the family members need to promote their own well-being and mental health while at the same time learning to navigate the mental health service system. Often families have a need to understand why their family member is experiencing mental health problems. Family members may have questions like, why us? Have I done something wrong? Should I have noticed something a long time ago? And what does this mean for the person's and the family's future? Families need for information, knowledge and understanding could be recognised in these questions. When working with families, these different questions and concerns may be encountered, regardless of the age of the family member. For example, children of a parent with mental health problems might have totally different kinds of worries and questions to that of a sibling, a partner or a friend. It is important to acknowledge, encounter and accept every one's concern and worry equally. In this way, the collaboration developed together brings different experiences and stories to the surface and ensures that everyone is heard. This means that different kinds of knowledge are brought together, and space is given not only to the theoretical and practical information but also other matters, like experiences and emotions and expectations of care. Often there are questions without clear answers, and part of the APMHNs' professional care is to listen and understand the emotions behind the questions, so that the emotional and information needs of the whole family are met. For people in distress, it is important from them to know that professionals have heard them and will get back if some more information is available. The most inhuman action is to neglect or dismiss these questions (see "Therapeutic Alliance").

Mental health problems might mean that life becomes less predictable in the sense that things which are out of the person's own control can happen. This is especially evident with first-episode psychosis but also with other mental health problems. But at the same time, it is important to remember that mental health problems or a diagnosis should not determine the life of the individual or the family, and there are always strengths in the family, although they might not be so explicit to others. Some examples of strengths could be the family's sense of belonging and caring for each other, mutual sense of humour or joint hobbies.

6.2 Family Strength-Oriented Therapeutic Conversations (Fam-SOTC)

The Calgary Family Assessment and Intervention Models (CFAM and CFIM) have been used as a theoretical framework to support in the implementation of family nursing in entry level as well as advanced nursing practice within several hospitals and community settings in several European countries: Denmark, Iceland, Spain, Portugal and Switzerland, to name a few [14]. Nurses and clinical nurse specialists (CNS) have integrated family-oriented principles into their care in these countries [14, 47]. The Calgary Family Nursing Models is underpinned by systemic and communication theories [14]. Although few studies are available on the outcomes of its use, one controlled study in Iceland which compared Fam-SOTC (68 clients and 68 family members) with family nursing care as usual (74 clients and 74 family members) in an acute inpatient mental health unit reported some positive results. Family members who received the Fam-SOTC reported significant higher cognitive and emotional support from the nurses than family members who received care as usual [11].

The core of the intervention in the family strength-oriented therapeutic conversations (Fam-SOTC) is listening and hearing the families' story about their mental health experiences—to get to know and understand the families' narrative and show empathy to the family situation and each family members' personal struggle. The whole process, including family interviews, assessment and intervention, is conducted in a safe environment with the family, with the main aim of the family conversation being to provide cognitive and emotional support to the family. The APMHN establishes a therapeutic environment and creates the therapeutic alliances with the family by joining them through respectful listening of the family's narrative about their mental health problems and with encouragements to tell their story. At the same time, the APMHN encourages the family members to listen to each other's concerns and feelings. When listening to the families' stories, the APMHN is in an ideal position to assess the structure and function of the family, noting the content and tone of interactions within the family. The APMHN uses assessment tools such as the genogram and ecomap, always developing them in collaboration with the family. The genogram (family tree) explores the three generational structures, relationship and attachments in the family. The ecomap explores the context, environment and family members' relational connection to society, for example, neighbours, schools, work, hobbies and church [7, 14, 47].

After establishing the therapeutic bond with the family, the APMHN may use cognitive, affective and behavioural intervention methods to support the family. The cognitive intervention involves knowledge sharing and informing the family, commending family members on their strengths and offering possible opinions to help the family find new solutions. Commendation is focused on praising family members on their strengths and using phrases such as 'You have stood by the side of your sister and supported her in her challenging situation'. The APMHN also draws on their knowledge on affective interventions to validate and normalise expressed emotions which is helpful when families are challenged by mental health problems. In the behavioural aspects, the APMHN may need to guide families in the area of self-care, such as the importance of achieving a balance between caregiving and rest. Furthermore, encouraging families in establishing rituals like having a regular meal together or lighting a candle to remember precious times in grief can help support healing processes and help establish family functioning and resilience in families. When exploring and working with rituals in family conversations, it is of importance to always respect and remember how cultures and contexts influence what rituals are important within a family unit [14, 47].

It can also be helpful to use a short evidence-based questionnaire like the Family Perceived Support Questionnaire (ICE-FPSQ) to explore if the interventions provided are meeting the informational, cognitive and emotional support needs of the family members [12]. The experienced APMHN can gain a comprehensive overview of the main issues a family is dealing with in a structured family assessment and intervention interview that lasts for 40–60 min. The APMHNs are not just in a leadership role in relation to conducting family conversation themselves. They are also in an ideal position to be role models for junior nurses and other mental health professionals on how to integrate the Fam-SOTC family conversation into services via education, training and supervision.

The following case vignette comes from Madeira Portugal where a mental health nurse uses the principles of Fam-SOTC in her mental health practice.

Case Vignette Family Strength-Oriented Therapeutic Conversation Approach

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Family Context

The family Brown includes three members living together: Nancy, a 58-year-old widow, with a diagnosis of depression after the death of her husband to sudden illness 4 years ago; Luca, 35, Nancy's son, unemployed; and Mary, 20, waitress, Luca's partner, living with them for 2 years. Luca expresses, feels and believes that his mother does not try hard enough to get out of her depression. According to Luca, they have their conflicts because they have different points of view. Nancy and Mary state that Luca is a controlling and obsessive person who has difficulties in managing criticism, even constructive criticism. Nancy reveals that Luca and Mary argue a lot with each other and she criticises some of her daughter-in-law's behaviour. Luca says he finds it difficult to manage Mary and Nancy's relationship as they both use him to get things off their chest and he does not know how to manage it. Mary reports feeling inhibited and insecure, avoiding expressing herself in the family. All family members show mistrust towards others. Each one thinks they know the other very well, but when they express themselves individually, they report not feeling understood by the others.

Family Nursing Intervention

The intervention included cognitive and emotional support methods according to the Calgary Family Assessment Models. During seven sessions, 3 weeks apart, I (Maria Hilda) sought clarifications about Nancy's health condition and the importance of family support; discussed the purpose of the intervention; systematically reassessed the family's perception of beliefs, strengths, resources, problems, difficulties and changes achieved; strengthened the facilitating beliefs about illness which supports positive beliefs about illness challenges; worked on family's cognitive appraisal of constraining beliefs; and commended/reinforced family members' positive changes and problem-solving skills. I completed the intervention by offering the family a therapeutic letter summarising the family's journey; highlighting the family's strengths and resources, changes and skills achieved; and thanking them for the opportunity to work with and learn from them.

Family Outcomes

Nancy' depression improved. She became less dependent on other people's comments and more self-confident and became aware of the attitudes that caused Mary's inhibition, avoiding them. Mary became able to express her feelings, without fear of judgement or feelings of inferiority towards Nancy. Luca negotiated strategies to be able to respect family members' differences, listening to them and avoiding controlling attitudes. He improved his self-esteem after enrolling in the employment centre and recognised that this benefited him and enabled him to change his behaviour from being so controlling and focused on Nancy and Mary. The family became aware of and recognised the importance of each one's role and learned to respect each one's abilities. They learned to recognise their strengths and to focus on solutions rather than problems and developed skills in identifying the best solutions for their problems. As a family, they felt more united, stronger and prepared to deal with difficulties.

The vignette comes from clinical research where names and personal identification of service users and family members have been changed for personal protection.

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6.3 Open Dialogue

Open Dialogue (OD) is a network-based, psychosocial approach which has been developed since the1980s in Northern Finland, in the Keropudas Hospital in Western Lapland. One of the main pioneers of the Open Dialogue approach is Professor Jaakko Seikkula. He developed the approach with his Norwegian colleague, Tom Andersen, and other fellow team members. They adapted and implemented the ideas beyond Lapland, that is, to other Northern European countries and later into more countries internationally (e.g. Seikkula and Olson [48]). Open Dialogue is described as a philosophical and theoretical approach as well as a system of care. The Need-Adapted approach which was developed to focus on the client's needs influenced the development of the Open Dialogue [49]. The background and history of the Open Dialogue have been widely described in the literature, and there is constantly the increasing number of studies from different viewpoints and from different countries highlighting the benefits of the OD approach such as preserving the client's agency and decreasing the use of mental health services in the long run (e.g. Seikkula et al. [50]). Open Dialogue was included in the latest publication by the WHO [3] as an example of good practices that promote rights and recovery of the client and the family.

There are seven principles underpinning Open Dialogue: *immediate help, social network perspective, flexibility and mobility, responsibility, psychological continuity, tolerance of uncertainty and dialogicity* (e.g. Seikkula et al. [50]). *Immediate help* is provided as soon as possible, within 24 h, and no meeting is held without the person in crisis. S*ocial network perspective* means that in the first meeting, the family members of the person in crisis, and the person, with other important people in his/her life are invited to join. This might include professionals from other services, friends, neighbours or other persons who belong to the social network of the person in crisis. *Flexibility and mobility* mean that the persons' changing needs guide all the therapeutical choices. *Responsibility* means that the person who was first contacted with the mental health services is responsible for arranging the first meeting and summoning the network together. The whole team is responsible for the care process, that is, the person in crisis and his/her network are part of this team. *Psychological continuity* means that the team is responsible for the treatment if it is needed. Open Dialogue acknowledges that in the time of crisis, no one has the answers, so *tolerance of uncertainty* is needed to create safety and trust. *Dialogicity,* the last principle, means that focus is primary on dialogue, not on change, which is different to other approaches where change is often the aim and desired result of the care provided.

Open Dialogue is by no means a 'cook-book' approach or model. In this text, we chose to introduce the Open Dialogue by describing the principles, to give an idea to the APMHNs on what it means to collaborate with families and networks through the OD approach. The following case study from Finland describes two persons' experiences of Open Dialogue.

Case Vignette Experiences from the Open Dialogue Approach

Hannele: The origins in my family's needs for mental health care have been in life crises we have experienced. Our needs for treatment have lasted for several years and there has been different kind of processes according to the changing situations. We have been offered individual and trauma therapies to deal with personal issues and couple therapy to strengthen our parenthood and relationship.

We have also had network meetings with our family and professionals from mental health care and from school to create shared understanding of the whole situation. These network meetings have been crucial to ensure support to my child at school. Those meetings have also taught me how to speak about challenging issues with and in the presence of my child. With help of professionals, I have been able to see also the good things instead of seeing only challenges and worries.

Overall, I am very satisfied with the treatment we have got. I have found it important that same professionals have worked with us during the process even if there have been also new ones in different therapies. Familiarity has enabled confidential and smooth collaboration. I have felt myself appreciated both individually and as a parent and for me it has been important to feel equality in treatment relationships.

Mia: My professional identity is built around dialogue and connection. In this breathing environment I have been able to learn with my collages and clients about the human suffering in ways I haven't experienced elsewhere. When the training offers a process of awareness in relation to our own life narratives, it offers a powerful invitation to people to explore their inner voices in relation to their practice. Also being able to work with clients` networks as a team has built a capacity for me to trust the dialogue, process, and people. When we succeed in our aims to build a joint meaning making processes, people are truly owning their stories and relationships in them and can heal and recover together as a family and network.

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Mia Kurtti, RN, Family Therapy Trainer
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7 Preventive Approaches: The Invisible Children

The research on adverse childhood experiences (ACE) has given wings to the development of approaches supporting children and their families. Moreover, the ACE studies influenced and encouraged mental health professionals and policy makers to place much needed emphasis on the importance of supporting children's early development [51, 52]. Mental health problems, including addiction problems in families, affect children, relationships within the family and family life. Consequently, children, whose parents experience mental problems, are at an increased risk of having mental health problems themselves. Not so long ago, children of parents with mental health problems were called the invisible children within the mental health services as they were neither identified nor were their needs met. Nurses and mental health nurses have described how children of parents with mental health problems 'carry an inhumane burden' and have joined other mental health professionals in the campaign to make these children more visible to increase their well-being [53]. Gregg et al. [33] highlighted the increased importance of offering parental support to families with children. The family approach needs to recognize and comprehend the reciprocal impact of psychological burden and mental health problems on parenting. Mental health professionals including nurses must have clinical skills and training to work with parents in adult mental health and community service [33]. In the following sections, we discuss two preventive approaches that APMHNs can apply in their clinical practice to support children of a parent with mental health problems.

7.1 Let's Talk About Children

Let's Talk about Children (LTC) is a simple structured conversation between parents and health professionals about the well-being of their children. The APMHN has health-promoting conversations with parents and focuses on the risk and protective factors in living with parental mental health problems. The implementation of these conversations with parents in adult mental health and in health care has shown to have beneficial impact for the mental health well-being of children and the entire family [32]. The main aim of the conversations in LTC is to improve communication and understanding and to lower the influential burden of the parental mental problems on the family, especially children. The LTC parental conversations are grounded in Beardslee's Family Talk Intervention's (FTI) framework [54] which is a structured therapeutic approach. In the FTI, two health professionals work together through 6–10 sessions, in a certain order using specific tasks, to build a communication bridge between parents and children. Moreover, in both the LTC, which is a shorter therapeutic conversation than the FTI conversation, the APMHN encourages, supports and listens to parents talk with their children about their own mental health problems. In the LTC, the first session with the parents covers the families' everyday life, mainly emphasising the support within the family and their networks, as well as supporting parents to identify and find more opportunities to support their children. The second session is about providing the parents with strength and resilience to become their own experts and find ways to work with weaknesses and vulnerabilities. Two sessions are usually enough to support the parents to believe in themselves and in their ability to take on their parenting roles. If the third session is needed for extra support, it is recommended that it is a network meeting. A network meeting is where the social and health-care service providers meet each other and get involved, always with the main aim of developing a supportive plan with the entire family.

When these parental programmes were implemented within the health-care services in many Nordic and European countries and evaluated in collaboration with service users, children, adolescents and parents, they demonstrated good outcome, to the extent that some governments have made them best practices and recommendations within mental health care [32, 54, 55].

7.2 The Solihull Approach

The Solihull approach facilitates a better understanding of emotional health and well-being of children and families that emerged from practice in the UK. The Solihull approach helps parents, professionals in mental health, social care and community, to understand child development, human emotions and what impacts mental health and children's brain development. Both qualitative and quantitative researches demonstrate the benefits of the Solihull approach for families' mental health and well-being [51].

The approach builds on three main concepts, containment, reciprocity and behaviour management, all important concepts for APMHNs' work with children and parents.

Containment is where 'a person receives and understands the emotional communication of another without being overwhelmed by it and communicates this back to another person' [56, p. 35]. The 'containment' concept comes from psychoanalytic theories. It emphasises that the APMHNs can educate and help parents to be better at receiving and understanding emotions and emotional communication without transferring them to their children which is helpful in decreasing transgenerational transmission of difficulties in families. *Reciprocity* describes the interaction within all relationships, like in the interactions between baby and a parent where both are engaged with eye contact, touch and vocal interactions. It can describe the interaction between a mother and a child before and after birth. The background of the concept of reciprocity comes from child development research. It emphasises the importance of APMHNs being aware and being able to read and interpret verbal and non-verbal interactions between parents and children. *Behaviour management* is a part of a developmental process where parents teach their child self-control to prepare them to interact and participate within the family and societal context. The background of the concept behaviour management comes from theories of behaviourism. The three concepts forming the Solihull approach provide a theoretical framework which helps professionals, including APMHNs, to work with parents in a meaningful way to improve their understanding and management of their children's behaviour, facilitating the relationship and well-being of the child and family [56].

8 Collaboration with Networks

We have focused on the professional practices with families, but the importance of families' own supporting networks and peer-support should not be forgotten as APMHNs have a role in working with these networks. There are several local, regional and national non-governmental organisations (NGOs) providing possibilities for peer-support, information and joint sharing of experiences. Some studies we have referred to, Vermeulen et al. [37] and the Cost of Caring, are provided by Eufami, the European organisation supporting families affected by mental ill health in several countries in Europe and supporting the national organisations and associations. The role of these kinds of local, regional and national organisations is important also from the viewpoint of APMHN to be able to provide information on these to families, to develop the collaboration between professional care and NGOs further, and for some APMHNs, they are also places to work. However, not all family members or people affected by mental health challenges are interested in joining this kind of activities, and therefore it is also important to support and value the family's own networks.

9 Conclusion

This chapter has defined the concepts of family and family-focused care and concepts which have changed over time and will in the future continue to be under review and critical discussion. The history of family-focused care in mental health reminds us of how important it is to approach clients and families with humility and open mind. The emphasis in mental health must be on the importance of inclusive clinical practice, education and research. Evidence-based findings support family-focused care although most mental health services in Europe have been slow in integrating the family approach. The rationale, or the 'why' of family-focused care, has been established, but it needs to be integrated and given more attention in mental health policies followed by implementation into mental health practice. From the APMHNs' viewpoint, the approach should be based on a humanistic approach with a common goal of understanding the viewpoints of each family member and collaborating with them in an equal and respectful manner. By working with families and networks, we acknowledge the role they play in supporting their family members and at the same time acknowledge their need for mental health support, thus providing better mental health care for all.

Reflective Questions

- What kind of experiences and meanings can you find when reflecting on your own family background; how can you use that knowledge in your work with individuals and families as an APMHN?
- How do you include families and other social networks in your daily mental health nursing practice as an APMHN?
- How would you develop, implement and study the family-focused care in your own practice? How about at your colleagues' daily practices and at your workplace?

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Advanced Practice Mental Health Nursing and Mental Health Promotion

Louise Doyle

Learning Objectives
The objectives of this chapter are to enable you to:

- Critically discuss the determinants of health and the risk and protective factors for mental health and illness.
- Critically discuss opportunities for mental health promotion across the lifespan.
- Identify mental health promotion opportunities within the mental health services and the role of the APMHN (advanced practice mental health nurse) in leading these opportunities.
- Distinguish the knowledge and skills required for advanced practice mental health nurses to engage in mental health promotion.

1 Introduction

Increasing evidence about the high personal, social and economic costs of poor mental health has contributed to a growing recognition of the need to prevent the onset of mental distress while also promoting positive health and well-being in those with and without mental illness [1, 2]. Although there is no agreed consensus on a universal definition of mental health promotion, most perspectives concur that it involves promoting mental well-being among all age groups of the general population and addressing the needs of those at risk from, or experiencing, mental health difficulties [3]. Mental health promotion involves not only minimising the occurrence of mental health problems but also focusing on enhancing positive aspects of daily functioning and strengthening protective factors. It involves actions to create

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living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles [4].

Although mental health promotion is not the sole preserve of mental health professionals, they do have an important role to play. Mental health nurses in particular can contribute significantly to mental health promotion as they are the largest group of mental health professionals and work across diverse settings and communities. It has been argued that traditionally mental health promotion has been largely neglected within mental health nursing [5]. However, many professional and accrediting nursing bodies now explicitly require the inclusion of health promotion-related competencies in nurse education, and mental health promotion is now seen as central to the practice of mental health nursing [6].

Advanced practice mental health nurses (APMHNs) have a key role to play in the promotion of mental health for the people they work with, in addition to their families and wider communities. A recent review of the role of advanced practice mental health nurses suggests that the promotion and prevention aspect of the role will increase significantly in the years to come [7]. This chapter provides an overview of key concepts within mental health promotion and identifies how the APMHN can contribute to the promotion of mental health for individuals with whom they work and in wider society. Examples are provided of initiatives and key opportunities for mental health promotion across the lifespan, and some of the challenges that APMHNs may experience when undertaking mental health promotion activities are identified.

2 Key Concepts and Definitions Within Mental Health Promotion

There are some key concepts within the mental health promotion literature which require some introduction.

2.1 Wellness and Positive Psychology

Wellness is defined as a process which requires a person to become aware of the lifestyle choices available to him/her and to make choices which lead to improved mental and physical health [8]. A wellness-orientated lifestyle constitutes a balance of healthy habits which focus on exercise, sleep, nutrition, supportive relationships, social contact, participation in meaningful activity and the avoidance of self-destructive behaviours [8, 9]. An individual is encouraged to recognise and proactively manage stressors and difficult situations and is encouraged to self-monitor his/her own health behaviour [9]. Wellness as a paradigm and a mental health promotion approach is becoming increasingly popular in the field of public mental health [10, 11].

Wellness is grounded within the field of positive psychology, a field of psychology heavily influenced by the work of Seligman and Csikszentmihayli [12]. Positive psychology is defined as the science of what is needed for a good life [13], and the approaches derived from it offer new opportunities for promoting mental health [10]. Underlying positive psychological approaches is the view that mental health and well-being are concerned not only with the absence of mental distress but also the presence of positive psychological resources such as hedonic well-being (positive affect, life satisfaction, happiness) and eudemonic well-being (self-acceptance, positive relations, purpose in life) [14]. The emergence of positive psychology in the early 2000s shifted the focus within mental health promotion towards the promotion of mental health as being more than the absence of mental illness. This is evidenced partly by the fact that most of the research within this discipline is conducted in isolation from research on mental illness, with a focus instead on well-being and positive mental health [15].

2.2 Flourishing and Languishing

These terms are commonly used within the field of positive psychology. Flourishing is understood as the presence of mental health, while languishing is considered to be the absence of mental health. To be flourishing is to have high levels of mental well-being, to be filled with positive emotion and to be functioning well psychologically and emotionally [16]. Conversely, those with incomplete mental health are languishing in life with low well-being where languishing may be conceived of as emptiness and stagnation [16]. Those who are not languishing or flourishing are considered to be in moderate mental health [17]. Keyes [16] conceptualised flourishing and languishing to exist on opposite ends of a mental health continuum.

2.3 The Mental Health and Illness Continua

The dual continua model of mental health and mental illness proposed by Keyes [16] suggests that these two concepts are related and yet distinct and therefore exist on separate continua (Fig. 1). A scoping review demonstrated that there is a large body of research which supports the existence of this dual-continua model [15]. The mental health continuum represents the presence or absence of mental health; those who are flourishing are mentally healthy while those who are languishing are not. However, it is not necessarily the case that those who are languishing experience a mental illness. A key study by Westerhof and Keyes [17] demonstrated that as people moved through the lifespan into older adulthood, the incidence of mental illness decreased, but this cohort did not necessarily experience better mental health. Similarly, in relation to the mental illness continuum, those who exist on one end of the continuum experience a mental illness, while those on the other end do not. Again, this is not to say that those who do not experience a mental illness are therefore mentally healthy, just as it is not possible to say that those who experience a mental illness cannot have moderately good mental health. This latter point has particular importance for APMHNs working with people who experience mental illness. Traditionally, mental health services and the healthcare professionals within them focused on the reduction of the symptoms of mental illness in order to improve mental health [15]. However, an increased understanding of the interrelated yet distinct relationship between mental health and mental illness has encouraged a greater focus on the promotion of mental health among people who experience mental illness.

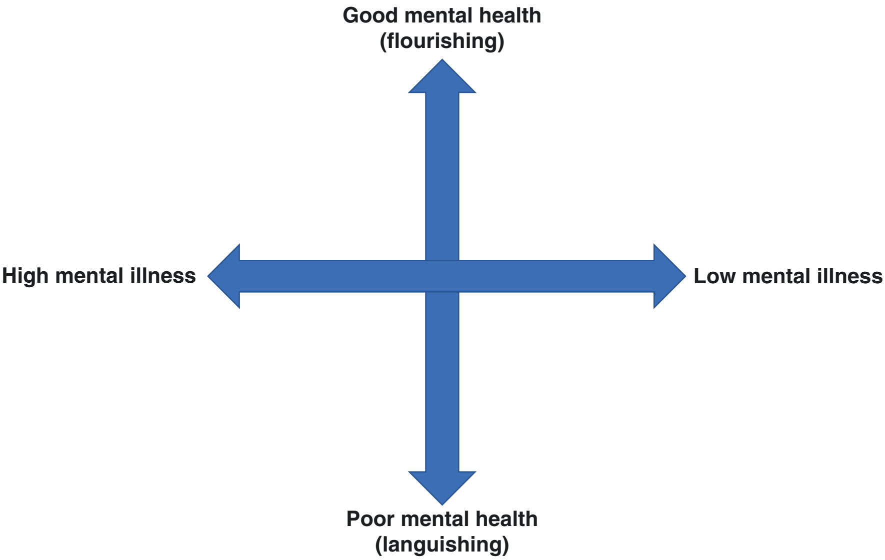

Fig. 1 Dual-continua model of mental health and illness based on Keyes [16]

3 Key Issues Within Mental Health Promotion

3.1 Determinants of Mental Health and Risk/Protective Factors

Mental health and illness involve the complex interplay of a number of risk and protective factors on an individual level but also on a societal scale. Much has been written about the key determinants of mental health within both empirical and policy literature (see also "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"). The personal, social and environmental factors that determine mental health and mental illness are clustered conceptually in the literature around three main levels:

1. Individual-level factors: These include the ability to manage thoughts or feelings and to navigate through life without significant difficulties, the presence of emotional resilience and the ability to cope with stressful situations and importantly to acquire skills to help cope in stressful circumstances.
2. Community-level factors: These include a sense of belonging and social support, a sense of social cohesion and the ability to contribute to and participate within a community in some way and feeling included within that community.
3. Structural-level factors: These include broader-level social, economic and cultural factors that focus on healthy and safe living environments and societies and include access to appropriate housing, healthcare, employment, transport, etc.

(Barry [3]; WHO [4])

These determinants of mental health at an individual, community and structural level translate into risk and protective factors which influence the protection of mental health and/or development of mental illness. Barry [3] sets out some key protective and risk factors for mental health across three key domains: (1) individual, (2) social and (3) societal.

1. Individual

   Individual protective factors for mental health include having a positive sense of self, good coping skills, social skills, good physical health and a sense of control over one's life. Risk factors include low self-esteem and self-efficacy, poor coping skills (e.g. emotion-focused coping rather than problem-focused coping), poor physical health and poor social skills.
2. Social

   Protective factors within the social domain include positive early attachment, supportive family relationships, a sense of belonging and inclusion and good communication skills. Risk factors here include adverse childhood experiences (ACEs) including violence, abuse or neglect, lack of social support and/or sense of belonging, social exclusion, discrimination and separation or loss (see "Trauma and Trauma-Informed Care").
3. Societal

   Societal protective factors include safe communities, quality housing, access to healthcare, equality (e.g. gender, sexual orientation, race, etc.), employment, educational opportunities and social and political participation. Risk factors which exist on a societal level include poverty, violence and crime in the community, poor quality housing and homelessness, lack of access to healthcare and education, poor employment opportunities and discrimination.

   The development of a mental health problem is largely understood to not be the result of the presence of one single risk factor nor the absence of a protective factor. Rather, the development of a mental health problem is often the consequence of a complex interplay between various risk and protective factors. The known risk and protective factors identified above have been shown in the literature to be responsive to interventions which can reduce risk factors and enhance protective factors [3]. From a mental health promotion perspective, there is great utility in focusing on harnessing protective factors and reducing risk factors as a method of mental health promotion rather than the narrower focus on prevention of mental illness.

   Traditionally within the mental health services, there has been a tendency to focus disproportionally on risk factors when working with people with mental health problems. However, over the past decade, there has been a better understanding of the importance of assessing for and harnessing protective factors and working with individuals and their families from a strengths-based approach. Mental health nurses have been at the centre of this reorientation of care with a move away from a deficit-focused care delivery to a more recovery and strengths-based approach. While it is clear that APHMNs may have a greater role to play in promoting mental health on an individual and social level, with intersectoral collaboration, they can also have a role in promoting mental health on a societal level with consideration of the broader socioecological perspective of mental health promotion.

4 Mental Health Promotion Through the Lifespan

One of the four key objectives in the global Mental Health Action Plan [4] is to implement strategies for promotion and prevention in mental health taking a lifespan approach to these mental health promotion initiatives. Therefore, it is important for advanced practice mental health nurses to consider a life course perspective when initiating mental health promotion activities as mental health nurses work with service users across the lifespan. This section will look at mental health promotion across four main stages of life, (1) childhood, (2) adolescence and emerging adulthood, (3) adulthood and (4) older age, identifying some potential areas for health promotion at each stage.

4.1 Childhood

Increasing attention is given to the importance of integrating mental health promotion approaches in the infant and early childhood period [18] often through prenatal, postnatal and early childhood development routine checks. Interventions at this stage of life can include screening for depression/anxiety antenatally which can also aid in identifying potential risk for the development of postnatal depression/anxiety leading to improved detection and management of it. The pregnancy and postnatal period presents an important health promotion opportunity for women and their families, and one example of a suite of health promotion activities, including mental health promotion, is available here www.tcd.ie/mammi. Interventions in this period also include home visiting parenting programmes which include activities to prepare parents for childbirth and the postnatal period. These interventions are clearly designed for parents and improve parental mental health with the ultimate aim of enabling parents to in turn promote the mental well-being of their child. These interventions do not generally fall within the remit of mental health nurses and are more often carried out by health visitors, public health nurses or social care workers. However, APMHNs working in maternal mental health can have a key role in supporting new mothers, particularly those who have a prior history of mental health problems or have developed a mental health problem postnatally. McConachie and Lamza [19] have identified how an advanced nurse practitioner in perinatal mental health has resulted in the development of a nurse-led perinatal mental health service with a clear person-centred clinical pathway from preconception to the first year postnatally which responds to the needs of women with mental health problems and their families. The establishment and rollout of advanced practice perinatal mental health nurse's posts means that direct referrals can be made to specialised skilled clinicians providing timely and needs-led routine and urgent perinatal mental healthcare [19]. Mental health nurses working at this level undertake biopsychosocial assessments, develop comprehensive mental healthcare plans, coordinate care with other healthcare professionals and services and provide monitoring and follow-up with the woman and her partner. An important aspect of this role, and indeed for all mental health nurses working at advanced practice level, is in the education of non-mental health clinicians (e.g. midwives, obstetricians, public health nurses). This is particularly warranted as research has demonstrated that non-mental health clinicians working with expectant and new mothers perceive that they have a lack of knowledge and skills which act as a barrier to discussing mental health issues with women [20].

4.2 Adolescence and Emerging Adulthood

The life stage of adolescence and early adulthood is recognised as a crucial time for the emergence of mental health problems. This is a period of transition, when young people experience a range of physical, emotional and social changes, and is a crucial time for the emergence of mental health problems which may persist into adulthood if timely intervention is not available. A large-scale recent study in England showed that there has been an increase in the scale of mental health problems with two in five young people scoring above threshold for emotional problems, conduct problems or hyperactivity [21]. A number of factors have contributed to decline in mental well-being in young people including bullying, worries about climate change and increasing schoolwork pressure [22]. Accordingly, it is the life stage which has the highest amount of mental health promotion programmes. Many of these mental health promotion programmes are located in the school setting, and mental health nurses are playing an increasing role in the provision of these initiatives [23]. Providing education, consultation and support to schools enables mental health nurses to contribute to the mental health and well-being of whole populations of young people and not just those who present to the mental health services [24]. There is an increasing collaboration between mental health services and schools and families, and APMHNs can play a central role in this setting. In particular, there is a recognition that mental health professionals including advanced practice nurses need to take a leading role to provide school staff with the necessary knowledge and skills to ensure that the school setting is a positive environment for mental health promotion with reduced inappropriate referrals to mental health teams with a concomitant reduction in waiting lists [18, 25].

Early intervention in mental health is an important component of broader mental health promotion and is defined as diagnosis at the earliest possible point, presymptomatically followed by treatment appropriate to that stage [26]. One of the most developed areas of early intervention in the mental health field is in the area of psychosis as the first symptoms of psychosis typically present in the late teenage and early adult years. Early Intervention in Psychosis (EIP) teams work most often with young people in the prodromal stage of psychosis or those in the high-risk group for psychosis. By responding early to developing or recently developed psychosis, there is opportunity to identify the early symptoms of psychosis, reduce the risk of transition to full psychosis, shorten the duration of untreated psychosis for those who do develop it and prevent the development of a more chronic form of psychosis. A systematic review of studies on early intervention in psychosis shows it to be associated with reduced symptoms, reduced treatment discontinuation, increased global functions, reduced hospital stays and shorter duration of hospital stays [27]. This, in turn, improves the person's chances of returning to employment, education or training and more generally their future quality of life. The emphasis is on an assertive approach to maintaining contact with the patient and on encouraging a return to normal vocational pursuits. The APMHN has an important contribution to make as a leader within the EIP team. Morse and Procter [28] have identified the multifaceted role of mental health nurse practitioners in EIP including acting as a leader in improving coordination between primary care and specialist mental health services in both the hospital and community settings. Within their role, they can enhance service provision and ultimately improve outcomes by providing advanced assessment and therapeutic care. They also have a role as educators, educating other non-mental healthcare professionals about risk and protective factors for psychosis with a view to enhancing their skills, in addition to educating service users and their families to recognise early symptoms of psychosis and how to seek help for them [28]. The increased focus on EIP interventions has resulted in an expansion of the services delivered to a larger cohort of people. In some cases however, this has created additional demands and increased workloads for mental health nurses working within these teams and requires that mental health nurses be supported through clinical supervision and continued professional education to undertake a key role in the early intervention team [29] (see Maintaining Professional Competence).

4.3 Adulthood

Adulthood is a period when many demands are placed on individuals including relationship demands, parenting, caring responsibilities and financial demands. During this life stage, work is a dominant activity, and it is therefore unsurprising that workplace mental health promotion and the promotion of mentally healthy workplaces are identified in many national mental health promotion policies. The impact of the Covid-19 pandemic resulted in long periods of working from home and prolonged absences from the workplace for many. While there were many perceived benefits to working from home for employees, there were also negative mental health outcomes including an increase in social isolation, a decrease in overall mental well-being and an increase in common mental disorders (CMD) for many workers which strongly highlights the importance of social connection achieved in the workplace [30, 31].

Many adults experiencing mental distress do not present to the mental health services for treatment, but many do present to the primary care setting. Primary healthcare is therefore an important setting for the identification of people at risk for mental health problems, treatment of existing mental health problems, prevention of further episodes and general mental health promotion [32]. A multidisciplinary approach has been identified as being crucial to the success of mental healthcare delivery within primary care [32], and the mental health nurse has a key role to play within this. A study of the Primary Care Liaison Nurses (PCLN) in the UK found that they played a particularly important role in working with people who were not experiencing symptoms severe enough to progress to secondary care but who nonetheless had complex mental healthcare needs which required assessment from a mental health professional [33]. Lakeman [34] found that mental health nurses working in primary care believed that they facilitated greater continuity of care for the people they worked with, were a key resource in facilitating access and referring to a wide range of services and contributed to a reduction or avoidance of hospitalisation, thereby highlighting the potential contribution of mental health nurses to primary care. The concept of facilitating access for service users to and from non-mental health services was one that also emerged in a systematic review of the role of advanced practice mental health nurses [35]. This review identified how APMHNs established collaborative relationships with many other healthcare professionals across a range of settings which facilitated them in referring service users to the services they required.

4.4 Older Age

Society is aging, between 2015 and 2050, the proportion of the world's population over 60 years is expected to almost double from 12 to 22 and for the first time in history, most people today can expect to live into their 60s and beyond [36]. However, there is little evidence to suggest that older people are experiencing better health than their parents did, yet it is acknowledged that if people can experience these additional years of life in good health and if they live in a supportive environment, then healthy aging can be a real possibility [36]. The physical impacts of aging are well known; however, there is now an increased focus on the impact of aging on mental health with the WHO recognising that older people are at a higher risk of experiencing mental health difficulties and identifying the importance of mental health promotion and prevention initiatives for this cohort [4]. Daly et al. [37] note that older people are just as likely to experience certain mental health difficulties like other cohorts including substance abuse and suicidal behaviour; however, mental ill health can be exacerbated by changes in their social relationships and an increasing sense of loss and isolation which can heighten depression and anxiety in this group. It is therefore unsurprising that a broad range of mental health promotion initiatives are directed towards the older person. A strengths-based approach to mental health promotion is particularly warranted when working with older people, and advanced practice mental health nurses have a key role to play in this [38]. Within this strengths-based approach, APMHNs work *with* the older person, moving away from a focus on the perceived deficits of the person and instead drawing from the individual's current strengths and resources for their own empowerment. However, Hirst et al. [38] have identified that while there is a growing body of research focusing on strengths-based health promotion programmes for older adults, there are very few which focus specifically on mental health promotion. This would suggest that the APMHN working with the older person is in a prime position to advance work on strengths-based mental health promotion programmes. A review of advanced practice nurses working with older people found that in long-term settings, there were significant improvements in outcomes including reduced mortality and admissions, increased patient self-care, increased patient and caregiver satisfaction and improved continuity of care [39] highlighting the potential benefits when advanced practice nurses work with older patients. For APMHNs, to reorientate towards a strengths-based approach to mental health promotion requires collaboration with interdisciplinary colleagues and education of professionals across community, hospitals and long-term settings about the potential of strengths-based programmes, in addition to advocating for funding for mental health promotion programmes that are strengths-based [38]. A move towards this strengths-based approach in older adult mental health promotion can lead to improved mental health, a reduction in loneliness, greater social inclusion and a greater sense of autonomy and ultimately empowerment.

5 Mental Health Promotion in the Mental Health Services

The World Health Organisation [4] identify how mental health service planning and delivery are not complete if they do not focus on the dual components of prevention and treatment of mental health problems and the promotion of mental health and well-being. Accepting the dual continua model of mental health and mental illness discussed earlier brings with it an increasing understanding within the mental health services that mental health promotion is just as important for users of the mental health services as it is for the general population [1]. Within the mental health services, mental health promotion requires that we move beyond considering only the individuals and their diagnosed mental health problem, to a broader more holistic consideration of their psychosocial needs and the needs of their families and/or caregivers who have an increasing role in supporting their family member [1]. There is also a requirement to reorientate practice to focus on the strengths and capacities of the individuals rather than their deficits [40]. Traditionally, mental health professionals have worked within the medical model of care focusing their attention on disease diagnosis, treatment and symptom reduction [13, 14]. However, with the increasing, albeit slow, reorientation of mental health services towards a more recovery-orientated practice, there is greater demand and opportunity for mental health nurses to expand their practice towards promoting and maintaining mental health in addition to working with distress and to promote positive mental health at the same time as working with someone to manage their mental illness [1].

Barry [3] identifies that for people experiencing mental health problems, there are three key mental health promotion strategies that can be focused on as follows:

1. Creating supportive environments
2. Reducing stigmatisation and discrimination and promoting inclusion
3. Supporting social and emotional well-being of service users and their families

The following section identifies how APMHNs can incorporate mental health promotion practices within these three areas.

5.1 Creating Supportive Environments

One of the key mental health-promoting roles of the APMHN is to help create and sustain supportive environments, on a micro and macro level, for people experiencing mental illness and their families. Included within this is working in a recovery-orientated way in supporting people to control their own lives enabling them to live a meaningful life [41]. One area that this can be problematic is around the area of risk and the assessment of risk including suicide/self-harm risk and risk to others. Historically, there has been a tendency to assess risk in a very narrow way with an almost exclusive focus on assessing deficiencies the persons are perceived to have or problems they experience with a consequent focus on risk reduction [11, 13, 42]. As a result, mental health nurses have often practised in very risk averse ways [42] bearing the responsibility of minimising risk, which can be in direct conflict with the promotion of mental health by removing control and self-efficacy from the person. From a mental health promotion perspective, however, an alternative assessment strategy is required which takes a strengths-based approach emphasising well-being over deficits with a more person-centred rather than professional-centred focus [13, 40].

Another important aspect of creating supportive environments is to create an environment in which service users' involvement is encouraged and their participation in decision-making about their care and treatment is facilitated. APMHNs are required to take a leadership role here to ensure that the voices and opinions of service users, and their families, are embedded in the care planning and delivery process. Research has demonstrated that when service users' voices are genuinely included in the decision-making process, treatment outcomes and satisfaction with treatment improve [43, 44]. However, studies also find that there is still some way to go before true shared decision-making occurs with some service users still experiencing a paternalistic approach to care and treatment and little involvement in decision-making, all of which results in service users feeling excluded and struggling to be perceived as competent and equal [44–46]. Mental health nurses and APMHNs need to be aware of the barriers to service user's involvement in shared decision-making, including structural limitations and professionals' attitudes, and work with service users to facilitate their voices to become central in their treatment plan. As the largest groups of mental health professionals, they have the potential to significantly impact on the inclusion of shared decision-making in practice. Coulter [43], however, is quick to point out that shared decision-making is a process rather than a one-off event, with Slade [46] identifying it as part of a broader movement of change in mental healthcare provision. This reiterates the importance of shared decision-making becoming a cornerstone of mental health-promoting practice, a feature of a supportive environment and an ongoing journey in which service users and clinicians are equal partners.

5.2 Reducing Stigmatisation and Discrimination and Promoting Inclusion

Many people who experience mental health problems, and their families, experience stigma and discrimination in their daily lives. These stigma and discrimination experiences can be major barriers to quality of life for those living with a mental health problem and are associated with a number of poorer outcomes including higher levels of poverty, poor physical health, increased social isolation and reduced employment opportunities [41]. While stigma and discrimination can act as barriers to good mental health, social inclusion, as identified earlier in this chapter, can act as a protective factor both for those without a mental health problem and for those living with mental illness, identifying the importance of focusing on these issues for APMHNs. Research has identified a number of interventions that can have an impact on reducing stigma and discrimination experienced by people living with a mental illness. Two of the most commonly evaluated interventions shown to have an impact are (1) increasing contact with people with mental illness and (2) the provision of educational/awareness interventions [47]. In addition to these, protest/activist movements have also been shown to be an important anti-stigma intervention. Mental health nurses working at an advanced level have a role to play in each of these stigma reduction initiatives.

The ‘increased contact’ interventions and the ‘educational/awareness’ interventions are two interventions that can be delivered separately but can also be delivered in an integrated manner. Indeed, research has found that that educational programmes that provide opportunities for personal contact with people with mental health problems have shown the most promising results in reducing stigma [48]. Social contact interventions are based around the research findings that those who have more contact with people with a mental illness are more likely to have a positive attitude towards mental illness [48]. Within these interventions, participants encounter instances of the stigmatised group that are inconsistent with their stereotypes of that group [49] encouraging them to challenge their prejudiced beliefs.

APMHNs can play a key role to increase public awareness of mental health problems and the consequences of stigma and discriminatory behaviour. One of the ways they can work to counteract stigma is to be vocal and campaign for improvements in the rights of people with mental health problems and challenge discriminatory attitudes and actions [41] recognising the role of mental health nurses as patient advocates. Gomes [50] argues that the mental health nurse ought to be a key contributor to the construction of mental health policies, particularly at a regional and local level, that are socially inclusive and challenging of discrimination. As discussed later in this chapter, this is not always a role mental health nurses are comfortable engaging in; however, for those working at an advanced practice level, political activism and advocacy should be embedded as a component of practice (see "Advanced Practice Mental Health Nurses as Leaders and Advocacy and the Advanced Nurse Practitioner").

5.3 Supporting Social and Emotional Well-Being of Service Users and Their Families

Participants in a study of how mental health nurses at an advanced practice level can work in a more health-promoting way suggested that mental health nurses require an awareness of and ability to apply wellness strategies in their work, which can help orientate practice away from an illness focus towards wellness and maintenance of recovery [51]. Wellness strategies have potential for utilisation across diverse settings and with diverse populations, and there is great potential for mental health professionals to incorporate these strategies into their practice [52]. One of the best ways to include wellness strategies into the care plan of an individual is to incorporate it into a self-management plan, thus ensuring that these strategies are available to draw from when required. A widely used self-management programme within the mental health services is the Wellness Recovery Action Plan (WRAP). This plan was developed by a group of people with self-experience of mental health problems, family members and care providers in 1997, facilitated by Mary Ellen Copeland. These were a group of like-minded individuals who had come together to undertake a programme of work on self-help skills and tools and who recognised the need to put their learning into a structured plan of action that would facilitate incorporating the use of these skills and strategies into everyday life [53].

The WRAP programme is a system of self-management which facilitates monitoring uncomfortable and distressing symptoms and through the use of pre-planned responses incorporates strategies which help to reduce the impact of these symptoms. A typical WRAP programme comprises 8–10 weekly sessions of usually group education to enable participants to improve their ability to take responsibility for their own wellness, manage mental health symptoms using self-help strategies and identify and use sources of support [54]. Incorporated within the WRAP programme is a plan for responses from others to be considered when a person's symptoms have made it impossible to make decisions to keep themselves safe and well [53]. A core tenet of the WRAP programme is that it is a strengths-based plan which, as previously identified in this chapter, is an important aspect of mental health promotion for people living with a diagnosis of mental illness. Using a strengths-based approach, and a plan which is developed *by the persons themselves,* enhances the sense of personal responsibility, achievement and ultimately autonomy over their own lives and mental health recovery. The WRAP programme was devised as a six-step programme, an overview of which is set out in Table 1, with relevant activities to respond to each step. The six steps of the programme are the following:

Table 1 Six-step Wellness Recovery Action Plan [53]

Step	Examples of activities
1. Developing a wellness toolbox	Exercise, good diet, reducing alcohol, rest, talking to a friend or peer, journaling and meditation
2. Developing a daily maintenance list	*Specific* activities which must be done everyday, for example, eat three balanced meals, drink eight glasses of water, get 30 min of exercise, get outdoors for 30 min and speak to a friend
3. Identifying triggers	Anniversary date of traumatic event/loss, being very overtired, work-related stress, spending too much time alone, increasing substance misuse, not enough sleep/exercise and physical illness
4. Identifying early warning signs	Lack of motivation, inability to enjoy things, avoiding others/isolating, increasing irritability and feeling generally anxious/nervous. This stage also requires that a plan is put in place to respond to the early warning signs as they emerge
5. Things are breaking down or getting worse	As with other stages of the plan, it is important for the person to identify signs of deterioration that are specific to them. They might include ongoing inability to sleep (or oversleeping), rumination, self-harm or thoughts of self-harm, substance abuse and not feeling anything. Again, a plan is made for what to do, and at this stage, it will likely include a prompt to seek professional help in addition to the self-care strategies
6. Crisis planning	There are a number of steps within this stage as follows: • The first is for the person to describe what they are like when they are well so that people who do not know the person do not mistake personality traits for signs of mental ill health • The second requires the person to identify the symptoms that indicate they need someone to take over responsibility for their care. While family members and health professionals can contribute to this phase, it is important that the persons themselves identify the final symptoms in this plan • The third lists the ‘supporters’ that the person want to take over responsibility of their care while they are unwell. This can include both healthcare professionals and family members • The next stages focus on the treatments/medications the person is amenable to and has responded well to in the past and also those treatments that the person does not want or has not previously responded well to. In addition, these remaining stages also focus on where the person would like to receive treatment including alternatives to hospitalisation if appropriate/available • The next stage outlines what actions supporters can take to help the person and can include actions like going out for a walk with them and taking time to peer counsel the person right through to taking actions to prevent the person from hurting themselves • The final stage of the plan identifies signs that the person has improved and supporters no longer need to follow the plan. Signs can include sleeping well for three consecutive nights, eating well and attending to self-care

1. Develop a *wellness toolbox* where strategies that have been used in the past to keep the person well or could be used in the future are identified making them easily accessible when required.
2. Develop a *daily maintenance list* which is a list of activities that the person feels is important to do every day to maintain their wellness.
3. Identifying *triggers* which are external events or circumstances which can, if unaddressed, make the person feel that their mental health is deteriorating.

4. Identifying *early warning signs,* which are different to triggers as they are internal signs and not necessarily related to external events or circumstances. This stage of the plan also involves the persons identifying how best to respond to these early warning signs to relieve them and to prevent their mental health from deteriorating.
5. Identifying when *things are breaking down or getting worse* is an important stage as there has been a significant deterioration in the person's mental health but crucially there is still some capacity for the person to take action to prevent a crisis. In addition to identifying these signs, the person also identifies strategies that can help in this situation – as the person's mental health has deteriorated, there need to be fewer choices with focused instructions.
6. The final step in the plan is focused on *crisis planning* and recognises that there may be times when the previous steps have not been enough to prevent the onset of a mental health crisis. The focus here is on the person having a clear crisis plan written when they are well so that when they become unwell and may feel out of control, their wishes and preferences can still be central in their treatment plan. A key difference in the potential responses identified here to those in the earlier stages of this plan is that the crisis plan will be implemented by others rather than the person themselves which requires that this section is clear and easy to understand by others.

Intervention trials of the use of WRAP have shown that participation in WRAP has positive outcomes for participants, particularly in the area of self-perceived recovery [54]. Qualitative studies have also demonstrated the potential benefits of undertaking the WRAP programme for people living with a mental illness with findings demonstrating that participants were able to maintain their wellness through the use of the WRAP tools and processes in addition to contributing to a more positive self-belief which is important in increasing self-efficacy [55, 56].

Advanced practice mental health nurses can have a key role to play in supporting the person to develop their own Wellness Recovery Action Plan, both as a trained facilitator in the delivery of the WRAP educational programme and in a more informal way in guiding a person in the development of their WRAP. The case study presented below provides an example of how this can be achieved. While many mental health nurses may have previously applied some of the wellness activities with the WRAP programme in their practice, undertaking training on the WRAP programme provides structured guidance and a step-by-step programme to support their practice and to provide them with the skills and confidence to help others develop their Wellness Recovery Action Plan [56]. Evidence has shown that in addition to improving the outcomes of the person with a mental health problem, the WRAP programme can also have a positive impact on mental health professionals resulting in more recovery-focused knowledge, attitudes and competencies and encouraging a more recovery-orientated and service user-led approach to care [57]. However, the evidence relating to sustained change remains limited suggesting the importance of continued organisational change in moving to more mental health-promoting and recovery-orientated practices. APMHNs need to take a proactive approach to lead and sustain this organisational change. However, as identified later in this chapter, there are some challenges to consider why trying to implement such paradigmatic shifts in mental health services.

WRAP Case Study: Dr Teresa Tuohy

My name is Teresa Tuohy. I am both a registered general nurse and mental health nurse. I completed a PhD with Trinity College Dublin. My interest in Wellness Recovery Action Plan (WRAP) began when I worked in a service that provided an alternative recovery option for people who might otherwise have to spend time in psychiatric inpatient units. I completed all stages of WRAP training and worked for a number of years as an advanced WRAP facilitator. This work involved facilitating WRAP with individuals in one-to-one sessions and with groups. The following case study, from my time working as a clinical nurse specialist (CNS) in the mental health services in Ireland, highlights how WRAP was used to facilitate a service user to develop a plan to improve both physical and mental health.

Mary was a 65-year-old woman who had experienced mental health problems ‘all her life’. Mary is widowed and has four children. She retired from work 2 years ago. Her daughter lives next door and Mary describes their relationship as supportive.

My first meeting with Mary was when she attended a 2-day WRAP workshop which I co-facilitated. The workshop was held over 4 weeks (4 h a week). Mary attended all sessions, and following the workshop, she said she would like to use WRAP to support her recovery journey. We arranged to meet for one-to-one sessions for 6 weeks.

The WRAP concepts of hope, personal responsibility, education, self-advocacy and support were used to underpin the sessions with Mary. When introduced to these concepts in the workshop, Mary felt that in embracing these concepts and in developing her skills, she could be an active participant in her recovery.

The first session was spent exploring Mary’s main health concerns, and we agreed a plan to promote her physical and mental health. Mary stated that she does not have a focus or structure to her day and feels that she just ‘muddles through’ and feels life is passing her by. She is physically inactive and eats ‘all the wrong things’ and as a result feels tired most of the time. She describes herself as a resilient and strong person who wants to have a more fulfilling life in her retirement. The next five sessions with Mary focused on developing her WRAP. Mary began with her daily maintenance plan and spent time thinking about ‘what I am like when I’m well’. This section of WRAP was a challenge for Mary. She had little opportunity before retirement (full-time employment and childcare) to think about herself. Mary agreed to visit her GP for a medical check-up before commencing on an exercise and healthy eating plan, which we developed together. In one session, Mary brought photos of herself as a child and young adult in an effort to remember a ‘well’ version of herself.

In the session, she described a happy, energetic and enthusiastic person and wanted to be that person again. She was hopeful that this could happen and realised that she would need to take personal responsibility and develop a supportive network to ensure a positive outcome. She developed a realistic and achievable plan to give structure to her day incorporating times for activities, meals and relaxation. In identifying triggers, Mary recognised the times she 'withdrew' from her usual activities and supports. One powerful trigger was the anniversary of the death of her son. We worked together to develop an action plan to support Mary, for example, when her son's anniversary was approaching, Mary identified a friend she would talk to, arranged to visit the grave and allowed herself time to feel sad. She recognised the importance of using her daily maintenance plan, during this time, to provide structure to her day ensuring she ate regular meals and engaged in her usual activities.

WRAP provided Mary with a way to support her physical and mental health recovery. She was able to anticipate and learn new ways to cope with life's difficulties, using her wellness tools and holding hope that her life could be more fulfilling.

6 Knowledge and Skills Required by Advanced Practice Mental Health Nurses for Mental Health Promotion

Sharma et al. [40] suggest that there is a lack of trained health professionals with the knowledge and skills to sufficiently advance the mental health promotion agenda. McAllister et al. [58] have identified the need for mental health nurses in particular to have specific skills to facilitate effective mental health promotion. There is certainly an argument that mental health nurses have insufficient education not just about mental health promotion generally but also crucially about utilising mental health promotion strategies with the people they work with. From a knowledge and skills perspective, mental health nurses working at an advanced level need to have information about the wellness and positive psychology interventions that work and be able to cite and evaluate the evidence behind them. As previously identified in this chapter, these interventions have utility across the dual continua of mental health/mental illness and can be used with service users and their families but also with colleagues in their work team in which the advanced practice mental health nurse has a leadership role. Similarly, APMHNs need to know how to include positive psychology techniques into their clinical work and how to promote social interaction and activities which have been identified by service users as helping to maintain their sense of well-being [59].

APMHNs need to have a good understanding about what enhances well-being and alleviates distress and have the skills to work with the service user in a sensitive way to facilitate them in developing and implementing their own wellness plan. This requires that APMHNs have the knowledge and skills to support reasonable goal setting and goal striving [13]. In this chapter, the importance of working from a strengths-based approach across the lifespan was identified. While mental health nursing generally is moving towards a more strengths-based focus, the move in some areas has been slow, and there is a requirement that mental health nurses become skilled at taking a strengths-based clinical history with a greater emphasis on the individual's goals and strengths. Mental health nurses working at an advanced practice level need to be leaders in reorientating the focus away from a deficit approach to assessment and treatment if the goal is to promote well-being harnessing a person's own strengths rather than treating illness [13, 51].

It was identified earlier in this chapter that promoting social inclusion is a key mental health promotion activity, and APMHNs need to become more involved in promoting social inclusion on a micro- and macroscale. This requires that APMHNs become active and vocal advocates for the service users they work with and become more involved in political activism, working meaningfully with service user and carer groups and engaging with public health campaigns [14]. Scheydt and Hegedus [7] also identify how public relations is a key role of the APMHN, and in the context of mental health promotion, this includes work on breaking down the stigma around mental health difficulties and the help-seeking process. Through this engagement with activism and public relations, APMHNs can promote change, empowering individuals and their families and communities to improve mental health and reduce inequalities [50]. APMHNs also have a leadership role to play in encouraging political activism and critical discourse around government policies which impact on mental health. Nurses 'on the ground' often see this activism as the sole domain of the academic and service user community. However, a much stronger approach is to work in collaboration with colleagues to influence the direction of policy that reduces social exclusion for the people with whom they work and the advanced practice mental health nurse can bring their colleagues along with them in this regard.

Advanced practice mental health nurses need to have the skills to work cross-sectorally, collaborating with different professionals and services to ensure the best outcomes for the people they work with. Collaborative working and partnerships have been identified as essential components of mental health promotion work and an area which requires further capacity building [60]. While historically mental health nurses have always been part of the larger multidisciplinary team working with other mental health professionals, this work within mental health promotion requires collaboration across sectors that may be unfamiliar to them (e.g. housing agencies, employment agencies, etc.). The role of the APMHN as a coordinator of care across different agencies and services has been identified as one of the key practice domains and one that has tangible positive outcomes for service users and their families [7, 35].

Finally, to engage meaningfully in mental health promotion, APMHNs need to ensure the use of evidence-based mental health promotion initiatives. Evidence-based practice is important in all fields; however, Barry [18] has identified how it is particularly relevant in the field of mental health promotion to demonstrate that interventions are a cost-effective use of limited resources which result in health and social gains for the population. In addition to utilising evidence in their practice, APMHNs also have an important role in leading and conducting research to ensure the generation of knowledge and integration of results into mental health nursing practice [7].

7 Challenges in Mental Health Promotion for APNs

The challenges of working within a health promotion paradigm for APMHNs are similar to those for mental health nurses across all grades of practice. Mental health nurses have traditionally worked within the medical model of care focusing their attention on treatment and symptom/illness reduction and traditionally have been more confident in working with illness rather than promoting mental health [13, 14]. Taking a strengths-based mental health promotion view requires a distinct paradigmatic shift. It requires a new way of thinking about preparation and education for mental health nurses and will require a change in how they practise if primacy is to be given to increasing well-being rather than to treating illness [13]. In order to ensure this change, mental health promotion needs to be more firmly grounded in mental health nursing curricula across all levels. Health services, and the workers within them, need to be reoriented with a shift on emphasis to health being a shared responsibility among individuals, community groups, health professionals, health service institutions and governments [1]. The APMHNs can play a significant leadership role in this reorientation, as they occupy positions that are heavily dependent on collaborative and cross-sectoral ways of practice.

A further challenge which arises is that although the literature suggests that service users are open to learning the skills required to promote mental health and to take an active role in their recovery, there is a learning curve here. This is particularly so for those service users who have essentially been a passive recipient of care and treatment within the parameters of the medical model (through no fault of their own). Not only is a paradigm shift required for nurses and other mental health professionals but also for some service users for whom these are new concepts.

Another challenge arises regarding short staffing in the mental health nursing workforce which may mean that essential care is prioritised and mental health-promoting activities may not be viewed by nursing leaders as an important role [24]. In the wake of the Covid-19 pandemic and the ‘firefighting’ exercise of keeping service users safe, there is a real danger that health-promoting opportunities are consigned to the sidelines of practice and viewed as desirable but not essential. Again, the advanced practice mental health nurse need to use their voice to ensure that the drive towards strengths-based mental health-promoting practices continues.

Finally, a significant challenge to reorientating practice to one that focuses more on mental health promotion across all levels is that APMHNs cannot progress this reorientation in isolation from other mental health professionals. Instead, it requires a multidisciplinary team approach with buy-in from each discipline within that team. It has been identified that if psychiatrists in particular are not ‘on board’ with this reorientation of practice, then it is difficult to progress change [51]. As previously identified however, the nature of the APN’s role which involves much cross-sectoral work means that they are in a key position to bring colleagues along with them in advancing mental health-promoting practices.

8 Conclusion

Positive mental health is a key resource for individual and population well-being and the long-term social and economic prosperity of society. Mental health promotion is the means through which positive mental health can be achieved and is as applicable to those with a mental health problem as to those without. Successful mental health promotion initiatives within mental health services are recognised as being based on a positive, non-medicalised approach to mental health that is strengths-based and focused on empowering the individuals to make healthy choices in their everyday lives. This requires a move away from the traditional medical perspective in which only ‘illness’ is emphasised to a more holistic perspective in which ‘wellness’ is also highlighted, even in the presence of a mental health problem. Traditionally, mental health nurses have been primarily focused on the management of mental illness with limited opportunities for mental health promotion which were usually within the tertiary setting. However, with the reorientation of mental health services to a more recovery-orientated paradigm, and the increasing diversity of the role of the mental health nurse across a range of settings, there is now a key opportunity to take this momentum and use it to embed mental health promotion as a central component of mental health nursing. The advanced practice mental health nurse, with their role in practice development and research, and with their cross-sectoral way of working, are in a prime position to lead on this continued development.

Reflective Questions

- What structural challenges (structural and individual) do you think exist in your area of work to working with a mental health promotion paradigm?
- Identify how you, as an advanced practice mental health nurse, might overcome these challenges.

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Trauma and Trauma-Informed Care

Jean Morrissey and Agnes Higgins

Learning Objectives
The objectives of this chapter are to enable you to:

- Discuss what is meant by trauma and its associated link with mental health and recovery.
- Outline the impact of trauma on the lives of people who have experienced trauma and use or need mental health support and care.
- Analyse the key principles underpinning trauma-informed care, and explore the challenges and opportunities that APMHNs face when implementing a trauma-informed approach within clinical practice.
- Critically examine the systemic changes required to meet the needs, well-being and safety of both those receiving and providing care across the mental health system.

1 Introduction

Trauma has and still occurs in many societal contexts, whether it is due to life events, war, disasters, adverse childhood experiences/abuse or other events. Exposure to trauma is therefore common [1], and its impact on individuals, families, communities and society cannot be underestimated. Historically, Europe, like other parts of the world, has experienced high levels of trauma related to

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human-made events. A massive burden of trauma across Europe resulted from World War II and the Holocaust. Institutional abuse has been common in history throughout Europe with a myriad of cases now brought to public knowledge. Various reports have exposed the startling scale of sexual abuse/violence within society, including the use of sexual violence as a weapon of war and an increase in sexual violence using digital communications technologies. Over recent decades, several European countries have also experienced the arrival of large numbers of forced migrants because of war, poverty and fear of oppression in their home country [2], which has been traumatic. In 2020, the toll of morbidity and mortality from the COVID-19 pandemic changed life globally and created pandemic stressors on children, families and society at large. Although ongoing vaccination efforts provide some hope towards the end of the pandemic, mental health professionals need to be prepared for the potential long-term consequences of this pandemic on physical and mental health. Emerging evidence suggests that public mental health has become an area of major concern and stress-related symptoms are highly prevalent [3].

Over the last two decades, there has been growing recognition concerning the implementation of trauma-informed services and trauma-informed care (TIC) in mental health policy, practice and discourses [4–6]. A key impetus to the development of a TIC approach in mental healthcare came about, in part, from the growing awareness among practitioners of the high prevalence of early trauma events in the lives of people accessing mental health services [7] and its effects [8]. Another key driver of a TIC approach is awareness of iatrogenic harm and the potential for re-traumatisation and vicarious trauma to occur in the context of mental healthcare [9]. Notwithstanding such developments and the growing international interest, studies continue to report that mental health services often provide care for survivors of trauma without addressing trauma or even being aware that trauma has occurred. All professionals working in mental health settings, including advanced practice mental health nurses (APMHNs), frequently encounter service users who have been exposed to trauma and therefore should possess knowledge of trauma and its impact both for the service user, family and themselves. However, while TIC is an emerging phenomenon within policy and research, responses to trauma within the mental health services have been challenged by the lack of awareness and understanding of trauma and its impact, as well as poor and inconsistent implementation of the principles and practices underpinning trauma-informed practice [5, 6, 9, 10]. Such challenges are further compounded by a mental health system that is predicated on power and coercion and by healthcare professionals' lack of awareness of the iatrogenic harm built into the foundations of mental health practices and services [11]. Iatrogenic harm refers to the harm caused to the service users and their family by the process of treatment and by a failure of staff to provide important information or choice regarding diagnosis, treatment or discharge planning.

If TIC is to be imbedded into everyday clinical practice and services, mental health practitioners, including APMHNs, need to give serious consideration to the prevalence of a traumatic history and its impact on people who seek or need mental health support and care. Failure of mental healthcare providers to implement trauma-informed care and treatment of trauma will result in trauma survivors continuing to present to multiple services and receiving fragmented ineffective care at high personal and social cost [11]. This chapter focuses on how APMHNs can, through their own practice, enhance the understanding of trauma, facilitate the development and implementation of a trauma-informed approach to mental healthcare and advocate for the systemic changes required to be better able to meet the needs, well-being and safety of both those receiving and providing care across the mental health system.

2 A Historical Perspective on the Concept of Trauma

The word trauma stems from Greek, meaning 'injury' or 'wound'. In cultural discourse, the word is used as a metaphor for a psychological wound [12, p. 452]. Historically, the use of the word trauma was first recorded in 1889, by Pierre Janet who published *L'atutomatisme psychologique*, his first book on the psychological processes involved in the transformation of traumatic experiences into psychopathology [13]. This book, the foundation of Janet's work, was based on his extensive and detailed clinical observations on patients with a large variety of symptoms. From these observations, Janet developed two broad syndromes, hysteria and psychasthenia. In hysteria, the main mode of adaptation was the dissociation of feeling or memories related to frightening experiences. Psychasthenia referred to a decreased capacity for creative adaptation to reality and included ruminations, phobias and anxiety. Although earlier French psychiatrists had already suggested that certain mental health problems originated in traumatic experience, Janet was the first to systematically study dissociation as the significant psychological reaction by individuals to overwhelming experiences. Janet's work also showed that traumatic memories may be expressed as sensory perceptions, affective states and behavioural re-enactments.

Impressed by Janet's investigations, Jean-Michel Charcot, an imminent clinician whose work supported the emergence of two concepts, the subconscious and the conscious, encouraged Janet to continue his studies of hysteria on the wards of the Salpêtriére Hospital in Paris. Charcot's work at the Salpêtriére Hospital at the end of the nineteenth century had already prompted psychiatrists, both in France and the USA, to explore how psychological trauma affects the psyche. Charcot's collaboration and work formed the basis for both Janet's and Freud's early theories about the nature and treatment of distress and psychopathology. Freud's theory of psychoanalysis also had its origins in the study of psychological trauma. Following a visit to Charcot's clinic where he became familiar with Janet's early work, Freud considered the core of trauma pathology to be the internal impression of a traumatic experience that is sealed off from the rest of the personality because of its unbearable nature [14]. Many of these ideas continue to inform our understanding of trauma and its impact to the present day.

3 Defining Trauma

Since the late nineteenth century, the definition of psychological trauma has been widely debated and revised throughout the growing scientific literature. As a complex construct, trauma has been the subject of much debate among practitioners and researchers, which is further compounded by the fact that the term ‘trauma’ conjures up different meanings and understandings among survivors of trauma. Furthermore, given that many survivors of interpersonal trauma/abuse do not conceptualise their experiences as trauma and some are often not able to name their experience, it is imperative that mental health professionals, including APMHNs, are explicit about what is meant by the term ‘trauma’, so they can use this knowledge effectively and sensitively to understand the range of trauma-related symptoms presented by service users across different mental health settings. It is also important for practitioners and service users to have a mutual understanding of what is meant by trauma, so that trauma experiences can be named and legitimised [15, 16].

Notwithstanding, trauma is not an easy concept to define, and definitions vary. In the two diagnostic manuals for mental health and behavioural disorders, the American Psychiatric Association Diagnostic Statistical Manual (DSM) (American Psychiatric Association (APA)) and the International Classification Diagnosis (ICD) (World Health Organisation), the description of a traumatic event has gone through numerous revisions [17]. The most recent DSM-5 [18] criteria for trauma leading to post-traumatic stress disorder (PTSD) includes exposure to traumatic events in one or more of the following experiences:

1. Experience of an actual or threatened death, serious injury or sexual violation
2. Witnessing of such events
3. Learning that the traumatic event(s) occurred to a family member or someone else in close relationship
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (common in emergency workers or police officers) [18]

Taking a broader perspective, the Substance Abuse and Mental Health Services Administration (SAMSHA) [19, p. 7] defines trauma as ‘an event, series of events or set of circumstances that is experienced by an individual as physically or emotional harmful or life-threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual well-being’. In other words, an event does not have to be life threatening; instead, any event or situation that threatens the person’s physical, social or emotional integrity can be experienced as traumatic. Thus, social traumas, such as poverty, discrimination, oppression and forced migration, are included within this conceptualisation.

4 Types of Trauma

Trauma experiences can present in many forms and can take place as a single event or multiple events compounded over time [15]. Typically, traumatic events are characterised by sudden and unexpected events which are shocking in nature or a threat to life or well-being as well as subjective feelings of intense terror or helplessness [18]. These events may be a major natural or man-made disaster (sometimes referred to as large ‘t’) or a more generalised form of a ‘stressful experience’ (little ‘t’) [20]. Events may be quite overt, such as physical and sexual abuse or witnessing domestic violence [21], or more subtle, prolonged or ‘chronic’ events such as an absent parent or ongoing emotional and physical neglect which can leave insidious effects. Throughout the literature, several writers have classified trauma in differing ways. Although people’s experiences of trauma are seldom that clear cut, the following groupings are helpful as ways of thinking about types of trauma.

Interpersonal/relational/attachment trauma refers to abuse that is commonly committed by someone who is in a position of trust against someone who is attached to or dependent on the abuser, for example, interfamilial abuse and child sexual abuse (see [22–24]). Common factors of interpersonal trauma include the use of coercion and control, the abuse of power, the distortion of reality and the dehumanisation of the person, the victim. Trauma within attachment relationships, whereby the person is dependent on the abuser to satisfy basic human needs such as safety and protection, is sometimes referred to as betrayal trauma and as a result can have more harmful effects compared with other types of trauma. Such effects are due to the presence of aversive dynamics such as betrayal of trust, dependency needs, loss of integrity and feelings of being trapped [16].

Any exploration of interpersonal trauma must consider the prolonged and repeated exposure to abuse in close relationship(s). A significant characteristic of interpersonal trauma within relationships is that the violations are not always perceived as painful or life threatening by the victim and frequently do not immediately evoke fear [16]. Writers in this area propose that dependency within the relationship puts pressure on the persons (victims) to adapt, as they cannot utilise their fight/flight response and easily leave the situation. Consequently, they may minimise awareness of the abuse or abuse-related information by using ‘adaptive’ cognitive and emotional processes, such as dissociations and emotional numbing [20]. As a result, the person’s reactions may be experienced by themselves and others as confusing or distressing, rather than traumatic. Victims may also appraise their experiences in such a way that they place the focus of the abuse on themselves as opposed to the perpetrator, by blaming themselves (self-blame) or thinking of themselves as dirty or bad (shame) [24]. While these responses may be adaptative in the initial abuse situation and help the person (victim) decrease awareness of the abuse and maintain attachment, they also increase risk of trauma, abuse and victimisation in later life.

Complex trauma refers to a type of trauma (emotional abuse and neglect, sexual or physical abuse or torture) that occurs repeatedly, usually over a period of time and within specific relationships and contexts in childhood (see Sanderson [23], Herman [15]). Complex trauma can have a pervasive impact on a child's physical, sensory, emotional, cognitive and social growth, which results in a loss of core capacities for self-regulation and interpersonal relationships. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment, for example, psychiatric and addictive disorders, chronic physical illness and legal, vocational and family problems. These problems may extend from childhood through adolescence and into adulthood [21].

Developmental trauma incorporates the features and impact of repeated and prolonged abuse through multiple or chronic exposure to one or more forms of interpersonal trauma such as abandonment, betrayal and physical and sexual assault (see [21]). While it does not always occur in early childhood and refers to events that occur over time, developmental trauma has a significant impact on relationships throughout adolescence and adulthood.

Transgenerational trauma refers to when parent figure(s) who have experienced trauma themselves transmit the effects of their trauma to their children. This results in the effects of trauma being experienced across one or more generations without exposure to the original traumatic experience or event [25]. Intergenerational trauma therefore encompasses both an exposure and a vulnerability for transmission relationally and is both a system (familial) and an individual process [26]. There is also an increasing understanding of the potential for any trauma to be transmitted through familial attachment relationships, such as parent and child. These traumas may include prolonged experiences of childhood abuse, emotional neglect, domestic violence or any other event or experience leading to sustained traumatic effects in the next generation [16].

The transgenerational impact of historical trauma has been well documented over the years, especially in the pivotal publication titled *International Handbook of Multigenerational Legacies of Trauma* [27]. Other studies that explored transgenerational impacts include the families of war veterans and prisoners of war [28, 29], survivors of the Holocaust [30], post-apartheid survivors in South Africa [31], survivors of the conflict in the former Bosnia-Herzegovina [32] and what is frequently titled 'The Troubles' in Northern Ireland [33]. All of these studies report the effects of trauma on individuals and family units, including transgenerational trauma. Although a great deal of research has found that trauma is passed from one generation to the next, there is little consensus about how this occurs. Some explanations put forward suggest that the second generation of people learn to think and behave in ways that replicate their caregivers' traumatic adaptations or that by being exposed to the secondary psychosocial effects of the caregivers' adaptations, the second generation similarly have to adapt [34]. More recently, frameworks used to explain the transgenerational trauma experienced by indigenous groups link the concepts of historical oppression and psychological trauma to explain how past human rights violations intersect with ongoing loss of culture and systemic discriminations [35].

Impersonal trauma refers, as the title denotes, to an event that does not involve a relationship (see Allen [22]). Typically, it is characterised by man-made or natural disasters. Examples of impersonal trauma include acts of terror, military combat, motor vehicle accidents or criminal assaults by a stranger.

Vicarious trauma/secondary trauma: The term 'vicarious traumatisation' was introduced by McCann and Pearlman [36] to describe how psychotherapeutic work with trauma victims can cause distress to practitioners. In comparison to the more acute phenomena of secondary stress or compassion fatigue which describes the stress-related syndrome that results from the cumulative emotional drain on the worker's capacity to care for others [37], vicarious traumatisation refers to a more pervasive, long-lasting shift in the practitioner's inner experience that results from empathetic engagement with the client's trauma material [38]. The symptoms include disrupted beliefs regarding themselves, relationships and worldviews. For example, a practitioner working within a socially disadvantaged setting might experience vicarious traumatisation through their experience over time with marginalised and 'at-risk' youth, for example, because of hearing stories of violence and extreme poverty or witnessing or observing the physical signs of emotional abuse. As a result, the practitioner becomes disillusioned about the value of their work and the services provided. It is also suggested that over time the practitioner develops some of the symptoms of posttraumatic stress disorder (PTSD), often meeting clinically diagnosable levels of PTSD [39], which mirror client symptoms but come from secondary exposure. The extent and degree of the impact of trauma-related stress are dependent on several organisational and individual factors, such as the practitioner's workload, workplace conditions and support network [37, 40], as well as the person's resilience and ability to deal with the effects using ongoing self-care and coping mechanisms [38].

While this section provided an overview of the various ways writers speak about or classify different types of trauma, it is important to remember that trauma varies in type, source and chronicity and is experienced at different stages across the lifespan and within different contexts, families, settings and cultures [15, 16]; hence, it is appraised and experienced by each person in his/her own unique way. While the above classifications differentiate between the different types of trauma, there is also an overlap between each type. For example, the experience of sexual trauma can be both impersonal and interpersonal—a stranger or date rape without a real established attachment. The experience of child sexual abuse can be a developmental, intergenerational, complex and/or interpersonal/relational trauma. Notwithstanding the overlap, it is important to remember that the spectrum of trauma may range from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse.

5 Impact of Trauma

Trauma results from an event or series of events that is both a physical and emotional embodied experiences for the individual. Researchers in the area of neuroscience point to the fact that trauma first occurs in the nervous system, not in the event

[41, 42]. In other words, humans' responses to a threat are primarily instinctive and biological and secondarily psychological and cognitive. Exposure to threat or trauma first stimulates the autonomic nervous system, resulting in sympathetic hyperarousal and parasympathetic hypo-arousal states which are accompanied by one of three innate actions known as fight, flight and freeze responses, which are common to all mammals [43]. The fight and flight responses are designed to get the person away from the immediate danger. However, if the person is overwhelmed by a threat and is unable to fight or flee from the abusive situation, instinctively the person employs the third action plan, the freezing response, also known as immobility or dissociation. It is now known that following the cessation of the threat, many people (victims) continue to suffer from autonomic sensitivity to stimuli either directly or indirectly related to the traumatic events. In other words, the brain and body continue to respond as if the threat still exists and continue to release the fight or flight hormones, which becomes bound in the body and mind, resulting in the symptoms of trauma [21, 42].

Although each person's experience and appraisal of trauma are unique, certain reactions or responses are considered universal because they are common to most traumatised people, with some reactions appearing sooner than others. Threatening and traumatic experiences result in a range of cognitive, emotional and physical reactions with the effects of trauma outliving the trauma itself. Traumatic effects are also cumulative; the more exposure a person has to traumatic experiences, the greater the emotional, physical and relational impact.

Reactions to trauma include flooded emotional reactivity, such as emotions of fear, shame and rage, numbing of feelings and body sensations, hypervigilant intrusive imagery, flashbacks and disorganised cognitive processing including painful negative beliefs about the self that intensify the distressing feelings and body responses [20, 23, 41]. Trauma can also result in limited relational capacity and negative coping, avoidance of situations, depression, psychosis, anxiety, somatic illnesses and risk of PTSD [44–46]. In addition, even if the threat is no longer present, strong somatic responses in which the body tends to become frozen, collapsed or hyperaroused driven are also reported.

While the experience of trauma is subjective and differs from person to person, with a person's ability to deal with the event emotionally being the deciding factor that makes an experience traumatic [47], the Window of Tolerance model [48, 49] is one way of understanding and explaining the fluctuation in responses. This model proposes that each person has an optimal window in which he/she can experience and manage the ebb and flow of everyday emotions, such as calmness, happiness, delight, surprise, sadness, etc. Some emotions such as anger, anxiety, hurt, grief, fear and disgust may bring us to the outer edge of that window, but the person can use strategies to maintain his/her emotions within the Window of Tolerance range. However, when people experience trauma, their autonomic nervous system is drastically altered either through sympathetic hyperarousal or parasympathetic hypo-arousal. Hyperarousal, which is the result of excessive sympathetic stimulation, leads to anxiety, fear, panic, hypervigilance and in extreme cases emotional flooding. This in turn makes it difficult for the person to sleep, relax, process information or regulate emotions. If hyperarousal continues, the body eventually shuts down by going into a hypo-arousal state, which may be characterised by depression, numbness, disconnection and disassociation. With a dysregulated nervous system that cannot modulate either heightened emotional states or states of numbing and depression, clients/service users often report difficulty in tolerating any emotional and physiological arousal without becoming overwhelmed, as well as having problems in recovering from experiences of intense activation or depression [41, 48].

Corrigan et al. [43] suggest that, for example, when service users with trauma-related disorders such as PTSD and borderline personality disorder develop greater ability to self-regulate autonomic arousal, their symptoms tend to diminish or ameliorate, and they can begin to engage more effectively in well-established treatments for trauma. Thus, the Window of Tolerance treatment approach focuses on supporting the person to develop strategies that help the person's self-regulating autonomic arousal within their Window of Tolerance so that they can think and feel without becoming overwhelmed. Strategies may include, for example, grounding exercises, breathing exercises and body awareness work.

6 Trauma and Mental Health Problems

Although many people show great resilience in the face of adversity, the role trauma plays in the development of mental health problems is now well recognised. There is an abundance of literature providing evidence that traumatic experience can cause significant psychological difficulties for large numbers of people. Of particular concern is the impact of traumatic experiences that occur in childhood on mental health [45, 50, 51]. In recent years, there has been renewed effort to understand the effects of early adversity on the development of various mental health conditions. Findings from the seminal adverse childhood experience (ACE) study by Felitti et al. [52] in the USA established an irrefutable link between childhood exposure to physical and sexual abuse, and neglect, and exposure and adverse health outcomes in adulthood.

Posttraumatic stress disorder (PTSD): PTSD is a mental health problem that may occur in people who have been exposed directly or indirectly to a traumatic event such as a natural disaster, a serious accident, a terrorist act, a war/combat or a rape or who have been threatened with death, sexual violence or serious injury. For example, PTSD could occur in an individual learning about the violent death of a close family member or friend. The exposure may have occurred in the distant or recent past, and pervasive symptoms such as intrusive thoughts of the event, hyperarousal to stimuli in the environment, negative moods and avoidance of cues related to the trauma are characteristics of both acute and chronic PTSD [18]. People with PTSD experience intense and disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; may feel sadness, fear, or anger; and may feel detached or estranged from other people. People experiencing PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

Trauma and other mental health problems: Reports indicate exceedingly high rates of trauma histories among people admitted to psychiatric hospitals and other mental health settings. Studies estimate that people seeking treatment for serious and enduring mental health problems have been exposed to emotional, physical and/or sexual trauma in their lifetime, with the presence of multiple forms of trauma being associated with more complicated psychological problems in adulthood. Findings from studies have also established an irrefutable link between the experience of trauma and mental health diagnoses, such as depression [53], adulthood psychosis [54] and personality disorder [55], with researchers reporting that around a third of individuals with severe mental health problems have comorbid PTSD [56]. Studies also provide support for a positive association between exposure to trauma and subsequent addictive behaviours [57], with the trauma-addictive relationship more evident in studies investigating the effects of childhood traumatisation in the adult population [58]. Studies also demonstrate an association between sexual abuse and an increased risk of a lifetime diagnosis of anxiety, depression, eating disorders and borderline personality disorders [59]. In addition, studies indicate that people who experience psychosis have been exposed to high levels of trauma [45, 51, 60]. Bailey et al. [61] suggest that childhood trauma is significantly correlated with hallucinations and delusions, with Hardy [44] positing that childhood sexual abuse is associated with voice hearing, whereas emotional abuse and neglect are associated with paranoid thinking. In addition to trauma being a catalyst for psychosis, there is also increasing recognition of the traumatising effects of experiencing psychotic symptoms. Significant numbers of individuals with psychosis are shown to develop a PTSD response to experiences such as threatening auditory hallucinations [62].

Overall, trauma symptoms pervade all aspects of life and can have detrimental effects for individuals if they are not identified, understood and adequately addressed in treatment [63]. Failure to identify and address individual stressors and risk factors in people with enduring mental illness is linked to frequent hospitalisation, difficulties with daily functioning and employment, social rejection and a lack of confidence in healthcare providers [64]. The prevalence of trauma-related illnesses coupled with evidence of iatrogenic harm/re-traumatisation in mental health services has led to the development of trauma-informed approaches [19].

7 Trauma and the Mental Health System

In recent years, mental health practitioners have become increasingly aware of how they relate to service users and how some aspects of care can potentially exacerbate or have a negative impact on the person's well-being or even traumatize those with no previous exposure to a trauma history [65]. While mental health practitioners do not intentionally set out to do harm, it cannot be ignored that some mental health settings and practices are predicated on the principles of coercion and control [8]. Hence, the growing body of evidence points to 'iatrogenic-induced trauma' or trauma induced as a secondary result of coercive or restrictive practices within mental health settings [5]. Restrictive/coercive practices may not only traumatise the people directly involved (service users and staff), but service users may be traumatised by observing other service users being subjected to coercive or restrictive practices. Coercive practices may include being detained under the mental health legislation, being given medication and electroconvulsive therapy against one's will and being subjected to practices such as restraint, seclusion and body searching, as well as intensive one-to-one observation [66]. Although much emphasis within the literature is on how restrictive/coercive practices traumatise the people involved, people may also be traumatised by not having their voice heard, not being believed and being excluded in decisions concerning their care or by practitioners who are insensitive to service users' cultural, religious, sexual and gender diversity. There is also recognition that telling and retelling one's story to different people or to practitioners who are emotionally disconnected and trauma unaware can also be traumatic.

Coercive or other disempowering practices by their very nature can cause re-traumatisation of people who have previous trauma histories, as these practices may resemble or have some symbolic resemblance to past experiences of violence, abuse or discrimination. Hence, they frequently evoke or trigger the same emotional and physiological responses associated with the original event; for example, responses such as flashbacks, dissociation, physiological reactivity, depression, aggression and/or self-injury may be triggered. However, the persons may not be aware that their current distress is rooted in past events [16].

8 Trauma-Informed Approach to Care

TIC is both an organisational model of care [67] and an individual practitioner's approach to care that is based on research demonstrating the wide range of effects of trauma on individuals' well-being, including their physical and mental health [45, 68]. Notwithstanding the growing international interest and statements of commitment, the implementation of TIC into practice has proven to be challenging [11]. It is therefore essential to explore what a trauma-informed organisational or system's approach to care includes and how trauma therapies differ from TIC, prior to outlining some of the key principles that underpin the individual APMHN's approach towards implementing TIC.

8.1 An Organisational Approach Towards Trauma

Emphasis at an organisational level is to increase the whole organisation's awareness of the widespread impact of trauma, increase recognition of the symptoms of trauma and provide clear pathways for trauma-focused therapy and supports for staff, as well as shifting structures and cultures that perpetuate the re-traumatisation of people within practice. In other words, the organisational system's approach to trauma is based on SAMSHA's [19] four pillars also known as the four 'R's: realise, recognise, respond and resist re-traumatisation. Thus, an organisational approach towards trauma ensures that people at all levels of the mental health system **realise** the extent of trauma in people's lives across all demographics and have a basic understanding of how trauma can affect families, groups, organisations and communities as well as the individual. People working within the mental health system must also **recognise** the signs of trauma in individuals seeking or providing services, signs which may vary from individual to individual.

The third pillar involves services understanding that the experience of traumatic events impacts all people whether they are service users or service providers and **respond** by either providing trauma-specific services/therapies for service users within mental health services or provide, through inter-organisational working, a clear referral pathway to those who wish to avail of services outside mainstream mental health services, based on a preliminary psychological formulation. Services must also respond to the needs of staff and recognise that establishing, sustaining and ending relationships with clients require commitment, compassion and hard work [69] and come with an emotional cost to practitioners [70]. Thus, organisations must **recognise** their duty of care by acknowledging the impact of working with trauma on staff's personal and professional life and **respond** by implementing proactive measures to reduce the impact, such as education and clinical supervision [71]. The final 'R' stands for **resisting re-traumatisation.** As such, an organisation that resists re-traumatising individuals is an organisation that continually monitors and limits the use of restrictive practices; works from policies, procedures and guidelines that are trauma-proofed and responsive to the racial, ethnic, gender, disability and cultural needs of individuals; and invests resources in educating and supporting staff on a continuous and ongoing basis about evidence-based trauma practices.

8.2 Trauma-Focused Therapy

Trauma-focused therapies, which may be part of a service offered within trauma-informed organisations, are different from the TIC approach. While the primary goal of trauma therapy is to directly address a person's past or historical trauma, TIC is focused on creating relationships and environments that promote recovery and prevent traumatisation or re-traumatisation. People attending trauma therapy have a known trauma history, whereas a TIC approach is based on recognition of the widespread prevalence of trauma in the lives of those seeking help and using mental health services.

Trauma therapies may comprise an eclectic application of therapeutic models such as eye movement desensitisation and reprocessing (EMDR), cognitive behavioural therapy (CBT) and other psychotherapeutic interpersonal approaches. While trauma-specific therapists may have differences in orientation, they all tend to focus on helping the person gradually develop adaptive emotional and behavioural actions to overcome their fears and structural dissociations that are results of the trauma, with an overall agreement on the stages/phases of progression/recovery across the spectrum of trauma syndromes [14–16, 20, 21, 41]. However, given that trauma affects all aspects of human functions, the biological, psychological and social recovery must be comprehensive and occur at each stage (Table 1).

Table 1 Stages of progression

Phase 1 Stabilisation	Phase 2 Processing	Phase 3 Integration
Stabilisation and symptom reduction—geared toward safety, identifying strengths, developing resources, acquisition and mastery of skills to facilitate emotional regulation, promote self-care and support network (widening window of tolerance)	Processing of trauma—exploration and realisation of the past, trauma experiences, split-off feelings, recurring themes and mourning	Integration—restore meaning, integrate experiences, build resilience, reconnection to self and others and posttraumatic growth

9 Trauma-Informed Principles to Guide APMHNs' Approach to Care

While a whole system or organisation approach towards trauma, including the provision of specific trauma services and interventions, is more impactful than individual practitioners adopting a trauma-informed approach towards care [19], APMHNs need to incorporate principles underpinning TIC into their day-to-day engagement and practice regardless of whether the organisation chooses to make trauma-focused interventions available to service users. As said, TIC is different from trauma-focused interventions or therapy, as its primary goal is not to directly address past trauma but to view presenting problems in the context of a client's traumatic experiences. Hence, the principles underpinning TIC are based on evidence that trauma is a possibility in the lives of all service users whether a person's trauma history is known or not. Notwithstanding that some APMHNs may have specific expertise in trauma-focused therapy and that trauma-informed care is a dynamic continuous process rather than a static or once-off event, the following principles have been developed drawing on trauma-informed literature. Like all practice principles, they are intended to guide APMHNs' practice rather than be a prescribed set of practices or procedures.

Reflecting on personal biases: Attitudes held by APMHNs towards service users' trauma, together with their knowledge, skill and sensitivity, are likely to influence their working relationship and hence the experiences and outcomes of effective TIC. APMHNs' attitudes may include disbelief, fear of re-traumatising, inability to tolerate uncertainty and challenges in managing shame. Such responses can impact on how the APMHN relates to service users and has the potential to hinder the development of a trusting working relationship. Hence, the first step in working through a TIC lens is to become aware of one's own views and biases in relation to trauma, actively moving past cultural stereotypes and biases, based on race, age, disability and gender, as well as acknowledging the relationship between trauma and mental distress and how multiple traumas intersect with each other as well as intersect with person's age, gender, culture, ethnicity, sexuality, etc.

Promoting safety: Irrespective of whether a person has a pre-existing trauma history or not, admission to a psychiatric hospital/setting can be traumatic for service users due to the loss of autonomy and voice and dislocation from normal supports and family. Feeling unsafe in a trauma-uninformed system can therefore cause service users to become distressed and feel powerless, vulnerable and helpless, triggering associated defensive and/or self-protective behaviours such as withdrawal, aggression and self-harming behaviour. Hence, people [children and or adults] using the service need to feel physically, emotionally and culturally safe. Indeed, Maslow [72] suggests that once a person's physiological needs are satisfied, their safety needs take precedence and dominate behaviour. Adopting a trusting and transparent relationship, which is respectful of the person's identity (age, gender, culture, ethnicity, sexuality, etc.) and promotes choice, control and involvement (see "Diversity and Culturally Responsive Mental Health Practice"), is important as many people seeking help and using mental health services have experienced relationships based on shaming, secrecy, betrayal and power imbalance, where their need for safety was not considered. Understanding how people who use or need mental health services define and conceptualise safety is also a good foundation for creating a sense of safety. Encouraging and supporting the person to discuss issues of safety can be therapeutic and can also enable a two-way dialogue that may reveal concerns (e.g. around sharing space, mixed sex wards, gender of staff, etc.) that require action to enhance a person's personal safety and well-being. While interpersonal interactions can promote a sense of safety, APMHNs also need to attend to the physical environment and ensure people feel physically safe. As the person's sense of safety can change within short time periods and can fluctuate in accordance with the person's trauma and mental health status [14, 15, 20, 24], assessment of the service user's emotional and physical safety should be carried out as an ongoing process rather than as a static or once-off event.

Moving beyond the biomedical lens: Mental health practitioners, including some APMHNs, are socialised to view behaviours and distress in the context of symptoms and diagnosis. A key component of working through a TIC lens involves moving beyond the biomedical lens and diagnostic labelling to viewing trauma through the lens of the person. This requires a shift in thinking and in approach from 'what is wrong with you' to 'what happened to you' [20, 23] as well as understanding how trauma not only impacted the person's past life but how it continues to shape their responses and experiences. Thus, APMHNs need to view the persons within their social and political context [11], including their traumatic experiences, and recognise that the person's emotional responses and behaviours, even what might be considered extreme, are not symptoms of some illness but understandable human adaptations to past adverse and traumatic experiences and are ways of coping and communicating distress. Thus, a one-size-fits-all approach that focuses on disease and diagnosis will not address the uniqueness of each person's experience and recovery.

Resist traumatisation and re-traumatisation: An important feature of TIC is recognition that trauma can occur from engaging with mental health services, thus ensuring that the care environment and practices do not inadvertently do harm or re-traumatize service users is a core principle. Hence, it is essential that APMHNs are mindful of the many ways people may be re-traumatised by their engagement with the mental health system and move away from practices such as locked doors, seclusion, restraint and forced medication as they are experienced by service users as re-traumatising, paternalistic and disempowering. In this context, APMHNs also need to be mindful of how other practices such as the telling of a trauma history in an unsupportive context, having one's voice subjugated or ignored and pathologising a person's response to racism, sexism or homophobia can replicate previous historical or cultural traumas. APMHNs also need to reflect on their position and power differential between themselves and the service user, to avoid using power in interactions that may replicate or have some symbolic representation of past disempowering experiences (see case vignettes at the end of this chapter for practitioner reflections on this issue). Equally, if someone refuses to have a certain procedure, or if they're upset about something (like having a physical examination), practitioners need to respond with compassion and work with them, rather than attempting to force them or becoming annoyed [16].

Engaging in trauma-informed conversations: The first step in engaging in a trauma-informed conversation is to recognize how common trauma is and to understand that although many people do not disclose trauma, every person seeking support and care may have experienced some form of trauma. While best practice suggests that everybody attending mental healthcare should be asked about their trauma history, research indicates that, for many reasons, there is sometimes great reluctance among practitioners to open the trauma 'can of worms' [45, 63]. A trauma-informed approach to asking questions is a relational process that is rooted in the therapeutic dialogue; thus, any questions or enquiries about trauma needs to be conducted sensitively, when the person is not in an acute crisis, using client-centred principles of practice [16]. This will include explaining why sensitive questions are being asked and normalising the question. For example, practitioners could address the subject by saying 'We know that many people using mental health services have experiences of various types of traumatic experiences. To help us understand and provide the best and most appropriate care I need to ask if you have experienced past traumas in your life'. To service users with a known history of trauma, practitioners should enquire 'Is there anything I can do to make your experience of being in hospital easier/safer?' Engaging in a trauma-informed conversation does not necessarily mean ascertaining the details of the trauma or abuse; instead, it is important to allow the person to control the pace and content of the conversation, as well as reassuring the persons that they do not have to disclose or talk about any issue they do not want to and are free to return to discuss issues at any time into the future. Using reflective open-ended questions that allow for freedom of response and adopting a non-judgemental and positive attitude towards the service user is also essential, especially as engaging in a discussion about trauma can be experienced by service users as challenging, anxiety provoking, embarrassing and shame inducing [24]. Should the person choose to disclose, facilitating the persons to tell their story though embodied listening, 'respectful curiosity' and reflecting and using emotionally supportive statements are central.

Good practice demands that practitioners, including APMHNs, are also continually aware of the impact of the care they are providing on the person, so asking questions especially before engaging in physical interventions is important, questions such as 'Is there anything in your history that makes having a practitioner of the opposite gender or having a physical examination difficult for you?' While relational ways of being with the service user are themselves essential therapeutic interventions [20], acknowledging limitations and referring people to trauma-specific therapies, if desired, is important.

Working in an empowering and collaborative manner: In keeping with the ethos of recovery and co-production, TIC is founded on the principles of authenticity, choice, collaboration, shared decision-making and empowerment [73] (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"). However, there may be times when APMHNs are required to make decisions around safety for the service user, especially if they are in an acutely distressed state. In such incidents, every effort should be made to introduce assisted decision-making supports and re-engage the person in collaborative dialogue as soon as possible. Additionally, it is essential that the APMHN continues to treat the person with respect and dignity and keeps the person fully informed and conveys an expectation of future involvement and recovery. TIC does not fall exclusively within the domain of any single profession or discipline; therefore, collaboration between all professionals within a multidisciplinary team is also essential. Seeking opinions from members of the multidisciplinary team can result in unique insights and recommendations and enhance the quality of clinical decision-making; however, the service user's voice should always be central. Collaborative working also includes recognising the value of utilising lived experiences through peer and mutual self-help as key vehicles in promoting recovery and healing.

Adopting a strength-based approach towards trauma: The recognition of what has been called posttraumatic growth in survivors after traumatic experience [74] is a new and burgeoning field of inquiry. Posttraumatic growth is the experience of positive change that occurs because of the struggle with highly challenging life crises. It can be manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities and a richer existential and spiritual life. Thus, APMHNs need to adopt a strength-based approach towards trauma; view the persons beyond their trauma and reflect upon their strengths, achievements and coping mechanisms as well as exploring with the persons how best to make progress using their current resources; and support structures and personal strengths available at a particular point in time. A strengths-based approach is also underpinned by professional optimism and a belief that people can and do recover from trauma.

Informing the person about the limits of confidentiality: Information disclosed by a service user should, by and large, be kept confidential within the team, as nurses are legally obligated to ensure that personal information is not disclosed in an unauthorised manner and without service user's informed consent. However, given that legislation and regulatory frameworks surrounding disclosure are different in different countries, there may be some instances wherein disclosure of information is required by law; thus, APMHNs need to be aware of local legal and professional requirements. For example, in Ireland, the Children First Act (2015) introduced several key child protection measures, one of which requires professionals as a mandated person under the legislation to report any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed or is at risk of being harmed [75]. In such instances, to minimise the risk of distressing and traumatising the person, it is a best practice to inform the service user of instances whereby their information must be shared with outside authorities or public services.

Engaging in self-care and supervision: Working with people who have experienced trauma and use or need mental health support can be both rewarding and demanding. Thus, as Norcross and Guy [76, p. 14] assert 'self-care is an ethical imperative for all workers in the field of helping so that they can maintain the provision and delivery of their work to the highest standard possible'. Continuous professional development in trauma and TIC together with regular supportive supervision is part of this process and essential for all practitioners including APMHNs. Professional supervision has been identified as crucial not only for developing and nurturing practitioners' clinical work but also for early identification and management of vicarious traumatisation [23]. Engaging in formal supervision can help to reduce secondary trauma or protect against it and as a result help decrease work-related stress and burnout. Formal supervision can offer APMHNs a safe and supportive designated forum to reflect on their responses arising from their work, to openly share/disclose difficult issues and, at the same time, receive constructive feedback to enhance the practitioner's personal and professional development [71]. Essential to this experience is the quality of the supervisory relationship, which plays a significant role in the quality of the learning alliance. Ideally, formal supervision should be done regularly with a qualified external person both in one-to-one and/or group-based format. Ongoing education can help to ensure that APMHNs keep up to date with new research, policies, tools and skills required for competent, caring, compassionate and reflective practice.

Building organisational and individual capacity: APMHNs also have a key role in enhancing nursing and multidisciplinary team colleagues' knowledge and awareness of trauma and the potential for re-traumatisation in clinical practice. As change leaders, APMHNs are ideally positioned to proof nursing policies and procedures to ensure that they reflect the values and principles of TIC as well as advocating for the professional and organisational shift required to develop a trauma-informed mental health service.

10 Conclusion

Modern mental health services are increasingly asked to acknowledge the prevalence of trauma, its impact on individuals' life and experiences and the risk of iatrogenic harm. As trauma survivors represent most clients in mental health settings, and APMHNs have no way of knowing who a trauma survivor is, it is a best practice to apply 'universal trauma principles' to all. In this way, APMHNs are routinely using practices that are person centred and recovery focused and are less likely to re-traumatize those already exposed to significant trauma. As leaders, APMHNs are also ideally positioned to play a leading role in embedding a trauma-informed approach into the systemic policies, procedures and practices of their service, as well as acting as educators and role models for colleagues on how to integrate knowledge about the effects of trauma and re-traumatisation into mental health practices.

Reflective Questions

- As an APMHN, how would you facilitate a conversation about trauma with a patient/service user who disclosed historical sexual abuse?
- As a change leader, identify three key factors that might hinder the implementation of a trauma-informed approach in your area of practice and what strategies you would implement to address such issues. Give specific examples.
- Reflecting on your practice of self-care, identify three factors that might precipitate periods of compromised self-care and what you can do to address such issues. Give specific examples.

Case Vignettes

The following two vignettes present different presentations of trauma and reflections to illustrate the importance of understanding trauma and its unique impact and being sensitive to avoid inadvertently re-traumatising and causing further harm to service users.

Vignette One

My name is Jane Kennedy, and I am an advanced nurse practitioner candidate working in the Child and Adolescent Mental Health Services, Linn Dara Dublin, Ireland. I am a registered mental health nurse and have a MSc, in Mental Health Nursing, and a MSc in Systemic Family Therapy (FTAI and ICP accredited).

Emily, a 17-year-old, was admitted to the Child and Adolescent Mental Health Services (CAMHS) unit because of her significant weight loss and restrictive eating. Emily lives with her parents and two younger sisters, aged 8 and 10 years. During the last 2 years, Emily's maternal grandmother and aunt were diagnosed with cancer and had died within 6 months of each other. Emily was very attached to both her grandmother and aunt. At the same time, Emily's best friend's Mia's mum died following a short period of illness. She remembers visiting her aunt prior to her death and asking her parents 'if she going to die?' and she knew she was ill as her parents changed the topic, 'just like they did when my grandma was ill'. Then, almost a year later, her father was admitted as an emergency to hospital with abdominal pain and severe vomiting and had major surgery for a non-malignant abdominal tumour. Although Emily's father has made a successful recovery, she does not believe her parents when they tell her that he is not going to die. Emily's parents disclosed that they found it a very difficult time and did not know how to talk to their children about death and dying, fearing such conversations would upset them. They managed it by distracting them and avoiding any questions.

Reflections

Working with Emily, as an APMHN candidate, I am aware of the importance of being sensitive to the following issues so that I do not inadvertently cause her any further harm:

- I am aware that Emily and her parents have experienced multiple losses of people who were significant in her and their life and that these losses impact Emily's mental health.
- I am aware that it is essential to acknowledge and invite Emily to talk about her grief and feelings of loss and allow her a space to be upset.
- I am aware that it is essential to respect Emily's level of maturity and invite her to talk about her fears and concerns about her father and death and be able to be present if she gets upset.
- I am aware that I am working/supporting Emily's parents to acknowledge and respect Emily's level of maturity and to respond openly to her questions and to trust her ability to manage difficult information.
- I am aware that I need to discuss in clinical supervision my feelings of helplessness and awareness that like Emily's parents, I am unable to 'fix it' or take away her feeling of sadness and loss.

Vignette Two

My name is John Staunton, and I am a clinical nurse specialist working in the First Episode Psychosis Services—Adult Mental Health Services—Linn Dara Dublin, Ireland. I am a registered mental health nurse and have a PGDip in Cognitive Behaviour Therapy and a MSc in Mental Health.

Paul is a 22-year-old first year student studying law, who lives with his parents and younger brother. He was referred to me following his discharge from the local in-patient psychiatric hospital, where he had been admitted for a period of 3 weeks under the Mental Health Act, after experiencing a first-episode psychosis. On meeting with me, although he found it difficult and distressing at times, Paul slowly talks about the distress he experienced by being admitted against his will to hospital, which was exacerbated by the fact that he was removed from his home in front of his family and neighbours. He now fears being called 'mad' when he returns home or to college. He also feels very embarrassed when he recalls his behaviour during a teaching session, when he shouted at his friends and lecturer for not believing him when he said, 'the voice in my head helps me to know who has COVID-19'. Consequently, he now feels 'so embarrassed about what people will think and is afraid of losing his friends'.

Reflections

Working with Paul, I am aware of the importance of being sensitive to the following issues so that I do not inadvertently cause him any further harm:

- I am aware that Paul has experienced iatrogenic-induced trauma, and it is therefore essential to listen to his experiences of being admitted to hospital against his will and to acknowledge its impact on him.
- I am aware that engaging with Paul and acknowledging his experiences of harm caused by his admission process can provide invaluable insight into the care we offer, which in turn enhances my practice and the therapeutic process.
- Listening to Paul, I am aware that he feels embarrassed and ashamed talking about his behaviour prior to his admission and the impact of his behaviour on others. It is therefore important that I validate his distress without judging him or his decisions. For example, 'Paul, I know this is difficult for you to talk about, take your time, we can go at your pace. I am here to listen and see how we can together find ways that can help you at this time'.
- I am aware that I need to discuss in clinical supervision my feelings of discomfort in relation to witnessing Paul's distress due to his first-episode symptoms and listening to him recount insensitive practices associated with his hospital admission.

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Mental Health Care in the Era of Growing Global Risk and Uncertainty: A Recovery and Person-Centred Approach

Jan Kåre Hummelvoll and Bengt Gunnar Eriksson

Learning Objectives

The objective of this chapter is to enable you to:

- Understand the significance of the theory of 'risk society' and to analyse its practical implications for mental health care/nursing.
- Develop openness to uncertainty and a searching and collaborative attitude amongst professionals and between professionals and users.
- Understand and analyse the significance of the concepts of risk and uncertainty in mental health care/nursing.
- Be critically aware of the experiences and perceptions of service users in their endeavour to cope with risk and uncertainty in everyday life.
- Evaluate and critically reflect upon how a recovery-oriented and person-centred model of practice can help professionals and service users to deal with risk and uncertainty.

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1 Introduction[1]

The quality of mental health care is finally decided in the encounter between the service user and the mental health worker, who in many cases is a psychiatric nurse, but can represent other professions like psychiatrist or social worker, too. What these encounters have in common is that it is the personal meeting and its qualities that carry possibilities for change. A condition for this to happen is that the user's needs, limitations and possibilities are at the centre of the helper's attention and interest. In other words, care, support and treatment must be person-centred. Consequently, it implies that the user's view of him or herself, with personal difficulties and resources, that is, the 'internal landscape', should be in focus. The growing knowledge of recovery processes for persons with mental health problems has contributed to the insight that even major difficulties can, completely or partly, be overcome.

However, the encounter between the service user and the professional does not take place in the light of these inner, personal factors and circumstances only. Many factors in the external world affect the individuals' situation, in their role as service users and professionals, respectively. External factors in the immediate environment have direct bearing on the individuals' situation, and so have general, societal factors and conditions, more distant from one's own life. These factors form a kind of 'external landscape'. The point of departure for our view on mental health care is that both the internal and the external landscapes should be included in a comprehensive view of the service user:

> There is no place where the world ends and the I begin. Human beings must be seen in an environment that is never static. He or she must be seen in a context—which is a process. Somewhere behind every person is a landscape determining their external conditions. Somewhere inside every person is an internal landscape. The outer and the inner landscape are bound together by thousands of fine threads. They give us identity. [1, s. 249]

Knowing the importance of the nearby and situational factors, we will in this chapter also pay attention to more long-term and structural changes in the 'external landscape'. Such changes at the societal and ultimately at the global level are affecting everyone in the society including service users and professionals. They are also affecting the conditions for mental health-care practice. Our starting point is some central concepts from the research on the emerging risk society, in order to describe these processes of change, and further on in the chapter, we discuss their consequences for mental health care. The first two parts of the chapter aim at

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[1] Text material from the following articles and book chapter has been frequently used in this text: *Recovery and person-centredness in mental health services: roots of the concepts and implications for practice*, by Jan Kåre Hummelvoll, Bengt Karlsson and Marit Borg (2015); *Coping and Meaning in Everyday Life: Living with Mental Disabilities in Late-Modern Society* (2012), by Bengt Eriksson and Jan Kåre Hummelvoll; and *People with mental disabilities negotiating life in the risk society*, by Bengt Gunnar Eriksson and Jan Kåre Hummelvoll (2008). Full references are to be found in the list of references.

creating a basis and a frame for the third and central part that deals with mental health care in the changed social context that the emergence of the risk society entails. The risk society implies negative consequences for people with mental health problems but opens some positive options as well. We think that mental health care should strive to keep and develop personal and durable relations, based on trust between service users and professionals, to counteract anonymisation and too much of a technique-based and 'manualised' practice.

Consequently, the aim of this chapter is threefold: firstly, to present a structural perspective on societal changes implying increased uncertainty and risk; secondly, to describe how these changes might influence—and really do influence—life for people with mental health problems; and thirdly, to highlight and develop how mental health-care practice is affected by and can cope with the changes that the risk society implies. In this connection, we emphasise the concepts of person-centredness and recovery. From our point of view, these concepts are central in mental health care in the postmodern society.

2 The Risk Society and the Return of Uncertainty

In the following section, we will discuss some central features in contemporary society that to a greater extent than previous societies are characterised by new risks and uncertainties.

2.1 The Basic Concepts of Risk, Uncertainty and Danger

The concept of risk is broad and not satisfactorily defined [2, 3]. A first, somewhat traditional interpretation of the term takes as a starting point the possibility of being affected by unwanted events, often from a physical perspective, like being hit by a natural disaster. This 'straightforward' concept of risk is characterised by its connection mainly to a technical interest of knowledge, aiming to prevent and minimise the probability of unwanted and negative incidents occurring. Such risks might be defined as 'remaining' consequences of an imperfect (technical) society. Second, one can also think of risk in the sense of noncalculable uncertainty, for instance, being affected by computer crimes or terror attacks, risks that are created by society's development as a result of technical or cultural processes. Paradoxically, these risks have emerged at the margin of societal development through advanced and complex mechanisms, such as highly developed communication technology, globalisation and commercialisation [4]. Boyne [5] holds that one ought to distinguish between the concept of risk and the concept of uncertainty (or danger). While a certain risk, or danger, can be predicted, calculated and to some extent prevented, uncertainty is characterised by its creeping, unpredictable nature. A third meaning of risk, connected with the last one mentioned, can be seen as a result of anonymisation and alienation in the late modern society [6]. A society, which to a growing extent seems to be abstract and virtual in several areas, is therefore creating a feeling of uncertainty and isolation. Relations and communication that in former times used to be personal and concrete are now replaced by non-personal and geographically intangible contacts. Society has literally become more and more incomprehensible to the individual, and societal institutions have increasingly become anonymous and distanced. We are focusing risk from the two last described aspects, closely related to the concept of uncertainty.

2.2 Risk Management and Its Risks

This chapter deals with risk and uncertainty from a societal and structural perspective. However, these concepts are far from new in mental health care. Rather they have been used in a number of meanings. The concept of risk has often been connected to risk assessment and risk management owing to the possible personal threat, in general, and specifically towards health professionals, from people with severe mental disorders staying in institutions or those living in the local community [7–9]. Methods and routines for risk assessment have been developed and used in order to reduce the risk for critical incidents and violence in connection with mental health-care practices. However, researchers have been critical towards this development as well. Slemon et al. [10] argue that it is necessary to shift perspectives on safety and risk in mental health care. They suggest that the 'risk management culture' should be replaced by individualised and flexible care, incorporating safety measures.

Sometimes, the perspective of risk assessment has been seen in connection with the risk people with mental health problems represent with regard to harming themselves [8]. In many cases, research on this topic has made a connection between the change in psychiatric treatment from institutionally based to community-based care and social support [11]. From another perspective, some research (e.g. Kelly and McKenna [12], Warner and Gabe [13]) has explored the risks in living in the community for people with mental health problems, for instance, due to stigmatisation and harassment from individuals and groups living nearby—and others have drawn attention to iatrogenic risks associated with treatment interventions like side effects of medication and trauma from malpractice and negligence [14, 15].

Other researchers (e.g. Zinn [16]) have, from an overarching perspective, been questioning the idea of risk assessment as entirely based on cognitive rationality. In the complex societies of today, individuals have to make numerous decisions on an almost day-to-day basis. As they often neither have sufficient knowledge, nor time to make a complete and thought-through analysis, decisions have to be taken on an incomplete ground, often relaying on experts and on one's own and other's previous experiences. Therefore, trust is a crucial quality. Zinn [16] proposes an *in-between* strategy in risk assessment, where cognitive rationality is complemented by intuition and emotion in addition to trust. Even though Zinn treats risk and risk management from a general perspective, his arguments are highly relevant in the discussion of risk assessment in mental health care. Following his line, risk assessment in mental health care should be less focused on technical and instrumental aspects and more on qualitative- and situation-based ones. We share his point of view and regard it to be highly compatible with the characteristics of the risk society which will be further developed in this chapter. In this respect, knowledge on the implications of the risk society can contribute to the development of mental health care, towards more of a person-centred approach. At the end of this chapter, we will return to how knowledge on the risk society can improve mental health-care practice.

2.3 The Risk Society and the Late Modernity: History and Key Characteristics

2.3.1 The Modern and the Postmodern Society

The society that developed during industrialism had its roots in the Age of Enlightenment of the eighteenth century, characterised by a belief in reason, the human being and the new (natural) science. The nineteenth century and the early twentieth century meant a radical transformation of society, with industrialisation and mass production, often according to the principle of 'the conveyor belt'. In many countries, an urbanisation process was started, from a poor agrarian society to a more urbanised and richer one. Modern societies developed, not least in Europe and the USA: Working life was modernised, housing was improved, society developed and prosperity increased rapidly. Functionalism, a trend that characterised important fields of social life, agreed well with the prevalent belief in progress, growth and development. This era, 'the modern project', also included welfare. Health and medical care, education and care of the elderly and of groups that could not support themselves due to handicaps/disabilities—it was all an expression of the idea that the general welfare should include the whole population. In many countries, a strong state apparatus to produce and administer welfare services was developed. In other countries, the responsibility was placed on separate organisations, working life or family, however, in most cases in close cooperation with the public sector.

We have to a certain extent left behind the society of modernity. The vision of society underpinning the industrialisation and modernisation processes can no longer be completely used as a description of the present stage of development. The modern society's secure anchoring in the belief in growth and increasing material prosperity to share is wavering gravely. We are in a different stage of development. Many researchers think that this stage differs on such decisive points from the industrial society that it ought to have a different name. It is in this connection that concepts like 'late modernism' or 'postmodernism' have been used. They all aim to describe a change from the previous industrial society, without having to define the coming one, the post-industrial society. The concept of 'risk society' also refers to the stage of society that we are now in but we want to focus on one aspect of this society, namely, its connection with the partly new risks and insecurities created by development itself. The reason why we have chosen to use 'late modernism' is rather the need for a broad and generally applicable concept instead of criticism of other closely related terms. In our description of the late modern society, we also include quite a few factors that have been paid attention to in the discussion of the risk society – since they have a special relevance to vulnerable groups and their life situation.

2.3.2 New Threats, Risks and Uncertainty: The Risk Society

The characteristics of the late modern society include processes like globalisation and an economy that does not know any national or geographical boundaries. Service production increases and an increasing proportion of the workforce are occupied with services. The role of mass media and social media grows. Communication technology is increasingly important and constitutes one of the strongest forces in society. News based on facts are sometimes competing with 'fake news' and information regarded to be of special interest for many 'goes viral'. The big visions of society, the grand stories, are challenged – maybe the age of the big stories is over? Power resides in many places and is more difficult to identify. Society has become more 'invisible'. New and previously unknown risks and uncertainties have emerged, at the same time as other notorious risks have changed or have become less threatening. These new risks and uncertainties can be exemplified by industrial or environmental threats but also risks produced in and by the abstract, often worldwide, systems that more and more manifestly also influence the everyday life of the individual. Huge accidents in nuclear plants, like in Chernobyl and Fukushima, can be seen as such environmental catastrophes. The risks of today's society tend to be global as in the case of pandemics. The Covid-19 virus, for example, was spread around the world in just some months, due to worldwide commercial and personal communications. Concerning mental health problems, researchers have highlighted how threats to physical health, like the Covid-19 pandemic, tend to covariate with increased risks, especially for people with preexisting mental health problems [17]. As other examples on these new forms of risks, one could mention terror attacks that can strike anyone, in principle anywhere in the world. Less frightening examples in this direction can be the possibilities of knocking out a society's electrical system by some abstract fault far away or speculation against a country's currency by unknown forces. Even such attacks can have disastrous and long-lasting consequences for countries and parts of the world or even globally.

These and similar new risks cause the term risk society to be used to denote this society—after modernity—a name that was established with great impact by Ulrich Beck's epoch-making work *Risk Society: Towards a New Modernity* (1992). Beck has, however, later himself questioned this term. Perhaps it should rather be said that there is a new kind of insecurity or danger that characterises the society of our time—and perhaps of the future. The traditional risks of the industrial society were to a much greater extent local, visible and possible to take care of. Modernisation's emphasis on reducing and eliminating risks in working life, social life and private life, for example, by means of work environment measures, traffic safety work and an extensive social policy, was intended to realise the vision of 'the good society'. In a certain sense, the industrial society's emphasis was on 'conquering nature' ('the end of nature'), for example, by converting natural resources into useful products.

The fight was between man and nature. The insecurity involved in being exposed to an unpredictable nature would gradually be overcome by means of technology and science.

In contemporary society, it is rather—to a certain extent—human beings' own products, the results of development, that constitute threats. The threats are man-made. Beck and Giddens speak about 'manufactured uncertainty' [18, 19]. It is these 'cultural products', results of the technical and economic development itself, that create risks and make society vulnerable. The uncertainty that the unpredictable nature could entail has largely been overcome; human beings have tamed nature—but uncertainty has been re-created in the unpredictability of the culture. Beck [20] speaks about 'the return of uncertainty to society'. Modernisation's faith in science's ability to solve global, national and individual problems, and to create the good life, has struck back: science solves many problems but also generates new ones. The optimism of the industrial society has been replaced by reflexive modernisation.

2.3.3 Individualisation and Reflexivity

In the postmodern society, the individual has become prominent in a completely different way than previously—a process that has been going on for several decades. Nowadays, we must as individuals continually create and re-create our social existence—one speaks about social reflexivity. While collectively based traditions and rituals in the previous society often functioned as guidelines for the various attitudes of the individual, these must now to a greater extent be formed by the individuals themselves. These choices are now instead guided by reflexive consciousness, considerations and consequence assessments in the light of one's own life. Guidance is not taken from over-individual beliefs but from people's own life history. To 'realise one's life project' or 'pin one's faith on oneself' have become established slogans that in the spirit of individualisation express social reflexivity in terms of positive possibilities. At the same time, it is evident that differences between individuals and groups tend to increase even more, for example, between social classes or groups with different educational backgrounds or social capital. Individuals are left more to their own resources in the form of material assets, social networks, knowledge, social competence and self-image.

Security and safety were to pervade the modern society, closely connected to high-technological production, an efficient economy and a positive view of the possibilities of science. The society that is now developing, the late modern society [21], means that the question of society's possibilities to create security and safety, and to inspire confidence in important respects, has changed.

2.3.4 Trust in the Risk Society

Questions of trust and confidence are thus closely connected to the successive transition from an industrial society to a late modern society characterised by global movements, technical and economic as well as political and cultural. Trust based on spatial closeness, personal acquaintance and cultural similarity is replaced by trust in anonymous expert systems which the individual has very little knowledge of but is nevertheless obliged to trust. Giddens [19] speaks here about the 'transformation of intimacy' from trust based primarily on personal acquaintance—trust in a person—into trust in relation to abstract systems, trust in a system. He uses the term 'disembedding' to describe this change in social relations. Disembedding means that the relations are removed from their ontological connection and have become abstract and impersonal. Living in late modern society involves demands for acceptance and trust without (always) being able to view and understand the entire situation. The individual is obliged to trust the competence of expertise just in its function of expertise. Trust is established for expert systems rather than for individuals and people one knows. Abstract systems like bank services, telecommunications, electricity supplies or booking systems for train services, for example, are what first come to mind, but it is not too far-fetched also to exemplify with the expert systems for nursing and other health and social services that are built up within the framework of social policy. As representatives of the welfare system, nurses and care staff have a central task to recreate trust in these abstract systems. Giddens [19] speaks in this context about re-embedding, which implies that the abstract expert systems are re-connected to the local provision of care services. This re-connection, which is decisive for the establishment of a new form of trust, under the conditions of late modernity, is of two kinds [19]: facework commitments (i.e. the user relates to a specific individual, a 'face') and faceless commitments. Examples of these commitments can be as follows: A meeting with the physician, the nurse or the therapist is a facework commitment (even if taken place via the Internet), while logistics around this meeting are faceless. The point is that in both kinds of commitments, the system representatives are acting in their role of experts, 'disembedded' from private contacts or the local community.

2.3.5 The Local Community Becomes an Important Arena

A phenomenon concerning trust in a broader sense in the late modern society is what Granovetter [22] refers to as 'the strength of weak ties'. In an individualised culture of contacts, people today have fewer but closer and more intimate friends chosen on the basis of personality and mutual interests. The networks are more geographically spread than in earlier times, which reduces the importance of neighbourhood and the local public environment as arenas for the development of close social relationships. People are less dependent on assistance from neighbours and protect themselves from social contacts that are too intrusive and demanding. Consequently, it is important that common meeting places exist outside one's own dwelling in order to maintain the desired balance between closeness to and distance from other people. Contacts that have the character of 'weak ties' might be initiated and ended without anybody being responsible for the outcome or feeling obligated to continue the contact [23]. Examples of 'weak ties' could be casual conversations with the bus driver, the shop employee or the waiter. Such 'weak ties' have a cohesive force in social contexts. They can function as bridges between groups and have an effect on individuals' integration into communities [22]. In the process and context of renewed trust, the local community with its manifold relations of strong as well as weak ties plays an important role.

In this part of the chapter, we have given a short view of the essence of the theory about the risk society, characterised by increasing insecurity and anonymity in regard to societal helping systems. A concluding remark might be that the change towards a risk society is more or less evident in different settings, areas and countries. The emergence of the risk society might be regarded more as a development in a certain direction than as a defined and definitive state or situation.

2.3.6 A Group at Risk in the Risk Society

The risk society does not affect all equally. Vulnerable groups are especially exposed. Factors contributing to vulnerability for persons with mental health problems are several. They experience varying degrees of impairment in functioning. Repper [24] points out that disability cannot be defined and understood in a vacuum. Persons are disabled in relation to particular social or physical contexts and the demands and expectations they comprise. Besides, a person experiencing cognitive and emotional difficulties, especially connected to serious mental health problems, will be socially disabled in much the same ways as persons with physical handicaps are, namely, they need help to have the psychosocial milieu adjusted in order to gain access to the roles, activities and benefits that people without disabilities have [11]. Being able to participate as a citizen and to facilitate access to services, roles, responsibilities and possibilities in the local community require support from public institutions and professional carers to reduce the social and economic obstacles related to psychosocial disabilities (e.g. lack of satisfactory housing, work and meaningful leisure activities and economic support).

Social disability connected to mental health problems can be viewed on the basis of three interrelated processes [24]. The first process concerns the symptoms that the illness itself involves for the individual: social withdrawal in order to protect oneself from too strong internal and external negative perceptions, to increase space for the inner world, as a confirmation of their felt and experienced outsider position [25]. The second is connected to social disadvantages that either precede the mental health problem or result from psychosocial problems such as poverty, unemployment, isolation, poor housing or poor education (i.e. 'social suffering'; [26]). The third process is linked to individuals' responses to others' reactions to their mental health problems, that is, the effects of marginalisation and discrimination [27]. These effects are often experienced as more disabling than the mental health problem itself. Such understanding of mental health problems can reorient the efforts from trying to make persons adapt to their environments to altering the milieu so that persons with mental health problems can achieve their own goals. In addition to specific interventions to reduce cognitive and emotional difficulties, attention should also be given to the specific barriers to individuals' meaningful living within the local community.

As nobody has a full overview or can be accountable for the risks created in today's society, individuals are placed in a doubtful and uncertain situation. It is not easy for most people to make up their minds about different scientific explanations and advice, that is, what might be threatening or beneficial or how to react to such knowledge. In late modern society, people have to rely on their own or their families and friend's experiences and assessments. Scientific knowledge cannot any longer be perceived as the sole convincing source of knowledge regarding risks and how to counter them [16, 28]. Social rationality derives from and develops through experiences of daily life within defined networks (family and friends). In this situation, many persons with serious mental health problems are vulnerable because they often have small social networks. Interpretation and comprehension are dependent on cognitive functions such as attention, memory, perception and language. For some people with mental health problems, impairments in these functions will be prominent, making it difficult to adjust to the need of learning new things arising out of societal change and complexity. Small networks and professionals' lack of attention to the learning difficulties of people with mental health problems can obstruct the process of personal and social recovery. In such a situation, problems related to adjusting and using personal, experiential knowledge can hamper a person's independent living. On the other hand, broad societal changes might give way for new and unforeseen forms of roles and relations.

Short summary: Our present time has been referred to as the postmodern era, when the industrial society, modernity, at least partly, has developed into a postmodern society. While many previous threats and risks have been reduced or eliminated, new ones have been added, amongst other things, as a result of globalisation, commercialisation and the opportunities that the development of communication technology has opened. The concept of risk society denotes this development towards greater uncertainty as a result of human activity. In contact with society's representatives, such as health and social care, personal relationships are replaced by expert dependency. Society has become more anonymous, 'depopulated' and detached. Trust built on personal relationships is substituted by trust built on expert knowledge. People with special challenges, such as mental health problems, risk being affected in several ways in this transformation of society. In addition to what effects the mental health problems entail, also through poverty, isolation and other forms of social suffering, they are furthermore influenced by the societal reactions towards their specific problems and social situation.

3 People with Mental Health Problems in the Local Community

The treatment and care of persons with mental health problems takes place mostly in the local community. Community mental health nurses and other professionals have been given the role of primary community representatives. This change requires a varied understanding of the concept of community in order to grasp the challenges facing professionals working to help persons with mental health problems to recover. These challenges deal especially with what kind of individual and social conditions that promote rehabilitation and recovery, and it requires insight into the local community processes that work towards integration and marginalisation, respectively [29].

The risk situation persons face—especially persons with aftermath of serious mental illness (risk of stigmatisation, social exclusion and marginalisation)—can be associated with the sociocultural phenomenon and concept ‘liminality’ [13]. This concept refers to a state of being ‘in-between’, a transition or an intermediate phase characterised by ambiguity, uncertainty and openness simultaneously. The liminal position can obstruct the process of rehabilitation and recovery for persons with mental health problems. When re-establishing themselves in their local community, they frequently meet reactions from neighbours marked by scepticism, curiosity, uncertainty and anxiety (cf. [7, 27]).

Given that the local community is the most important arena for contemporary mental health care, it is necessary to examine our conceptions about the (local) community. Drevdahl [30] has made an interesting contribution to elucidate and recognise the complexity and ambiguity of the community concept. Community on the one hand can be understood as a physical and relational place where its members are observed and disciplined. On the other hand, community is also the place where relief from everyday strains takes place and injustice can be counteracted. To emphasise the tension between integration and marginalisation, Drevdahl introduces the metaphor ‘home and border’. ‘Home’ represents what is safe, known, creates trust and stimulates feelings of belonging, while ‘border’ is associated with transition, the unknown, and what is threatening (represented by ‘the others’). Here, people experiencing mental health problems, the poor and substance abusers might serve as examples of ‘border residers’.

Being a member of a border community with fixed and unified identities can bring about a sense of communality and belonging, thus experiencing the border community as a home. The homelike feeling creates a physical and emotional safe place which its members can seek to, recover and feel whole again [30, p. 16]. Such a community can inspire action (e.g. seeking membership in a user organisation, living in sheltered housing or attending a day centre). Through reflection and joint action, the members can challenge power relations by an increased understanding of oppressive conditions and also discover possibilities and strategies to influence their life conditions in an empowered way. Consequently, such communities might become a place where people stay because it strengthens their ability to endure and resist and where they can envision alternative ways of living. Membership in a border community also gives access to social capital which is characterised by trust, social norms and their enforcement, social networks distinguished by reciprocity, concern and involvement for the common good [31].

For people experiencing oppression by the dominant society, the process of recreating identity and rehabilitating oneself through political resistance represents a kind of identity politics. But identity politics also motivates examining who is excluded from the community/home. Members of a border community also protect their space by controlling who is allowed membership. In this way, the border residents mark their own community. An overall story is developed about what the group has in common (a ‘shared otherness’) which explains their situation and at the same time contributes to silencing those not belonging to the group. Thus, dominant user organisations could exclude those who potentially should have been entitled to membership if they do not sufficiently share or contribute to upholding the unifying and explaining story about the vulnerable situation they are in and their need to protect and regain their civil rights, a process which might expose these groups even more as set aside [29].

4 Everyday Life in Late Modern Society: Users' Experiences and Perspectives on How to Manage Risk and Uncertainty

In light of the theoretical perspectives of the risk society and its consequences to people with mental health problems as presented above, we will now proceed to report some service user's experiences and their views on living with mental health problems in late modern society [32, 33]. In order to learn more about what these long-term societal changes really mean, a study (cooperative inquiry design and multistage focus group interviews) was conducted with members of a user-governed centre in Eastern Norway. The focus group met three times, and the results were presented and discussed in an open meeting at the centre. The thematic analyses resulted in five comprehensive themes, namely, *change and uncertainty*, *mental disabilities and societal obstacles*, *the technological dominance*, *individualisation and loneliness* and *searching for a meaningful everyday life*. These themes will be described (also with some quotations from the interviews presented in *italics*) and discussed in relation to the earlier description of the societal changes and its effect on people with mental health problems.

4.1 Change and Uncertainty

Swift societal changes and demands for readjustments in a variety of arenas create an experience of uncertainty and insecurity; thus, there is a longing for a safe footing for one's orientation in the world. These changes seem to imply that social relations based on spatial closeness and long-term thinking tend to be replaced by anonymous, 'technified' and shorter-term relations. The concept 'disembedding' is used to describe just this process—that relations are removed from their ontological context. The result tends to be anonymisation and alienation [19]. The emphasis on efficiency and busyness seems to lead to a situation where meetings between people become more superficial and anonymous: *'There is anonymity in society as a whole and in everything public—quickly in through the door and fast out again—and as cheap as possible'*. 'Waiting music', which is common in shopping centres or when making phone calls to various offices and firms, for example, can be viewed in the same perspective, as an anonymising sound barrier which is hard to stand. For people with mental health problems, the result can be increased stress and concentration difficulties. One of the participants describes it as a 'process of alienation'. The rapid pace of change and demands for increased efficiency have the same effect—it reduces the possibilities for spontaneous and informal meetings. The familiarity of the local community seems partly to be replaced by a society which is difficult to comprehend and which creates feelings of alienation.

4.2 Mental Disabilities and Societal Obstacles

This theme addresses the relation between the individual and society. The participants give examples of how their mental health problems are made evident in various societal contexts. Disabilities and problems are experienced in society and in relation to not being able to cope with necessary daily tasks. Thus, disabilities are connected with the individual person's life in the community. However, defining mental disability is not easy. One participant highlights two solutions related to well-known challenges: *'If a person chooses to avoid the bus at times when it is usually crowded, and instead chooses quieter periods of the day—is this then a disability? And what about shopping food on Monday morning instead of shopping when it is crowded and busy. Is this then a functional deficit? Does it only become a hindrance if it obstructs you from doing things you otherwise would have done if you were 'free'?'*

Bureaucratic administrative routines, shortage of time and lack of a personal and long-term contact make societal contacts difficult and, paradoxically enough, can contribute to accentuating the mental health problem instead of mitigating its consequences. *'You don't get trust in eight different people. Trust must be built over time'*. This quotation illustrates Giddens' expression [19] 'transformation of intimacy'. In contemporary society, trust can be built on personal contacts to a lesser extent. But the quotation shows even more clearly the difficulty of trusting a system that seems impersonal and incomprehensible. The problems are also evident in the meeting with a society that in general demands more and more adaptation and streamlining, for example, when it is a question of getting a job and a reasonable income. Concepts like 'employability' indicate this development—it is the individual that is to be adapted to the labour market, not the other way around. A weak financial situation in combination with a great need of support and service, which often cost money, contributes even more to a feeling of being an outsider: *'It is expensive to be poor'*.

4.3 The Technical Dominance

A prominent feature in late modern society, as in the discussion about the risk society, is the technological dominance. Advanced computer and communication technology characterise practically every area of social life and for the individual. Knowing how to handle the technology and having access to computers and mobile phones are regarded as more or less implicit conditions for a functioning everyday life: *'Things are more accessible—only one keystroke away—but at the same time more closed for those who don't have the knowledge or the possibilities'*. The participants in the study see several problems with this. For those who do not have access to a computer of their own and connection to the Internet, it can be difficult to handle contacts with authorities and professionals. Information via the Internet is often more difficult to understand than necessary; the participants would like to see the participation of users when web pages (concerning services) are set up. If one is familiar with the Internet and has access to modern computer equipment, then technology offers new possibilities. For those who can find face-to-face contacts difficult, particularly meeting groups of people, computer technology makes personal communication possible, but on their own terms, they can be close and distant at the same time. Personal blogs can be used as means of building one's identity and to make a profile of interests and competence. One can show the sides of oneself one wish to disclose but at the same time keep other parts private. Thus, computer and information technology entails both limitations and advantages for the individual; however, up-to-date knowledge is decisive: *'If you lack knowledge, you will easily be outside and powerless. If you have knowledge, you are inside'*.

4.4 Individualisation and Loneliness

The development towards increased individualisation can be traced over a long period of time, and it is not primarily caused by the rise of late modern society. Nevertheless, the individualisation process is very clear in today's society, where both possibilities and responsibilities rest to such a high degree on the individual. The possibilities to create and form one's own life have never been greater. Globalisation, unbounded technology, a higher level of education and a generally higher material standard of living are important factors here. Paradoxically enough, they also involve greater pressure on the individual to live up to various standards and fashions, at the same time as the demand to *'stand up for what you are'* increases: *'Everybody is supposed to follow the mainstream. This is more important now than before.—Hasn't it always been like this?—Yes, but the problem is that it is so many streams to follow'*. It can be difficult to meet these apparently conflicting demands. A greater feeling of loneliness can therefore go with increased individualisation. The distance between people seems to increase. The participants even think we have created a 'terror society': *'… we are afraid of the neighbours and are sceptical towards them—the 'risk society' is marked by loneliness'*.

As is shown above, the characteristics of late modern society can to a great extent be found in the everyday experiences of the participants. For those who suffer from mental health problems, society has become more anonymous, 'depopulated', inaccessible, demanding and insecure: '*Risk society… yes, we are lonely, and there are constantly new things we have to learn and respond to—simultaneously*'. How much more sensible then to seek new ways for fellowship and belonging?

4.5 Searching for a Meaningful Everyday Life

This theme focuses on two of the arenas of the everyday life, namely, work and social network. Through the development of computer and communication technology, new possibilities have been opened for adapting working life also to various forms of mental health problems: *'A disabled person can participate if the work situation is tailored. Nowadays, people can work from their home—the options are multiple and flexible if they are used. But this flexibility isn't utilised'*. However, for this to be possible, employers must have the will to do so, and the participants experience that this is not always the case. Instead, there is a tendency towards increased medication, something that can be 'a chemical lid over what is difficult'.

Just as important as having a job or something meaningful to do is belonging to a social community (which certainly can be related to a job). The participants in this study come from a user-run centre associated with the user organisation Mental Health. The Centre provides opportunities to build new social networks and to promote the feeling of belonging to a social community. The Centre is a 'free zone', members are met with trust and positive expectations and they support each other and show genuine care: *'We really mean it when we ask: How are you?'* It is not a question of a get-together without demands, but the demands are adapted to the person and the situation; one of the participants compared the centre with a 'greenhouse' where everyone has the possibility for personal growth on their own terms.

The user organisation Mental Health and the activities in the Centre are examples of how people with mental health problems (as one of several groups) have developed a greater degree of user organisation and influence in recent years. Late modern society leaves more freedom of choice and responsibility to the individual but also opens the way to new forms of organisation and support. In one sense, this society leaves—more or less—the individual to his or her own fate. The vision of an all-embracing and united world society of the modern society, the industrial society, can partly be regarded as having cracked. But in the cracks, new possibilities appear. The activity at the Centre can be regarded as such an alternative organisation, an answer to the needs that the societal development has created—but at the same time—made possible.

The participants think that the larger society can learn something important from such alternative fellowships like the Centre. Some of its special characteristics are the flexibility both in relation to organisation and content and the positive balance between individual and collective focusing. Besides, the Centre has something to teach to others about different expressions of trust, mixture of age and gender and the tolerance for diversity which characterise the milieu. Being met with care and trust strengthens personal responsibility and the feeling of community. Such beneficial social relationships seem to promote recovery processes [34]. Public service systems could develop in a more user-friendly way if they were based to a greater extent on trust and shared responsibility instead of distrust accompanied by the need for control systems, namely, a welfare system in alliance with the users 'focusing on supporting them to deal with the uncertainty that is a feature of late-modern society' [35, p. 23].

5 Working with Risk and Uncertainty: A Recovery-Oriented and Person-Centred Practice

> *"Insecurity, it is difficult to make an enduring platform because things are constantly changing. You meet demands to adjust and be able to deal with all the new things that arise"* (service user).

As expressed by service users (see previous section), all the changes and demands for readjustment in a variety of areas generate an experience of uncertainty, alienation and stress: Societal institutions are sometimes hard to reach, abstract and impersonal. All the technological advances increase demands but at the same time open new possibilities. In order to cope with daily challenges, support and companionship are needed. User-run day centres, for example, may offer a new way of building friendship and trust in others and support the individual in recreating one's social identity/existence and inspiring the quest for a meaningful everyday life. An essential task for mental health professionals is to be 'faces' and to perform face-work commitments with the service user—in contrast to all the faceless commitments they have to deal with in their interaction with abstract and disembedded private and public enterprises.

The central work areas in mental health care related to the risk society perspective are several, and they get their justification from the challenges described above. Amongst other things, it is about acknowledging that risk and uncertainty are phenomena that belong to our living conditions. For advanced clinical practitioners, it is important to be able to help identify the types of risks involved for the relevant service user or user group in specific (choice) situations and to develop a collaborative relationship that is aimed at meeting challenges and opportunities that the individual encounters in society on their path to recovery. In this context, we choose to emphasise the importance of a person-centred and recovery-oriented approach, that is, we focus on both the person's 'internal and external landscapes'. Recovery and person-centredness presuppose that the goals of mental health care are anchored in the individual's life goals/values and that the service user's rights are respected when making decisions about all aspects of their recovery [36]. Such an approach presupposes a broad knowledge base that emphasises users' and relatives' experiential knowledge together with professionals' theoretical and experiential knowledge, when searching for adequate attitudes and actions in the face of risk and uncertainty in everyday life. In what follows, we will outline some aspects of uncertainty in mental health care and then continue to approach risk and uncertainty in a collaborative manner by means of dialogue and shared decision-making. Finally, we will clarify the concepts of recovery and person-centredness combined with some practical implications.

5.1 Living with Uncertainty

Mental health work and care are basically concerned with ambiguity and uncertainty. Avoiding risk is complicated and difficult and cannot be reduced to simplistic methods. In many ways, mental health-care workers are 'experts in uncertainty', and they should develop mutually trusting, respectful relationships with their service users and make well-reasoned judgements about risk and dare to work creatively. This attitude leads to an understanding of risk management as positive risk-taking (see later) and thus implies the potential of empowering the person [37].

It is well known that uncertainty is a companion to clinical practice in mental health care. Pomare et al. [38] have studied types and situations of uncertainty experienced by mental health-care professionals. The authors point at three overarching and largely interrelated aspects of uncertainty: decision-making, professional role and external factors. Situations of uncertainty emerge in situations filled with fluctuating probability, high ambiguity and complexity. Typical situations of uncertainty can include deciding on a diagnosis when symptoms are diffuse, trying to use abstract criteria to real-world problems—or when facing the problem of predicting the development of the disease. These situations are felt uncomfortable and may lead to a feeling of personal insufficiency. The study indicates that uncertainty does not necessarily decline with experience and that some aspects will remain 'unknowable'. This is particularly the case in situations of decision uncertainty—and uncertainty related to external factors—where the right decision cannot be known with absolute precision. What is important is to acknowledge uncertainties and actively try to clarify role ambiguities when working alongside diverse professionals in mental health care.

Risk assessment constitutes an integral part of clinical practice. Traditionally, risk has been portrayed as a twofold concept, and its assessment regarded as a test that can be correctly or incorrectly classified. Dixon and Oyebode [39] discuss how risk assessments are less straightforward than is commonly perceived and are often complicated by various forms of uncertainty. These uncertainties arise where psychiatrists or other mental health-care professionals are insecure about their interpretation of information, where information is missing or where interpretation of the risk situation is open to challenge. A range of strategies are adopted to resolve uncertainties. These strategies, which often involve some 'risk-taking', enable clinicians to make a more confident decision.

Therapists often seem to approach risk in a cautious way—especially when faced with uncertainty [3, 37]. This may be connected to a working climate characterised by an 'atmosphere of blame' and the fear of criminalisation if making diagnostic or therapeutic mistakes. In such a climate, it may seem that psychiatrists and other therapists respond to uncertainty by being defensive and restrained ('wait and see') in their practice. Dixon and Oyebode [39] have an interesting overview of types of uncertainty that therapists encounter when assessing risk: illness-related uncertainty (related to diagnostics, severity of the illness and prognosis), therapeutic uncertainty (concerning 'treatability' and patient cooperation), evidentiary uncertainty (due to missing and unreliable information) and justificatory uncertainty (connected to interdisciplinary challenges and relatives' pressure to contain risk). The strategies used to deal with uncertainty in psychiatric risk assessment are external consultation; assessment-induced evidence; watch, wait and see; and negotiated compromise (with patients) and allow to fail. Otherwise, 'gain time, gain information, gain control and share risk' are common strategies for dealing with uncertainty when it comes to risk assessment. To reduce uncertainty when assessing risk, information about the service users' mental health problem will be helpful, for example, known connections between people's suffering and their risk behaviour, how the person's previous reaction to therapeutic measures has been and finally how the person has collaborated on therapeutic initiatives.

However, from a person-centred service point of view, risk should primarily be seen in terms of the risk faced by the patient/service user. Thus, risk assessments should be a consensual process, with the person and the professional helper striving towards a common language and conceptualisation of the risk and uncertainties and then deciding how best to manage it, not as a stigmatising moralistic discourse [3]. What is important is to treat people with care and in a collaborative and ethically justifiable way, as outlined in the next section.

5.2 A Collaborative Approach to Encounter Risk and Uncertainty

> Risk assessments are seldom linked to improved therapeutic outcomes, and often further marginalise disenfranchised groups by labelling rather than understanding and helping to resolve their difficulties. Moving forwards, risk assessment needs to be focused on safety issues, secured by a desire to improve, reintegrate and foster recovery [40, p. 4].

Several authors support the statement above [10, 41]. Thus, a collaborative approach to safety assessment—in partnership with service users—is recommended. This aspect, the move towards safety planning, is also underscored by Boardman and Roberts [42]. They hold that standardised techniques may still be useful for those who present the greatest risks—if they are used in a context of recovery-supportive relationships and co-produced safety plans. They argue that a person-centred safety planning not only has potential benefits in terms of more effective management of risk but also is likely to be more acceptable to staff and people using the services.

From service user's perspective, the 'dignity of risk' and the possibility to be supported in the endeavour to make important choices are crucial to recovery. Therefore, a certain amount of risk-taking is important to consider [36, 37]. Risk-taking in mental health care is based on a view of the service user as an active citizen with rights and responsibilities and that taking risks is a means of empowering and promoting personal development. Boardman and Roberts [42] hold that *positive* (or responsible/constructive/creative) risk-taking and risk management are not to be understood as accidental, permissive or careless attitudes. It should rather be linked to the planning for safety, learning and the possibility for personal growth and thus support the person's recovery. Risk-taking can serve as a way to enable people to take responsibility for their choices and gain confidence in their ability to stay in charge of their lives.

It is customary to make a distinction between dramatic and everyday risks [42]. *Dramatic risks* have traditionally involved harm to others, self-harm, suicide and serious neglect of self-care. The emphasis on dramatic risks supports a narrow, professional view on risk that is preoccupied with threat of extreme harm and is not appropriate to the majority of service users. On the contrary, most service users are worried about *everyday risks*—such as making choices, taking out a loan, buying a new apartment and applying for or changing jobs. Other forms of risk for service users (risk from others and 'iatrogenic' risks) are often overlooked. These may stem from many sources, for example, stigma, racism, social exclusion, harassment, discrimination, financial exploitation and side effects of psychotropic medications and exposure to various restrictive practices [10, 43]. People have different understandings of risks, and therefore it is relevant to ask service users what they see as main risks associated with mental health problems. We would like to point out two strategies for structuring the dialogue on these kinds of everyday risks, namely, shared decision-making and collaboration planning, well aware that there are a number of other, more or less, similar means to achieve the same goal.

5.2.1 Shared Decision-Making and the Significance of Dialogue

The aspects that need attention in recovery-oriented care, because they are central in the development of a new identity (or old identity restructured), are also those that should figure on the agenda of shared decision-making and therefore need to be taken stock of [43]: (1) wishes and ambitions, (2) strengths, (3) values, (4) supports and (5) risks and challenges. These aspects serve the dialogue between professionals and service user as part of shared decision-making. This exceeds the restricted narrative of diagnosis that often predicts negative outcomes. Someone's story is much more the vehicle for making meaning of one's experiences and re-positioning of one's social identity when necessary. A shared decision-making process yields good results if it is based on reciprocity, trust and a satisfactory and good/efficient working alliance between the service user, relatives and professional caretakers [43]. It is worth noticing that sharing goes beyond merely exchanging views and reaching consensus; in fact it is a moral praxis in which commitment from both parties is decisive.

5.2.2 The Collaboration Plan

Conversations over time, and thus building a relationship, are conditions for realising a humanistic and recovery-oriented view of human beings. The dialogue is basic to the development of a trusting relationship. The fact that the service user can open up for responsive and attentive caregivers can improve his or her self-understanding and thereby enable the person to retell his or her story and so have the opportunity to see themselves anew through the other's understanding. Therefore, relationship has an opportunity in itself to heal and to get a grip on the situation and everyday life. Various pedagogical tools can be used to get to know the person seeking help. One such tool is the *collaboration plan* which consists of five components, namely, problems, resources, previous problem-solving strategies, desired goals and new problem-solving strategies [26] (Table 1).

The first four components attempt to approach the person's lifeworld, as well as being an expression of the concept of insight that is embedded in a holistic, existential model for psychiatric nursing/mental health care. The holistic view implicates generally that the helper seeks to stimulate the person's understanding and recognition of his or her problems, possibilities and resources and how external factors have influenced them. Furthermore, insight involves understanding of how the person previously has tried to solve or cope with problems and finally to recognising what values he or she wants to guide life. The collaboration plan is characterised by a quest for understanding. This happens through an increasing specification of each component of the plan and looking for interactions. In this way the person's insight, and the helper's knowledge of him or her, will increase. The collaboration plan documents activities and structures the collaboration, thus contributing to greater

Table 1 The collaboration plan

Problems	Resources	Earlier problem-solving strategies	Desired goals	New problem-solving strategies
– What bothers you most right now? – Why did you seek help?	– What are you satisfied with in your life? – What qualities do you like about yourself? – What interests do you have? – Do you have someone to talk to about the things that concern you?	– In what way have you tried to solve your difficulties earlier?	– What would make your life situation more satisfactory? – Try to be specific in regard to family life, housing, work and leisure time	– Can you think of other ways to solve or deal with your problems? – How do you think the staff best can help you? – What advantages and disadvantages will the new strategy involve for you? – Which of the new possibilities will you try?

overview of the life situation. Furthermore, there is a challenge to take action in a broad sense. Everyday care emerges through investigating what the person intends to do with increased self-understanding and what sort of help, support and challenge the person needs on the path towards recovery. Working with the collaboration plan requires an authentic dialogue where the person seeking help and the helper negotiate what is to be written on it. Using the words of the service user and the alliance between the service user and the professional will probably reduce some of the feelings of alienation and powerlessness, which can easily result from extensive use of technical terminology.

5.3 Implementing a Recovery-Oriented and Person-Centred Approach When Working with Risk and Uncertainty

During the past decades, the concepts of recovery and person-centredness have again become familiar in mental health policy, practices and research as well as in voicing service users' experiences of mental distress and processes towards well-being and citizenship [44]. These two concepts, person-centredness and recovery, are interdependent in that they presuppose each other. Recovery, like person-centredness, is about the person maintaining and keeping control over one's life situation, being assisted in making informed decisions and supporting real partnerships between persons, families and services. The settings for recovery are experiences and challenges in everyday life. The roots of recovery, however, are based on service user and activist organisations and disability movements, while the roots of person-centredness can be traced back to Carl Rogers' work from the early 1940s and also from humanistic-existential oriented models of nursing care in the 1950–1970s, for example, Hildegard Peplau [45] and Joyce Travelbee [46].

Person-centred care is increasingly being considered as an essential element in good quality care and as a distinctive feature of a recovery-oriented system. Within mental health care, person-centredness involves conveying a holistic approach and respect for the individual and their unique experiences and needs [47, 48]. Thus, person-centred care is a cooperative, empowering process between the person seeking help and the professional—with awareness of contextual factors involved in the collaboration.

Recovery is described in several ways, as a process, an approach, a vision and a guiding principle. However, recovery can roughly be divided into three main types, namely:

1. Recovery as a spontaneous, natural event. Even if one has got a diagnosis, it is possible to recover without treatment. Phenomena such as resilience and personal robustness may underlie this process of recovery.
2. Recovery as a consequence of effective treatment interventions. This refers to that a person is free of symptoms and can cope with the tasks of daily life.
3. Recovery despite of symptoms and functional impairments, yet the person carries the hope and ambition to live well and meaningfully in spite of remaining hindrances. Prerequisites for recovery to occur, especially in the last meaning, are that help and support are offered from the environment which makes it possible to live a safe and worthy life (cf. [49]).

In general, recovery develops and occurs holistically in an interaction between a personal-, relational-, social- and spiritual-/meaning-seeking processes.

The personal process is typically described in terms of regaining self-esteem, self-control, coping and moving beyond being a service user or patient. Here, redefining self is crucial, like renewing the understandings of mental health problems so that they only become one of many aspects of one's identity. The personal process is also about re-awakening hope for the future, developing a sense of meaning and purpose in life and doing things you want to do.

The relational process covers both relationships and interactions with other people. While relationships are personal encounters that leave traces, interactions will cover what happens in more 'technical' and formal situations. The relational domain is especially important for the recovery process because the good, helping relationship can stimulate hope and courage in the person who is improving. This presupposes that the helper actively investigates whether the help or cooperation is useful and that the person is given choices regarding how help and support should be arranged.

The social process emphasises the dynamic relationship between the person and the environment. Living conditions, social welfare, feeling safe, work opportunities, community involvement, friends and families, helpful professionals and available and accessible services are essential for the people's recovery processes. Much of the recovery literature describe these life processes as dynamic and contextual and imply that regardless of one's aetiological perspectives on the nature and causes of mental distress, it is in everyday life and the community that the numerous situations and consequences need to be addressed [50]. Recovery is not about cure but about learning to live with and controlling what is distressful.

The spiritual process is related to the ideology world, that is, the world that creates perspective, height and depth of human life [26]. Here the individual seeks meaning in life. Spirituality is not tied to any particular religion or tradition. Although culture and beliefs can have a central place, all have their own unique experience of the spiritual, whether they have a religious faith or not. Spirituality is linked to the area where the personal meets the universal, that is, the spiritual sphere of human experience [51]. It rests on three components: the need for meaning in life, the need for hope and will to live and the need for trust and belief in oneself, others or God. Moreover, spirituality involves experience of belonging, acceptance and feeling of wholeness. Spiritual aspects of the recovery process are, for example, working towards regaining hope and commitment in one's own life [49], participating in spiritual practices, experiencing that one can mature through adversity and recovering in nature.

To make recovery and person-centredness influential in practice, the following four strategies are outlined [44]:

1. Realising the radical change in placing the person in the centre. In present services, much of what is talked about, decided upon and done is on the premises of the service systems and professionals. Meeting the person as an autonomous individual in his or her social and cultural context involves developing collaborative partnerships. Harlene Anderson [52] states that the essence of collaborative dialogue is the professional's stance: a way of being 'with' the other. It includes the notions of mutual inquiry, relational and social competence, privileging the wisdom and expertise of the person and his or her network and learning to live with uncertainty, that is, trying to avoid quick and premature decisions and letting procedures stand in the way for the person's life.
2. Acknowledging mental health problems as personal, relational, social and spiritual. The individualistic biomedical knowledge base is a barrier to understanding what is going on as well as to meeting people as human beings in their local community with strengths and challenges in their lives. It is also a barrier to develop helpful care. The core problems identified may well be more related to the community than the person. WHO policies [53] request commitment to this position emphasising the transition from social marginalisation to full citizenship.
3. Mental health issues are about well-being and finding ways of getting on with life and cannot easily be manualised or generalised. Recovery and person-centred approaches involve awakening and strengthening hope for the future, developing a sense of meaning and purpose in life and doing the things you want to do. It is about taking back control over your situation and nurturing and pursuing ambitions. Therefore, we need to take practice-based evidence seriously in service developments, where service users', family members' and practitioners' lived experience is recognised.

4. Paying genuine attention to the spiritual process of recovery—the domain in people's life where hope and meaning are sought. Spirituality has rightly been described as the forgotten dimension of mental health services. Spirituality has amongst other things to do with renewing hope and commitment in one's own life: This aspect of recovery contains hope and belief that it is possible to renew self-esteem and life goals—followed by the urge to change and motivation. Being hopeful can be spiritually grounded or be stimulated by others having faith in you [49]. Hope can be seen as an essential element in life because it sustains joy of life. It may be a sense of general future opportunities or more specific, valued openings like getting a job or to finding meaningful relationships. Hope does not exist in a vacuum but is embedded in interpersonal, reciprocal relationships.

These four aspects of mental health care will help mental health professionals to take some steps forward in order to support people's recovery by means of person-centred care.

5.4 The Importance of the Local Community

The local community represents our external landscape and environments that affect us in different ways, all depending on the degree to which we experience a sense of belonging to the community or have feelings of estrangement and alienation. In the late modern society where the individual has been given a free hand and can shape his or her own lifestyle based on personal choice, there is an extended room for action. This relates to the 'diversifying society' which is characterised by cultural diversity. However, people with mental health problems and disabilities are often exposed to different tests; they are in many ways 'persons put to test', for example, whether they are to be considered as equal citizens or still patients [54]. It is especially two fundamental reactions which seem to mark the relationship towards persons perceived as 'liminal others', namely, fear and curiosity [23]. In order to bring forward an inquiring and open attitude by the locals towards persons with mental health problems, it is important to have meeting places or arenas in the local community which serve as free zones for 'easy contacts' (i.e. 'the strength of weak ties'). Opportunities for this type of non-obligated interactions may be meaningful in daily life and reduce experiences of alienation for people with mental health problems. The same applies for membership in alternative networks like user organisations. They can constitute 'border communities' in Drevdahl's [30] terms and form the basis of joint action. Through such memberships, experiential knowledge can be shared and contribute to giving risk situations and their possible sources, new determinations and explanations; the scientific rationality will be evaluated against experience in life. Alternative understandings of the reality, and other self-understandings than the professional expertise offers, can be developed and contribute to making what is threatening in the environment understandable and possible to cope with.

The new role as user creates a relation to public institutions and the citizens that is in accordance with the principle of the interested party's right to influence. User participation implies possibilities to influence the services they use. This comprehension rests on two principles: the respect for the individual person and the right to have an independent living—which demands involvement in the decision processes where the individual is affected. Thus, user participation implies that the professionals accept the service users' competence as equal to theirs. This presupposes that the professionals develop consciousness of perspectives within the services, for example, from an economic, administrative, scientific or user perspective.

6 Conclusion

In the first parts of this chapter, we have given an overall account of long-term structural changes in society, which affect us all but can be expected to be particularly noticeable for people in vulnerable positions. The changes pose a new kind of threat and lead to another form of insecurity, created by human action in various parts of society. They go hand in hand with globalisation and increased technification, amongst other things through the development of information technology. Society is becoming more anonymous and its institutions increasingly 'depopulated' and distanced. At the same time, long-term societal changes have entailed growing individualisation, where the individual is gradually detached from social bonds and connection to his local community, which have traditionally been sources of security and trust. In the time of reflexive modernisation, the individual is left to 'choose his life', with the hindrances and difficulties—and also opportunities—this causes. Several characteristics of this emerging society of risk or uncertainty were recognised and nuanced by a group of users within a Norwegian user organisation (see Part IV).

The concluding parts of the chapter focus on various mental health-care practices, where the structural perspective on risk and uncertainty forms a soundboard. Service users face a progressively complicated world around them, with growing demands for capacity to change, rising social barriers and increasing (communication) technical complexity—all this in a society that requires more and more of individuals' own actions and decisions. Mental health care is in itself encircled by uncertainties in various respects. The role as professional is characterised by complexity and by many factors that are incompletely known, that is, aspects that might be regarded incompatible with professional strive to establish more of a stable knowledge- and evidence-based ground for action in the mental health system. The features of the risk society, such as increasing distances between people and growing anonymisation and a greater dependence on experts, also affect everyday practice. In such a societal climate, there may be risks that the view and treatment of service users are also 'manualised' and formalised, for example, when it comes to assessing risks of self-harm or threats to professionals or third parties. We believe that there are several ways to work to reduce trends in this direction.

6.1 Cornerstones of Mental Health Care in Contemporary (Risk) Society

It is essential that the professional works together and in dialogue with the service user. Creating a trusting relationship is a condition for successful collaboration. The trust that previously, especially when the need for help and support was long-lasting, could often be based on personal knowledge has now been replaced by contacts with more anonymous experts, who also frequently take each other's place. Expert competence is of course, now as before, an important and indispensable part of the content of the professional's contact with the service user. In order to create genuine trust, it is also necessary to dare to show the person behind the expert façade and sometimes be able to reveal sides of oneself as a fellow human being. Trust is created in a mutual process, which is based on both parties showing their vulnerability, in confidence that the other does not misuse this knowledge. In order to build a trusting relationship, reciprocity is needed, and both parties have to do their part. However, the responsibility to initiate this process rests heavily on the professional, who is a priori in a structurally superior position.

Based on such mutual trust, several perspectives and working methods can be used in mental health care. They are all in line with the basic perspective of person-centredness and realise various forms of cooperation between the service user and the professional. We have described as prominent examples various forms of shared decision-making, as well as working on the basis of a structured collaboration plan. Dialogue and openness are basic features of these and related working methods. At the same time, this joint work gives the contact a certain structure and predictability. We believe that this combination of professional knowledge and situational forms of structured work provide the conditions to support the service user in a long-term process of recovery, given that it rests on mutual trust.

Reflective Questions

- After your reading of this chapter—what are the main characteristics of the so-called risk society?
- In what way can one argue that people with mental health problems may be particularly at risk in the postmodern society?
- What is the essence of a person-centred and recovery-oriented practice related to management of risks?

6.2 Implications for Research and Development

The growth of the risk society can be regarded as processes on the structural level, but it affects all sectors of society. Aspects of these structural changes should therefore be taken into account by research and development work on mental health care and on the situation for those living with mental health problems. As person-centredness and recovery processes have been seen as means to overcome negative consequences of the late modern society, research strengthening mental health practice in these and nearby areas should be given priority.

The negative consequences of the risk society affect all but probably vulnerable groups even more. Therefore, experiences made by people with mental health problems are especially important, and the service users should be active participants in research and development work, for instance, organised as participatory action research (PAR). Research strategies like PAR should also be used to involve mental health-care workers, as their practice and working conditions are, and probably will be, affected by the societal change towards a risk society.

Besides, the emergence of the risk society means that the overarching aspect of uncertainty is becoming more prominent and thus bringing to the fore existential consequences of living in a society where feelings of safety and predictability decrease. Research and development work should address what these consequences might mean for people with mental health problems as a vulnerable group in the society.

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Interface Between Physical and Mental Health

Gearóid Brennan and Evanthia Sakellari

Learning Objectives
The objectives of this chapter are to enable you to:

- Explore the risk factors for physical health problems among people with mental health problems.
- Coordinate and address physical health needs of people with serious mental health problems within a multidisciplinary context.
- Integrate public health as a dimension of the APMHNs' role in the prevention of physical illness and the promotion of physical health.

1 Introduction

The links between mental health and physical health have gained considerable attention within peer-reviewed literature in the past decade [1]. Evidence suggests that the two domains are inextricably linked [2]. Indeed, health is defined by the World Health Organization as 'a state of complete physical, mental and social

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well-being and not merely the absence of disease or infirmity',[1] and thus physical and mental health are both an integral part of health. Despite this, people with a diagnosis of severe mental health problems (SMHPs) such as people with a diagnosis of schizophrenia, bipolar disorder and severe depression do not experience optimal health [3]. For a variety of complex and interrelated reasons, this population group die 10–20 years younger compared to the rest of the population. It is a global problem, faced by health systems throughout the world [4, 5] which as WHO suggests requires targeted intervention [6]. The health disparities faced by people with SMHP are so vast; Gray [7] has deemed it the 'silent scandal' and suggests that if these health outcomes were evident in any other area of healthcare, they would be on the front of every newspaper!

Recovery-orientated practice requires nurses, including APMHNs, to take a holistic approach, working alongside people rather than 'doing *to* or *for*' people. As part of this, one of the *ten essential shared capabilities* (10 ESCs) [8] developed jointly with people with lived experience and professionals is 'challenging inequality'. This concept of challenging inequality has not only been a policy mandate but is considered an imperative by the UK nursing regulator, the Nursing and Midwifery Council (NMC). Indeed, in the previous edition of education standards regulating pre-registration programmes, the NMC (2010) requires APMHNs to 'promote mental health and well-being, while challenging the inequalities and discrimination that may arise from or contribute to mental health problems' [9]. This sentiment is also echoed in the International Council of Nurses' Code of Ethics [10]. While several authors have suggested that the practicalities of 'challenging inequalities' are somewhat intangible [11], others suggest that one way mental health nurses could meet their policy and regulatory mandates is to address physical health needs. Indeed, Elliott and Masters [12] are clear that this is very much within the scope of mental health nurses stating:

> It may be argued that given the strong influence of social and economic factors in determining mental health inequalities, the impact of the health provision, including that offered by mental health nurses, may at best be limited. However, this does not absolve mental health nurses from acting to mitigate mental health inequalities in areas where they may have some influence. […] Physical health and employment are interesting examples where mental health nurses need to link with key services. [12, p. 767]

In this chapter, we explore the physical health issues faced by people with SMHPs as well as the risk factors contributing to them. These included both mental health-based and organisational-based factors. We then introduce the multilevel risk framework and explore how it can help APMHNs provide interventions as well as relating the interventions to the Royal College of Nursing's four pillars of advanced practice, namely, clinical practice, facilitating learning, leadership and research [13].

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[1] WHO (1948). Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June–22 July 1946, signed on 22 July 1946 by the representatives of 61 states (official records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

2 Bidirectional Nature of Physical Health Problems

There is no doubt that the relationship between physical and mental health is bidirectional. Mental health problems place a person at risk of developing medical disorders; similarly, physical health disorders may lead to mental health problems. Indeed, comorbidity between physical and mental health problems tends to be the rule rather than the exception. For example, a US epidemiological study found that more than 68% of adults with a mental health problem reported having at least one general medical disorder and 29% of those with a medical disorder had a comorbid mental health problem [14]. We also know that long-term physical health conditions/disorders can lead to people suffering poor mental health [15]. For example, there is an established interplay between cardiovascular disease and depression, with 31–45% of people with coronary artery disease suffering from clinically significant depressive symptoms [16]. A high prevalence of anxiety and/or depression was found for cancer (30.3%), diabetes (41.9%), chronic obstructive pulmonary disease (COPD) (40%) and obesity (50.1%) [17], with depression being approximately 2–3 times more common in people with a chronic physical health problem than in people who have good physical health [18]. As the focus of this book is on the role of the APMHN, emphasis within this chapter is on the physical health needs of people who experience SMHPs. As discussed already, this population group die significantly younger and have significant levels of comorbidity. The WHO has identified this mortality gap as a discrete health inequality gap requiring global action [6]. This will be discussed in more detail throughout this chapter.

3 Prevalence of Physical Health Problems in People Experiencing SMHP

People with severe mental health problems are at a significantly increased risk of developing numerous physical comorbidities [19, 20]. These are both acute disease processes such as sepsis, pulmonary embolism and arrhythmias [21]. However, long-term conditions pose much more concern. People with SMHPs have higher rates of respiratory conditions such as COPD and asthma [20, 21]. Their prevalence is linked to high rates of smoking, as well as environmental factors. However, the rate remains high even when smoking- and substance-related risk factors are taken into account [19]. Cardiovascular diseases such as ischaemic heart disease, hypertension and stroke occur at a higher rate compared to those who do not have a SMHP. It is estimated that people with SMHPs experience 2–3 times higher rate of such conditions and up to 75% of people with schizophrenia die of coronary heart disease, compared to 33% in the general population [19]. Endocrine-related conditions, such as thyroid disease and hyperprolactinaemia, are also a concern, though the most common endocrine problem is diabetes [21]. It is estimated that one in five people with schizophrenia will go on to develop diabetes [22]. People with bipolar disorder and diabetes are 50% higher risk of dying than someone with diabetes alone [20]. Rates of blood-borne viruses are also higher, while it is estimated that infection from the human immunodeficiency virus (HIV) is 3.8 times that of the rest of the population [23].

4 Risk Factors to High Rates of Morbidity and Mortality

The contributing factors are multifactorial. Like everybody else, people who experience mental health problems are also impacted by genetic-related factors. However, in this section, we explore the risk factors that contribute to poor health outcomes under three categories: illness-related, socio-economic and organisational factors. While risk factors are presented here in three broad categories, it is important to state that there is no one reason to explain the current state of poor physical health for people with SMHPs, and there are multiple contributing factors, which interact with each other [1, 24]. It is the interaction of these risk factors that results in people with SMHPs dying between 10 and 20 years younger than the rest of the population [25]. These factors also lead to an increased number of complications which impact people's quality of life and worsen the prognosis of both the physical and mental health issues.

4.1 Illness-Related Risk Factors

While people with SMHPs do have higher rates of death due to unnatural causes (accidents, homicide or suicide) than the general population, the majority of deaths among people with SMHPs are attributable to physical health conditions, both non-communicable and communicable [19]. As mentioned earlier, premature deaths are common among people with mental health problems, with 10–20 years lower life expectancy [26]. This is mostly due to physical health problems which are often not diagnosed or managed efficiently and lifestyle factors which negatively affect physical health [27]. In the report by the English Chief Medical Officer, it is highlighted that approximately 60% of the excess mortality in those with mental illness is avoidable [28].

4.1.1 Cardiovascular Disease

Cardiovascular disease (CVD) appears to be the most substantial contributor to the increased mortality rate. Rates of CVD are 2–3 times higher in the SMHP population [29, 30]. SMHPs are also associated with an increased risk of stroke and higher risk of mortality and further vascular events, even when care pathways and clinical guidelines appear to be followed [31]. There are numerous risk factors for CVD including obesity, smoking, poor diet, metabolic disorders, hypertension and reduced physical activity levels [24, 32]. Some of these are further compounded by the side effects of antipsychotic medication, which can result in cardiac changes, in particular QT abnormalities detected via electrocardiogram (ECG). The Disability Rights Commission (DRC) [33] found that 31% of people with schizophrenia were aged under 55 when they were diagnosed with CVD, compared with 18% of the general population. Studies also show that there are disparities around intervention and prognosis from myocardial infarction for people with a SMHP, with poorer outcomes even when evidence-based treatment is received [34].

4.1.2 Respiratory Disease

Respiratory disease is also a concern, with higher rates of COPD and other respiratory diseases in this population being attributed to the higher rates of smoking and increased exposure to passive smoking compared to the rest of the population. A systematic review and meta-analysis of tobacco smoking and psychosis published in 2015 found that there was conflicting evidence on whether there is a causal link between tobacco use and psychosis [35]. However, due to the high rates of smoking within this population group, it is not surprising that higher rates of lung cancer are found. The death rate from respiratory disease is four times higher in people with a SMHP compared with the general population [36]. Conversely, mortality is often not attributed to this, with some theorising that people experience an early death from CVD before reaching the age they would expect to die from lung cancer [37].

4.1.3 Metabolic Disorders

The relationship between schizophrenia and diabetes has been researched and discussed more than any other comorbidity [30]. Individuals with a SMHP also have double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome and five times the risk of dyslipidemia than the general population [26]. Meta-analyses also show that one in three people with a SMHP met the criteria for metabolic syndrome, with one in five having significant hyperglycaemia [38]. The reasons for this are complex. Weight gain that is attributed to lifestyle choices and sedentary activity is compounded by weight gain induced by antipsychotic medications. These are, namely, second-generation antipsychotics. This medication-induced weight gain has been linked to the mechanism of the drug and in particular their actions on serotonins 5-HT2A and 5-HT2C, dopamines D2 and D3, histamine H1 and muscarinic M3 receptors [39]. Antipsychotic medication also impacts on hormones associated with appetite and metabolism, in particular leptin, adiponectin and ghrelin. It has been found that these changes are a direct impact of the medications. This increased weight gain further impacts on lipid levels and glucose tolerance which further contribute to an elevated risk of cardiovascular disease.

4.1.4 Sexual Health

Despite variability in sexual activity among people with a SMHP, rates of bloodborne viruses, such as HIV and hepatitis C, have been found to be higher among people with SMHP. It is estimated that HIV is 3.8 times higher in this population group compared to the general population [23]. High-risk sexual behaviours are more prevalent in this group (such as unprotected sex,multiple partners, sex trading and injecting drug use, coupled with lower rates of screening for sexually transmitted infections (STIs)) [40]. In addition, it is estimated that women with a diagnosis of schizophrenia are 10% less likely to undergo screening (smear test) for cervical cancer than women who do not have a diagnosis of schizophrenia [33]. Additionally, this population group are three times more likely to experience sexual assault and abuse [41, 42], with risk behaviours being influenced by substance use, cognitive-behavioural factors, abuse history and social relationships, including homelessness.

4.1.5 Mental Illness-Related Factors

Some would argue that these risk factors are simply related to poor lifestyle choices, including poor diet and illicit substance misuse [43]. This is a controversial contention, as others would argue that they are not ‘choices’ but instead that substance use is a form of self-medication and self-management as a consequence of having a SMHP. There is a strong link between motivation and physical health. If someone has poor physical health, it is likely to affect motivation levels and vice versa [29, 44]. We also know that symptoms such as lack of pleasure in activity and a blunting of emotion (whether it be directly related to the mental health problem or prescribed medication) can make it incredibly difficult for people to remain motivated. This motivational challenge may impact on someone’s ability to engage in activities that may contribute to good mental or physical health [45]. Nurses in turn find motivating people who are experiencing poor motivation to be a time-consuming endeavour [46].

People experiencing very acute symptoms of a SMHP which can be incredibly distressing and debilitating may find it difficult to take on board and apply lifestyle advice, let alone independently maintain their own well-being. Stein-Parbury [47] found that people over the age of 50 years with a diagnosis of ‘schizophrenic disorder’ were less likely to self-report comorbidities to a health professional in comparison to a similar group who experienced physical morbidity alone. This may be due to the impact of the mental health problem on cognitive processes, which may mean people are less aware of physical problems or simply are unable to articulate that they have a problem. It may also mean that people themselves interpret symptoms of physical disease as another manifestation of their mental illness [48].

Another factor in the mental illness-related factors is the side effects associated with prescribed medication. The side effects and their significant impact on people are well documented throughout the literature. Side effects from antipsychotic medication and their action on the neurotransmitter dopamine can result in hyperprolactinaemia, hypertension and tachycardia [21]. They also have cholinergic effects which result in dry mouth, blurred vision, constipation, gastrointestinal upset and concentration problems [49]. Older antipsychotics are particularly associated with a variety of movement disorders such as tardive dyskinesia, akathisia, dystonic reactions and Parkinsonian symptoms [50]. For reasons outlined above, medications also contribute to weight gain and metabolic disorders. They can also cause sexual dysfunction, something that is often not discussed by the healthcare team but something that is very distressing for people [51]. The drug clozapine is associated with a side effect profile that includes possible agranulocytosis and therefore requires careful monitoring. For more information, consider accessing some of the ‘useful resources and texts’ recommended at the end of this chapter.

4.2 Socio-economic Risk Factors

Illness and biological determinates are not the only contributing factors. Inequality plays a massive role in contributing to these statistics (see also “Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing”). Poverty, unemployment, lack of stable housing and social isolation are often faced by people with mental health problems. These social factors increase people’s vulnerability to developing chronic physical conditions. For example, people who are not able to afford healthier food options often experience nutritional deficiencies, and poor nutrition is a significant risk factor for the development of physical health problems such as heart disease and diabetes [52]. Similarly, it is more difficult to be physically active when living in an unsafe or unhealthy neighbourhood [53]. Equally, the availability of transport coupled with reduced mobility as a consequence of multiple comorbidities and stigma [54] may also make it challenging for people to maintain contact with health services. For example, in rural areas, some people reported that a lack access to transport impacts their ability to attend general practitioner (GP) appointments [55]. While there has been much focus on health inequalities, the recent Marmot Review shows that the poverty gap is widening as opposed to decreasing [56].

4.3 Organisational Risk Factors

Up until now, we have focused on illness-based and socio-economic risk factors. However, we also need to consider wider organisational risk factors as these also significantly impact on the physical health outcomes of this population group.

Regardless of the country, people voice barriers to accessing appropriate physical healthcare. These include mistrust of services and a lack of consideration given to people’s mental state, lack of coordination between primary and secondary care, low competency of staff, poor staff attitudes and diagnostic overshadowing [45, 57].

4.3.1 Barriers to Accessing Services

Studies from various regions across the globe demonstrate that not being able to access appropriate services is an issue. Despite the higher risk of poor physical health, people with SMHP are not consistently offered appropriate or timely physical health assessments. Neither are they supported to use available health information and advice or prompted to avail of tests and interventions that reduce the risk of preventable physical health conditions [58]. Studies have also identified that this population find it difficult to access primary care services [59]. In some regions, general practitioners (GPs) may not accept people who have a SMHP or allow them to 'bulk buy appointments'[2] [59]. In other regions such as Sweden, the system depends partly on the person's ability to initiate contact, which is not always possible for people with SMHP and which makes addressing unmet need difficult [57].

4.3.2 Diagnostic Overshadowing

There is an extensive literature that points to diagnostic overshadowing acting as a barrier to healthcare [44]. Diagnostic overshadowing is 'a process by which physical symptoms are misattributed to mental illness' [60]. Such behaviour is in part driven by stigmatising and negative attitudes towards mental health issues, as well as a lack of understanding on how people may present because of experiencing a SMHP. This may lead a practitioner (medical and nursing) to misattribute a physical health symptom to an expression of mental illness rather than a genuine physical complaint. Diagnostic overshadowing may further lead a person with mental health problems receiving inadequate or delayed tests or treatment [60]. A qualitative study in emergency departments (ED) identified several factors leading to diagnostic overshadowing. Direct factors are complex presentations or aspects related to poor communication between people with SMHPs and staff and people presenting in a way staff find challenging. Background factors such as the crowded nature of the ED environment, time pressures and stigmatising attitudes held by a minority of staff also contributed to negative experiences in accessing care [61]. In some studies, mental health nurses have recounted examples of the people in their care experiencing discrimination when engaging with primary and general medical care, which in turn contributes to poor physical health outcomes [57].

4.3.3 Organisational Support

Studies demonstrate that healthcare professionals find it difficult to engage in physical healthcare practice for a variety of organisational reasons. A lack of clear organisational guidelines and policy around roles and responsibilities can lead to a culture in mental health services where practitioners question if physical healthcare is within their scope of practice [62]. A recent literature found that the principal role of mental health nurses in physical healthcare is one of assessment and ongoing monitoring. However, the review identified many barriers to nurses performing this role, including how services support nurses to do so, a consistent approach to maintaining competency along with clear and consistent policy [63].

One of the barriers to screening for physical health problems is an uncertainty regarding which member of the multidisciplinary team (MDT) has responsibility for screening and assessment [24]. Studies indicate that nurses are not always happy

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[2] A system of payment used as part of universal health insurance system in Australia and some US states. It allows people to access a variety of healthcare services such as GP and secondary care. The system works by the practicioner billing the government the majority percentage of the cost (e.g. 75%), therefore reducing the upfront cost to the person accessing the service.

to engage in screening, worrying that screening could turn into another bureaucratic and time-consuming process. They also question if it was their role and have raised questions regarding whose responsibility it is for follow-up or actions as a result of any screening [64]. Some of these issues are valid ethical points. Arguably, nurses should not be facilitating screening if they do not have the knowledge and skills to follow up on identified issues or if the resources and personnel are not in place to follow up with appropriate care plans.

However, this cautious view of screening is not universally held. Bressington et al.'s [65] study involve community nurses (*n* = 11) in Hong Kong perception of the Health Improvement Profile, a screening tool designed for people with SMI, who report that the tool is feasible to use in their day-to-day practice. The nurses in the study reported that the tool not only reminded them of the importance of providing holistic care but its use increased their motivation to provide physical healthcare for people. (Further details, along with other SMHP-specific screening tools, can be found in Table 1.)

Table 1 Details of various physical health screening tools for people with SMHP

Tool	Details
Health Improvement Profile	The Health Improvement Profile (HIP) is a one-page form developed in the UK as a tool for mental health nurses to assess people's physical health needs. It has also been adapted for use in primary care and in a variety of geographical regions from Finland to Hong Kong. There is a separate tool for male and female. Each contains 27 items based on physiological measurements, blood tests, screening, lifestyle factors and medication. It scores each item as either a 'green flag' or 'red flags'. The more 'red' flags, the more intervention the person requires. The tool should be used in conjunction with the comprehensive manual, which contains evidence-based recommendations of interventions to manage and improve red flags [66]
Lester Tool	The Positive Cardiometabolic Health Resource is known as the Lester Tool in honour of Professor Helen Lester, who led its adaption in the UK. The tool is based on work by clinicians and academics in New South Wales, Australia. It was designed specifically for people experiencing psychosis and taking antipsychotic medication, though it can be used with other people. It has been endorsed by several royal colleges in the UK and charity groups. It can be displayed as a poster in clinical rooms. The tool is based on six domains: smoking, lifestyle and life skills (poor diet, lack of exercise), BMI, blood pressure, glucose regulation and blood lipids. The tool aids clinicians to identify 'red flag' issues and then suggests appropriate interventions to help reduce risk. It has been designed to be used across primary and secondary care [67]
Physical Health Check	The Physical Health Check (PHC) tool was developed by the charity Rethink Mental Illness. It is based on work undertaken by clinicians in the West London Mental Health NHS Trust, Central and North West London Mental Health NHS Trust and Hammersmith and Fulham Social Services [68]. The tool covers similar items to detailed in the HIP but it is completed by the person themselves or their advocate. It is then used to in conjunction with a healthcare professional to develop an appropriate action plan

Nurses also cite a lack of organisational support as a barrier. Lack of support to undertake education around physical health [69], a lack of equipment, such as sphygmomanometers and weighing scales as well as workload were barriers to implementing physical healthcare [45]. People with SMHPs also report that nurses were too busy to help address physical health behaviours [70]. Other organisational processes that can impact physical healthcare delivery included performance review and the care programme approach.[3] While these processes contributed to the heavy workload, they also acted as a trigger for staff to attend to physical health needs. However, this was felt to be driven by external monitoring processes as opposed to practitioners' concern for the welfare of people with SMHPs [71].

4.3.4 Staff Competence

It has been well documented that staff, including mental health nurses, do not always feel competent in the delivery of physical healthcare [64]. This issue is more prevalent when we consider that in some regions, secondary mental healthcare is not always delivered by nurses but instead by generic 'care coordinators' or 'mental health workers' who may come from a variety of professional backgrounds, that is, occupational therapist and clinical psychologist. This may mean that not everyone has the requisite skills and experience to provide appropriate physical health monitoring and interventions for people with a SMHP [72].

4.3.5 Data Quality

There is also an issue with the type and quality of the data collected that is required to monitor progress. When physical health monitoring is documented, it can be patchy, inconsistently recorded or not fully recorded. Sometimes, only essential data (weight, vital signs) that do not require much expertise are recorded. A fragmented service delivery across regions can make monitoring quite difficult as data might be collected multiple times in different services. This can be further complicated by inadequate computer systems, making information sharing across teams and professionals difficult [71] as well as making data retrieval and the treatment and management of physical and mental health comorbidities more difficult and possibly less effective [73].

Therefore, the level of need is great, and the reasons contributing to that need are multifaced and complex, which are summarised in Fig. 1.

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[3] The care programme approach (CPA) is a way of working within community mental health services. Each person is allocated a care coordinator, who may be a nurse, social worker or occupational therapist. Each person will have a detailed plan focusing on strengths, goals, support needs and difficulties. The approach is used for people, who may present with significant risk or who because of the severe and enduring nature of their mental illness require support from a variety of different services in order to meet their needs.

Fig. 1 Interrelated dynamic elements affecting people's physical and mental health. Taken from Thomas [27]. (Reproduced under the UK Open Government Licence)

5 Multilevel Framework

In responses to the gravity of the situation, the WHO developed guidelines for the management of physical health conditions in people with SMHPs [6]. This framework builds on previous work by the WHO [74, 75] which led to the creation of a multilevel risk model (MRM) (see Fig. 2). This model which underpins the 2018 guidelines is meant to help all interested parties to think about what is required when designing, implementing and evaluating interventions aimed at reducing mortality rates [6, 19]. The framework's aim is untimely to reduce excess mortality in people with SMHPs by providing practitioners, services and governments with a 'systems approach' to inform the design, implementation and evaluation of interventions.

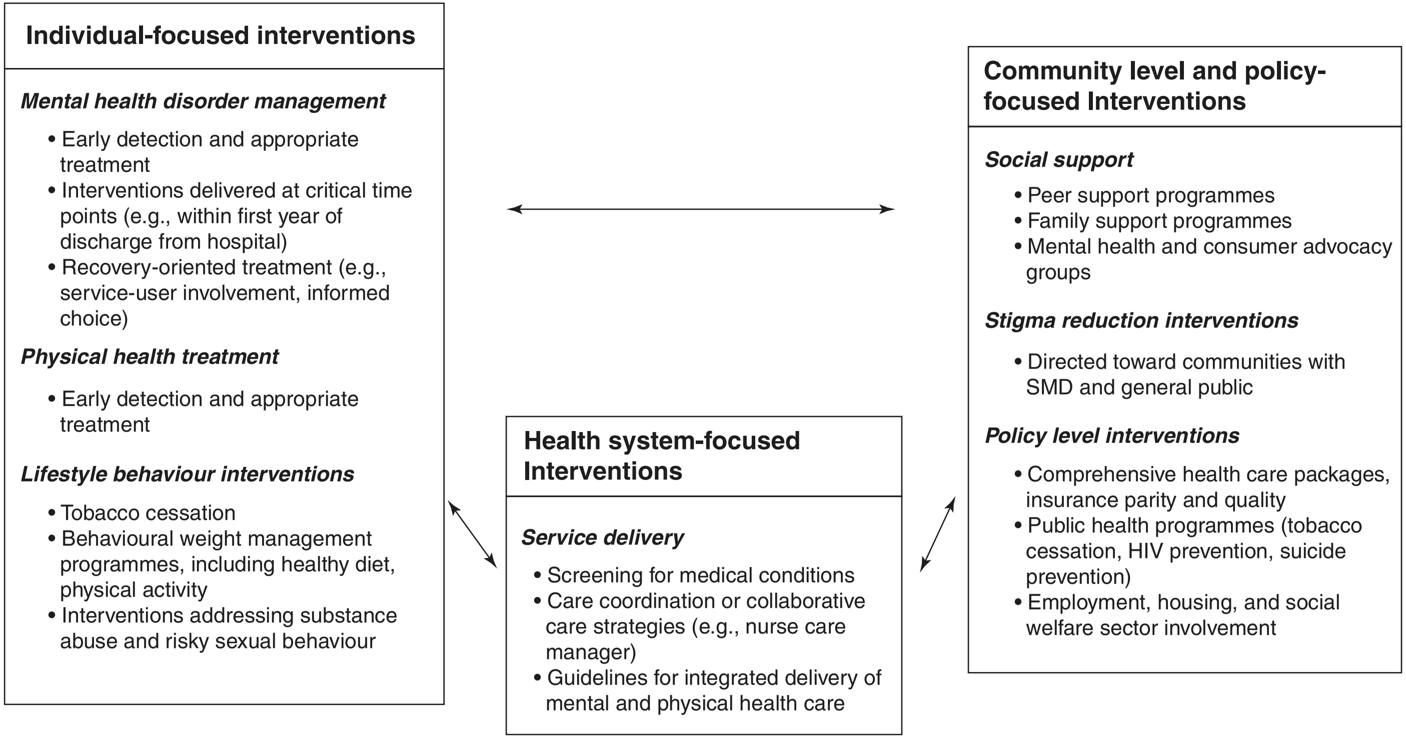

Fig. 2 Multilevel model of interventions to reduce excess mortality in people with SMHP. (*Source:* Liu et al. [19])

In essence, the model is about taking a ‘whole government’ or ‘systems approach’ to tackling the excess mortality. Often interventions either lack an evidence base and are delivered in a ‘generic’ manner without considering the unique needs of people with a SMHP [1], or the focus is on a single or limited number of risk factors when it is the combination of multiple risks that contribute to poor outcomes. Addressing a single risk factor is not enough when the issues are so interconnected. It is for this reason that the model requires a systems approach, with interventions being considered on an individual, community and health system basis. The model also considers risk factors beyond illness- or treatment-related factors to include socio-economic inequalities such as poverty and housing. For the model to be successful, governments are required to adopt this approach for policy development, as well as providing clear financial investment.

If we consider the four pillars of advanced practice (clinical practice, facilitating learning, leadership and research) [13], APMHNs have a clear role in all aspects of this model. That may mean providing direct clinical care, as well as providing education to people with a SMHP, families, communities and other non-mental health professionals. APMHNs also have a role in providing strategic leadership across an organisation as well as sitting on national working groups which may steer national policy. They will also be involved in developing and evaluating interventions and therefore contributing to the evidence base around interventions which result in improvements to physical healthcare for people with a SMHP.

6 Interventions

In this section, we will use the multilevel model framework to explore different interventions which APMHNs may be involved in at both a micro and macro levels.

6.1 Individual-Focused Interventions

Individual-focused interventions focus on supporting people to manage their mental health problem, as well as addressing the management of their physical health and lifestyle behaviour interventions.

6.2 Supporting People to Manage Their Mental Health Problems

The APMHNs have a key role in supporting people to manage their mental health problems. They also have a recovery-orientated approach to care, which involves a holistic assessment, drawing on the person’s strengths and abilities and one which involves the person’s support networks including families while avoiding diagnostic overshadowing. Considering how physical and mental health are interlinked, the APMHN will promote the role of good physical health in recovery from mental distress. The APMHN also has a role in safe administration of psychotropic medication, including the monitoring of side effects. This involves appropriate baseline physical health checks, such as before commencing medication. They will also be part of regular multidisciplinary reviews of ongoing care. The APMHN may also work to establish or lead an early intervention service for treatment of mental health problems.

6.3 Physical Healthcare and Treatment

People with SMHPs require and are entitled to the same high-quality care that other members of the population receive for all physical health issues, including early detection of health problems. Several studies highlight the nurses' role in delivering interventions to improve physical health, with the majority focusing on health screening [62, 76]. Screening is the first essential step in identifying potential issues and therefore appropriate interventions [62]. For example, a review by McDaid and Smyth [22] found that MHNs have a role to play in the early detection and monitoring of metabolic disorders. While there is limited evidence to support the widespread adoption of screening tools or evidence to support their effectiveness [1, 77], APMHNs should continue to screen.

Screening can be considered a form of assessment, and assessment is the first phase of the nursing process. As such, a lack of a developed evidence base is not an excuse not to screen. Table 1 provides a list of tools that are available to support screening and assessment.

Should issues emerge from the screening/assessment process, the APMHN has a role in ensuring that people with SMHPs are referred to appropriate specialist assessment for physical health issues, such as endocrine, cardiac or sexual health service. In this context, the APMHN also takes on a coordinating role to ensure people have access to key services in a timely manner.

6.4 Lifestyle Behaviour Interventions

It is in the area of lifestyle behaviour interventions that the APMHN has a key role. Considering the risk factors discussed earlier in this chapter, lifestyle interventions are key to addressing the health needs of people with SMHPs. These include health promotion interventions focused on increasing physical activity, healthy eating, smoking cessation, addressing drugs and alcohol issues and sexual health education. These often take a motivational interviewing approach. Indeed, in some countries, such as England, health policy identifies mental health nurses as essential to tackling lifestyle behaviours for people with mental health problems [27].

One of the issues around the evidence of particular lifestyle interventions is that the outcomes are variable and at times contradictory as studies use different outcomes and measurements of health. In addition, few studies have a follow-up period, so any reported improvements in health may have been limited to the intervention period [62]. In addition, several of the health-prompting interventions used in the general population have been applied without adaption to people experiencing mental health problems. This no doubt has contributed to their failure in this population. All interventions, regardless of the behaviour addressed, need to be able to fit into people's everyday life and take account of unique challenges facing people with a SMHP as well as the persons' preferences. Interventions also need to increase people's confidence in their ability to make change themselves. This may be challenging when people may have experienced care that did not draw on their strengths and abilities but rather focused on their deficits.

APMHNs are perfectly placed to adapt and tailor interventions for people experiencing mental health problem interventions. APMHNs are also skilled at building and maintaining therapeutic relationships, often over a long period of time, and skilled at promoting and building people's confidence. Therefore, they can take a long-term view, which is what is needed when delivering physical health interventions to this population. Irrespective of what intervention is implemented, the APMHN has a role in evaluating the intervention.

Wynaden and Heslop [78] also argue that as APMHNs administer medications with well-documented side effects, they have a professional and moral obligation to monitor these as well as provide interventions to counteract these side effects. This would include regular monitoring of vital signs and ECGs. Additionally, the APMHN may use validated side effect rating scales such as the Glasgow Antipsychotic Side-effects Scale (GASS), the modified GASS for people prescribed clozapine (GASS-C) and the Abnormal Involuntary Movement Scale (AIMS), to help people to communicate not only the side effects they are experiencing but also the severity and impact of the side effects on their quality of life.

6.5 Health System-Focused Interventions

The health system part of the multilevel model focuses on improving service delivery. It involves the APMHNs exercising their influence in all four pillars of practice: clinical practice, facilitating learning, leadership and research.

Better partnerships between primary and secondary care (community and hospital care) can help share expertise and overcome barriers to high-quality care. Thus, the APMHN has a key role in coordinating care across services. This care coordination role involves having an overview of how the persons' mental state may be contributing to their physical health problems and vice versa. But it may also involve linking the person into a variety of interventions or services, including housing, education and work which contribute to tackling health inequalities and improving health outcomes. The APMHN also has a key role in enabling people to attend routine national public health screening programmes available in their country such as breast, bowel, cervical or prostate cancer screening.

Good communication between all healthcare professionals involved in the care of those with mental health problems will help avoid duplication or fragmentation of care [79]. Interventions aimed at the primary prevention of chronic physical diseases should optimally be integrated into treatment of all mental health problems in primary and secondary care [80]. As a key person in the coordination of care, the APMHN can direct and support people to optimize care pathways and ensure they receive appropriate, effective and easily accessible care.

At a more strategic level, the APMHN have a leadership role within their organisation in supporting change in this area, such as taking a leadership role in the development of guidelines for integrated care and ensuring that gaps in service provision are identified and reduced. Part of this may involve designing and delivering new services or roles. Gray [7] points out that 'our job is to promote health and enable the people we care for to lead full and productive lives' (p. 191). At this level, APMHNs also have a role in educating staff in the wider organisation around the health inequalities faced by people with SMHPs, the impact of these inequalities on physical health and the strategies they may use to improve physical healthcare. Several studies that measured the attitudes of nurses towards the physical healthcare for people with SMHP across the globe demonstrate a link between mental health-specific education and positive attitudes. Studies using the Physical Health Attitudes Scale (PHASe) in England [81], Australia [82], Hong Kong, Japan and Qatar [83] and Jordan [84] clearly show that the nurses who have a specialist registration in mental health nursing (e.g. UK) or post-graduation qualifications have better attitudes towards this area of practice.

7 Community-Level- and Policy-Focused Interventions

7.1 Social Support and Stigma Reduction

In this domain, APMHNs are exercising their leadership and facilitation of learning skills. This may mean working in partnership with the third sector, namely, charity and non-statutory organisations, to develop services and supports that promote better physical health and tackle inequalities. For example, the Scottish Government has been supporting the Scottish Association for Mental Health (SAMH) to develop programmes around physical activity. This may also involve working in partnership to help develop peer support groups to support people with a SMHP in tackling their physical health. It may also mean supporting family members and others within the person's network, by providing them with education.

The APMHN also has a role in addressing the stigma that people with SMPHs face because of their mental health issues. This is important as stigma may be a factor in why people with a SMHP do not access healthcare services. The APMHN's skills in leadership make them ideal team member to lead education to the wider organisation and non-mental health-specific professions on the impact of mental health problems and tackle stigmatising attitudes that professionals may hold.

7.2 Policy-Level Interventions

Policy is an organised set of values, principles and objectives for improving health and reducing the burden of health problems in a population. It outlines a vision for the future and helps to establish a model for action. Well-formulated health policies also identify and facilitate agreements for action among the different stakeholders in the health field and designate clear roles and responsibilities. Without policy direction, a lack of coordination, fragmentation and inefficiencies in the system will weaken the impact of any health intervention [66]. Indeed, several academics have called for APMHNs to show leadership in this area [70, 78]. A bottom-up approach to tackling the issue alone may fall on deaf ears unless nurses in established positions of leadership and responsibility, such as APMHNs, use their influence to change the culture and argue for the appropriate infrastructure and resources required. APMHNs are well positioned to have a role in developing policy at national and indeed regional or organisational level. However, for APMHNs to fulfil this leadership role, they need to see physical healthcare as a dimension of their role.

One way APMHNs may influence policy is by joining established national campaigns/projects. For example, in the UK, the Royal College of Nursing (RCN) has established the Parity of Esteem project. They define parity of esteem as ‘an absolute need to equate the importance of mental health and mental health service provision with physical health and physical health service provision’ [25]. This has become the theme for the RCN’s current programme of work around addressing the mortality gap.

The state of Victoria in Australia has also taken a strategic approach, developing a framework for mental health services to follow to improve physical healthcare for people with SMHPs [85]. While championed by the government’s Chief Nursing Officer, the framework takes a strategic ‘all government’ as well as a multidisciplinary approach. The framework has clearly defined priority areas and clear actions that service providers need to take. It requires each mental health service to plan how they are going to deliver on the framework. The Victoria framework is clear that outcomes are not going to improve in the space of 1 or even 5 years but rather over a decade to 20 years. This long-sighted view does not fit with the political cycle, which is focused on the next election. However, such an approach would allow for the allocation and coordination of resources and work across the whole health and social care sector.

8 A Specialist Role for APMHNs

There is a growing body of evidence that supports the role of the APMHN as a specialist role in supporting the physical health needs of people with SMHPs. The development of such a role is seen as one way to address the need of people with SMHPs, while also bridging the gap between different services [86], including mental and physical health services.

Numerous state governments in Australia have paid for a APMHN to be integrated into primary care services. Evaluation demonstrates that nurses regularly discussed the health of people with SMHPs with the GP and other professionals, as well as being positive about physical health screening [64, 82]. APMHNs described their role in flexible terms in order to meet people's need [87].

Happell et al. [88] surveyed members of the Australian College of Mental Health Nurses (ACMHN) about the possible introduction of the cardiometabolic specialist nurse role into services. Although quantitative results indicated that nurses were positive about such a role, qualitative analysis suggested that nurses were generally ambivalent about the role and expressed fear regarding role fragmentation and dilution of role and were of the view that responsibility for physical care should remain with the wider team [89]. Such concerns have also been expressed by people with SMHPs, who worried that APMHNs would be used as a substitute for a lack of GP services [70]. This ambivalence however appears to have subsided after a six-month trial of the role within a mental health service, with nurses articulating the positive impact of the role on practice [90]. This goes to show that when properly implemented, fears and concerns can be addressed, and specialist roles result in a positive impact.

Further studies from Australia demonstrate that embedding a specialist physical health nurse role within the mental health services has tangible benefits to people's health in an inpatient and community context [91–93], including significantly increasing the rates of metabolic screening as well as increasing in referrals for follow-up as a result of screening interventions. People with SMHPs who were in receipt of care reported that the APMHN provided verbal and written advice about healthy eating, weight loss and physical activity as well as providing advice about the side effects of psychotropic medication. Those interviewed reported implementing the health promotion advice offered, which resulted in lowered blood pressure, blood glucose levels and cholesterol and improved mood and social relationships.

9 Conclusion

Nurses are the most prominent professional group working in mental health services across the globe [94] and are in a unique position to make a positive impact on the well-being of people with SMHPs through practice, education and research [30]. This is not to say that there are no challenges to overcome. These challenges are not just about addressing the complex reasons why people with SMHPs have poorer physical health but will require a degree of creativity and ingenuity from the APMHN to address organisational and structural challenges. Indeed, Collins et al. argue that nurses need to move past the rhetoric and begin to take practical steps by establishing an evidence base around physical healthcare, as well as identifying examples of good practice and areas where improvements are needed [24].

The epidemic of poor health faced by people with SMHPs is so great that APMHNs cannot wait for a clear evidence base but must forge ahead and create it. We have every confidence that as APMHNs begin to incorporate physical healthcare for people with SMHPs into their role, a strong evidence base for interventions will emerge. Not only will APMHNs be delivering the evidence base but they will be leading on its creation, alongside people with lived experience.

While this chapter and indeed whole book is about APMHNs, it is imperative to emphasise that it is not one single intervention that is needed to improve health outcomes. Nor it is down to one single professional group. But as the largest professional group in health services across the globe [94], APMHNs have a vital role and significant contribution to make across clinical practice, education, research and leadership in relation to physical healthcare.

Reflective Questions

- Reflect on the healthcare system of your country and identify if there are gaps of integrated care. And if so, what are these gaps, what are the factors that contribute to these gaps and how might these be overcome?
- Consider which actions you could take as an APMHN in order to ensure that the care pathways address the physical health needs of a person with a mental health problems.
- Consider your role as an APMHN in the organisation you now work, and list the changes you would need to make in order to integrate mental health and physical healthcare into your everyday practice.

Case Vignette

Stephen is a 34-year-old gentleman, attending the local community mental health team. In the past, Stephen used to love going fishing with his older brother, Jimmy. He was also in the scouts and regularly went rock climbing and to the gym. Stephen is very talented at drawing and painting. He went to Art College on finishing school. He stopped going to classes in the second term of his second year. It was around that time that he was first admitted to hospital and experienced his first episode of psychosis. He subsequently dropped out of the course soon after. In the past, he has used opioid-based substances and was on a substitute programme of methadone. Several years ago, he managed to reduce and eventually stop his methadone prescription. He has not misused opiates since but regularly uses cannabis. He is currently unable to work and is in receipt of welfare payments.

Stephen shares his small one-bedroom flat, with Jimmy and his cat, Ringo. Jimmy does all the housekeeping and makes sure that Stephen has food, and the flat is reasonably clean. Stephen struggles to maintain the environment. Jimmy is currently receiving cancer treatment and is currently an inpatient at the local hospital. Stephen has no support beyond his community psychiatric nurse (CPN). Stephen has been offered regular packages of support but has always voiced that he does not need them and is often reluctant to accept support. He has no other family.

Stephen finds it difficult to motivate himself and leave his flat some days. Since developing psychosis, he has given up a lot of his hobbies and interests. He has gained weight to the point that his BMI is now 40. He keeps pictures of 'the old' Stephen on his phone as a reminder of how he once looked but this often adds to his distress. He finds that he is breathless when he goes for a walk to the shops. His only form of exercise is walking to the corner shop, where he purchases a 20-pack of cigarettes, a pouch of tobacco, 2 L bottle of Cola and a multipack of crisps and a couple of large bars of chocolate. He can also drink around eight cups of coffee a day. Stephen drinks cheap cider, often five cans at a day, though he does not drink daily.

Stephen was previously on olanzapine 20 mg daily but found some of the side effects distressing and so stopped taking it on discharge. That resulted in him being readmitted to hospital and commenced on a depot of zuclopenthixol decanoate 200 mg IM depot injection on a fortnightly basis. This was under mental health law. He had marked side effects on this, and it had to be stopped immediately because of an unexplained cardiac event, which resulted in him requiring a period of observation in a cardiology ward. Subsequently, he was commenced on paliperidone, which is administered every four weeks. While Stephen has less side effects, he has voiced significant distress from auditory hallucinations. It was felt that Stephen was a good candidate for the drug clozapine and he reluctantly agreed to give it a try. He is currently being titrated onto a therapeutic dose.

Reflective Questions

What are the structural and social determinants of health that are contributing to Stephen's health status, and how might the APMHN factor these into supporting Stephen to improve his physical health?

What are the ethical issues the APMHN may face in addressing Stephen's physical health?

What opportunities are there to take a recovery-orientated approach while also supporting Stephen to improve his health?

How might the multilevel model outlined in the chapter support the APMHN in providing interventions that will improve Stephen's health?

Useful Resources and Texts

Thomas, B. (2016) ***Improving the physical health of people with mental health problems: Actions for mental health nurses*****. London: Public Health England. 61 pages.** https://tinyurl.com/3ms395tc

While written as a policy document, this booklet contains lots of evidence-based information on how mental health nurses can improve the physical health of people in their care. There is a clear focus on lifestyle risk factors.

Taylor, D., Gaughran, F. and Pillinger, T. (Eds). (2021). T*he Maudsley Practice Guidelines for Physical Health Conditions in Psychiatry (The Maudsley Prescribing Guidelines Series*). 1st Ed. London: Wiley Blackwell. 752 pages. ISBN: 978-1119554202

A new accompaniment to the well-established *Maudsley Prescribing Guidelines*, this is a very comprehensive textbook. It takes an organ/body systems approach to provide guidance on the assessment and management of over a hundred different medical presentations commonly seen in people with SMHP.

Royal College of Nursing Physical Health in Mental Illness

https://www.rcn.org.uk/clinical-topics/mental-health/physical-health-in-mental-illness

The Royal College of Nursing's Mental Health forum steering group has collaborated with the charity, the Charlie Waller Memorial Trust, to create this resource for nurses. Produced by Dr. Sheila Hardy, one of the co-authors of the Health Improvement Profile. As well as videos, the website also contains a link to a Dropbox folder that contains a link to nearly every single resource you could possibly need on physical health in mental illness. This includes sample guidelines, as well as screening tools and a host of links to further training.

Anisman, H. (2021). ***Health Psychology: A Biopsychosocial Approach*****. London: Sage Publications. 571 pages. ISBN: 978-1529731620**.

This book explores how biosocial, developmental and lifestyle factors impact on the development and maintenance of illness as well as how we deliver interventions. It contains chapters on diabetes, cardiovascular disease, cancer pain and addictions, to name a few.

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Integrating Spirituality as a Dimension of Practice

Julian Raffay

Learning Objectives
The objectives of this chapter are to enable you to:

- Understand how spirituality influences the well-being of people who use mental health service.
- Recognise how an informed understanding of spirituality can help APMHNs collaborate with service users to improve mental health services.
- Explore and respond to what service users have to say about spirituality and their recovery.
- Learn how to work effectively alongside people whose culture, faith and worldview may be different from our own.

1 Introduction

Spirituality is sometimes informally defined as 'the reason we get up in the morning'. It concerns both our inner motivations and our connectedness with the wider world, with one another, and for many people, with a sense of transcendent or divine encounter. Spirituality is arguably a facet of all our lives. Indeed, by such a reckoning, only the dead are not spiritually aware. Thus, spirituality is not something we might only attend to with a service user or patient; rather it reaches beyond the clinical encounter, beyond the clinic, yet it is also part of holistic professional practice [1, 2].

As spiritual beings, spirituality is as around us as sight. If we have the privilege to be sighted, we only need open our eyes to see the physical world. Similarly, all

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that is needed to recognise spirituality is to be open to its presence in ourselves and in those we encounter.

The selected definitions of spirituality and reflections below, offered in date order, show an interesting trajectory of thinking from spirituality as a more abstract concept to something related to APMHN interventions. They point to different framings of humanity and, in some instances, call for a different kind of service. In each instance, the emphasis is mine:

> In every human being there seems to be a spiritual dimension, a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning, and purpose… …The spiritual dimension *tries to be in harmony* with the universe, strives for answers about the infinite, and *comes essentially into focus in times of emotional stress*, physical illness, loss, bereavement, and death (Adapted from Murray and Zentner [3, p. 259]).

> If spirituality is to be relevant to nursing and applied in clinical practice, then spirituality must be defined in a manner that makes it *both meaningful and relevant for patients and nurses* (McSherry 2000, p. 28).

> …the spiritual road is not a psychotherapeutic motorway. It has very little to do with personal growth or achievement and has other purposes and processes… We have taken these ancient and wise [spiritual] traditions and beaten and twisted them into a personal growth framework in to [sic] which they fit uneasily [4, p. 31].

> This mismatch in the world view of people seeking help from mental health services with those who provide it may be explained by psychiatry focussing predominantly on [a] scientific framework for reference, with the medical model for treatment [5, p. 8].

> Spirituality may […] be considered *in significant part to be a mechanism used* by service users *to retain their sense of self in response to being treated according to the bio-psycho-social model*. It may be a defence against perceived (or actual) totalising influences, whether directly attributable to treatment or broader aspects of institutionalisation. For most of the participants, it expressed itself in overtly religious terms but this need not necessarily be the case [6, p. 9]

Further, if I may introduce another one of my own in the wake of the COP 26 Climate Change Conference: ‘A deep awareness of what truly matters, what it means to be human’. None of these definitions is individualistic. They stand in contrast with a positivist framing of service users as individuals who can be considered in isolation from their context, a point we will keep returning to throughout this chapter.

The definition by Raffay et al. [6] recognises that a service user’s apparent spirituality may have both intrinsic elements and extrinsic ones. Spirituality, thus considered, is dynamic rather than static. It is a means by which someone frames, engages with and responds to the world around them.

Whether primarily religiously framed or otherwise, research evidence shows that a person’s spirituality affords them both resilience and purpose [7]. While we can expect spirituality to be deployed alongside other coping strategies, we need to avoid reducing it to a coping strategy. Many people’s spirituality is far more than that; indeed, I sometimes liken my personal spirituality to enjoying a colour in contrast to a monochrome screen.

In mental health contexts, a person's spirituality may be heightened, flattened or otherwise altered by their experience, illness or interactions with those around them. It may be suppressed or displayed in relation to perceived or actual staff engagement or its absence [8, 9]. This may be evident in Mike and Fran's account which occupies the rest of this section.

1.1 Mike and Fran's Account

My name is Mike Watts. Both my wife Fran and I experienced and recovered from 'enduring mental illness'. I was diagnosed with 'pathological shyness' after reporting hearing voices. Fran was diagnosed with post-puerperal psychosis and then schizophrenia, schizoaffective and bipolar disorders. Our lives became unmanageable. There were frequent hospitalisations and a growing cocktail of powerful drugs. We lived on a small farm in the West of Ireland intending to create the perfect alternative lifestyle. When that dream shattered, I came to a point of total despair.

Recovery began when we stumbled across Grow (https://grow.ie/), a form of peer support. At the very first meeting, there was this tangible sense of hope and possibility. People were talking about mental illness as an ordinary thing. We realised others had been there. We heard inspiring stories of recovery.

In Grow, you are asked to choose a task for the week ahead. You then report back on progress. My early tasks were to do with overcoming shyness, saying hello to people instead of looking away. Whatever your progress, the group provided loud affirmation. This was like manna from heaven. I was encouraged to join things. It was difficult. I felt so awkward among people, but it got easier. I learned how to absorb negative feelings of fear and repulsion. Leadership had a profound effect. I had a warped attitude to leadership. Leaders were BIG SHOTS seeking control. In Grow, you are called to help other people; you are asked to lead meetings, to tell your story to help others.

Social involvements that helped included creative writing, playing the tin whistle, art and toastmasters. They educated me emotionally. I also went back to college as a mature student and studied psychology and later family therapy. This provided a new and exciting identity. It also led to employment in Grow, first as an area and then as national coordinator.

I began to try to improve the mental health system. I was a member of Ireland's first Mental Health Commission, a group advising Amnesty International on Mental Health Policy, and I began teaching in various universities. I also completed a PhD seeking to understand recovery processes at work within peer support.

Fran also recovered by a similar route but with very different involvements.

Looking back, I genuinely believe that life is essentially spiritual. I am a unique spirit living within a physical and a social body. Sayings such as 'Seek and you will find' and 'When the student is ready the master will appear' suggest the reality of providential benevolence which directs you towards life-giving support once you make the leap of admitting you need help. We could not have recovered were it not for our warm and welcoming neighbours in Clare, the nurture provided by people in Grow, and different significant others who appeared along way. In the early stages of recovery, medication was a lifesaver, but it became a trap and we need to explore its role as perhaps a starting point for recovery.

Mike and Fran's moving account offers deep insight into their broadly non-clinical framing of their recovery. It invites the APMHN to consider more carefully what the person (patient) perceives to be happening in their encounter with mental health provision. We will return to this matter in due course, but we first explore some of the complexities (and indeed richness of spirituality as a concept).

Having hopefully offered some framing as to how APMHNs might approach spirituality, culture and religion, I now outline the contents of my chapter. In the first part, I explored changing approaches to spirituality. I next explore the relationship between religion, spirituality and culture. Section 3 explores the relationship between spirituality, resilience and recovery. It begins with the research evidence that spirituality is commonly conducive to recovery and that, for most but not all, service users, belonging to a faith community, serve as a protective factor. Section 4 uses spirituality as a means to re-evaluate common notions of patient-centred care. Section 5 explores spirituality and its relevance to care planning.

Section 6 builds on this body of evidence to argue for integrating spirituality within APMHN and wider mental health practice. Section 7 makes the case that APMHNs are particularly well placed to work alongside chaplains and others in implementing an approach that balances expertise and compassion. Section 8 explores how the insights gained could help re-engage communities in supporting the welfare of people encountering distress or mental health problems. Finally, Section 9 offers broader philosophical reflections on what we have considered in the chapter. Having charted the territory, I now explore the relationship between religion, spirituality and culture.

2 Religion, Spirituality and Culture

The outstanding academic authority on spirituality is Duke University in the USA [10]. Their research is extensive, indeed colossal. For now, the important thing to note is their overall conclusion that spirituality is relevant to mental health service users, a significant determinant in recovery, and that practising religious faith is for most (though, sadly, not for all) beneficial to well-being.

However, our understanding of spirituality and spiritual care has changed over the years. Initially, its most common usage concerned specifically religious practices related to the major world faiths. While many service users, carers and staff welcome this framing, others prefer a broader, perhaps more, phenomenological understanding (as illustrated by Mike's account above), one that focuses on our hopes, fears and self-understanding within the society, the wider world and frequently the environment or indeed the cosmos.

I do not wish to detract from such understandings and would certainly not wish to dispossess anyone's 'capital' in shaping their care or in determining healthcare priorities. However, from an APMHN's perspective, it is important to expect that a service user's expression of their spirituality will be influenced by their context. This will undoubtedly include their society, culture and family, but its immediate expression will be further shaped by their perception of mental health services. Koslander and Arvidsson [9] found that service users hoped to explore spiritual issues with professionals but would alternatively turn to their peers when they perceived that staff failed to engage.

Many older healthcare professionals and service users will be familiar with the religious study approach to spirituality, faith and religion. This is greatly to be commended for its interest in diversity, yet it also suffers significant weaknesses. In healthcare settings, it commonly resulted in chaplaincy departments producing handbooks on how to respond to religious *needs*. These handbooks served a purpose akin to that of a pharmaceutical formulary. They gave staff knowledge and the confidence to dispense or procure rites and rituals at the proper times. While such handbooks continue to have their uses, their disadvantage is that they portray service users as having specific *needs* that need catering for in similar fashion to dietary needs.

It may be apparent that such a needs-focused framing of spirituality sits uncomfortably with the definitions we have just considered. If, as the evidence suggests, spirituality confers *resilience* [11], then we would do better to think in terms of spiritual *strengths* and *needs*. This more positive reframe equips us to better understand spirituality, but let me first take us deeper into the heart of the matter with a case study. It is fictional but rooted in my encounters with nurses over many years.

I remember Jenny[1] as an excellent, diligent and kindly senior mental health nurse. One day, she asked: 'Julian, I've got a Sikh patient. What can you teach me about Sikhism?' At face value, it was a fair question to ask a chaplain. Indeed, there was no doubting Jenny's desire to be culturally competent. However, I felt overwhelmed by sadness. I was not sad because I was not sure if I could remember Sikhism's 'Five K's' and feared exposure as a charlatan. I was not disheartened because she was interested in Sikhism rather than my own faith. I felt discouraged by the realisation that this outstanding nurse thought she could best help the elderly Ranjit by aspiring to an encyclopaedic knowledge of his faith.

Jenny and I could have pooled our ignorance. We could have downloaded key facts of Sikhism. We might even have spent a fortnight together in an academic library. But to what avail? Jenny, in her mid-30s, was never going to match Ranjit's grasp of his religion (any more than I was). Yet that is what her training had led her to believe she needed to do. In short, she was making a category mistake, wrongly assuming that properties from one category (e.g. medicine) can be assigned to another (i.e. spirituality). Ranjit's faith and his spirituality, his religion and his culture were never going to lend themselves to the kind of systematisation that randomised controlled trials (RCTs) best address.

Whereas RCTs excel at prediction, the approach is perilous when it comes to cultural characteristics. Let me explain with another anecdote. I got on particularly well with Ahmed, a Somali-born service user who asked me one day: 'Why do the staff keep giving me curry? I hate curry'. It did not take long to grasp what was happening. Ahmed had asked for halal food. So far so good, the staff had quite

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[1] All names have been anonymised, but the following accounts are otherwise authentic.

reasonably responded accordingly. However, this also led to the category error. They failed to realize that, because most Muslims in the service's catchment area were of Pakistani origin, asking for halal in Sheffield meant a predominantly curry-style diet. Arguably, it was unrealistic to expect overworked staff to appreciate that Somalia is literally an ocean apart from Pakistan with unsurprisingly different dietary traditions. The account of Ahmed illustrates the problematic nature of cultural or religious generalisations.

Returning to Ranjit, we may appreciate that even had Jenny acquired encyclopaedic knowledge of Sikh faith, spirituality and Indian culture, she might have been no nearer understanding Ranjit himself. Indeed, though Jenny's actions were clearly well intentioned, neither Ranjit nor Ahmed would have particularly appreciated a white Westerner setting themselves up as expert on their culture. Paradoxically, they would have felt misunderstood [12] and rightly so. Had we enquired sufficiently into Ranjit's religion, faith or culture, we would most likely have found aspects in which he was atypical, non-adherent or noticeably adherent.

So, if we risk being considered ignorant on the one hand or possibly racist on the other, should we simply steer clear of anyone not like ourselves because it is just too complicated to get involved? What might the APMHN, let alone a more junior staff nurse or support worker, need to learn, to understand and to discover? First, and perhaps most importantly of all, we need to recognise that approaching spirituality through a positivist lens will most likely prove a sterile venture [13, 14].

We can illustrate this with reference to Buddhism which offers a good example of the complexity we are faced with. Buddhism spans Asia, a continent approximately 6000 miles or 11,000 km in length and covering some third of the world's land mass. In many areas, it is mountainous and, despite modern communications, consists of diverse nations and cultural subgroups. What is surprising is that anyone, other than those who are naïve, might imagine that Buddhism, with its 2500 years history and mostly loose organisational structure, could possibly be a uniform entity. Ticking a box stating that a service user is a Buddhist should ideally invite questions about what tradition within Buddhism they follow, whether they were brought up in a Buddhist or Western culture, what tenets they adhere to and how they relate their faith to their worldview and sense of self. And all that before we consider other variables concerning their demographics! Ultimately, to assert that someone is a Buddhist (or considers themselves to be a Buddhist) is to say something about a way of understanding life. But, beyond that, the variation in people's belief and response is huge. Indeed, much the same is true of Judaism, Christianity or Islam, not to mention many minority world faiths. Only those religions with strong central organisational structures like Mormonism may perhaps achieve greater conformity within their membership.

Whatever the academic merit (or otherwise) of comparative religion, the systematic classification of spirituality, faith and culture simply cannot handle the diversity we encounter among mental health service users in today's postmodern multicultural societies. Though religious studies are unfit for that particular purpose, spirituality's tenacity as a concept suggests that it warrants attention. Of one thing we can be certain spirituality, religion and culture will outlive Western psychiatric practice.

It is not only religions or belief systems that we risk stereotyping. Indeed, though the tick boxes in clinical databases may force binary thought and practice, we do well to avoid stereotyping people as ‘religious’ or ‘not religious’. Many people whom others would consider religious have their moments of doubting (sometimes described as a ‘dark night of the soul’). Many, and perhaps most, secularists will pray when in difficulty. Further, a person of faith will typically observe certain but not all aspects of their faith that others might anticipate. An atheist might choose to practise aspects of his/her culture that has religious overtones or a religious heritage. For instance, there may be many reasons why a woman might wear a hijab or a man attend a synagogue. It is always preferable to interact with the persons and explore their unique world view, meaning-making, and self-understanding within their community and society than to stereotype them prior to such a conversation.

3 Spirituality, Resilience and Recovery

In their systematic review of spirituality, Milner et al. [15] identify a ‘religiosity gap’ between service users and healthcare professionals. While endorsing their findings, I propose that there may more broadly be a ‘spirituality gap’. I am not suggesting that clinicians lack spirituality—that is another matter—rather that many, perhaps, most do not consider it a legitimate or sufficiently important part of their professional practice. The reasons for this will be varied, from context to context; they may be individual, the expressed opinion of professional bodies, or the result of organisational expectations, or indeed any combination of the above.

Using thematic analysis, Milner et al. [15] found that service users, in contrast, deploy religious and spiritual concepts to make sense of their experience. They define their second theme ‘identity’ in the following terms:

> The centrality of spirituality for many people’s lives and core sense of self. Spirituality represents for many the core essence of who they are, shaping their identities through their experiences of illness, struggle, recovery and meaning-making. Participants draw on their spiritual frameworks to develop and negotiate a spiritual identity [15, p. 5].

Clearly, we cannot ignore spirituality as simply irrelevant. One service user, in an earlier study I conducted, expressed his spirituality in relation to his faith:

> [spiritual care’s] very very important for mental health; sometimes it’s the only thing that seems, that can maybe get through to someone. It’s a different sort of level of understanding, that goes beyond words that goes beyond, something you can touch, it goes beyond all that and I do believe in the power of Grace. I do believe in the Almighty God and I do believe that Jesus was the best healer that this world had ever known [6, p. 5].

Another spoke more uncompromisingly: ‘As a service user, it frightens me silly that my spirituality might be overlooked. If that was overlooked, I don’t see any point in even looking at recovery because that is what my recovery would be about’ [16]. Additionally, Wood et al. [17] reported that service users hugely valued chaplains’ ability to listen to them in a manner congruent with and respectful of their beliefs and values.[2] Though chaplains are experts in this field, there is no reason to believe that this applies uniquely to them.

Based on these statements and what I have argued thus far, I propose that spirituality is of immense significance to APMHNs and their colleagues and indeed to the whole mental health enterprise. I assert this because, properly understood, a 'thick' [18] or rich understanding of spirituality affords the possibility of resolving many of the tussles between professionals and service users.

Spirituality deserves consideration regardless of our personal stance on religion. True, it may include religion or religious perspectives, but I suggest that in mental health (and potentially other services), there is much to be gained by re-framing our understanding of spirituality to include the relationship between the service user and the provided service. This is not to reduce spirituality to this relationship alone but rather to focus on a particular aspect of it. We might expect a service user to continue practising their spirituality years after their last contact with mental health services (MHSs).

Before exploring in greater detail, let me first defend myself from the charge that I am simply affirming what used to be called 'bedside manner', therapeutic alliance, or indeed Rogers' 'unconditional positive regard' [19]. These matters are all of course important, arguably vital, but they are also weak constructs inasmuch as they rest on a superficial conceptualisation of the philosophy of science [20]. For now, my point is that they take the clinical intervention as self-evident and consider things from the clinician's perspective alone. My focus is at least as much on the person as on the service.

What I say below may appear critical, and before going any further, I should say that I recognise that many people have been helped by mental health services. Many quite literally owe their lives to clinical interventions. I have had lengthy conversations with people who had lost all hope, stopped eating and recovered only after several rounds of electroconvulsive therapy. Others living with bipolar disorder have been safeguarded when at their most poorly. The view I express is not intended as antipsychiatry but rather offered in the belief that an understanding of spirituality offers insights that could reconfigure mental health services towards something far better.

I can best explain with reference to my personal life. I have had my own share of what might reasonably be termed mental health problems and anxieties. Yet, despite working alongside mental health professionals for years and having many good friends among them, I have not wanted to use their services (at least not formally). In fact, where my own welfare has been concerned, I have preferred the support I have been able to get elsewhere. It is not that I have disliked mental health services staff not for one moment. It is the approach that I find problematic [9, 21, 22].

When I have felt overwhelmed, even at the limit of my endurance, I have looked elsewhere for support. Why? I suspect for much the same reasons that Halliburton [23] observed people in Kerala (South India) with chronic mental ill health preferring what was on offer at their mosque, temple or church. Again, why?

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[2] This is not to suggest unquestioning acceptance.

We gain insight from the Schizophrenia Commission which described English mental health provision as 'a broken and demoralised system that does not deliver the quality of treatment that is needed for people to recover' [24, p. 12]. Chandley [25] is similarly critical, observing within MHS cycles of indolence, defensiveness or chronic laziness. He anticipates that secure services will 'one day be preserved as museums to detainment' (p. 54). He envisages 'tour leaders showcasing seclusion rooms with tales of inhumane treatment and questions of the workforce about segregation and how the mentally disordered could have gravitated to this in a period of collaboration?' (p. 54).

Despite the occasional high-profile scandals [26], arguably inhumane treatment is rare (though those describing themselves as 'survivors' may disagree). More endemic (and therefore far more problematic, I suggest) is the consequence of services' emphasis on evidence-based medicine (EBM) and outcome measures. While EBM has led to enormous gains in many branches of medicine, it is insufficient in psychiatry. Though it may indeed yield results against metrics, my observation is that 'it risks causing wards to become "emotional deserts", places unsafe for staff, let alone service users and carers' [22, p. 185]. The question with such metrics is whether they are ones that are actually relevant to service users, carers and staff.

Let me counter the image of 'emotional deserts' with the good spiritual care received by an inpatient I refer to as Shahida. I first found Shahida near collapse in the airless hospital prayer room. Ramadan had fallen during a long hot summer's day in Northern England. Despite being pregnant and diabetic, she had fasted from dawn. After she had received first aid and a good rest, I listened to her. It turned out that she had recently acquired an expensive digital Qibla compass (to find the direction of Mecca) she had requested for her birthday and had gone into the prayer room to check the alignment of the arrow sticker on the ceiling. She had discovered it was out by 0.1 of a degree and was wondering how she might climb up and sort it.

Shahida's parents were successful senior executives in a pharmaceutical company, and she had found herself overwhelmed by their high expectations of her. In seeking their approval, she had become increasingly fastidious and had projected her experience of her parents onto her faith. She had come to believe that Allah (God) was harsh, unforgiving and quite intolerant of any imperfection. Her imam had often spoken about 'Allah, the All Merciful', but his words had gone unheeded.

Her long rehabilitation provided Shahida ample opportunity to recalibrate not only her compass but also her faith. A female night nurse who was familiar with the Qur'an invented a game in which each had 30 min to find the most Surahs (verses) pointing to Allah as 'The All Merciful'. Over time, Shahida came to believe herself to be loved by God. This equipped her to gain a more differentiated understanding of her parental upbringing and to work out what she wanted from life. Shahida trained as a counsellor and volunteered with the service for several years after her discharge.

Such insightful practice may be less common than we might hope. My grounded theory-based research [22] found a disturbing mismatch between a healthcare provider's promotional literature (and possibly senior managers' self-belief) and what service users hoped for. I wrote:

> Despite some positive accounts, participants related many painful experiences. I most coded feeling 'knocked back'. Feeling knocked back extended beyond being asked to return later. It describes frequent reinforcement of low self-esteem through the continual experience of disadvantage, however seemingly trivial each instance. Participants across all five groups [service users, carers, staff, faith community leaders, and community organisers] expressed disappointment with MHSs. Fear was widespread. Detention, compulsory medication, risk of aggression, availability of illicit substances, and enforced communal living challenged service users, carers, and staff alike (p. 81).

Ejneborn Looi et al. [12], in their study of coercive measures in Sweden, reported similar findings. Using qualitative content analysis, they identified three categories which we might anticipate would have been important to Ranjit and Ahmed: 'a wish for understanding instead of neglect', 'a wish for mutual relation instead of distrust and 'a wish for professionalism instead of a counterproductive care' (p. 96).

This mismatch between a healthcare provider's promotional literature and what service users encounter is exposed by spirituality when the latter is conceptualised as a person's 'experiential response to their encounter with the totalising impact of a reductionist institution' [27, p. 236]. This unapologetically phenomenological definition puts service user experience centre stage and relegates metrics, in football terminology, to a lower division. Spirituality, thus understood, holds out the prospect of remedying the situation where a service user on an advanced care plan could not recall the name of their community psychiatric nurse because they never see the same one twice [22].

Do not get me wrong, I am not suggesting that MHSs should pander to every narcissistic streak of our consumer culture. Neither am I suggesting they should meet every service user's whim. Expressing things differently, I do not believe that we can deliver safe and value-for-money services unless they are co-designed, co-researched, co-delivered and co-evaluated, specifically *with* those whom we purport to serve.

Spirituality, understood as a person's 'response to their encounter with' the institution, draws attention to what may need fixing rather than where we have been trained to put our efforts. By analogy, the King's Fund found that money spent on improving patient experience in cancer clinics had a significant impact on recovery rates [28].

An unexpected corollary of focusing on the 'encounter' is that it opens our eyes to the possibility that at least some (and possibly the majority) of the challenging behaviour we blame service users for may have its aetiology in the services rather than the service user. This may, for example, be true of hyper-religiosity where a service user seeks escape from an environment that knocks them back more than they can bear [22, 29, p. 10].

The relevance of spirituality becomes more pronounced when we explore the second half of my definition, the reference to the 'totalising impact of a reductionist institution'. My allusion to Goffman's *Asylums* [30] is deliberate. Healthcare providers squeezed by neoliberalism and increasing regulation risk losing sight of the service user and frontline staff in their futile attempts to address so-called 'cost improvements' and uncertainty [31–33]. Seeking to reduce operational costs, service users get 'clustered' [34] and, to quote the band Pink Floyd [35], can end up feeling like 'just another brick in the wall'.[3]

Spirituality becomes acutely significant when we recognise its political importance as a rallying post for those wishing to confront MHSs' love affair with EBM and big pharma [36]. In essence, spirituality becomes (at least in part) a call for a very different kind of service, perhaps one that practises the 'pleasant processes' [23] observed in Kerala. Exploring spirituality opens our eyes to the possibility that service users, carers and staff might collaborate towards services shaped around what service users want (and indeed what APMHNs may also desire) rather than what others think they might need, services that restore rather than crush their autonomy [37, 38].

4 Spirituality and Person-Centred Care

Thus far, I have introduced the idea that spirituality in mental health invites the exploration of conceptualisations beyond the clinician-defined positivist frame. I now explain why this might be important by analogy with a traditional travel agent, the sort that has a shop that you can walk into as a customer. What I am about to say may appear to ignore many of the real improvements that have been made in mental health services in recent years. I appreciate how hard some staff, service users, carers and others have worked towards improvements, and I have no wish to sound carping or cynical.

Imagine you walked into a travel agent and, instead of asking you what kind of holiday you wanted, the person behind the desk decided for you. If you turned up with a rucksack and trainers, they might conclude you were hyperactive and in need of a beach holiday or a cruise. If, on the other hand, they considered you carry excess weight, they might suggest you go skiing or hillwalking.

We could extend this admittedly preposterous analogy by imagining what would happen if anyone who walked into the agency was compelled to take the holiday chosen for them. Even worse, we might imagine travel agents roamed the streets or had spy drones or could monitor your web usage and send tour representatives to your home to seize you. It all sounds rather dystopian, doesn't it? But Zimbardo's prison experiments [39][4] remind us of the dangers of giving one group of people power over another.

I recall what I continue to experience as a traumatic Kafkaesque experience at Paris's Gare du Nord. Our Eurostar train back to England was substantially delayed without any explanation offered. The crowd's reasonable and unremarkable frustration turned into distress when the police started moving among us with fierce-looking Alsatian dogs. It is entirely possible that the station manager achieved their metrics

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[3] Inevitably, clustering best serves those nearest to the focus of the cluster and offers inferior service to those on the periphery.

[4] In 1971, Zimbardo simulated the experience of becoming a prisoner or guard. Within days, the 'guards' started mistreating the 'prisoners'.

and slept peaceably that night, oblivious to the trauma caused to the passengers. We might ponder what led them to approach the situation in the way they did and how things might have been better handled from everyone's point of view.

Recognising that coercion is sometimes used in mental health, Chambers et al. [40] found a brilliantly simple way of understanding the experiences of compulsorily detained service users. They drew on the expertise of service user researchers to interview recently detained service users once they had time to recover. They asked the service users what might have been done differently. The researchers then used these experiences to shape subsequent detentions. This was a simple matter of respect that would ideally have been practised in every mental health setting. Its absence was driven home dramatically when a service user I will call Helen told me 'I know I was poorly, but I wouldn't have hit the nurse if he'd been able to tell me my cat would be looked after while I was in hospital'.

The above anecdote shows the damage that arises when someone feels 'knocked back'. The nurse was injured, and the service user struggled with remorse. Both were effectively harmed, arguably by an 'indolent' system that had not incorporated Chambers et al.'s [40] insights. They were harmed by a system that pitted staff and service user against each other, forcing one to be the expert and the other into Parsons' [41] sick role. Thus construed, a tussle was almost inevitable.

Whether a fictional totalitarian travel agent, the abuse of rail passengers or inconsiderately handled detentions, the same principles apply. In each instance, we are dealing with negative experiences which may be interpreted spiritually, whether momentarily or in the longer term. Of course, we would hope that service users might feel heartened by their experience of mental health provision. Regardless, we may recognise that there is value in framing spirituality in the nexus between the service users and their 'experiential response to their encounter with the totalising impact of a reductionist institution'. But if spirituality in mental health is indeed, as I have suggested, a rallying post for those desiring a different approach to mental health provision [27, p. 236], what positive vision or visions might it offer us?

A more 'pleasant' system [23] would likely have approached the service user and cat situation differently. Had neither the nurse nor the service user construed each other as different, as 'categorizable', they might well have had more respectful, nuanced conversations. They might both have been better able to frame the differences between them as opportunities for encounter. Indeed, Kara [42, p. 131] reminds us that reality is more complex than the interpretative frameworks through which we are taught to make sense of 'our' service users. She helpfully observes that both service users and staff have altogether more mutable identities than we mostly pretend.

What if the nurse in question had been able to be more honest about his own mental health difficulties or anxieties and use these insights more creatively in responding to the situation? What if together they had been better equipped to manage the outer boundaries of the situation—namely, that Helen had to be detained—and if they had successfully handled this without conflict, with co-production of what is deemed quality of service user/staff experience, not least in addressing her cat's welfare? What insights, learning and trusting relationships could have emerged even before Helen found herself admitted?

In case I appear idealistic, rest assured, I am well familiar with the challenges encountered in psychiatric intensive care units and the intractable problems faced by service users in the community. I am not making light of the paranoia, often exacerbated by substance abuse, that characterises many more difficult admissions. Neither am I overlooking the busyness both qualified and unqualified staff can experience. It is easy to advocate more haste, less speed when not in the thick of it or emotionally exhausted. But I have also seen how effective spiritual care can mitigate conflict from arising in the first place.

You might be thinking that such spiritual care is none other than authentic client-centred care. It stands to reason that those different approaches to quality care might show considerable overlap; however, the emphasis that specifically spiritual care brings is twofold. Firstly, it affirms the service user's spiritual, cultural and religious identity and aspirations. Secondly, it allows care to be defined by the service user's frame of reference as much as by the clinician's [17]. Obviously, there are times when this may be problematic, but I have observed that, even in the middle of psychotic episodes, much can be gained from a level of encounter that is deeply meaningful to both service user and staff, one that goes the extra mile. I saw this in the case of Abdul, a practising Muslim. Like Helen, he found himself in conflict with the ward staff. He was deemed non-compliant, refusing his antipsychotic medication.

It was an agency support worker on 1:1 observation with Abdul who turned things around. The support worker engaged with Abdul and simply asked him: 'What's the issue with your medication?' Abdul replied: 'Well, it's Ramadan and the medication makes me drowsy for Midday prayers. Unfortunately, the nursing staff simply don't listen'. The support worker, himself a Muslim, wisely asked: 'If they gave it you earlier, would you take it?' Abdul replied: 'Of course, I do want to get better'. Thankfully, the ward manager listened to the support worker. Abdul's medication times were changed, and his relationship with the ward turned round to such an extent that, after his discharge, he returned for many months as a volunteer gardener.

This approach concurs with recent research into cultural humility (see "Diversity and Culturally Responsive Mental Health Practice"). It fits in with Duncan's insight that therapeutic alliance is paramount [43]. Right down the bottom of the list are the techniques and methods commonly prioritised by professionals. Over 20 years ago, Forrest et al. [21] had reached similar conclusions in their study on service user involvement in psychiatric nurse education. They reported that

> many service user participants suggested that nurses who had been educated and professionalized through the hospital based mental health 'system' ended up perceiving and interacting with users as 'textbook cases', rather than individuals with unique experiences of distress. Professional qualities were also seen as eroding the human qualities they valued and this in turn led to 'distance' (pp. 52–53).

While hospital-based healthcare may seem remote to APMHNs working in outpatient services and NGOs, service user aspirations are unlikely to be altogether different across the different contexts.

Well worth noting in Forrest et al. [21] is the depth of service user insights in their study. Especially striking was the service users' compassion for the nurses whom they recognised as, dare I say, ‘straitjacketed’ by the system. It may be apparent that we are somehow very close to the heart of spirituality, to that deep awareness of what truly matters and of what it means to be human.

If ‘spirituality in mental health can be understood at least in part as an experiential response to encounter with the totalising impact of reductionist institutions’, then perhaps it is as relevant for staff as for service users and carers? If in the words of one of Forrest et al.’s participants ‘The most important thing nurses can do is abandon their training’ [21, p. 53], then what might spirituality teach us in this regard? If spirituality becomes (at least in part) a call for a very different kind of service, then what might that look like? I approach this from the perspective of ‘Tom’, a reconstruction of genuine dialogues containing autobiographical elements. I deliberately use the first person.

I went through a tough patch in my life, during which others said that I looked like Jesus. Perhaps, it was my long beard and sandals. Okay, I admit that I looked like a shepherd in a Nativity play, but my world seemed in such a mess. I guess, I imagined that if I looked like a shepherd, I might get to meet Jesus, and he would heal me and those I loved. I tried so hard to make things better by giving away my food in the clinic and praying for the other service users and staff. I really did try to help and yet I also appreciated the staff who urged me to make sure I had food too.

My key worker was fantastic. I realise he had mentioned my case to one of the chaplains. I realise with hindsight that I was delusional, but the chaplain realised that my delusions helped me to believe I had value. The chaplain affirmed the use of medication to manage my psychosis but also explained how appreciating my spirituality could support my recovery. You see, I had told the chaplain how I had been repeatedly abused as a child by my alcoholic father. My father had offered me to anyone in exchange for a bottle of whisky. I first went into the cathedral as a place where I thought my father would not look for me. The cathedral staff were welcoming but did not intrude. Strangely, I found myself enjoying the ritual of the services.

I read the Bible avidly, finding in it an alternative to the lifestyle I was brought up with. I was particularly attracted to Jesus and thought that if I became more like Jesus, I could not only make up for what I mistakenly interpreted my fault in inviting the abuse but also help others in similar distress. What in another might have become a life of generous service became a psychotic flight for me. When my father died of an overdose, the powerlessness and pain caused me to overidentify with Jesus and led to my breakdown.

From a spiritual perspective, my excessive religiosity was both pathological but also the source of my resilience. Without my community of support, and admittedly psychotically entangled faith, I think there is every chance I would have taken my life long ago. Realising this, and with the medical team’s support, my key worker and I met with the chaplain for several weeks. They helped me navigate my illness and find my way to recovery. Over time, I discovered not only how my faith might support my recovery but also how to make purposeful life choices more broadly. A few years after being discharged, I became a volunteer with ‘Circles’, a UK-based charity that helps people with a history of paedophilia avoid reoffending.

Critical to Tom’s account and to our discussion is where spirituality is to be framed in relation to the biopsychosocial (BPS) model. Notwithstanding the fact that the elements of the model were classically championed by different professions, advocates of spirituality have mostly suggested it might be a fourth element. We might call this a BPSS or BPS-S model. However, when we used grounded theory to explore service user's perspectives on spirituality, they led us to a very different framing [6, pp. 7–9]. This suggests that 'spirituality interacts with the other dimensions and yet also transcends them' [6, p. 8]. In the language of Venn diagrams, spirituality is the universal set containing the three overlapping circles representing the three BPS dimensions. Arguably then, we have in algebraic terms an S(BPS) model which seeks to redress the BPS's reductionist approach.

Though Kara [42] rightly observes that in many ways service users, carers and staff may be more alike than they commonly choose to acknowledge, that does not exclude the possibility that they might be more unalike in other characteristics. Or, expressed differently, freed from the straitjacket of reductionist outcome-driven expectations, staff's interests might align more closely with those of service users than they are permitted to recognise. Walsh [44] identifies one such area in religious beliefs which prospectively sheds an interesting light on Milner et al.'s [15] work. My reading of Wonders [45] uncovers what difficult territory this is [20, 38]. To this we now turn.

5 Spirituality and Care Planning

Walsh [44] compared electronic service user medical/nursing records with service users' recollection of their interactions with staff around spirituality. Her study, unique in mental health, found 80% error in the service user database as evidence 'the majority of Care Coordinators are unable to see the relevance of spiritual or religious concerns, or feel incompetent to record them faithfully' (p. 161).

Despite some study limitations, this research is hard to dismiss for even a 10% error rate was arguably unacceptable, even by the standards of the day. The 80% error rate suggests a neglect of matters important to service users, likely to have 'a negative impact upon their overall care and well-being' (p. 162). In Chandley's [25] terms, Walsh identified indolence. Of course, Walsh's findings may have reflected a poor service overall.

Reflecting on the same fieldwork, Walsh et al. [46] recommended that

> the Care Plan should be regularly reviewed with the service user concerned; and that the service user may be encouraged to articulate their religious and spiritual concerns and practices in their own terms rather than those supplied by the database and/or Care Coordinator (p. 162).

Walsh's work ties in with earlier findings from Burkhart and Hogan [8] who, from a nurse perspective, recognised the reciprocal nature of positive interaction in spiritual care:

> The patient must invite the nurse to provide spiritual care. Nurses can create an atmosphere to increase the likelihood that the patient will offer this invitation by assessing their patients with a spiritual openness of love, hope, and compassionate caring (p. 931).

This suggests a distinct possibility of something more akin to a standoff than a stalemate. Where both nurse and service user are fearful and awaiting the other to take the initiative, there is every likelihood the conversation will not take place. Indeed, unless nurses can find time for close relationships with service users, significant conversations around self-harm, suicidal ideation, sexuality, abuse, spirituality, religion and many other vital matters are unlikely. Whether this necessarily happens in Halliburton's [23] more 'pleasant' settings is of course not guaranteed.

Queen Gertrude's oft-quoted (and misquoted) quip, 'The lady doth protest too much, methinks' (*Hamlet*) is aptly applied to medicine's all too common insistence on its alleged neutrality and yet more aptly applied to science's utilitarian prop:

> The scientific ideal of contemporary social science, namely, can be most revealingly read not as an isolated entity, but rather as one emerging from and pervaded by Western culture. Positive psychology overtly and enthusiastically endorses this ideal, so despite its best intentions to become a culture-free, universally applicable, and normatively neutral science, [it] turns out to be "pervaded by Western cultural values and assumptions" […]. This fact, importantly, is usually unacknowledged and remains hidden, not only from the general public view but also from the theoretical self-awareness of positive psychologists [20, p. 23].

The aspect of the scientific method that is 'usually unacknowledged' concerns the fact that, on the one hand, EBM mostly achieves what it sets out to achieve, namely, that replicated procedures generally lead to replicated findings. Indeed, RCTs have led to life-changing discoveries. On the other hand, what is 'usually unacknowledged' is the inevitable circularity whereby preference is given to researching that which can be measured, replicated and evidenced. Within the strictest confines of EBM, anything unlikely to yield replicable data is rejected a priori. This is a natural outworking of positivism.

Many have argued that psychiatry (from Greek words meaning 'healing of the soul') should not confine itself to methodologies particularly appropriate to treatment of the physical body [36, 47]. Kinderman interestingly proposes that psychology is better placed than medicine to contribute to service user recovery. Indeed, as the professions compete for status, jobs and income, service users risk becoming pawns in a complex game in which the professions compete to extend their status and reach [48, p. 123].

Regarding spirituality, Wonders [45] illustrates, though seemingly unintentionally, how this is relevant to our understanding of nursing (and indeed our valuing of the various allied health professions):

> In the secular setting, the scientific domain still holds precedent and there is some indication that spirituality is, at best tolerated or worked with inconsistently or at worst, avoided or sidelined [*sic*]. The literature consistently highlighted the influence of organisational factors and the professional atmosphere on therapists' practice (pp. 34–35).

We may note her use of the word 'still', acknowledging a shift away from modernism. While that may be true, neoliberalism has resulted in entrenchment and the use of utilitarian metrics, few of which have been chosen by service users.

To assert that ‘Spirituality in mental health can be understood at least in part as an experiential response to a service user’s encounter with the totalising impact of reductionist institutions’ is effectively to launch a counterattack. This counterattack is twofold, first in arguing that there is value in an ‘experiential response’ and second in arguing that when positivist reductionism excludes other perspectives, it can cause real harm. I contend that no one, whether service user, carer or staff member, can survive long in an ‘emotional desert’ [22, p. 185].

Of course, this is not to suggest that spirituality is solely an emotional response. Murray and Zentner’s [3, p. 259] framing of it as ‘a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning, and purpose… …[that] tries to be in harmony with the universe, strives for answers about the infinite’ should help us recognise that there is far more to a service user than their encounter with mental health services. We might even ponder whether the spiritual corresponds to God, gods or simply forces within the cosmos beyond our current understanding, whether personal or otherwise. That however is to engage in philosophy, metaphysics or theology. Suffice to say, encounter with spirituality invites the APMHNs (and other frontline staff) to think big.

To assert that overreached positivism can cause harm is not simply to repeat the claims of the anti-psychiatry movement. It is rather to invite a wider, less myopic frame of reference that is more ‘pleasant’, one more palatable to the human spirit. Wonders’ work indicates, albeit perhaps unwittingly, the merciless ‘totalising impact’ to which I have referred. She remarked that ‘two […] studies utilised samples of therapists who rated RS [religion and spirituality] as important […] *and therefore may be biased* [my italics]’ [45, p. 21]. Of course, they may have been biased, but she does not even entertain the possibility that therapists who disregard religion and spirituality might also be biased. Effectively, she has consciously or otherwise made an a priori judgement on anyone not taking an implicitly positivist stance, implying that they are a rebel or perhaps even disloyal.

Such a view can hardly be considered ‘neutral’ within Banicki’s [20, p. 23] framing but will probably catch out the inattentive reader. Indeed, it would appear to have remained ‘hidden’ from her own ‘theoretical awareness’ [20, p. 23]. Regrettably from our perspective, she offered no insight into the ‘organisational factors and the professional atmosphere’ driving the perspectives adopted by the staff who participated in her study (2014, pp. 34–35, 59).

The second part of Wonders’ study explored clergy experiences of working with mental health services and corroborates the suggestion that the persistence of spirituality suggests that something may often be missing from MHSs. Wonders used interpretative phenomenological analysis with Christian clergy. One of her participants showed deep insight, arguing that

> Min[i]sters don’t have tight boundaries, whereas often the [English] NHS is absolutely screaming with boundaries and I think that there are plusses and minuses to both....and I think you have a lot of burnt out Ministers [sic] who don’t know how to put any boundaries in and I think you have some NHS health care professionals that can’t do diddly squat because some rule has said they can’t and that is a real shame (p. 80).

The important point here for APMHNs (and other frontline staff) to consider is that insights beyond the confines of our professional bodies (or indeed beyond mental health professionals' theoretical self-awareness) may have something valuable to offer. My research suggests that service users take from mental health services and faith communities what they need to recover. Several participants reported finding skill in the former and compassion in the latter [22, pp. 108–118] yet needed both.

On a broader canvas, I find it strange that Western practitioners can be quick to discard non-Western approaches as ineffective without asking why people continue to seek solace and healing in religion and alternative and Eastern medicine. Arguably religion and Eastern medicine are not ineffective if people continue to choose them, and it may be Western medicine that is failing to recognise important facets of human nature that lie beyond its sometimes myopic vision. Perhaps Western medicine needs to face up to the fact that it may, in Halliburton's [23] terms, be insufficiently 'pleasant' for people to choose it, except when they are desperate and often as a last port of call when other more 'pleasant' approaches have not given them relief.

6 Evidence for Integrating Spirituality

In considering the evidence for integrating spirituality, as previously mentioned, the outstanding authority is Duke University in the USA [10]. Their findings could be summed up in the following phrases:

1. Spirituality is relevant to mental health service users and significant determinant in recovery.
2. For many service users (while admittedly not all), religious practice and belonging to a faith community both benefit their well-being and provide resilience. It achieves this by offering belonging and framing meaning beyond the individual.
3. Service users whose spirituality is independent of religious organisations are more vulnerable to delusional thinking without the (mostly) moderating insights of peers and leaders within their faith community.[5]
4. APMHNs should support spiritual practices (such as prayer, charitable giving, acts of service and fasting) except where there is clear indication that a person's practice or thinking is likely to result in harm to them or to another.

While seeking to support spirituality, we should be alert to the possibility of violent extremism. However, it would be unfair to stereotype most people whose spirituality motivates them towards greater concern for others and for the environment. Anyone concerned that a person's spirituality may harm them would benefit from reading Rosmarin and Koenig [10, Ch. 5] or Crowley and Jenkinson [49]. The latter suggest that

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[5] This would be the case for someone describing themselves as 'spiritual but not religious'. Groups like the British Humanist Association may provide valuable points of reference.

> Rather than attempting to classify groups into ‘good or bad’, ‘harmful and not harmful’, and their beliefs into ‘true’ and ‘false’, it can be helpful to consider a continuum with a critical point after which a group can progress to become harmful, if it takes its beliefs and/or practices to the extreme (p. 255).

Though most people practising their faith do so in service to their wider community, the APMHN may want to consider whether a particular service user may be vulnerable to exploitation by terrorist groups or indeed pose an immediate risk. If in doubt, they should seek urgent advice from their national authorities.

Those interested in specific faiths should turn to the earlier edition [50] which, though a little dated, has more extensive content on the subject.

For a British nursing perspective, the authority is McSherry who, as is evident from my italics below, similarly sees in spirituality not just an individual approach to life but also as an outlook that can drive a very different kind of service.

> Much has been learned about spiritual care over the last few years through a wide variety of research across contexts and countries. While there is much still to learn, enough is known to provide a solid evidence base. Evidence, motivation and educational support is available to enable nurse managers to develop best practice in this dimension of caring […]. *Spiritual care has the potential to address issues of poor care delivery, staff motivation and the limits of a medicalized approach to care*. A rapidly growing body of research indicates that it is too important to be ignored, for the sake of both practitioners and service users [1, p. 966]; emphasis mine.

Notwithstanding the fact that some psychiatric conditions have indisputable physiological manifestations, harm risks occurring when a medical framing is inappropriately imposed a priori, whether by lay people or clinicians. Anyone familiar with the *Diagnostic and Statistical Manual (DSM)* manuals [51] will be aware how behaviours including smoking and undesired weight gain have been included among an ever-increasing number of diagnostic categories. In fact, psychiatry has been so successful in shaping language that people experiencing distress of any kind commonly use the phrase ‘my mental health’.

Spirituality may be a useful framing (among others) for understanding the tragic impact of abuse and neglect on people’s lives. Shooter [52] in her book subtitled *The Authentic Spirituality of the Annihilated Soul* begins with the shocking words (which I have purposefully indented):

> By the age of 18 around 25 per cent of girls and 10 per cent of boys have been victims of sexual abuse, so most available statistics tell us (p. 1).

Yet sexual abuse, suicide and religion remain all too commonly taboo areas for mental health practitioners. Surely, it is hard to comprehend how medication might prove a lasting solution for someone whose soul has been ‘annihilated’ at an early age. Medication may have a role but equally has limits. A healthy spirituality will rightly recognise what are physical properties but also what are not (and would also acknowledge the error in regarding the two as entirely binary). Unbeknown to many, philosophers and faith leaders have explored these debates for centuries.

7 APMHN Involvement in Endorsing Spirituality

An experienced senior nurse described her work in the following terms: ‘It’s all pills and paperwork’. I suggest the solution lies in recognising the circularity (or to use its technical philosophical term ‘unfalsifiability’) of EBM. It behoves us to re-evaluate our practice. The temperature control of a domestic shower offers a useful metaphor here. We might liken the art of nursing to the hot tap and the science to the cold [53]. Any APMHN will be alert to the dangers of overheating relationships but may be less aware as to quite how unpleasant a cold shower can be, even for a few moments.

In a piece of grounded theory research, I reflected [22]:

> evidence-based practice chooses places where it can find evidence and leave[s] out humanity. I identified ‘a self-reinforcing utilitarianism […] that is not only attracted to that which it can evidence but also narrows what it […admits] to that which can be evidenced, possibly in an ever-decreasing circle’. I asked myself whether ‘nurses and other health professionals have a relationship with those they work with [i.e. service users]’ that is useful to the latter (p. 83)?

If indeed, it is ‘all pills and paperwork’, then we may have turned ‘nurses into technicians and service users into data’ [54, p. 39]. In case this sounds depressingly fatalistic, it is not intended to be, but my experience (and perhaps yours too) corroborates Burkhart and Hogan’s [8] findings mentioned earlier. Again, using grounded theory, they concluded that (as previously quoted)

> The patient [sic.] must invite the nurse to provide spiritual care. Nurses can create an atmosphere to increase the likelihood that the patient will offer this invitation by assessing their patients with a spiritual openness of love, hope, and compassionate caring (p. 931).

So, we find here another possible outworking of my previously stated circularity. If neither nurse nor service user has confidence that spiritual openness and mention of spirituality will be welcomed (or fear that it may be pathologised), then the chances are that neither will see it as a topic they feel safe to explore. Senior nurses, however, are well placed to influence organisational policies and staff training in support of promoting spiritual care and spiritually conducive approaches (including recovery). They can expect to find allies in chaplains and occupational therapists (and others).

The late Professor Peter Gilbert, a publicly open service user, would commonly say that the nursing term ‘assessment’ comes from the Latin word *assidere* meaning ‘to sit alongside’. Only when sitting alongside service users will nurses reconnect with the ‘art’ of their discipline and discover that service users are ‘individuals with unique experiences of distress’ rather than ‘textbook cases’ [21, p. 53]. Jenny (Ranjit’s nurse whom I mentioned in my introduction) had fallen into this very ‘textbook cases’ trap. She would have done better to *assidere* with Ranjit and have an easy but interested conversation about his life, his motives and his hopes and fears. Once she had gained his trust, there is every likelihood that Jenny could have learned *from him* about his faith and spirituality. She would then have found herself equipped to explore how they might contribute to his recovery, either directly or indirectly [4].

In nursing terms, it exposes the security we can find underneath a nurses' metaphorical starched apron, funny upside-down watch, and registration badge (or staff badge or whatever marks us out as aligned to our role or profession). It also suggests how, if we but use our imagination, we could reach towards a very different kind of service, one that offers hope to Shooter's [52] 'annihilated souls'. If we, as senior nurses, 'sit alongside' service users (and prioritize at least some of our time in doing so), then we put ourselves in the place where we stand to exercise 'flair' [55]. We also model best practice.

My reflections after 15-years' working in mental health services is that service users may languish for weeks, months or indeed years, in 'emotional deserts' until they finally are set free by a nurse, support worker, OT, cleaner, consultant, chaplain or whatever, who shows flair, who relates to them as an equal and gives them hope.

But this need not be the case; far from it. One person who greatly inspired me was a station ticket collector, a very ordinary man, but one who made space for people. He transformed what many might regard as a tedious task into something quite wonderful. His personal humility, graciousness and simple courage—indeed flair—turned the most everyday repetitive action into something that lit up people's lives. Within each of us lies a spiritual spark, a connectedness with something bigger:

> a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning, and purpose… …The spiritual dimension *tries to be in harmony* with the universe, strives for answers about the infinite. (Adapted from Murray and Zentner [3, p. 259]).

There is probably not a great deal standing between us and reconnecting with our wellsprings and recognising the possibility of lighting up other people's lives. It can be such a delight too! Thankfully, as Mike indicated, there are many agents in the community who can promote recovery (indeed my ticket collector was one such). If we can re-engage such individuals and co-produce community involvement, we are likely to achieve a great deal. To this we now turn.

8 Re-engaging Communities

Faith leaders are sometimes criticised by mental health professionals as meddlers and as ill-equipped and yet, as I have hinted matters, are more complicated than first meets the eye. I recall the difficulty I encountered as a (Christian) faith leader when trying to elicit help for people who clearly required professional intervention. Despite several years' employment in acute mental health, I found myself simply not taken seriously. My experiences were corroborated by Wood et al. who found that

> collaborative working between clergy and mental health professionals has been negative for some of the ministers in this city. Many comments were generated to this effect including "CMHT [community mental health team] is inaccessible" […] "System is under resourced so it cannot be accessed when needed" [56, p. 778].

More positively, they found that "'in other areas care professionals meet regularly and share concerns" […] and advice "do a bit of myth-busting and talk to community group leaders"' [56, p. 778]. But the dismal referral patterns reported suggest the meetings were largely for mutual support. How much this remains the case 10 years on will undoubtedly vary from country to country and between the many models of service delivery. Undoubtedly, the entire landscape has been reconfigured by Covid-19, and I expect we are all awaiting to see how things settle both for those who use MHSs and those who seek to support them.

Well managed, faith communities and indeed other community agencies can complement MHSs, providing supportive local networks and identifying early relapse. If many clergy (not to mention other faith community leaders) wish to work in partnership with MHSs, I suggest that the best possible model would be for faith leaders, MHSs and other community agencies to come together as critical friends [22, 108 ff.]. A shared stepped care model could both support mental health prevention while reducing the number of people needing expensive professionally delivered services [22, 108 ff.].

More immediately, perhaps, the tsunami of human distress resulting from Covid-19 is teaching us that expensive bureaucratic professional-dependent solutions cannot replace the social capital within healthy communities. In my research, I reflected that 'if problem-solving models fail to address loneliness', then the pressure on mental health service beds may be 'a self-induced illness arising from deskilling [sic] the community' [22, p. 91]. When more and more expressions of human distress are being classified as diseases (and by implication requiring exclusively professional expertise), we must choose between an ever-increasing share of our nations' gross domestic product being allocated to medicine and its allied professions or alternatively rekindling resources within our communities.

My personal observation is that the 'broken and demoralised system' [24, p. 4] has within itself the resources to recover, but surprisingly those resources do not lie in the places where we may be most inclined to seek them. I suggest that the resources for mental health service recovery lie within the ordinary, day-to-day humanity of service users, carers and frontline staff [21, 43]. The resources for community well-being lie within the community, not least including churches, gurdwaras, mosques, synagogues and their equivalents.

Biomedical ethics continues to provide an invaluable tool for clinicians and has importantly placed ethics at the heart of many healthcare decisions. However, in mental health at least, it is often insufficient on two grounds. Firstly, it fails to see beyond the clinician's (or clinicians') perspective. As such it risks overlooking courses of action that a service user might have considered and thus paradoxically may undermine their autonomy. Secondly, being focused on the individual clinical encounter, it cannot comprehend possibilities where the clinician might not be centre stage. It does not entertain the possibility of radically different services where service users collaborate with one another and with community agencies with their primary focus being on social inclusion.

Co-production concurs with my experience of those who have helped me most during my struggles. Very occasionally, they have been insightful people who have been able to offer a helpful formulation for my troubles, but if I am truly honest, they have mostly been far more humble people who have simply believed in me, who have wanted me to get through, to succeed in some measure. More commonly, it was someone who made me smile or laugh. One person who greatly inspired me was the aforementioned ticket collector. Was he an effective nurse or chaplain or perhaps the best of both, though actually neither?

I cannot begin to estimate how many people this man must have helped, possibly how many people he prevented from jumping in front of trains. I have come across countless other unqualified 'mental health workers', gracious, humble people who contribute to a community's social capital and lifesavers, many of whom have their own story to tell. They include hairdressers/barbers, shop assistants, post office and bank staff, hotel receptionists, *Big Issue* vendors and ministers of religion.[6] This vast army of unsung heroes not only triage distressed people but also (for the most part) give people hope and enable them to discover resilience. I suggest they are the true 'frontline' workers who mostly see and support people, long before they come anywhere near mental health professionals. Perhaps we only see their 'failures'.

But what are the qualities that cause such people to be so effective? What do they offer? I gained some insight into this in my research on acute psychiatric wards. A striking theme was a grounded theory category I termed 'flair' (which I touched on earlier). I wrote:

> Participants named some staff members as having exceptional ability to support dramatic improvements. Significantly, they ascribed Flair [sic] to personal rather than professional qualities. Flair recognizes unqualified staff—support workers, housekeepers, receptionists—as capable of making outstanding contributions [22, p. 95].

Two key points warrant consideration. First, if we are senior in rank (as we probably are if we are reading this chapter), we may experience discomfort in reading these levelling words. However, unless our security is founded in a zero-sum game, we should not think that affirming cleaners undermines professional staff. Instead, in an effective team, all feel supported and equipped to perform to their best. A football manager, for instance, would be foolish to treat their substitutes with contempt. Neither should we forget, as one of the participants in my research readily acknowledged, that 'doctors and nurses genuinely want to be human' [22, p. 100]. Significantly, it was those who found the energy, imagination and courage to do so who showed the greatest flair.

Indeed, what really seemed to fuel recovery was where someone shared (in an appropriate manner) a personal account that resonated with the service user. I recall a time when I was privileged to do so. I share the story of our encounter not to draw attention to myself but as an illustration of how one can help another. I once listened to a service user telling me he was worthless because he was 'unwanted' and considered himself unloved. He explained that he had been fostered and adopted. He went on to describe himself as a reject and a failure. Listening carefully to him and to myself, I considered it appropriate to share that I, a seemingly 'successful'

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[6] *The Big Issue* is a magazine sold by homeless people in the UK to earn a livelihood.

member of staff, had been fostered. He was discharged a few days later, an altogether more optimistic man.

This account could be considered a simple reframe, yet it emphasises who we understand ourselves to be, how we frame our self-understanding and how we live our lives. If connecting with our own experiences equips us to be effective, to show flair, then it may be as Kara [42] suggests that those of us with 'mutable' identities have privileged insight [22, p. 100]. Our ability to contextualise enables us to see what others cannot or perhaps dare not see.

Please bear with me as I quote (rather than plagiarise) my thesis afresh:

> Fernandez and associates question EBM's gold standard, the randomized controlled trial, suggesting such trials do not 'assess real world outcomes'. (2015, p. 6) Despite EBM's seemingly rigorous adherence to scientific method, it suffers from circularity, seeking to evidence that which it can evidence, potentially limiting medicine's scope and effectiveness. Notwithstanding its notable merits in emergency medicine, EBM remains an approach based on a particular philosophy of science practised in a specific political context [22, p. 47].

The key for the APMHN is to know what combination of Peplau's [53] 'art' or 'science' may be required in any clinical context, perhaps in a manner not entirely unlike getting the right temperature for a shower by blending the output from the two taps. If we too 'genuinely want to be human' [22, p. 100], then spirituality would suggest we need to supply more 'art' and to rediscover the confidence to do so. Again, Forrest et al. [21] express the matter well: 'Nurses are able to possess both human and professional qualities concurrently. However, the key appears to be that if a nurse cannot function at the 'human' end of the continuum there cannot be progress towards professional help' (p. 53). All this suggests that distance may be the opposite of flair. (Obviously, over-involvement or sharing that is about focusing on the self as opposed to helping the service user is another matter again.)

Ultimately, co-researching, co-designing, co-producing and, supremely, co-evaluating services with service users, carers and staff hold the best prospect of quality assurance. In *Spiritual Care: Understanding Service Users, Understanding Ourselves* [57], I argued that our professionalism causes us to dissociate from our true identity. Consequently, our professional identity is a diminished, albeit polished version of ourselves. Reconnecting through our own lived experience and collaborating with others, whatever their mutable identity [42], hold out the possibility of redressing the repression that can cause such harm. These ideas are more fully developed in Raffay et al. [58] where the authors outline their diverse experiences of implementing co-production. Much centres around the discrepancy highlighted in my 'RCT' (see below) contrasting what nurses feel their role requires of them and what those same individuals would wish were they admitted.

My earlier image of achieving the correct shower temperature begs the question of whether we seek to do so from our own viewpoint or rather from that of the service user. We explore this matter further as we consider the broader philosophical issues of our role.

9 Philosophical Reflections

Let me return to Peplau's [53] 'art' and 'science' of nursing in which she argues that both scientific expertise and 'expressive response' can be observed in the effective nurse's practice:

> The unique blend of ideals, values, integrity, and commitment to the wellbeing of others, expressed in a nurse's self-presentation and responses to clients, makes each nurse a one-of-a-kind artist in nursing practice (p. 11).

I simply endorse her perspective and invite you to keep it in mind as I illustrate how easily we are influenced. I conducted an experiment on a nursing team as part of a training exercise. In the manner of many trainers, I randomised the staff into two groups A and B and put them in separate rooms. I asked group A: 'What do you think is important in your job?' I asked group B: 'What would you hope for if admitted [onto a long-stay psychiatric ward]?' Though perhaps unsurprising, the results could hardly have been more different. Group A described outputs, outcomes, metrics and similar. Group B prioritised humanity, friendship, 'someone to understand me' and encouragement to address the issues.

This crude 'RCT' demonstrated the influence of framing (as practised in cognitive behaviour therapy) on a nursing team. Forrest showed how hard it can be to change deep-rooted interests that maintain some in power and position while causing others get knocked back, to experience inequality and injustice.

Though positivist science alleges neutrality, it benefits those able to speak its language, belong to its academies and practise its arts. The philosopher MacIntyre [59] alerts us to beware of assertions around evidence-based practice. He argued that the 'polymorphous character of pleasure and happiness' makes utilitarianism 'a pseudo-concept available for a variety of ideological uses' (p. 64). Expressed more plainly, metrics make complete sense if there is (a) consent that what is being measured is what is important and (b) that measurable things are more important than the unmeasurable.

Anyone who has known the transcendent pleasure of falling in love with another will recall the unfathomable nature of their experience. They may reasonably question whether it is the measurable things that make life most enjoyable. Ultimately, people want different things. It may suit a clinician to frame a service user's experience within a diagnostic category, but Walsh et al.'s [46] work alone forces us to ask who should decide the metrics when staff and service users desire different things.

MacIntyre [59, p. 64] argues that whenever we observe utilitarianism being advanced, 'it is always necessary to ask what actual project or purpose is being concealed' by its use. We need to be alert to the 'nosological colonisation' of human distress [22, p. 17] and understand why it may not be altogether 'pleasant' [23] to be on the receiving end of care that is determined by someone else's metrics. I have previously argued that

> A Copernican revolution in our understanding of spirituality is advocated, namely that our understanding of spiritual care should revolve around the perceptions of service users, carers and frontline staff, instead of predefined definitions sourced from textbooks [32, p. 68].

I now suggest that the entire ‘broken and demoralised system’ [24, p. 12] needs reorienting through co-production *with* service users and carers being granted genuine influence to shape and evaluate not only outcomes but the very nature of the service itself. We do a disservice to co-production if we imagine it to be an anti-intellectual exercise [58]. As I have suggested, it is not a matter of blindly kowtowing to every service user whim. It is instead about service users, carers *and* frontline staff [32, p. 68] bringing their best insights to the table and working collaboratively towards the best possible outcome. In Salvador-Carulla et al.’s [47] terms, we want to be affirming both evidence based on data, knowledge based on expertise, and everything between. There is something deeply spiritual about co-production at its best and yet also deeply purposeful:

> By tapping into patient experience, we are most likely to learn how to provide an effective and efficient health service. […] As soon as we begin to understand matters from the patients’ perspective, we may find that concepts such as spiritual care and recovery cease to bewilder us [60, p. 947].

I remember once hearing Bach’s *Art of Fugue* (a piece of classical music) ‘performed’ by a computer. Everything about it was theoretically perfect; the pitch and the timing were without equal. For the first couple of bars, I was quite taken but within moments walked away from this frankly pathetic and lacklustre pastiche, an insult to both composer and those musicians whose expertise and effort convey something altogether more satisfying. Relating this to service user’s experience, professionalism without humanity will likely be experienced as deficient and as inauthentic and may surprisingly do as much harm as the good that may be intended.

Again, on a personal note, I recall landing on my face and injuring myself to the extent that I needed an ambulance. In casualty, a mental health liaison nurse who recognised me from the psychiatric wards came over and hugged me. She buried her head in my injured side and then fetched me a sandwich. It was a spontaneous, beautiful and loving action. From an infection control perspective, the action was arguably flawed, yet since I was about to get my face covered in surgical alcohol, it hardly really mattered. I have since joked that an acute nurse probably would not have hugged me and certainly not on my injured side. They might even have subsequently billed me for the sandwich! A humorous account but from the patient’s perspective, she showed flair, and the memory of the event gave me courage during the dark months of concussion that followed.

We may actually find ourselves wondering how we ended up so enthralled by our textbooks rather than tending to the often ‘annihilated souls’ [52] of those we are paid to care for. The tragedy of all this is that many service users have deep insight into their experiences and the quality of care provided [6]. As previously mentioned, like Chief Broom, they may be the ones who actually get the full picture and perhaps were the ones whose spiritual impoverishment has led us to become part of Kesey's [61] 'combine'.

A positivist may readily equate spirituality with religion and shut down the conversation (particularly if they have had bad experiences themselves). However, in doing so, they may not only fail service users but also stifle the organisation they serve. Including spirituality within APMHN practice provides an altogether more hopeful approach, albeit one that may sometimes prove challenging to those preferring certainty.

10 Conclusion

If spirituality is a rallying post to a different kind of service, then it suggests that utilitarian metrics alone may be incapable of providing the kind of services people require to get better. It suggests that we may need to reorient our practice towards the 'art' of nursing and away from the conditions that risk creating 'emotional deserts', places unfit for either service users or staff.

I have proposed that insights from clustering and triage could guide our thinking towards more healthy relationships between MHSs and community agencies within the voluntary and faith sectors. It makes sense for MHSs to attend to those with the most serious conditions (and greatest distress) without simultaneously degrading the social capital and support infrastructures within communities.

Using expertise to enhance lay provision may not only be cost-effective but also enables people to receive 'pleasant' support and reintegrate in their community. Additionally, people exercising leadership within their communities usually have better knowledge of local need and will be well placed to support health promotion.

Such a framing of spirituality should not be understood as anti-psychiatry, let alone as opposed to evidence-based practice per se. It might be conceived of as a critical friend, which sees psychiatrists, APMHNs and psychiatric medicine as part of broader understanding of human distress. While its primary focus is on service user's welfare, it is also genuinely concerned to address the moral injury that staff may suffer when disempowered by un'pleasant' systems that prevent them from doing 'diddly-squat because some rule has said they can't' [45, p. 80].

If would-be service users (and I include myself here) choose other sources of help, then we need to acknowledge the, at least, theoretical possibility that staff disregard entire domains (and not just spirituality) that are deal-breakers for anyone with lived experience of mental health difficulties [8, 9, 62, 63]. This might explain Wood et al.'s [56] findings that people with mental health problems often approach faith leaders as their first port of call. Indeed, were mental health service providers to unequivocally provide a more 'pleasant' service with better outcomes, we might expect no one to bother with faith leaders and purveyors of alternative remedies [23]. Yet, clearly these others thrive, leaving MHSs some hard questions to address if they have the courage to do so. Alternative practitioners and faith leaders stand in contrast with a positivist framing of service users as individuals who can be considered in isolation from their context.

To conclude, may I leave you to ponder the questions below:

1. If spirituality in mental health can be understood at least in part as an experiential response to a service user's encounter with the totalising impact of a reductionist institution, then if we dismiss their spirituality, we effectively close down communication [8] and risk destroying any future therapeutic alliance.
2. Flair invites us to review our lives and consider how what has given us resilience may be a resource for those who are struggling. We should, provided it is in the service user's interests, consider being more ready to share accounts of our successes and struggles.
3. Halliburton's [23] account of 'pleasant' surroundings should make us reconsider whether our services might be encountered as un'pleasant' or whether EBM has turned our ward(s) into an 'emotional desert' [22, p. 185]. We need to beware that the less we understand spiritual or religious beliefs, the greater the likelihood that we may cast and reframe them as delusional. We should not be quick to interpret requests to see a priest or pastor as a symptom of illness rather than as an opportunity for discussion and engagement with the person and members of their wider community.
4. We need to be honest about how our own insecurities and prejudices can hinder or sabotage therapeutic encounters. The less someone is like us, the more we stand to learn from their perspective and world view, also the more we are likely to experience them as threat.

Potential Research Questions (RQs)

The following RQs are deliberatively provocative but are also offered as being of genuine worth and as practicable projects:

- How might MHSs be co-produced towards (a) facilitating service user's social inclusion and (b) enabling service users to achieve valid life goals within wider society: a staff/service-user/carer focus group-based study?
- How might a more experiential understanding of mental health mitigate the tendency of reductionism to turn psychiatric wards into 'emotional deserts'?
- How would mental health research expenditure be shaped if a significance proportion of it were determined primarily by service users?

Reflective Questions

These questions will serve you better if you pick one or perhaps two and reflect in depth. The questions are deliberately searching and may make you feel uncomfortable. They are intended as a professional ‘workout’, so the harder you work at them, the greater the likely gain. However, please consider coming back to them some other time if you are feeling fragile.

- Spend 5 min or more reflecting on my account of how I was easily able to influence nurses’ behaviour on the study day. Consider how you understand Peplau’s [53] art and science or Forrest et al.’s [21] professional-human continuum. Whichever phrasing you prefer, using the shower temperature, metaphor if helpful, consider how you might choose to change your practice.
- If you have never been admitted (or if you have), reflect on how you might experience the wards you work on as a service user. Ask yourself, without judgement, what it would be like to receive care from yourself or from some of the nurses within your team. How could you contribute to improvement?
- Ask yourself who has helped you during the darkest, most difficult times in your life. Think of the people involved and ask yourself what made a difference. Was it something the people did, something about their character, or was it the quality of their listening and attentiveness?

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Diversity and Culturally Responsive Mental Health Practice

Rebecca Murphy and Agnes Higgins

Learning Objectives
The objectives of this chapter are to enable you to:

- Appreciate how dominant mainstream narratives of heteronormativity, cisnormativity and ethnocentric models of mental distress and illness frame perceptions and actions.
- Interrogate one's own biases and respond to the needs of the person from a position of cultural humility, gender sensitivity and inclusive care.
- Engage with the constructs of cultural humility, minority stress, intersectionality and affirmative practice as lenses to explore diversity of experience.
- Promote and develop a culture of inclusion and affirmative action within own practice and the wider mental health system.

1 Introduction

The Constitution of the World Health Organization [1, p. 1] states that the 'enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. This basic right to health is further nuanced by well-established international recognition [2] that 'there is no health without mental health' [3, p. 1]

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and endorsed by the United Nations Human Rights Council Resolution that explicitly states the right of everyone to the enjoyment of the highest attainable standard of physical *and* mental health [3]. Despite this aspiration, mental health and access to quality mental health care are not equally distributed across society. Significant disproportionate differences are found across groups/populations in the rates of mental health problems, the access to mental health services and the experience of care within services. These disparities are the result of societal inequalities, the minoritised and/or stigmatised status experienced by some groups and the design of mental health service provision, which emulates dominant mainstream narratives, such as heteronormativity, cisnormativity and ethnocentrism (see definitions in Table 1). The 2019 report of the UN Special Rapporteur explicitly states that: 'Respecting the broad diversity of how human beings process and experience life, including their mental distress, is critical to ending discrimination and facilitating equity in mental health provision' [3, p. 15]. The UN Special Rapporteur specifically argues that models of mental health care, which solely operate from a

Table 1 Glossary of terms

Ethnocentric refers to an implicit assumption made by a person, a system or a state that their way of being and knowing is the correct, standard and/or superior way. All other ways of being and knowing are compared against these ethnocentric standards and considered as 'other' or 'inferior to'.
Heteronormative, or the 'heterosexual norm', refers to the world view that heterosexuality is the typical and 'normal' or preferred sexual orientation. This assumption often results in '**heterosexism**', a system of attitudes, exclusion or discrimination towards other sexual orientations and gender identities, including LGBT.
Cisnormative or cisnormativity refers to the assumption that the person gender identity aligns with their assigned physical sex at birth. It is related to the terms cisgender, which describes a person who experiences their gender in a way that correspond to the biological sex they were assigned at birth.
Ableist or ableism is the term used to describe discrimination, prejudice and oppression towards people with disability (physical, intellectual, mental health) and/or people who are perceived to be disabled. Is it rooted in the assumption that people with a disability are inferior to the non-disabled people and need to be 'fixed' or 'mended'.
Normalising refers to social processes through which ideas and actions come to be constructed and seen as normal, natural and taken for granted in everyday life.
White gaze occurs when white people implicitly or explicitly view and appraise the experiences, knowledge and creations of black people through the lens of ethnocentrism.
Privileged positionality refers to a person's identity and the extent to which their ascribed characteristics (e.g. race/ethnicity, cultural background, skin colour, sexual orientation, ability, gender) align with societal norms and as a result can facilitate enhanced access to educational, physical, psychosocial and financial security.
Epistemology is the study of the nature, limits and validity of human knowledge, or what is sometimes referred to as the theory of knowledge production. The word itself comes from the Greek words 'episteme' meaning knowledge and 'logos', which can be translated as reason.
Ahistorical is a term used to describe something, which is lacking historical perspective or context.
Global north/global south are sometimes described as crude terms utilised to denote the grouping of countries along differing and uneven patterns of wealth, privilege, development and geopolitical power.

biomedical perspective and/or 'one-size-fits-all' approach, are in direct conflict with the right to health. Consequently, the UN Special Rapporteur recommends the establishment of a diverse package of empowering, rights-based mental health care supports, which are culturally responsive and sensitive to gender and life cycle requirements. In alignment with such international human rights guidance, alongside the increase in internal and external migration, social and legislative changes in relation to gender and sexual diversity and progressive social movements in support of anti-racist, human rights and recovery-focused care [4], mental health services and practitioners are recognising the need to design and develop services that are more inclusive of and responsive to all voices and perspectives.

Core to providing equitable, person-centred, culturally responsive and recovery-oriented care is an appreciation of the diverse spectrum that each person who uses the mental health service experiences in accordance with their ethnicity, religion, gender, age, sexual orientation, socioeconomic status, language, education, physical and intellectual ability and geographic background. Regardless of a practitioner's aspirations, a lack of understanding in relation to this diversity can impact the therapeutic relationship, create a sense of 'other', perpetuate stereotypes and ultimately lead to decreased quality of care and poor mental health outcomes. Advanced Practice Mental Health Nurses (APMHNs) and members of the multidisciplinary team have a distinct world view that influences and biases their understanding of diversity and mental distress, which in turn implicates their mental health practice. APMHNs who recognise how these unconscious biases and explanatory models of mental distress influence their perceptions and actions are less likely to demonstrate negative, stereotyping attitudes, ethnocentrism, heterosexism and racism. Further, APMHNs work within an organisational culture wherein the systems of knowledge production and mobilisation are often biomedical in orientation and strongly informed by a decontextualised and global north understanding of mental health and distress. In their leadership role, APMHNs are in an optimal position to inform and champion the systemic changes needed to safeguard the provision of culturally responsive care at each point along the organisational pathway of care.

This chapter endeavours to move beyond homogenous, essentialist assumptions about people who experience mental health problems and 'one-size-fits-all' approaches to their care that are based on master identities, such as 'age', 'gender', 'ethnicity' or 'diagnosis'. Instead, this chapter strives to promote culturally responsive mental health practice and systems that embrace intersectional and pluralistic understandings of, and approaches to, mental health and distress. Our use of the term 'culturally responsive mental health practice' includes an expansive conceptualisation of cultural identity. Traditionally, the construct of 'culture' is equated with ethnicity with limited acknowledgement of its iterative evolution and interdependent relationship with other intersections of cultural identity (e.g. gender, socioeconomic status and sexual orientation). A narrowed lens on ethnicity limits space for consideration of intersectionality, the potential cumulative disparities in mental health and mental health care experienced and the specific needs that may exist with regard to other aspects of a person's cultural identity. As a result, opportunities to discuss and allow an individual to define their own salient identities are stifled. In

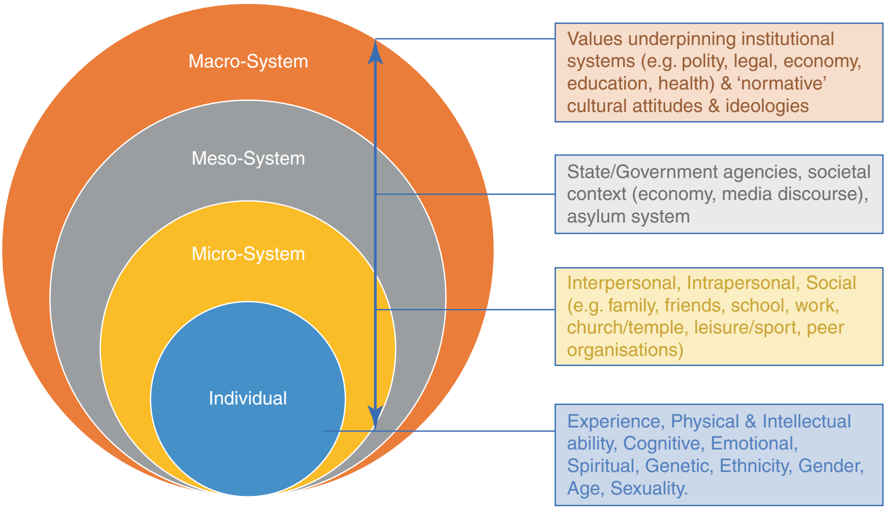

Fig. 1 Socio-ecological forces that influence cultural identity

this chapter, a socioecological conceptualisation of cultural identity underpins the arguments expressed, wherein the individual's cultural identity is understood to be dynamic, relational and deeply contextualised within, and by, socio-ecological forces. In Figure 1, we use Bronfenbrenner's [5] ideas of micro, meso and macro systems (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing") to map some of these forces.

In many academic and clinical spheres, the default practice, when discussing culturally inclusive practice, is to weight much of the content and discourse on learning about and discussing the beliefs, behaviours and experiences of minoritised and culturally diverse populations. Notwithstanding the efficacious limitations of this approach, which are discussed in more detail later in the chapter, we, the authors, are identified as White, cis-gender and heterosexual; therefore, to represent the lives of the minoritised through the lens of our privileged positionality would be inappropriate, voyeuristic and further propagate the White Gaze. An alternative approach is utilised in this chapter in which we turn the magnifying glass towards ourselves to learn and critically reflect about our cultural identity, the systems we work in and how we contribute to and cyclically reinforce the structurally embedded trauma experienced by minoritised populations.

2 Achieving Culturally Inclusive Practice Through Cultural Humility

In efforts to enhance the mental health workforce's understanding of diverse explanatory models of mental distress and improve the mental health care experiences of minoritised populations, the concept and practice of cultural competency has proven popular in both academic and clinical spheres. However, in recent years, the efficacy of cultural competency has drawn doubts and its underpinning approach attracted increasing criticism [6, 7]. From the shadows of cultural competency's identified deficits, the alternative concept and approach of cultural humility has gained increasing traction. While cultural competency and cultural humility share a common goal of addressing the inequitable care experiences of minoritised populations, they differ significantly in approach. Cultural competence emerged as a framework for addressing diversity and inequality in health care and as a counterbalance to the movement for evidence-based mental health care, which tends to lead to a 'one-size-fits-all' approach [8, p. 160]. The loci of focus in most models of cultural competency centre on the practitioner acquiring knowledge of 'the others' cultural values, practices and behaviours with the core goal being to become 'competent' in understanding another's identity. While it is essential that APMHNs have competence in areas such as therapeutic engagement and ethical reasoning, the idea of cultural competence, in particular the word competence, not only runs the risk of foregrounding the practitioner as the 'expert' and thus reinforcing power differences, but it assumes that there is a fixed technical body of knowledge that can be acquired about each group or community, which, once acquired, can be applied in a technocratic manner in practice [9]. This view not only decontextualises the formation and evolution of a person's cultural identity from the dynamic and interrelated socio-ecological forces, which inform it, but it is also misaligned with the principles of coproduction (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"), a core principle underpinning recovery-oriented approaches to mental health care. Further, the predominantly individualised orientation of many cultural competency activities, such as individual practitioner's knowledge acquisition, can equate to an absence of attention and action on the socio-structural barriers minoritised communities experience to accessing and receiving equitable mental health care. Without commensurate focus on activities, which help mitigate socio-structural forces, such as entrenched interdisciplinary power dynamics and organisational cultures, many models of cultural competency often fail to achieve the transformative agenda required to address systemic mental health inequities [10]. Critics also argue that models of cultural competency, which predominantly focus on 'knowing the other', negate the need to self-reflect on our own cultural identity and positionality, the conscious and unconscious bias and assumptions, which are informed by it and which can perpetuate power differentials within the provider–client relationship [11]. Our cultural identity shapes the type and form of care we provide, including our appraisals of the person-seeking support, our interactions with them and the therapeutic approaches we offer to them. Failure to account for how the cumulative, interrelated factors, which comprise privileged cultural identities and positionalities (i.e. White, cis, hetero, ableist, ethnocentric), can translate into the clinical encounter risks reinforcing the discriminatory and exclusionary practices embedded in wider society and other social institutions.

For these reasons, in this chapter, we speak of cultural humility. Cultural humility (1) acknowledges the dynamic, subjective nature of culture; (2) focuses on lifelong learning of self in relation to others and (3) challenges individuals and organisation to address systemic inequalities [10]. Cultural humility urges us to recognise the limits of our cultural knowledge and to collaborate ethically and respectfully with people who use services to develop an effective working alliance [12] as well as creating service and spaces that are safe for people to express their identities. In other words, cultural humility shifts our focus from what we know, to a lifelong journey of acknowledging the unknowns [13] and learning with, through collaborative dialogue. In moving from learning about to learning with, emphasis is placed on respecting and engaging with the other person's life world, to develop an understanding of, and celebrate similarities and differences within, between and among diverse groups. Cultural humility also encourages each one of us to engage in a lifelong process of inward self-reflection *and* action on how our individual and organisational culture can contribute to power differentials within the therapeutic relationship and perpetuate wider societal patterns of racism, ethnocentrism, ableism, classism, homophobia and transphobia. In so doing, cultural humility explicitly asks us to understand a client's experience, capacities and opportunities through a wide lens, a lens that captures the dynamic nature of a person's cultural identity and the interrelated socio-structural forces, which shape that identity. Cultural humility also requests that we engage meaningfully with the structurally embedded trauma informing the inequitable experiences of minoritised populations.

2.1 Operationalising Cultural Humility in Mental Health Systems

Operationalising cultural humility, according to Fisher-Borne et al. [10, p. 174], is comprised of three core elements: lifelong learning and critical reflection, institutional and individual accountability and mitigating power imbalances. Conceptualised as interrelated gears, individual and organisational accountability is driven by iterative cycles of critical self-reflection on privileged positionalities and systemic power imbalances. The following sections of the chapter will engage with these core tenets of Fisher-Borne's model and apply them specifically to the role of the APMHN and their organisational working environment of mental health systems. Firstly, to help instigate and guide APMHNs' academic engagement with cultural humility in mental health systems, critical reflection is provided on some of the core epistemological and institutionalised social norms, which underpin and perpetuate power imbalances in mental health practice and systems. This is then followed by a consideration of the pragmatic strategies that an APMHN may utilise to operationalise accountability and embed cultural humility into their own therapeutic practice, the practice of others and the systemic organisational culture.

2.2 Lifelong Learning and Critical Reflection

To aid academic engagement with the first core tenet of Fisher-Borne's model (lifelong learning and critical reflection), critical reflection on some of the dominant epistemological and ontological beliefs underpinning mental health practice and systems and the consequential power imbalances, which are perpetuated as a result, are discussed in this section. There are many '-isms' underpinning the dominant epistemology and ontology within mental health practice and systems, including ageism, racism, ethnocentrism, ableism, classism, cisgenderism and heterosexism, which require deep critical reflection and dismantling. While we recognise this depth and breadth of privileged, structurally favouring, cultural identity, the included critical reflections in this section will focus on the '-Isms', which primarily align with our own cultural identities and which we have academic expertise in, including ethnocentrism, cisgenderism and heterosexism. We discuss how these not only impact how we understand mental health and distress but also shape our interactions with people who use the services and perpetuate power imbalances.

2.2.1 Ethnocentrism

Ethnocentrism operates at a mostly implicit level, predisposing individuals, communities and state structures to consider their distinct world view or ways of being and knowing, as the natural, perhaps superior, and certainly the universal status quo. Viewed through this ethnocentric lens, one's world view is considered the universal point of departure with all other ways of being and knowing interpreted as 'divergent from' or 'other' [14]. Ethnocentrism can permeate all societal processes and structures, including the systems of knowledge production and knowledge mobilisation informing, and operationalising within, the mental health system.

Historically emerging from the European Enlightenment, the epistemological world view informing the practice of many 'Psy' disciplines (e.g. clinical psychology, psychiatry and psychiatric nursing) is underpinned by positivist and reductionist approaches to knowledge production. Positivism postulates an unwavering conviction that objective meaningful reality is value neutral, ahistorical and cross-cultural, therefore presenting an unambiguous, accurate and certain knowledge of the world. Today, the Psy sciences continue to be informed by this same positivist framework. As such, psychiatry postulates that 'mental illness' is an objective entity, which is at once ahistorical, value free and cross-cultural [15]. A cultural critique of the 'Psy' sciences argues that this modus operandi of psychiatry undermines and devalues the influence of sociocultural contexts on mental distress [16]. It argues against the universality of 'mental illness' espoused by psychiatry and highlights how the foundation and operation of psychiatry is a cultural product in and of itself. Psychiatry's positivist orientation, its perception and definition of normal/abnormal behaviour, and thus 'mental illness' and symptoms, are founded in Western culture and continue to be developed and reinforced within the Western culture. For example, Kirmayer [8, p. 251] argues that the majority of basic and clinical mental health research is 'heavily weighted toward studies of Western, middle class, educated young people and drastically under-represents the ethnocultural groups who are the majority of potential clients in most places'. Consequently, the generalisability and cross-cultural validity of findings from ethnocentric research are limited, and our ability to appraise the universal effectiveness of treatment approaches severely challenged.

The Psy sciences' ethnocentric bias in knowledge production extends into knowledge mobilisation and application within mental health systems. Fernando

[17] explains that Western, ethnocentric bias is built into the clinical assessment/evaluation, diagnostic process and therapeutic approaches. As Hernandez et al. [18, p. 1047] suggest 'culture influences what gets defined as a problem, how the problem is understood, and which solutions to the problem are acceptable'. To apply 'eurocentric notions of dysfunction and healing' [15, p. 726] universally across cultures, where the coherence of such definitions and categories of illness arguably do not hold true, is to conduct what Kleinman calls a category fallacy [16]. He states, 'the reification [concretism] of one cultures' diagnostic categories and their projection onto patients in another culture, where those categories lack coherence and their validity has not been established is a category fallacy' [16, p. 15]. Other writers argue that to universally apply and practise white, ethnocentric notions of normality and abnormality across cultures is demonstrable of psychiatry's entrenched institutional racism [17]. There have been concerted efforts to attend to the Psy' science's Eurocentric systems of disease classification, epistemology and clinical practice, including a welcome redefining of 'culture' within the most recent revision to the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5), and the continued development of the Cultural Formulation Interview [19]. However, critics argue that limited and/or asymmetric application of such advancements indicates that the vast majority of 'Psy' knowledge and practice continues to be a culturally constrained, ethnocentric activity, which 'emphasizes neurobiology and decontextualizes distress' [20, p. 347].

It is important to understand that psychiatry's positivist, biomedical orientation is not the true, correct, and universal understanding of and response to mental distress. Despite its global scope and application, it is but just one form of knowledge about mental distress, the evidential basis of which is contested by many [21]. A significant body of research highlights that knowledge about the constructs, causations, manifestations of and treatment responses to mental distress can change between and within cultures [17, 22]. Alternate knowledge about mental distress includes diverse forms of indigenous medicine and traditional healing, in addition to the models of environmental and psychosocial supports that explicitly attend to the diverse socio-ecological causations of mental distress. Mental health systems and practitioners who fail to accommodate alternate knowledge about mental distress detrimentally affect a myriad of clinically relevant variables such as help-seeking behaviour, accessibility of care pathways, treatment engagement, the therapeutic relationship and treatment satisfaction and outcomes [23].

2.2.2 Heteronormativity and Cisnormativity

The term heteronormativity coined by Warner [24] has multiple uses and definitions (see [25]), depending on theoretical lens and context. Here, we use the term heterosexist-heteronormativity to describe the dominance or institutionalisation of heterosexuality (attraction to the opposite sex or relationships between heterosexual cis men and heterosexual cis women) as the desired social norm. In other words, heterosexuality is always assumed, expected and implicitly privileged and normalised [26] within societal structures, institutions and discourses. Embedded within heterosexist-heteronormativity is the dominant narrative of cisnormativity. Derived from the Latin word cis, which means ‘on the same side’, cisnormativity assumes that people’s gender identity aligns with their assigned physical sex at birth in socially accepted ways [27]. In other words, there is an assumption that a person’s body, birth assigned sex, legal sex, gender identity, gender pronouns and gender expressions are aligned along a binary construct of ‘man’ or ‘woman’ across the life cycle.

In structuring systems, including the health care and legal system around this taken for granted belief, a hierarchy is created—a hierarchy that calls into question any sexual behaviour that falls outside the heterosexual social order and one that views and frames other sexual identities such as lesbian, gay, bisexual or queer (LGBQ) identities as abnormal, deviant and ‘stigmatised other’. Similarly, the cisgender narrative marginalises, silences and calls into question, people whose gender identity or gender expression does not conform to this societal expectation, including people who are identified as transgender male and transgender female or those who are identified as neither men nor women (e.g. agender or non-binary) or move between binary genders (e.g. gender-fluid) [27].

Not surprisingly, people who were deemed as holding a non-heterosexual orientation and/or nonconforming gender identity have a long and troubled history of their identities being pathologised by the mental health system and psychiatry. Although homosexuality has been declassified as a mental disorder by the American Psychiatric Association since 1973 and the World Health Organisation since 1992, the continued presence of gender dysphoria in DSM-5 and the common requirement that transgender individuals be diagnosed as such in order to access support for transition care continue this tension. In addition, evidence suggest that mental health practitioners through routine practices continue to perpetuate the marginalisation of LGBTQ people. LeFrancois [28] among others [29] reveals how heterosexist-infused power relations are exercised within the mental health system to reify heteronormativity. Common examples include mission statement, policies, images and signage that frame identities within the heterosexual lens, or do not make sexual or gender diversity explicit, documentation or spaces such as bathrooms that only accounts for gender in the binary, practices that assume that one’s partner is always of the opposite sex, the disregarding of some identities, such as bisexuality and gender-fluid as not valid identities, the use of incorrect pronouns in conversation and documentation and the use of transgender people’s birth names as opposed to their preferred name.

Other ways heteronormativity and cisnormativity are reified is in our attempt to treat everyone the same, by being ‘blind’ to issues of gender and sexual identity. Despite evidence of the differing needs and challenges encountered by sexual and gender minority groups, services or interventions designed specifically to meet the needs of sexual minority groups are limited. The assumption of a ‘one-size-fits-all’ not only ignores the impact of gender and sexual identity on people journeys into and through the mental health services but also recreates and maintains societal inequalities within the mental health system. Equally, when we strive to avoid prejudice by not assuming a person might identify as an LGBTQ person, we are, in effect, assuming that the person is heterosexual and distinctly a man or woman. As

Baker and Beagan [30, p. 594] point out 'there is no view from nowhere' and any attempt at maintain a 'neutral and non-judgemental' stance 'not only veils the heteronormativity and gender normativity embedded within the health care system… and clinical environment but also obscures the presence of LGBTQ people' (p. 592). In addition, these heteronormative and cisgender assumptions not only increase invisibility but also exacerbate feelings of stigma and lack of trust and confidence in the practitioner and mental health system. They also can negatively impact people's feelings of safety to be 'out' and express their true self, as well as their willingness to disclose health-relevant information, thus increasing the likelihood of early disengagement from care and services.

2.3 Accountability: Creating Culturally Sensitive, Safe and Affirmative Relationships and Spaces

The preceding critical reflection on some of the dominant epistemological beliefs underpinning mental health practice and systems, and the consequential power imbalances, which are perpetuated as a result, is the first step to achieving cultural humility within individual practice and systemic organisational culture. However, an equally proportionate core tenet of cultural humility is accountability. Cultural humility explicitly advocates the need to move from passive critical reflection and knowledge acquisition towards an assertive accountability, which calls both individuals and organisations to act. Achieving authentic culturally humility, the ultimate goal of mental health equity, requires strategies and activities, which are designed to catalyse the necessary transformative systemic change. In the following section, the individual and organisational level activities that an APMHN may utilise to operationalise and embed cultural humility into their own therapeutic practice, the practice of their peers and the systemic organisational culture are outlined.

2.3.1 Actioning Individual Accountability

As stated in the introduction, the starting point for actioning individual accountability is with the 'self' and looking within the self to interrogate one's own stereotypes/attitudes and beliefs. Confronting our own social location is core to understanding how uncontested normative practices not only create blind spots in our vision but also shape and subjugate the lives of those whose identities are constructed as 'other'. This self-reflexivity is necessary to develop an understanding of how each of us unconsciously or consciously imposes our own values on the person as well having expectations that people should adapt to or adopt the norms and values of the dominant discourse. Hence, self-reflexivity and humility open the door to a deep questioning of how one's own identity (sexual identity, race, ethnic, religion, class) is linked to and perpetuate power and privilege. In other words, it requires us to notice difference and delve into what those differences might mean in terms of perspectives and unconscious bias. Shifting from a sense of individual mastery and the all-knowing expert, to individual accountability or what Mosher et al. [31] call an 'other-oriented' mindset, involves asking challenging questions. For example, asking questions such as: how does my cultural and educational background impact how I frame issues such as mental distress, expectations of person-seeking help, conception of family/family roles etc.?; how is my race/ethnicity/gender/sexual orientation/religion linked to power; how might the multiple identities I hold impact the therapeutic alliance; what do I think of people who are culturally different to me; how willing am I to seize meaningful opportunities to discuss their cultural identities with them in order to co-create a plan of care that is reflective of their views. Individual accountability also requires us to question the extent to which the evidence base that underpins our assessment practices and proposed interventions is cross-culturally valid.

A culturally humble approach to practice is not an independent practice approach, but an approach that is designed to enhance the APMHNs' existing integrative therapeutic approach to recovery-oriented care (see Case Study at end of chapter). From a position of respectful curiosity and authentic dialogue, the APMHN deliberately communicates to the person both implicitly and explicitly with a genuine desire to understand the person's cultural background and experiences so that they can gain a nuanced understanding of the person's beliefs and practices, in order to reduce the risk of reproducing and normalising taken for granted narratives within mental health practice. For example, the APMHN might enquire about the persons cultural (race, ethnicity, gender, sexual orientation) background and explore issues such as how they understand the problem, how their cultural position in the world might be linked to the presenting issue and how their cultural position might influence their desired goals or desired solutions/interventions. Part of this process also includes exploring family structures, the meaning of family and how their family might explain the problem in order to understand what role their family/friends/community might play in their recovery journey. Thus, a culturally humble orientation is a commitment to knowing and accepting the person as a cultural being, engaging in cultural dialogue with a view to collaboratively co-producing a recovery plan based on the person's needs, desires and cultural understandings, as opposed to an expectation that the person conforms to the practitioner's lens of understanding and the ethnocentric, heteronormative epistemology that frequently underpins practice.

Cultural humility also requires attention to the use of language as it is not a neutral vehicle for the expression of thoughts and emotions. Words, labels and categories carry different meaning and hold positive or negative connotations depending on culture, time and context. They may exclude or include and respect or disrespect difference, thus understanding why one person may choose to identify using a preferred term while another may find categories restrictive, and stigmatising is also central to the provision of person-centred care. For example, in the area of disabilities and mental health, some people may prefer person-first language (person with a disability or person with, or experiencing psychosis) in an effort to reduce stigma and stereotyping, whereas another person may describe themselves using language of 'disabled person or bipolar person', as an activist position of taking pride and value in their disability or as a result of internalising the psychiatric label imposed by more powerful others. Similarly, with greater awareness around the restricted nature of binary gender identities, people may use and prefer third-person plural pronouns such as ‘they’, ‘them’ and ‘their’, as a way of conceptualising gender experiences. Older people may consider the term ‘queer’ as a derogatory and insulting term for people with same-sex desires or relationships. And activists and younger people who reject traditional binary gender identities of male and female and seek a broader and deliberately ambiguous alternative to the perceived restrictions imposed by lesbian, gay and bisexual sexual orientations may describe themselves as queer. In terms of ethnicity, facilitating self-labelling of ethnic identity is recommended as preferences can differ significantly, in accordance with age, geography, sociocultural history, political or social implications and/or degree of acculturation [32]. Alexis et al. [33, p. 1336], in their paper on language, caution us to enable the person to self-define and choose their own words, as the changing nature of language and cultural contexts means that frequently terms used by ‘the majority’ are not reflective of the language used within communities.

A culturally humble practitioner also recognises that despite best efforts to create a culturally safe and affirmative environment, cultural mistakes or ‘microaggressions’ do happen. Microaggressions are brief and subtle slights or derogatory acts that may or may not be intentional but communicate hostile and negative viewpoints towards minority individuals [34] and may fracture the relationship (for more in-depth examples, see [35–37]). Thus, cultural humility also requires a willingness to own one’s mistakes and biases, apologise for hurt caused as well as invite corrective feedback from the person. In addition, a culturally humble practitioner is sensitive to how experiences of minority status are related to oppression and is open and willing to reflect on this in a meaningful way. Two theoretical lenses of understanding that may assist APMHN are minority stress and intersectionality theory. The next section of this chapter briefly explores these two constructs.

2.3.2 Minority Stress

One of the most used theoretical frameworks that explain the disparities in mental health experienced by cultural minority groups is the minority stress theory [38, 39]. Although the theory was originally developed to explain social stress and mental health among sexual and gender minorities, the theory has been applied to populations, such racial/ethnic minorities, and immigrants. Essentially, minority stress refers to specific stress that is experienced as a result of one’s identification with a group that is stigmatised and is the target of discrimination and prejudice [38]. Underlying this theory is the premise that in addition to the array of everyday life stressors and traumas (bereavement, physical illness, employment loss/insecurity relationship breakdown, becoming a parent), individuals from minority or stigmatised groups face many unique stressors not experienced by the wider populations. These stressors, which result from cultural/institutional structures and social processes, including health care systems and processes can result in minority groups living in a perpetual state of stress and adaptation, which in turn increase vulnerability to psychological distress causing adverse health outcomes.

Mayer classifies these into two interconnected groups: (1) external/distal stressors in the environment and (2) inner/proximal stressors (Fig. 2). Distal stressor or external stressors are discriminations perpetrated by another person toward the individual.

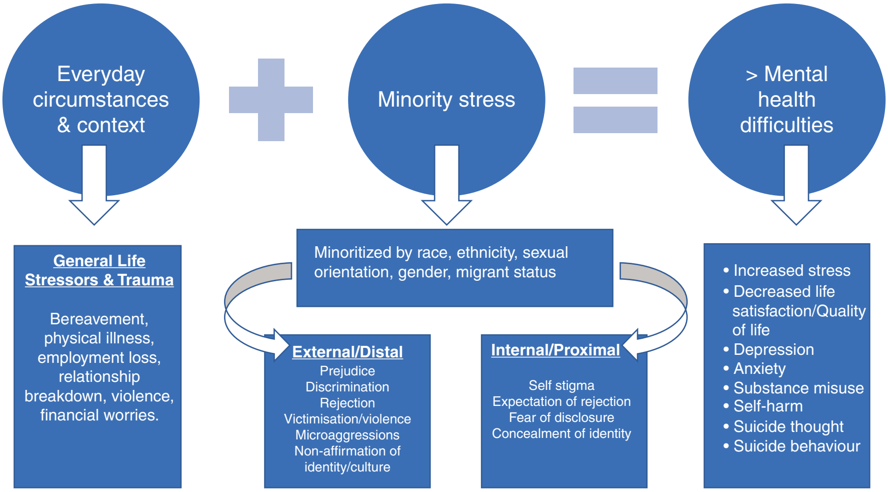

Fig. 2 Role of minority stress in onset of mental health difficulties

They include prejudice events, such as direct acts of discrimination and harassment within school, work or wider society, which can range from verbal harassment or physical assault/violence to microaggressions or what Nadal et al. [40, p. 234] describe as ‘death by a thousand cuts’. This group of stressors also include the stress arising for non-affirmation of identity, be it race, gender, sexual orientation or religion, by others, including social institutions and health care systems.

Proximal stressors are a more subjective form of stigma in that the processes occur within the individual. First, the internalisation of negative societal attitudes and beliefs, depending on cultural group, can be internalised homonegativity/heterosexism/disablism or racism. This *internalised-related oppression*, which can become accepted and internalised without conscious awareness, can lead to anticipated or expectations of rejection, also called anticipatory discrimination. People from minority or stigmatised groups are continually faced with the dilemma of discerning what others are thinking about them, which requires considerable mental energy and an ongoing vigilance of personal safety, as well as appraisal of the positive and negative consequences of revealing oneself. The *continual expectations of rejection* and the constant monitoring and censoring of one’s thoughts and actions in social situations, including interactions with health care practitioners, not only deplete cognitive resources but also interfere with relationships, as it inhibits expression of the ‘true self’. In addition, it can result in inner conflict and feelings of uncertainty, unhappiness, social alienation, loss of self-esteem anxiety, depression and self-harm. The *invisibility or ‘erasure’ of some identities* in mainstream culture and within health care culture can also damage people’s self-esteem and make it hard for people to feel a sense of belonging to a society or developed a therapeutic relationship with a practitioner that seems not to recognise they exist.

Minority stress theory not only provides a useful framework for APMHNs to reflect with the person on their experiences but also provides a framework for the

APMHN to consider how their assumptions, beliefs and actions may be adding to the distress experienced by the person. In addition, it reinforces the need not only to understand the world of the person but also to underpin practice by trauma-informed principles (see "Trauma and Trauma-Informed Care"), which are core to cultural safety.

2.3.3 Intersectionality Theory

The term intersectionality, first coined by Kimberlé Crenshaw [41], refers to the interaction and interplay between multiple identities. People are not contained discretely in unitary categories of identity, but hold many co-occurring identities that intersect to influence their experiences. In other words, intersectionality theory asks us to move away from homogenising approaches, disentangle the diversity of people's experiences and consider the interrelationships between the multiplicity of people's identities and statuses [42]. Intersectional theory reminds us that people may face multiple aspects of discrimination based on their colour (racism), gender (genderism), sexual orientation (homonegativity) and age (ageism). For example, if you are a member of an ethnic minority group, you must negotiate racism, and if you are an older person, you may have to negotiate ageism, and if a woman, you negotiate the sexism that all women face. Therefore, intersectionality theory demands that we ask questions such as: How does being a low-income, immigrant, lesbian woman combine to produce disadvantage? How might the stigma and exclusion be more pronounced for people who identify as coming from a sexual minority group as well as from an ethnic or religious context that do not affirm same-sex attractions, relations or behaviour? How might the challenges in seeking mental health care be greater for a young Black male who is identified as gay and living within the asylum system. In other words, this perspective challenges us to move away treating each identity as independent and examine how multiple social identities or positions simultaneously intersect with structural societal factors to produce inequities [43, 44].

Although all members of minority community are at a greater risk of experiencing discrimination and hate crime compared to majority communities, certain groups have been found to be at particular risk, including those from Black and ethnic minority group and young LGBT people who overtly violate traditional masculinity and femininity expectations. Minority communities, themselves, are not immune to the negative attitudes that exist in wider society, for example, sexual minority communities may hold negative attitudes towards people of colour, people experiencing mental health problems or people who do not conform to the traditional binary gender identity. Similarly, people within ethnic minority communities may also hold negative attitudes towards people with physical/perceptual/learning disabilities.

In other words, all the 'isms' of oppressions work together, with the dynamics of each form of oppression exacerbating the consequences of the other to produce and compound injustice. This is aptly summed up by a participant in Daley et al.'s [45] paper on LGBT issues and traversing the margins. Drawing on Maya Angelou's description of oppression as a bird's cage, a participant in their study commented:

‘Any one wire doesn’t contain the bird; it’s the grouping of multiple wires together that create the cage’ (P.22). Hence, the need to explore the ways intersectionality of not only age, gender, sexual orientation, religion and ethnicity but also other identities (such as mental health, disability status) impacts people’s experience of exclusion and considers the challenges experienced in navigating life both within and outside the mental health system.

2.4 Actioning Organisational Accountability

The mental health inequities experienced by minoritised groups are not singly driven by mental health professionals’ lack of awareness or implicit/explicit bias about minoritised groups. Eliminating mental health inequities therefore cannot be rectified by cultural humility strategies, which focus purely on enhancing awareness, catalysing attitudinal changes and adjusting individual therapeutic practices. The path to equitable mental health care rests in a holistic approach, which is inclusive of both individual and organisational change. Mental health systems must acknowledge that its epistemological and ontological underpinnings perpetuate and facilitate implicit and explicit bias. Changing the systemic structure of service delivery and processes will not only help reduce inequitable mental health care experiences of minoritised communities but also provide a supportive culture to promote the fruition of a culturally humble workforce. To begin the work of championing systemic change, an APMHN can lead on a number of cultural humility activities to systemically embed culturally responsive practice at each point along the organisational pathway of care from initial presentation right through to assessment, care and treatment approaches.

2.4.1 Co-production with Community

As a point of first principle and in line with recovery approaches to mental health care (see “Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing”), it is of upmost importance that a methodology of co-production underpins all efforts to embed cultural humility into the systemic practices and culture of mental health systems. Research indicates that effective change is more likely when change is co-produced with the people who will be impacted, and so the knowledge of minoritised communities must underpin the vision, design and implementation of all components of a culturally humble service. Organisations must have the humility to learn from minoritised individuals and communities about their needs and the resources that their cultural context might contribute to the mental health system. Reaching beyond the confines of the mental health system to establishing authentic partnerships with service users from minoritised communities and representative ally community organisations is the first step to making services more relevant, accessible and acceptable to diverse peoples. Conducting an initial local need assessment, in partnership with ally community organisations and peer representatives, will help determine the distinct needs of a specific service’s catchment population and will help identify accessibility barriers and acceptability of and satisfaction with existing service provision. Following on from these initial engagements, a transparent and accountable plan outlining how the service will address the expressed needs of the communities is required, if trustworthy and reciprocal partnerships are to be sustained. At each step of implementation, whether it be inclusive policy development or the identification, design and development of specific therapeutic interventions, co-production with the community should be the foundation upon which all changes are designed, implemented and evaluated. Research indicates that it is organisations with authentic partnerships with minoritised communities and a commitment to diversifying and supporting minoritised members of the workforce which demonstrate enhanced cultural humility (see "Enhancing the Quality of Care Through Participatory Generation of Evidence").

2.4.2 Implementing a Culturally Responsive Organisational Pathway of Care

At each point along the pathway of care from initial encounter right through to assessment, care and treatment, there are actions required to embed cultural humility into the organisational culture and practices of mental health systems.

Inclusive and Affirmative Communications

From the outset, it is important that informational and promotional materials are accessible to all, as these are often the first point of contact a person may have with the service. The content of materials, including websites, informational booklets, pamphlets, posters and promotional videos, should reflect an inclusive approach in service ethos and delivery. Content modifications could include representative imagery and explicit acknowledgement of diverse perspectives and values to mental health. For some populations, targeted supplemental resources would be advised to strengthen accessibility including provision of translated and simplified materials. An integral addition to accessible communication materials is the employment of linguistic expertise. Evidence indicates people with limited proficiency in a country's primary language experience limited accommodations for their linguistic needs while accessing and attending mental health services. For example, research suggests that they experience difficulties accessing an interpreter and appropriate language services when attending mental health services. Consequently, language barriers are a leading cause of inequitable mental health experiences, contributing to misdiagnosis, poor follow-up and incorrect medication use [46]. While many national policies acknowledge the need for linguistic justice, utilisation of interpretation services remains limited. All too often, family members, friends or untrained staff are providing ad hoc linguistic support, which can result in miscommunication and errors in diagnosis, treatment prescriptions and/or treatment compliance [47, 48]. To ensure linguistic justice and enhance accuracy of communication and satisfaction with care provided, systematic use of professional interpretation services needs to be embedded as standard practice in all mental health systems. However, effective intercultural communication is more than technical language translation.

Linguistic justice can be further enhanced with the support of cultural brokers or mediators, the role of which is discussed later in this chapter.

Inclusive and Affirmative Assessment Tools

Psychometric screening and diagnostic tools are widely used across mental health systems. Fundamentally, however, the development and design of psychometric scales are underpinned by Eurocentric, biomedical conceptualisations of 'illness'. The symptom constructs included, in addition to the wording and measurement of scale items, is Eurocentric. Despite linguistic translation and back translation efforts, conceptual and linguistic equivalence across culturally diverse populations is not guaranteed [49, 50]. Previous research has revealed that cross-cultural equivalency is hindered by differing understandings of terminology used in scale items and response options of Likert type scales such as conceptualisations of time (e.g. 'the past seven days', 'very often', 'sometimes') and quantification of feelings (e.g. 'not quite so much', 'definitely not so much', 'less', 'hardly'). Further, the individualised and decontextualised conceptualisation of emotional states in psychometric scales, such as references to 'happiness', can have little relativity for people for whom these types of emotional states are embedded in, and inseparable from, family and wider social relations. In addition, there are many languages for which there are no translated versions of standard psychometric tools, particularly languages of the global south. In these circumstances, English language versions of the scales may be administered via an interpreter. In efforts to enhance comprehension and attune to cultural sensitivities, interpreters may feel the need to tailor the tools in accordance to the individual's needs. Non-standardised re-interpretation or tailoring of the scale items may affect scoring and compromise reliability. The integrity of scales also rests on frank and uncensored disclosures. APMHNs need to consider identity-specific factors, which may impact the individual's willingness to disclose and reliably answer psychometric tools. The topics asked about in some scale items may induce very strong feelings of shame or guilt for some individuals or can be appraised as very private and inappropriate to discuss with a person outside the family unit. Fears about confidentiality can be especially amplified for some individuals wherein mental health difficulties are strongly stigmatised in their communities [51, 52].

While for some of these tools, comparative diagnostic performance across culturally and linguistically diverse (CALD) and English-speaking populations is tentatively indicated, the limitations in sample size and demographic composition, in addition to heterogeneous study designs, suggest that cross cultural validity and reliability cannot be assumed and informed clinical judgement must continue to be exercised. For these reasons, APHMNs may consider the integration of the Cultural Formulation Interview (CFI) into the initial assessment process. In a 16-item semi-structured interview protocol, the CFI is designed to improve the cultural sensitivity of the diagnostic and treatment process [19]. Understood to enhance therapeutic communication, it focuses on capturing the perspective of the person-seeking support and their social context. In doing so, pertinent information, not ordinarily accessible via standardised psychiatric evaluation, is elicited and can help augment the provision of culturally responsive care. Nascent research tentatively indicates feasibility, acceptability and clinical utility of the CFI [53]. However, efficacious administration of the CFI is thought to be optimal when utilised in conjunction with good clinical communication, through an interpreter when needed, and when adequate training of clinicians on how to use it is provided [19].

Inclusive and Affirmative Treatment Approaches

When appraising the cultural responsiveness of current therapeutic practices within mental health systems, it may be useful to consider what changes are required at both micro and macro levels. At the micro level of individual therapeutic options or treatment approaches, there may be a tendency to review and adapt existing therapeutic interventions for minoritised populations. However, there is concern that the differences in ideas, values and conceptualisation of mental health difficulties may significantly hinder the transferability of some mainstreamed interventions. That being said, while the transferability of some mainstream interventions may be more amenable to adaptation, minor adaptations from mainstream protocols or interventions may not be sufficient to effect optimal change. For example, interventions and therapeutic approaches informed by recovery and trauma-informed practice may have enhanced alignment with diverse explanatory models of mental health and so be more conducive to adaptation despite linguistic, cultural and social differences. Irrespective of the specific intervention, whether it be mainstreamed biomedical, or recovery/trauma-informed in orientation, the key to identifying the most culturally responsive therapeutic approach will be through implementing the aforementioned tenets of Fisher-Borne's model and authentic engagement in the methodology of co-production with the community and with each individual-seeking support.

The micro process of providing culturally responsive therapeutic interventions would be assisted at a macro level through the adoption of an overarching health pluralism model of mental health service provision. Increasingly, the value of adopting a health pluralism approach to supporting mental well-being is lauded due to simultaneously recognising the benefits of allopathic medicine while also actively including alternative therapeutic approaches [4]. A core strategy to begin working from a model of health pluralism is to embed diverse world views into the design, development and implementation of organisational processes and therapeutic practices by ensuring *diversity of representation* in the mental health workforce. The mental health workforce should mirror the demographic profile of the population it serves. However, achieving health workforce diversity requires steadfast political will to implement progressive policies that support minority communities enhanced access to, and retention in, tertiary education, as well as the subsequent training and education in the distinct mental health professions. At an organisational level, recruitment policies and procedures must be reviewed and brought into compliance with principles of equality, diversity and inclusion, and international graduates from minoritised communities must be acknowledged as having distinct and valuable skillsets, which could optimise the cultural humility of our mental health systems.

National professional accreditation bodies need to embrace proactively accessible procedures for international graduates to gain recognition of their existing education and credentials, including flexible pathways to licensure and opportunities for integration in the workforce.

The integration of diverse cultural identities and world views into the provision of mental health care can also be achieved through partnership working with *cultural brokers or mediators*. In the field of mental health, linguistic and cultural brokerage is deemed particularly valuable as clear communication, and understanding of cultural differences in thoughts and behaviours is integral to the establishment of safe and effective therapeutic relationships [55]. The cultural broker workforce is trained in intercultural work and also has experiential expertise, which aligns with the life experiences of the service users. This can help facilitate a shared and deep understanding of the service users' context and world view and act as a cultural bridge between the service user and mental health professionals from dominant majority populations. While in some jurisdictions, accredited training programmes for interpretation and/or cultural brokerage roles are in existence, in other countries currently, there are no standards for training, assessment and quality assurance of culture brokers, nor are there established methods for funding this essential resource. In these instances, working in collaboration with community organisations to develop, train, support and regulate a cadre of culture broker's is necessary.

Diversification of the mental health workforce will also help to facilitate the provision of *ethnically and/or gender-matched specialist services*, wherein the gender and ethnicity of service user and practitioner are matched. Gender/ethnic matching aims to bridge the cultural divide between the minoritised service user and the Eurocentric, heteronormative and cisgender orientation of mainstream models of care. To date, while there is no evidential consensus as to its effectiveness, with mixed findings in relation to impact on clinical outcomes such as service utilisation, service retention and post-treatment functioning [54], there remains acknowledgement that individuals prefer mental health professionals with similar cultural identity and are more satisfied with their care as a result. Consequently, there is consensus that, when feasible, the provision of ethnic or gender matching should be facilitated and encouraged. It is important to nuance this discussion with the caveat that matching does not necessarily equate to congruence of opinions, attitudes, beliefs or values between service users and mental health professionals. Other commentary indicates that other factors such as culture, religion, social class and age all need to be considered [56] and that for some the cultural identity of a practitioner is less important than their attitudes, openness, practice skills [57–59] and their willingness to engage with and understand diverse world view, as opposed to working from a Eurocentric, heterosexual, cisgender perspective. Further, the resources needed to achieve such matching in specialist services for every person are often prohibitive [60], and in some cases, it may be a service user's preference to work with providers outside of their community, particularly if the community is small, because of concerns surrounding confidentiality.

3 Research-Informed Activities

A core aspect of the APMHN role is to engage with and help embed the most up-to-date research-informed evidence into their own practice, the practice of others and the systemic organisational culture (see "Knowledge Translation and Linking Evidence to Practice" and "Maintaining Professional Competence"). When implementing change to create a culturally humble mental health service, it is prudent to monitor and evaluate progress. From the outset, at an organisational level, a critical analysis of the organisation's cultural system is required. For example, understanding the organisation's readiness and capacity to act and implement change is an important step to help foresee potential challenges and points of friction. Existing Organisational Readiness to Change Assessment surveys [61] can be adapted to suit local context and can help profile the availability of resources (e.g. education/training, aligned initiatives/programmes, community partners), as well as identify the overall interest and commitment of the workforce, managers and leaders to developing a cultural humble organisation.

An audit of current practices and policies may also be useful in identifying the degree of cultural inclusivity and responsiveness in organisational policy, practices and therapeutic approaches. Although generic or broad metrics may be included in existing audit tools, a more sensitive culturally and clinically reliable bicultural audit tool is needed. Already developed bicultural audit tools, such as Cultural Competency Assessment Tool for Hospitals [62], Consumer Notes Clinical Indicators (CNCI) and the Professional Practice Audit Questionnaire (PPAQ) could be adapted to enhance responsiveness to local organisational context [63, 64]. This will assist in identifying areas in need of change and for which an action plan of accountability can then be designed, implemented and monitored. To garner a holistic understanding about the progress in achieving cultural humility throughout the care pathway, quantitative data capture should be accompanied, when practicable, with qualitative data from minoritised communities about their experiences of accessing and engaging with their mental health service and whether their experiences change as activities of cultural humility become embedded within organisational and individual workforce practices.

4 Conclusion

International human rights guidance mandates the provision of culturally responsive mental health care as the path to end the inequities experienced in access to and delivery of quality mental health care. Cultural humility offers a holistic framework through which the transformative systemic change required to achieve equitable mental health care can be catalysed. It mandates APMHNs *and* organisations to undertake a deep level analysis of their power and privilege to understand how their own identities, beliefs, practices and systems impact their interactions and care provided to people who use the mental health system. While avoiding complete reliance on the person for cultural education, cultural humility demands that the APMHN puts aside their perceived expertise in the face of unfamiliar cultural identities to focus instead on the experiences and the meanings of those experiences to the 'other' and the valuable knowledge that they bring about their mental distress to the therapeutic endeavour. Further, as professional leaders, role models and advocates, APMHNs are optimally positioned to support the actioning of organisational accountability by playing a leading role in embedding cultural humility into the systemic policies, procedures and practices of their service, as well as engaging with research and audit that broadens the evidence base in this area of practice.

Reflective Questions

- How might clinical supervision support your development as a culturally humble practitioner?
- As an APMHN, how might you foster and support the development of culturally humility in more junior staff and within the organisational culture?
- With whom and in what ways can you begin to build authentic partnerships of co-production with minorities populations in your service's catchment area?

Case Study

My name is Toni O'Connor, an advanced nurse practitioner working in an adult-eating disorders service at St Patrick's Mental Health Services, Dublin, Ireland. I trained in both general and mental health nursing, furthering my studies at the Tavistock Institute in London with an MA in working with people with eating disorders. I completed a PhD with Trinity College Dublin in 2017. My clinical practice includes the assessment, care planning and treatment for people with eating disorders. Because of the medical, psychiatric, cultural and social complexities associated with eating disorders, assessment is not usually confined to a single session, but following an initial in-depth exploration of the problem, assessment is an ongoing process that continues throughout treatment. This allows us to make timely and culturally sensitive changes to a treatment plan in response to a service user needs as they arise. The following account demonstrates the social and cultural complexities facing a service user who attended for assessment and treatment for bulimia nervosa.

My initial meeting with Danah was scheduled for 90 min on a Tuesday mid-morning when her children were in school. We used this time to think about her difficulties together, and in developing a shared understanding of the meaning of her experiences, we were constructing a foundation on which we could work together in a way that she felt understood.

Danah was a 34-year-old married Muslim woman who had moved to Ireland from Pakistan, with her husband, 10 years previous. Despite having access to a good support network of other women with similar cultural and religious background who met regularly as a group, Danah stated she was very lonely without her family, and she turned to food for comfort. The comfort eating escalated to binge eating and vomiting by the time her two children had started school, and she was alone in the house. In addition, many of the social gatherings within her ethnic community involved lengthy preparation and eating of a wide variety of what Danah called 'triggering' foods. These social occasions always triggered an episode of bingeing and vomiting, and by the time she attended for assessment, she was bingeing/vomiting at least 5 days per week, and her mood and self-esteem were very low, and she stated she felt very hopeless and alone.

The barriers to seeking help, for Danah, were complex. The shame she experienced in relation to bingeing and vomiting and the understanding that these behaviours went against her religious beliefs prevented her from confiding in anyone. Compounding her shame was her worry about how the therapy sessions were paid for. Her husband believed she was attending a personal development course, which he was happy to fund. She was very fearful that what she considered 'her dishonest and shameful' behaviour would be exposed. Therefore, she needed her therapy to be kept secret, and she was unsure how long she could keep attending.

Mindful of the cultural, religious and family-related barriers facing Danah's ability to attend for treatment, our therapeutic interventions needed to be provided in a flexible way. Danah's preference was to attend her GP service for medical monitoring and dietetic support. We worked closely with the dietician, devising a meal plan that would facilitate nutritional stability while providing for a flexible eating plan to accommodate periods of both fasting and celebratory eating. Danah attended one morning group therapy session per week, which gave her the opportunity to link with others who were experiencing similar difficulties. Individual cognitive behavioural therapy for eating disorders (CBT-E) with an adjunct compassion-focused therapy for eating disorders (CFT-E) was provided when Danah was in a position to attend. CBT-E and CFT-E, evidence-based therapies recommended for people experiencing eating disorders, allowed her with the opportunity to develop skills to manage the eating disorder thoughts and behaviours, while the emotions of shame and guilt were targeted by focusing on developing self-compassion.

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Collaborative Prescribing and Advanced Mental Health Nursing Practice

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Learning Objectives
The objective of this chapter is to enable you to:

- Critique the emergence of nurse prescribing as an element of Advanced Practice Mental Health Nursing in Europe.
- Compare and contrast nurse prescribing practices across Europe.
- Critically discuss the nature and elements of collaborative prescribing within Advanced Practice Mental Health Nursing.
- Reflect on ethical and professional issues that affect nurse prescribing and discuss ways of addressing issues that emerge within contemporary Advanced Practice Mental Health Nursing.

1 Introduction

The use of psychotropic medications has emerged as central to the treatment of mental distress since their discovery in the 1950s [1, 2]. Since then, their use has become widespread with suggestions that one in six people takes some form of psychotropic medication [3]. For the discipline of psychiatry, psychopharmacology cemented the dominance of the biomedical approach to the treatment of mental

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distress, which had been somewhat overshadowed by psychological interventions up to that point. Not only did psychopharmacology provide some viable treatment options for mental distress, it also set a research agenda that has firmly established the discipline of psychiatry as the leader of mental health service provision throughout the world [4, 5]. For mental health nurses, the arrival of psychopharmacology proved to be a double-edged sword. On one hand, medicinal technologies to treat mental illnesses that were at the time thought of as untreatable allowed mental health nurses to move away from roles that were mainly custodial in nature. In addition, the discovery of psychopharmacology coincided with criticisms of the asylum system that was dominant throughout the world at the time, allowing mental health nurses to engage with service users in the community once they had been discharged. On the other hand, psychopharmacology further aligned mental health nursing with the biomedical model of care (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"). This is a position in which mental health nursing has found difficult to distance itself from, even as it has established itself as a distinct specialist profession, and perhaps this is especially true for Advanced Practice Mental Health Nursings (APMHNs). With the growing numbers of nurse prescribers throughout Europe, APMHNs have the opportunity to integrate a traditionally biomedical approach to the treatment of mental illness with the core values associated with mental health nursing. The aim of this chapter is to examine nurse prescribing in the context of advanced practice mental health nursing and to discuss elements of mental health nurse prescribing that foster collaborative, recovery-orientated prescribing practices. In addition, the chapter will outline some contemporary, ethical and professional issues relevant to nurse prescribing and offer some case exemplars to illuminate real-world experiences across a number of contexts. While we have alluded to the process of medication management for mental health service users, we have not covered it in detail within this chapter.

2 Emergence of Nurse Prescribing in Mental Health Nursing

Mental health nurses have had a considerable role to play in the administration of medication both in hospital and community settings. In traditional physician-led practices, this role centred on ensuring compliance and monitoring effects and side effects. Although nurse prescribing emerged in the United States in the 1960s [6], the United Kingdom was the first county in Europe to permit nurse prescribing in 1992 with health visitors and district nurses permitted to prescribe from an extended formulary although there have been many developments since then [7]. Up to then, mental health nurses did have some role in prescribing by advising physicians on what medications to use and making pro re nata (PRN or as needed) decisions. As scope of practice guidance became more embedded, extension and expansion of nursing roles grew allowing for the proliferation of APMHNs working across a range of diverse settings [8]. However, while the term nurse prescribing has become widely recognised as a practice, the activities associated with it vary in and between countries [9]. In addition, legal frameworks and educational requirements to enable

Table 1 Brief overview of models of nurse prescribing

Independent prescribing	Supplementary prescribing	Medication protocols
In general, the independent prescribing model is autonomous, allowing nurse prescribers to prescribe and diagnose without direct medical involvement in the process—the nurse has full accountability and responsibility for the diagnosis and prescribing for that patient [14]	In contrast [to independent prescribing], nurse supplementary prescribing is based on a voluntary prescribing partnership between the physician and the nurse that facilitates the nurse to prescribe any drug listed in a patient-specific clinical management plan once the patient has been diagnosed by a physician [14, p. 878]	Medication protocols are written directions that allow for the supply and administration of a named medicinal product by a registered nurse or midwife in identified clinical situations. A medication protocol involves the authorisation of the nurse or midwife to supply and administer a medication to groups of patients in a defined situation meeting specific criteria and who may not be individually identified before presentation for treatment [15, p. 6]

nurse prescribing also vary considerably [10]. Generally, nurse prescribing is either open to all registered nurses who meet predefined registration requirements or open only to a distinct subgroup of nurses [11]. In addition, prescribing practices are either limited to an agreed formulary of extant medications, or the nurse is permitted full prescribing authority including the initiation of new prescriptions [11], commonly referred to as independent or supplemental prescribing although these are referred to as initial prescribing (authority to prescribe a new medication independently) and continued prescribing (authority to prescribe medications once they have been initiated by a physician) by Maier [12]. A third category of non-medical prescribing is also in existence referred to as medication protocols. A brief overview of these three models is presented in Table 1, although it should be mentioned that practices vary despite these models, which appear standard. Currently, 13 European countries have adopted nurse prescribing rights, and in most countries, these licenses are provided after the completion of post bachelor prescribing courses within a restricted list of medications. In other countries, such as Ireland, the Netherlands and the United Kingdom, wider independent authority is allowed within a specific domain such as mental health. It should be noted that not all countries permit the prescription of psychotropic drugs and APMHNs need to be aware of the legislation and policy guiding practice in their home country. Common across all countries is the need for the nurse to complete specialist education and in most cases has a recorded qualification that allows them to prescribe and have some form of supervision, most commonly from a physician [12].[1]

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[1] For a detailed analysis of prescribing across 13 European Countries, see Maier [12]. For an international perspective, see Ling [13].

A Cochrane review conducted in 2016 found that prescribing practices among non-medical prescribers including nurses was comparable to physicians [16]. For nurses, prescribing is viewed in a positive light with this expansion of practice seen as enhancing and improving practice, leading to increased accountably and patient safety [14]. In the United Kingdom and the Netherlands, studies have found that nurse prescribing does not result in more safety issues when compared with physician [17, 18]. In Ireland, a study of nurse prescribers with different clinical specialities found that the prescribers were confident with their prescribing and the nurses engaged in similar prescribing practices from initiating new prescriptions to deprescribing [19].

With the increasing emphasis on the provision of mental health services in the community, mental health nurses began working more independently to support service users, initially to prevent relapse and subsequent readmission to hospital, and during acute presentations of distress as well. With the emergence of advanced practice, emphasis was placed on autonomy and the ability to complete a full episode of care for service users. It is logical to assume that within mental health nursing, given the high numbers of service users taking medication, prescribing authority would soon follow. However, while there has been widespread support for the role, there is some evidence that the uptake of prescribing practices within mental health nursing is slow [17] and that support from key stakeholders including physicians is required to support implementation [20]. A survey completed in 2012 found that lack of renumeration for extending practices, lack of support and not feeling educationally prepared to prescribe were some of the reasons for the poor uptake of nurse prescribing roles in mental health nursing [21]. This is despite a systematic review of qualitative studies [20] suggesting that there was general support from both service users and nurses for the role of nurse prescriber. Mental health nurses believed that nurse prescribing enhanced continuity of care and medication management suggesting that service users experienced a holistic approach to their care [22]. In addition, another study emphasised the relationships between mental health nurses and service users suggesting in some cases an enhanced relationship, with nurses being perceived as less paternalistic and easier to speak to than their medical counterparts [22]. A study that used the Consumer Quality Index also found that service users highly valued the involvement of nurses in medication management [18]. An Irish study completed by Frain et al. [23] found that the service users in their study valued the holistic approach used, and for them, prescribing was enhanced by the therapeutic relationship that they had with the mental health nurse. In addition, the participants also valued the additional time and flexibility that could be provided by mental health nurses [23]. In 2016, a survey conducted in the United Kingdom found that the numbers of prescribers among mental health nurses had increased with more nurses engaging in independent prescribing [17]. While there are studies examining nurse prescribing from multiple perspectives, Fong and colleagues [24] suggest that there is a lack of research on the actual outcomes of prescribing practice.

3 Collaborative Mental Health Nurse Prescribing

As the mental health services move away from a dominant biomedical approach, there has been a greater emphasis on the concept of recovery. This has meant a greater role for service users in terms of involvement in decisions about their care. This has coincided with growing criticisms of the role of medication as the main treatment of mental illness and increased calls for more psychosocial interventions. As mental health nurses adopted prescribing authority, there was a realisation that they needed to ensure that they could maintain symmetry with this and their roles as providers of psychotherapeutic support. In exploring the concept of collaborative nurse prescribing, there is a focus on the collaboration between the mental health nurse and the psychiatrist or responsible medical officer and the mental health service. This collaborative process often sets out the parameters of the nurses' prescribing authority, and this will vary in the context of national rules and legislation associated with nurse prescribing often with an emphasis on professional regulation. Our conceptualisation of mental health nurse prescribing within advanced practice emphasises the relationships between nurses and service users and presents an interwoven framework for understanding the core issues that APMHNs need to be aware of when engaged in prescribing practice. This conceptualisation is required to reflect the complexity of prescribing intersected with the specialist nature of Advanced Practice Mental Health Nursing practice:

- professional, ethical and legal issues,
- competencies for prescribing practice,
- therapeutic relationships and interpersonal skills,
- recovery-orientated prescribing,
- shared decision-making,
- working with families and significant others,
- oppositional discourses,
- education, research and audit.

3.1 Professional, Ethical and Legal Issues

Professional, ethical and legal issues are concerned with professional regulation and the ethical and legal frameworks that exist, which permit nurses to prescribe and dictate the extent of their prescribing practice. These rules and laws will vary from country to country but must be understood as the blueprint for safe and accountable practice. In addition, professional, ethical and legal frameworks will outline the professional relationships that must be in place and the role of these relationships for mental health nurses to prescribe. For a detailed analysis of legal and policy issues related to nurse prescribing across 13 European countries, please see Maier [12]. In addition, the mental health services also operate within a legal framework, and service users may be subject to compulsory admission to hospital where they have to comply with medication. In addition, where they exist, community treatment orders may be in place for service users, and these will often dictate if the service user is required to take medication while living in the community. These legal frameworks will also vary across Europe, and APMHNs need to be aware of the statues and how they influence and, in some cases, dictate their prescribing practice with individual service users. Practices such as the administration of psychotropic medication without consent constitute a coercive practice, which infringes on individual liberty and may lead to trauma [25, 26]. This issue is complex and beyond the scope of this chapter. However, strategies to reduce the use of coercive practices and protect service user autonomy, personhood and rights by finding alternative solutions are required [25]. Codes of practice for registered nurses also provide guidance about how nurses can provide care in a professional, safe and ethical way. Prescribing practices need to be underpinned by these codes of practice, and APMHNs also need to be cognisant of the ethical principles outlined by Beauchamp and Childress [27] as applied to prescribing and other interventions (respect for autonomy, beneficence, non-maleficence and justice).

3.2 Competencies for Prescribing Practice

Competency is defined as not just knowledge and skill acquisition but also the attainment of integrity and professional and ethical values that are required to enable registered nurses to practice effectively [28].[2] Nurses, at the point of registration, have acquired key knowledge and skills that must now be augmented to prepare them for prescribing practice. Within advanced practice, this generally requires formal education to master's degree level and requisite clinical experience in a specialised area that may vary in different domains. In addition, registration as a nurse prescriber will require successful completion of an approved prescribing education programme, which includes both theoretical and clinical practice components including supervised and assessed prescribing practice. This is delivered as either part of or adjunct to the master's degree, or as is becoming common in the United States, a clinical doctorate, Doctor of Nursing Practice (DNP). The Royal Pharmaceutical Society in the United Kingdom [29] have outlined a competency framework for prescribing, which contains ten elements that are essential for effective prescribing practice within the United Kingdom regardless of profession of origin. These competencies pertain to consultation and prescribing governance, and a brief overview of the competencies is contained in Table 2. Each of the elements within the competency framework points to theoretical and clinical expertise, which will at times varies depending on the nurse prescribers' scope of practice and individual specialist area. Recognition of the nature of competence as non-static and as

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[2] The full document is available at: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Prescribing%20Competency%20Framework/RPS%20Competency%20Framework.pdf?ver=AlHRKuior3ef_fNnaMd3iA%3d%3d.

Table 2 Overview of competency framework (adapted from the Royal Pharmaceutical Society, Prescribing Competency [29])

Consultation		
1.	Assess the service user	Completes a comprehensive assessment of the service users collaborating with other health professionals as appropriate
2.	Identify evidence-based treatment options available for clinical decision-making	Considers the appropriate evidence-based intervention (which may be non-pharmacological, deprescribing or no intervention) and is aware of the implications of prescribing in terms of risks and benefits
3.	Present options and reach a shared decision	Works in partnership with the service user to establish a plan of care and acknowledges the service user's autonomy in terms of their preferences for treatment approaches
4.	Prescribe	Prescribe a medication that reflects contemporary understanding of the medication actions, effects and side effects and is within the prescribers' scope of professional practice
5.	Provide information	Provides the service user and other stakeholders with information about the medication and the medication regime and ensures that service users understand this information. Supports the service user's capacity and potential to self-manage their condition using pharmacological or non-pharmacological approaches
6.	Monitor and review	Monitor and review the service user's treatment including monitoring and responding to adverse effects
Prescribing governance		
7.	Prescribe safely	Prescriber is aware of their scope of practice and prescribes within any predetermined frameworks that have been established and under the supervision of medical practitioners and pharmacists as appropriate to local arrangements
8.	Prescribe professionally	Prescriber is aware or legal, ethical and professional standards associated with nursing and their prescribing capacity. Strives to maintain competency and accepts responsibility for their prescribing actions
9.	Improve prescribing practice	Works to improve prescribing practice both individually and in other prescribing professionals
10.	Prescribe as part of a team	Works collaboratively as part of a multidisciplinary team (MDT) and receives and provides supports as appropriate to prescribing practices

regular, reflective prescribing and continuing professional development is essential to maintain competence, which is also explicit within most frameworks [30]. Further information about competencies for Advanced Practice Mental Health Nursing and maintaining professional competence can be found in this book.

3.3 Therapeutic Relationships and Interpersonal Skills

Therapeutic relationships underpin the practice of mental health nursing. The relationships that are fostered and developed with service users, and when appropriate, members of their families and support network, provide the backdrop for any therapeutic activities and support the competency framework [29] briefly presented in

Table 2. It is not the intention of this chapter to provide an in-depth discussion outlining elements of the therapeutic relationship or alliance, and we refer to the corresponding chapter in this book for a more in-depth discussion of this important issue, but to act as a reminder of the centrality of the nurse-service user relationship within mental health nursing practice (see "Therapeutic Alliance"). Here, it remains important to keep in mind that any attempt at collaborating with service users around prescribing begins and ends with the therapeutic alliance, and this alliance underpins each element of collaborative mental health nurse prescribing presented here.

3.4 Recovery-Orientated Prescribing

Recovery has received a lot of attention over the last number of years, and it is becoming the underpinning philosophy for many mental health services. Despite this, there is some confusion about the concept of recovery and a lack of understanding about how it translates to mental health service delivery. The Health Service Executive in Ireland has developed a national framework for recovery in mental health [31] and has articulated a clear definition of recovery (p. 1):

> *Recovery is intrinsically about people experiencing and living with mental health issues in their lives and the personal goals they want to achieve in life, regardless of the presence or severity of those mental health issues. Put simply, it's living a life of one's own choosing, having dreams and ambitions with or without the presence of mental health challenges, and regardless of the severity of those challenges.*

The key for APMHNs is translating this philosophy into practice while also recognising the impact that medication might have on services user's personal conceptualisation of health, mental health and recovery. A conceptual framework to support the implementation of Recovery, **CHIME**, has been developed and is widely used by both service users and mental health services to support the delivery of recovery-orientated practices [32]. In Table 3, the key processes associated with recovery as identified by the **CHIME** framework are presented along with their characteristics. Each one takes an element of the recovery process and provides the main component of that element to support implementation.

For APMHNs, there is a need to ensure that nurse prescribing practices are harmonious with the characteristics associated with recovery as outlined in Table 3. In addition, APMHNs need to be aware of the potential tensions that might emerge where service user's conceptualisations of personal recovery collide with practitioners focus on clinical recovery. Furthermore, the potential for psychotropic medications to impact service users' ability to achieve a sense of personal recovery must be considered. For example, many medications have side effects, which may affect the person's ability to engage in a meaningful life and social roles. One of the key roles of the nurse prescriber is making sure that the service user is properly and clearly made aware of risks, benefits and alternatives to treatment and that informed consent is acquired and documented before prescribing takes place. Another essential task of the nurse prescriber is the appropriate monitoring of possible side

Table 3 Processes and characteristic of CHIME (reproduced with permission [32, p. 448])

Recovery process	Characteristics
CHIME: Conceptual framework for personal recovery in mental health	
Connectedness	– Peer support and support groups – Relationships – Support from others – Being part of the community
Hope and optimism about the future	– Belief in possibility of recovery – Motivation to change – Hope inspiring relationships – Positive thinking and valuing success – Having dreams and aspirations
Identity	– Dimensions of identity – Rebuilding/redefining positive sense of identity – Overcoming stigma
Meaning in life	– Meaning of mental illness experiences – Spirituality – Quality of life – Meaningful life and social roles – Meaningful life and social goals – Rebuilding life
Empowerment	– Personal responsibility – Control over life – Focusing on strengths

effects. This needs to be done through a thorough clinical interview, through lists and scales such as the Abnormal Involuntary Movement Scale (AIMS) for symptoms of tardive dyskinesia [33] and through side effect monitoring tools such as the regular and Clozapine versions of the Glasgow Antipsychotic Side Effect Scale (GASS and GASS-C) to name only a few [34]. In terms of using these validated scales, it is also important for APMHNs to make sure that local policies and frameworks are used to support which ones are used as part of their clinical practice. Equally important is the appropriate monitoring of vital signs, weight, height and laboratory work for possible signs of metabolic syndrome and other side effects that are common for many of the more potent psychopharmaceuticals used in contemporary clinical practice. In addition, APHMNs need to consider the broad range of adverse effects that can sometimes be hidden or overlooked especially if the service users are embarrassed talking about them. For example, sexual dysfunctions, such as reduced libido, are often under estimated and their presence not perceived as a clinical priority despite evidence to suggest that they impact negatively on service user quality of life [35]. APHNMs need to be confident that they can encourage these discussions to take place in a sensitive way without minimising the experience or engaging in a compliance monologue, which advocates clinical outcomes over personal experiences [36, 37]. Issues such as taking medications may perpetuate the idea that the person is still ‘mentally ill’ and individuals may not see themselves as recovered unless they are medication free. Nurse prescribers need to be aware of these potential conflicts and be able to understand the meaning of mental illness experiences for individuals who are prescribed psychotropic medications.

In addition, prescribers need to accept that medications alone may not be wellness tools for many people and that psychosocial interventions may be a more appropriate approach for some or required in addition to medication. Moreover, helping and supporting individuals to reduce or discontinue medication may be more therapeutic in certain situations than prescribing or maintaining medication regimes. This approach may create a tension within traditional MDTs, and APMHNs may need to ensure that service user's wishes are heard and that their autonomy is protected. Deprescribing will be discussed in more detail later in this chapter. Central to recovery-orientated prescribing is the acknowledgement that prescribing medication is but one approach among many that the APMHN can use to support people who experience mental distress. One of the risks APMHNs face is when they receive the proverbial hammer (the prescription pad), which states that everything starts looking like a nail. The thought of not prescribing or deprescribing slowly stops being inside the realm of possibility, and the view that all problems can and should be addressed through psychopharmacology becomes the norm. Thus, other potential interventions and aetiologies slowly drift away into the abyss. This reductionist approach is the antithesis to recovery-orientated approaches, which supports medication as part of a range of interventions that may be used depending on service users' needs, personal preferences and robust evidence.

3.5 Shared Decision-Making

There is an overlap between the concept of shared decision-making and elements of recovery-orientated practices especially in terms of service users' personal responsibly, control over life and focus on the individual's strengths [32]. Shared decision-making is defined by the National Institute for Health and Care Excellence (NICE) [38] as a collaborative process that supports a person and their healthcare professional to work together to reach a joint decision. *Shared decision-making in this context refers to decisions that directly affect the service user in the context of the care and treatment options that are being discussed with the APMHN and the MDT*. Adopting a recovery-orientated approach to prescribing will ensure that the service user's autonomy will be respected and that their voices will be heard in any discussion about their care and treatment. It is natural to assume that decisions made following these discussions will be based on the shared decision-making principles as outlined by NICE [38]. In the context of prescribing, these should ensure that all the treatment options are fully explored, including the decision not to prescribe any medications. In addition, any medications that are being considered need to be discussed in the context of their benefits and their risks and how they can support the service user's personal recovery journey. Ultimately, the decision needs to be reached in partnership with the APMHN and the MDT, and this may not be the decision that the APMHN prefers. Shared decision-making is not about medication adherence or convincing service users to take medication. It is about facilitating transparency in the decision-making process and supporting service users to make informed decisions based on the best available information. In this process, issues such as the individual's capacity to consent and make decisions about their care and treatment will need to be considered. In addition, issues such as the person's legal status, which will vary from country to country, will also need to be factored in. Shared decision-making, in some cases, will raise professional, legal and ethical issues, which will require the APMHN with prescribing authority to be clear about their scope of practice and the legal and ethical frameworks that they are permitted to prescribe within.

3.6 Working with Families and Significant Others

Recovery-orientated approaches have further emphasised the need for mental health services to be embedded within the community, and this has seen an increased role for families as service users' supports and support network (see "Collaboration with Families, Networks and Communities"). Skärsäter et al. [39] in their critical review have detailed the knowledge skills and attitudes that are important when working with families. Here, relationships, while remaining paramount, become more nuanced as consideration needs to be given to the relationship with the service user while also considering the service users relationship with their family and significant others. The service user's family is often primary members of the service users' social support network and in that sense needs to have information and support from the APMHN in order to continue to provide that support and avoid undue burden. In terms of prescribing, the family will generally be supportive of medication management and will require education about medications, their effects and side effects. However, tensions may emerge where the wishes of the service user conflict with the wishes of the family especially where there are differences of opinion on the role of medication. Keogh et al. [40] found that families sometimes place emphasis on the role of medication and will see it as the primary intervention for mental distress. In addition, the family may exert pressure on service users to continue taking prescribed medication compromising their autonomy as decision-makers [41]. Here, it is important not to form alliances with the family to support medication compliance. Instead, the APMHN needs to engage with the service user and their family to discuss their individual concerns and offer support that does not infringe on the autonomy of the service user.

3.7 Oppositional Discourses

While the developments in psychopharmacology have undoubtedly improved the lives of many people who experience mental distress, this view is not an objective truth, and there are oppositional discourses[3] that challenge their use in particular their long-term use. These oppositional discourses have emerged from social

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[3] Visit www.madinamerica.com and www.madintheuk.com for more information on some of these discourses.

scientists and philosophers, from within the discipline of psychiatry and from individuals/families who have been prescribed these drugs. In general, these oppositional discourses challenge the legitimacy of diagnostic criteria and the subsequent drugs prescribed to treat individuals once diagnosed. Examples of some of what we consider are the main oppositional discourses are briefly presented in Box 1. Taken together, these oppositional discourses allow APMHNs to view the use of psychopharmacology in a more holistic way and acknowledge that the use of medications as a treatment approach for mental distress is not unchallenged. As mental health nursing knowledge draws from a range of theoretical perspectives, it is essential to view the use of psychopharmacology through a lens that is wider than a purely biomedical one.

Box 1: Overview of Oppositional Discourses

- Lack of evidence to support diagnosis, for example, biomarkers
- Diagnosis considered a social construct
- Interrater variability, same diagnostic criteria despite heterogeneous individual experiences
- Lack of emphasis on the intersectionality of individual experiences, the role of trauma and the social determinants of health
- Role of racism and misogyny
- Physical harm caused by drugs in terms of side effects, which can sometimes be life altering and affect morbidity and mortality, for example, metabolic syndrome
- Concerns about the evidence to support the efficacy of drugs use
- The role of marketing and ‘big pharma’
- Acceptance of psychopharmacology as the main treatment technology
- Criticisms from individuals who experience mental distress about the overuse of drugs and the need for more psychotherapeutic approaches
- The tendency for drugs to be seen as a long-term treatment for mental distress especially for individuals diagnosed with schizophrenia
- Criticisms of the ‘chemical imbalance’ theory as lacking evidence or being too simplistic

3.8 Education, Research and Audit

A central role of the APMHN is to engage in research and audit [42]. The extent of this is sometimes dictated by their scope of practice and may extend to other scholarly activities such as teaching and practice development. It is necessary for the APMHN to define their research agenda and to build capacity as their careers progress. It is also important for APMHNs to develop evidence to support practices that are related to their prescribing role. The extent of the APMHN’s specialist area and prescribing practice will dictate part of this agenda, but it is important that research remains on mental health nursing focused with the primary goal of improving the experience of services and building evidence for practice. While audit in this context might include formal audits of prescribing practices, reflective practice and critical incident analysis as a form of self-audit, it may also support personal and professional development and a nuanced prescribing practice. There is also an important education and consultation role for APMHNs. For example, coaching families or other mental health care providers, providing psycho-education and helping student nurses understand psychopharmacology including interactions, side effects and medication management in line with recovery-orientated prescribing principles are some examples of important areas that might be considered. In the context of a holistic episode of care, APMHN prescribing will also include medication management in the broadest context of exploring the impact of medication on the service user's life and working in partnership with service users to manage the adverse effects of medication. In addition, supporting service users to recognise adverse effects and report them where necessary is also part of this role. This may include formal reporting of adverse effects to medication regulatory bodies, and APMHN prescribers will need to be familiar with their national arrangements and support service users to access them when necessary.[4]

4 Deprescribing and Supporting Individuals to Discontinue Medication

Deprescribing is defined '*as the systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values, and preferences. Deprescribing is part of the good prescribing continuum, which spans therapy initiation, dose titration, changing or adding drugs, and switching or ceasing drug therapies*' [43, p. 828]. There are many reasons that individuals may want to stop or reduce the doses of medication they are taking. Service users may still experience symptoms even though they continue to take the medications [44]. In addition, side effects can be so severe and disabling that the risks associated with taking medication may outweigh the potential benefits [44]. Furthermore, as discussed earlier in this chapter, taking medication over a long period of time, may not 'fit' with an individuals' conceptualisation of wellness and recovery, which they believe can only be achieved if they are medication free. Moreover, many individuals have had negative experiences with the mental health services and wish to put that experience behind them, including the medications that they were prescribed, which were sometimes administered to them against their will [41]. Despite these legitimate concerns, individuals prescribed with psychotropic medication may feel pressure to continue taking the medication by family, friends and mental health professionals and sometimes are threatened

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[4] A list of national medication regulatory bodies for the EEA can be found at: https://www.adrreports.eu/en/report_side_effect.html. In the UK, the yellow card scheme for reporting adverse reactions can be found at: https://yellowcard.mhra.gov.uk/the-yellow-card-scheme/.

with rehospitalisation under mental health legislation if they do not comply [40]. Consequently, individuals may not disclose that they do not want to take their medication or stop taking them altogether without informing the prescriber.

The importance of the relationship between the APMHN and the individual cannot be overstated here. That relationship should be founded on knowledge of the individual's personal beliefs about their health and mental health and their attitudes towards the medication they take. Furthermore, individuals should be aware and encouraged to talk to their APMHN about any aspect of their care (or other issues) that affect them including taking medication. Individuals' contact with the mental health services, where they have been detained in hospital under mental health legislation or experienced rapid tranquilisation[5] against their will, for example, may be interpreted as traumatic and may need to be worked through using trauma-informed approaches (see "Trauma and Trauma-Informed Care"). Past experiences may cloud any future engagement with the professional mental health services and need to be addressed in a sensitive way. Decisions to stop taking medication should not happen without a thorough discussion about the process, which may include a risk benefit analysis and an opportunity to plan the process in conjunction with the MDT where necessary. Even where APMHNs may not agree with the decision, they still need to be supportive and remember that medication management is just one part of their role in the provision of holistic care.

Helping the individual to manage their mental health difficulty without medication and ensuring that the process is carefully monitored are important if the individual feels that this is the right course of action for them. Supporting individuals to stop taking medication may feel counterintuitive. This may be because mental health nurses have often been socialised to work within a primarily biomedical paradigm. However, there is an opportunity here for APMHNs to work closely with service users, to further develop the therapeutic relationship and to move beyond purely biological interpretations of mental illness. There is limited evidence in the area of deprescribing and supporting service users to stop taking psychotropic medication safely [37], and this research gap offers APMHNs an opportunity to lead in this area. However, there is an important caveat here, and APMHNs will need to ensure that supporting individuals to taper off and stop taking medication falls within their scope of practice and their level of competence. In addition, they need to make sure that they have the authority to this within the context of their practice and the legal and ethical standards they practice within. Appropriate deprescribing needs to consider the pharmacokinetics and pharmacodynamics of the medications involved, be carefully planned and monitored, and APMHNs need to be aware of any possible withdrawal or discontinuation effects (e.g. re-emergence of symptoms, physical withdrawal symptoms, etc.) and have knowledge of the approaches that can be used to deprescribe medication [46].

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[5] Rapid tranquilisation is a practice where psychotropic medication is administered parenterally, usually against the service users will, to achieve urgent sedation [45].

5 Models of Prescribing

Numerous models of prescribing exist and have been developed to assist APMHNs in their prescribing practice. Whatever model is used, it is paramount that the APMHN does not lose their underpinning philosophy of person centredness in the process. The model that is applied in practice will depend on numerous factors, such as legislative and educational factors, and their scope of prescribing practice; however, they still need to focus on the whole person. In the chapter regarding on integrative care planning, the authors outline an approach referred to as the Integrated Treatment Plan (ITP) model, and we refer to it here as an additional tool to ensure all factors are considered when prescribing for an individual. This could then help the prescriber and the individual they are prescribing for see outside the narrow confines of the biomedical model and truly integrate a holistic view into their practice. The risk of a reductionistic outlook that can come with prescribing is well known and has been documented [47], and models of integrated care can be used to ensure a holistic approach is maintained.

Case Example 1
Name: Dr. Kristin Hjartardottir
Qualifications: BSc, RN, PhD

My name is Kristin Hjartardottir, and I am an advanced practice nurse with Allina Health, in Minneapolis, Minnesota. My highest academic degree is a doctorate of Nursing Practice (DNP), and my specialty is in psychiatric mental health nursing. My current role is on the Consult-Liaison Psychiatry service at a large metropolitan hospital. I see individuals who are admitted to the general hospital for medical or surgical reasons as psychiatry consult for their primary team. My role is to assess individuals and their circumstances and make recommendations for the team. Most of the individuals that I see experience depression and anxiety, delirium, dementia, substance use disorders and psychosomatic illnesses. While I work independently on a team of three, both my colleagues are psychiatrists, and we are able to discuss and share experiences, which is a practice I find extremely helpful and supportive. I completed a BSc in nursing at the University of Iceland and my doctorate of nursing practice degree at the University of Minnesota. My graduate programme was a total of 16 semesters, or 3 years in total, and about 1000 clinical hours. In my role in the hospital, I am authorised to not only write prescriptions for medications while individuals are hospitalised but also to provide them with prescriptions upon discharge as required. At times, I see the same individuals throughout their hospitalisation, and some of them I see each time they are admitted. The people I see are generally medically complicated, and I collaborate extensively with all members of their team including hospitalists, neurologists, cardiologists, etc. I am certified with the Minnesota Board of

Nursing and am required to renew my advanced practice licence every 5 years and my registered nurse license every 2 years. My certification is through the American Nurses Credentialing Centre (ANCC), and I have to complete 75 continuing education hours (CH), including 25 h of pharmacotherapeutics, and 1000 h of clinical hours every 5 years. I keep up with my Continuing Medical Education (CME) credits by various methods including attending conferences for psychosomatic medicine and psychiatric nursing and reviewing literature in my specialty.

With my background in nursing, I am able to fully assess and incorporate individual's needs and goals and their supporting systems, in my plan of care. To be effective in meeting people where they are at, I spend a lot of time assessing their abilities in navigating the healthcare system and connecting with services outside of the hospital. At times, I am needed in addressing complex decision-making processes such as determining whether someone needs to be admitted to the mental health units, or if they have the capacity to make decisions on their own behalf. In my role, I am often the person's advocate, which can be challenging but in most cases very rewarding.

Case Example 2

Name: Daniel McTiernan

Qualifications: RPN, RCN; RNP, MSc Mental Health (Child, Adolescent and Family); Prof, PG Cert (Advanced Practice); FFNMRCSI

My name is Daniel McTiernan, and I am an advanced mental health nurse practitioner working for the Health Services Executive—Linn Dara, Child and Adolescent Mental Health Services (CAMHS) in Dublin, Ireland. I specialise in working with young people with attention deficit hyperactivity disorder (ADHD), and my prescribing practice is focused within that area. Nurse prescribing is tightly regulated in Ireland, and it is only since 2017, following changes in legislation, that registered nurse prescribers working in the specialist area of child and adolescent mental health were permitted to prescribe the controlled drug methylphenidate hydrochloride, which is used in the treatment of ADHD. This change has really enhanced my practice as it allows me to complete a full episode of care for the young people that are referred to the ADHD Assessment, Diagnosis, Management initiation, Research and Education (ADMiRE) service. Prescribing is only one element of my role as an ANP, but it complements my approach to mental health nursing, which is both person-centred and holistic, requiring me to work closely not only with young people but also their parents/guardians and siblings as well. My prescribing practice is underpinned by the therapeutic relationships I develop with the families I work with and a sound theoretical and clinical knowledge of ADHD and the medicines that are used to treat it.

Because my expertise is in the area of ADHD, my scope of practice permits me to prescribe medicines typically used in the treatment of ADHD. Prescribing medication requires an assessment of the young person's bio-psychosocial needs, the provision of psycho-education around diagnosis and management of ADHD, gaining consent from parents/guardians and assent from young person, utilising evidence-based titration procedures and the monitoring of therapeutic responses and side effects. This presents some challenges in the sense that educating young people about ADHD, their prescribed medication(s) and their effects require novel approaches to psycho-education. In addition, managing expectations about the efficacy of drug treatments need to be carefully managed for both young people and their parents/guardians. This is made easier by my expertise in the area and the maintenance of relationships with young people and their families, which allows open discussion about the risks and benefits of pharmaceutical approaches. The addition of prescribing to my ANP role has resulted in shorter waiting times and greater choice for the young people referred to the service while also allowing me to work autonomously to assess, plan, treat and discharge young people independently. While there are marked benefits to nurse prescribing, there are some challenges. The tight regulation meant that a number of support systems needed to be in place before I was able to practice as a nurse prescriber. In addition, legislative restrictions mean that nurse prescribers in CAMHS are not permitted to prescribe lisdexamfetamine dimesylate, an alternative to methylphenidate for young people who do not respond to or cannot tolerate methylphenidate. In these instances, I need to refer the young person to my medical colleagues for treatment, which is disheartening as I have often worked closely with them and their family. Recently, as part of my leadership role, I have led the submission of a position paper advocating that CAMHS nurse prescribers be allowed prescribe lisdexamfetamine in light of the improvements that nurse prescribing has brought to the experiences of young people within the ADMiRE service.

Case Example 3

Name: Fauzia Khoenkhoen

Qualifications: RN, ANP, MSc

My name is Fauzia Khoenkhoen, and in the past, I worked in community primary mental health care as an advanced nurse practitioner in the Netherlands. In that setting, my caseload consisted of approximately 90 service users. Independently, I completed the initial assessments for anti-depressant prescribing although in complex cases, the psychiatrist takes the lead in prescribing activities. I was also reluctant to prescribe medication for individuals outside my own caseload. Since 2011, I am legally licensed to prescribe the full spectrum of psychiatric medication. However, it was helpful to focus on medication for anxiety and mood disorders at the start of my ANP career. This was an ongoing in-depth learning process and being mentored by an experienced psychiatrist who enhanced my competencies in this specific area gradually. Apart from this clinical post, I am also appointed as lecturer in clinical reasoning at the University of Applied Science, Utrecht, in the Netherlands and the Institute of Nursing Studies.

I am currently appointed in a totally different setting: a psychiatric ward in a prison. In this setting, I am involved in 22 complex cases, mostly prisoners experiencing hallucinations, delusions, elevated mood and suicidal episodes. In this setting, I expanded my prescribing practice to include the prescription and monitoring of anti-psychotic medication. Again, being able to consult other clinicians is vital; however, this is the same for physicians. In the prison setting, my role is valued as an exponent of the bio-psychosocial model and supports the other staff in the process of systematic observation, treatment planning and health promotion. The team works from a holistic perspective, which tries to deliver personalised care, investing extra time to establish therapeutic relationships to support the prisoners with their mental health needs and support medication management where necessary. Therefore, Dutch ANPs need to be trained at master's level, and in terms of lifelong learning, they need to engage in continuous practice development skills to maintain registration with as substantial number of these courses related to prescribing and pharmaceuticals. In the Netherlands, ANPs in mental health care settings have independent diagnostic and prescribing authorities. ANPs also take care of structured psychiatric evaluation, physical examinations and medication management. We realise we have to ensure public and multidisciplinary trust by transparent clinical reasoning. For this reason, we constantly review the latest relevant scientific findings and include these in our clinical reasoning process. Our core aim is not only to enhance the best possible service user outcomes but also to foster patient safety.

6 Conclusion

Pharmacology plays an important, and at times, essential, part in many evidence-based care plans for people who come into contact with the mental health services. Prescribing is an emerging speciality within advanced practice roles in mental health nursing. Approaches to nurse prescribing vary across countries that currently permit nurse prescribing in Europe, with frameworks for prescribing dictated by legislative changes and regulatory bodies. Independent prescribing is favoured over supplemental prescribing, which is thought to favour greater flexibility in terms of responsiveness to service user need [47, 48]. While research about nurse prescribing generally is in existence, there is a lack of research specifically within mental health nursing. More research, which explores service users and mental health nurses' perceptions and experiences of nurse prescribing, is required to support and enhance its implementation especially as part of the APMHNs role. Perhaps, the most important element of nurse prescribing is the nurse's ability to provide a complete episode of care, which can lead to reduced medication errors and reduced waiting times for service users [19]. More research, which teases out these elements within mental health nursing practice, is required. We believe that nurse prescribing, carried out in an organised and holistic manner, can enhance quality and access to care for mental health service users where medication is indicated. The values that underpin mental health nursing must be inherent in prescribing practices to ensure that the needs of service users remain central and that the therapeutic relationship, autonomy, choice and shared decision-making are the lens through which all prescribing decisions are made.

Reflective Questions

- Thinking about your own practice, in what ways does prescribing enhance the care that you provide to the service users you work with? If you are not a nurse prescriber, how might prescribing enhance the care you provide?
- How does a recovery-oriented philosophy fit with the concept of nurse prescribing?
- What strategies do you use to maintain your competence specifically within the nurse prescribing domain?
- With reference to the oppositional discourses presented in Box 1, in what ways does knowledge of these discourses enhance your prescribing practices?

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Part IV

Beyond the Clinical Dimension of the Advanced Practice Mental Health Nursing

Educational Aspects in Advanced Mental Health Nursing Practice

Nina Kilkku and Bengt Karlsson

Learning Objectives
The objectives of this chapter are to enable you to:

- Critically reflect the theoretical underpinnings of the educational aspects of the advanced practice mental health nursing role.
- Recognize and appreciate the different forms and dimensions of knowledge influencing practice.
- Enhance collaborative knowledge development in different educational levels of mental health care.

1 Introduction

In nursing, the issues of knowledge and learning have always been part of the caring. We might not always recognize this, but as our work in mental health nursing is based on an attempt to understand and collaborate with another human being, it invites and demands us to step into these joint learning processes. In these spaces, we learn with the person who is seeking help, not only from each other but also about each other. We are not only sharing knowledge but also developing knowledge together in a way that is beneficial for the current situation and beyond [1, 2].

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The context for these encounters is most often within the dyad of the nurse-patient relationships[1] [3], but similarly, we can enter this kind of collaborative processes with families, networks, and other professionals in different mental health care settings. Actually, this collaborative approach is now emphasized as primary for all health care services [4].

Several studies highlight the importance of educational aspects of good mental health care from the viewpoint of service user [5] as well as families [6, 7]. Families would like to know more, for example, on how the mental health challenges develop in the long term, and many would like to be more involved on decision-making with professionals [7]. Families and service users need knowledge to be able to participate and to have possibilities for self-determination and choice, but it is not only knowledge possessed and transferred by professionals but also knowledge developed in collaboration with service users, families, and professionals to support recovery journeys [8, 9]. Advanced Practice Mental Health Nurses (APMHNs) are in key positions with other professionals to answer these needs. The international descriptions of the role of Advanced Practice Nurses (APN) highlight the educational role in addition to the clinical practice, research, and clinical leadership roles [10]. From the viewpoint of education, APNs are in a leading role in relation to the translation of knowledge into clinical practice, in educating others and in ensuring one's own ongoing learning [11].

One of the most common taxonomy used in the areas of education and learning is Bloom's taxonomy on competence with the concepts of *knowledge*, *skills*, and *attitudes*, including *values* [12]. These three concepts are used here to guide the structure of this chapter although in a different order, as attitudes and values are consider as primary in mental health nursing they are first and followed by knowledge and skills. So, this chapter commences by exploring some perspectives on the humanistic tradition and human rights, which are considered the foundations of mental health nursing [13], including the educational aspects of mental health nursing. Concepts like inclusion, freedom of choice, and self-determination become actualized in the everyday practice of mental health nursing when knowledge is developed together in the collaboration with the nurse, service user, and/or family. In this collaboration, power could be used in different ways. Besides being visible in actions, power often becomes visible in the words and concepts used. The language used can enable and support or hinder the collaborative recovery process [14]. Language plays a major role also in educational practices, just like Bertau and Tures [15, p. 14] have summarized from the viewpoint of dialogical learning: "*Learning is a dialogic activity shaped by language activity*." Therefore, the issues

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[1] In mental health nursing, we are using terms like patients, clients, service users, and people with lived experience, to describe the persons seeking help because of mental health challenges. These terms have changed in time, reflecting the theoretical, philosophical, and ethical approaches adapted in the field. In this chapter, the term "patient" is used in the historical context and when referring to Peplau's interpersonal theory (1952), Peplau's theory is considered as the key theory also from the viewpoint of educational aspects in mental health nursing. Later in the chapter, the terms "service user" and "people with lived experience" are used to highlight the more collaborative nature of the educational processes in advanced mental health nursing today.

of language, power, and the different dimensions of *knowledge* are highlighted as focal points, which could and should be critically examined, recognized, and positioned in different levels of educational practice in advanced practice mental health nursing. To advance this discussion, ideas around interpersonal, professional, and institutional levels of educational practice, in which different kind of educational *skills* are needed, are introduced together with different levels of health prevention as well as examples of some educational theories. The main focus of the chapter is on the interpersonal level, the service user-nurse relationship, in which the educational aspects are not seen as separate interventions but undivided parts of both the relationship and the whole caring process. In the end of the chapter, some consideration is given to education within new settings. To encourage the readers to consider the different options and settings of mental health nursing from the viewpoint of the educational aspects and collaborative knowledge development, some projects that are being conducted internationally are presented as case examples.

2 Setting the Scene

"*My heart is crying every time I see a patient being treated like that. Imagine if that was one of us*." The quotation is from a mental health nurse in an acute psychiatric ward observing a patient being restrained with a belt and left alone in a room. The statement can be seen as an illustration of the nurse's empathy toward the person being treated in this way and resistance to the application of such treatment. The statement can also be interpreted as a revocation of the position as a professional, and the attempt to see oneself as a fellow human being in relation to the person who suffers mentally. It can also express a resignation over the psychiatric system as an exercise of power that ignores service users and staff as conscious and opinion-seeking individuals or an appeal to possible change and rebellion that may lie in trying to take the other's position.

A service user at the same ward said: "*I really need someone to talk to. One whom understand me. I have never had a professional who tried to see things from my point of view*." The quotation is from a person with over 30 years of lived experience of being a service user and having mental health challenges. The significance of the conversation in the relationship and in the collaboration between a nurse and a service user is the cornerstone of mental health nursing. The conversation as a metaphor and idea—"to empty oneself"—gives a very precise expression of what is to happen in the collaborative relationship. Many former service users use terms such as "emptying themselves of bad things" and insist that this is necessary to move forward in their lives. The experience of not being met or not being given the opportunity to talk for those who want it can be experienced as abusive and inadequate care [16]. This is contrary to the nurses' professional values and an empathetically understood perception of what good care should be characterized by. The service users' experiences of suffering mentally are crucial to be able to understand these experiences as people's own experiences of suffering. The conversation in mental health nursing can help highlight the experiential knowledge of the service user and give direction for clinical practice. The quotes above show how basic humanistic concepts and ideals are put into play in humanistic practices within mental health nursing. The humanistic tradition in mental health nursing actualizes concepts such as respect, dignity, freedom, and self-determination in both theory and practice. There is a historical and contemporary perspective in mental health nursing that manifests itself in daily meetings, encounters, and conversations between a service user and a nurse.

2.1 Human Rights and Mental Health Nursing

In the Human Rights Council resolution 42/16, the Special Rapporteur elaborates on the need to set a right-based global agenda for advancing people's rights to mental health. In relation to this, the Special Rapporteur continues: "*This frozen status quo reinforces a vicious cycle of discrimination, disempowerment, coercion, social exclusion and injustice. To end the cycle, distress, treatment and support must be seen more broadly and move far beyond a biomedical understanding of mental health*" [17, p. 1]. The Special Rapporteur highlights the need for global, regional, and national conservations on how we currently understand and respond to people experiencing mental health challenges. Discussions and actions are centered on a rights-based, holistic, humanistic approach, and rooted in the lived experiences of those left furthest behind by harmful sociopolitical systems, institutions, and practices [17, 18].

Among the number of recommendations made, the Special Rapporteur also states: "*All people are entitled to active and informed participation in issues relating to their mental health, including at the level of care and support services. Everyone, regardless of their diagnosis, the voices they hear, the substances they use, their race, nationality, gender, sexual orientation or gender identity, or other status, is guaranteed the right to non-discrimination in accessing care and support for their mental health. Respecting the broad diversity of how human beings process and experience life, including their mental distress, is critical to ending discrimination and facilitating equity in mental health provision. The obligation to respect diversity requires establishing a diverse package of options for people seeking care and support. "One size fit all" care models (in the absence of alternatives), particularly those which favor a rigid biomedical narrative of psychosocial distress, are not considered compliant with the right to health. Peer-led initiatives, harm-reduction approaches, and co-produced models of care and support offer much promise in facilitating flexible, non-discriminatory, and respectful therapeutic alternatives*" [17, p. 15].

A humanistic position does not imply a requirement of infallibility on the part of either institutions, systems, or individuals. However, an analysis is needed to reveal both the humane and inhuman traits and practices simultaneously occurring within institutions and organizations and how one can systematically work to promote the human. A useful starting point may be to acknowledge the ambiguity of care; one can both give and receive too much and too little care [19]. Hummelvoll [20] refers to Barker [21] in elaborating what values a nurse in practice can be helped by to meet the human being in a psychiatric setting:

1. **Do no harm**: When we have caring responsibilities for someone, it is necessary to keep asking: What would be helpful? How do we avoid doing harm? Doing no harm requires sharp attention, watchful presence, and moral sensitivity.
2. **Maintain dignity and respect**: When people become patients, service users, or clients, they may be in danger of being reduced to their illness and thus be subjected to various forms of violation. Therefore, we need to cultivate an atmosphere, a caring culture, where the person's dignity is maintained and where the individual is respected as a person. This in turn will probably result in the staff being treated with dignity and respect in return.
3. **Provide a safe haven**: Ensure safety. People need a place where they can experience tranquility and peace, a sanctuary/sacred space where they can get the opportunity to come to terms with their distress, illness, and situation; a place where they feel protected and where the pressure of suffering is eased by being shared with "helpers"/supporters.
4. **Accept people for who they are**: Any person or "patient" is someone's mother, someone's son, someone's best friend, or someone's lover. They are special to someone. However, people who need professional help and care can often be demanding or difficult to help for various reasons. What we need, as helpers, is to accept the person for who they are, namely, a person who is special to someone—and who now is experiencing mental health challenges or problems.
5. **Feed them well and keep them comfortable**: Provide good food and make people feel comfortable. Food, drink, and personal well-being cannot be overstated. Often, too little attention is given to these basic needs. Tasty and healthy food and a pleasant meal atmosphere do not solve the problems that led the person to the mental health service or hospital. Nevertheless, this kind of care not only demonstrates respect but also will help build the strength needed on the journey toward recovery that lies ahead.
6. **Nurture an atmosphere of hope for recovery**: Nurture the hope of recovery. Most people want to overcome and to solve their life problems as quickly as possible. Good care and treatment are all about promoting an atmosphere where the person can begin to imagine a good life—and then take the practical steps necessary to manage personal everyday life in the community.

All these above values mentioned by Hummelvoll [20] are also guiding the educational aspects of mental health practices as they demand communication and collaboration between the service user and the nurse. In these processes, both the service user and the nurse learn and mature [3].

2.2 Power from the Viewpoint of Knowledge and Mental Health Nursing

In every relationship in mental health care, and in mental health nursing, power is at stake, especially when related to knowledge. This applies not only in the service user-nurse relationship but also in relationships between different professionals.

“Knowledge is power” or “Knowledge itself is power” are slogans introduced during the fifteenth and sixteenth centuries by Sir Francis Bacon and his successors. Having or sharing knowledge was introduced in connection with reputation and influence [22]. This idea of knowledge as a power can also be seen today in different situations of mental health care. For example, sometimes a mental health nurse can presume to “see” what is needed or presume how the best help should be provided without asking the person’s viewpoint. The person can thus be set aside, his/her opinions ignored, or instructed or told how to receive help. This approach is seldom useful and can be characterized as the use of relational power or power over the person. This approach epitomizes the idea of trying to change people from outside and against their will by using power. As mental health nurses, this didactive or instructive kind of help and knowledge is seldom useful. The help provided must be discussed and developed within the relationship, and the help must be recognized and felt as useful for the person.

Power manifests itself also in nurses’ responses to the questions asked by service users and the focus they put on the collaboration and conversation. Sometimes, unfortunately, power is used by ignoring the questions asked by service users [23] or by limiting information provided to service users [24], such as limiting information on side effects of prescribed medication because of fear of noncompliance [25]. The questions asked by practitioners, including APMHNs, also demonstrate power over, as they are often based on theoretical and practical knowledge. Focusing solely on questions from the professional perspective maintains the ambiguity and asymmetry in the helping relationships.

Foucault [26] claims that there are power relations everywhere and that it is crucial to study these as concrete power practices. Power is an element in all human relationships and is not basically positive or negative. In every relationship, we define and create meaning. The same goes for creating power and the relationship between power and knowledge. The relationship between a mental health nurse and a person seeking help is also asymmetrical. At the same time, this asymmetric relationship is a prerequisite for dialogue. The fact that the nurse and the service user have two different positions gives the basis for the meeting, the relationship, and the dialogue they are having. The meeting is not random. They meet in a context where one seeks help for something. The other can decide whether the person should receive help or not and what it may consist of. This gives asymmetry and expression of power on the part of the mental health nurse. The dialogue and the relationship between the two will determine whether the mental health nurse uses the power in a negative or positive way. The mental health nurses may make themselves available to the person with the intention that the person is in the driver’s seat. The crucial question is whether and how the person influences the relationship and the provision of the help given. By bringing different voices into the collaboration, multiple aspects of knowledge can be developed and a challenge made to the powerful and traditional understanding of expertise, helpful help, and power [27]. The power relation between a mental health nurse and the person do not disappear even with the best intentions and ideas. It is the professional who has the knowledge and power to frame and define the problems, symptoms, abnormalities, diagnoses, or normality, even if the interaction takes place in the person's home or elsewhere outside the nurse's domain. The basic fact is that the nurse can prevent or facilitate the help that the person wants or not. At the same time, power is productive, as Foucault emphasizes [28]. It enables the change that could be initiated by either the service or nurse or both. The changes can be made to develop a common expertise in the relationship between the nurse and the person seeking help. These changes can involve an expansion of the knowledge base, other roles and staff compositions, other roles for the person as well as understanding, making visible and working with conditions that represent barriers to the person's life processes. Such barriers can be medication, stigma, abusive language and conditions in the services, poverty, exclusion from the local environment and working life, and violations of human rights. This involves understanding and changing the power relations. The person's understanding and expertise should take precedence—not the nurses. Most important of all, however, is simply to ask one or all the following questions:

- What is important to you?
- What do you dream of?
- What are your wishes?
- What are your goals?
- What do you think it will take to achieve your dreams, wishes, or goals?
- What is stopping you from achieving these?
- Is there anything that can be changed in the environment and in your daily life that may help you move forward with what you wish for?

These kinds of questions can invite the person seeking help to share his or hers dreams, thoughts, and ideas. It is nurse's ethical demand to meet the persons responses with dignity and respect, to try and understand the spoken and non-spoken messages the person is conveying, and to join in discussion, in a joint learning process, with the knowledge the nurse possess. Power is used negatively when nurses hide their uncertainty in a professional jargon or increase the distance in the relationship in other ways, while the person seeking help might expect more closeness [29].

3 Different Dimensions of Knowledge for Advanced Mental Health Nursing

Aristotle argued that there are three basic dimensions of knowledge: experiential knowledge practical knowledge, and theoretical knowledge, all of equal importance—one is no more important than another. Experiential knowledge is gained through direct encounters with people, places, and things. This is the dimension of knowledge APMHNs gain in and through encounters with service users, families, and other professionals in different settings. Practical knowledge has to do with actions, competence, and skills, such as skills required to engage in different therapeutic collaborations, whereas theoretical knowledge is knowledge of something, which is expressed through theories in advanced mental health nursing. The development and use of these three forms of knowledge are core parts of advanced mental health nursing practice. In addition, the different dimensions of knowledge in advanced mental health practice are also enhanced through consideration of other forms of knowledge such as tacit knowledge, experimental knowledge, and evidence-based knowledge and practice.

3.1 Tacit Knowledge

Tacit knowledge is a knowledge dimension that has been given increased attention in mental health nursing in recent years [19]. Polanyi [30] introduced the concept of tacit knowledge and seeks to capture the unarticulated side of knowledge that takes place in the encounter between the individual and culture through action. Every day people meet and convey perceptions, ideas, and attitudes that are seldom articulated directly. Cultural frame of reference is taken for granted thinking that this is the way the world is—without questioning either the world or how we understand it.

A wealth of knowledge is transferred within the cultural and daily frame of reference of which people have mostly indirect or subordinate awareness. Learning happens by looking, imitating, listening, and reflecting on a variety of phenomena in daily life often without talking about it. It is an aspect of knowledge that is understood and shows itself in practice. In Polanyi's meaning of tacit knowledge, it involves understood or implied knowledge processes that are developed in action and interaction. It is a form of knowledge that can be difficult to articulate but that is tacitly understood (see Case Vignette: The Bubbling Body and the Hot Shower in "Therapeutic Alliance"). Polanyi argues the importance of experience and gaining experiences of tacit knowledge and is of the view that theoretical or formal knowledge is insufficient on its own.

3.2 Experimental Knowledge in Advanced Mental Health Nursing

Experimental knowledge or knowledge through experience can be drawn at least from two sources of knowledge. *The first source of knowledge is the service user.* She or he is the main source of knowledge on lived experiences about their specific life challenges and what can help. Every service user has experiences of what helps and what does not help. Everyone has some thoughts on what they want for the future and what is most urgent. It is through listening to their knowledge that the current lack of focus on how service users understand and experience their situation and what they think is helpful [31] will be reversed.

The other source of knowledge is the *mental health nurses' experiences*. Nurses' experience-based knowledge is closely related to the context in which they work and to service users' everyday lives and issues. Mental health nurses are sources of knowledge themselves, as they witness the persons' distress and suffering, as well as when they are experiencing their own emotional and cognitive reactions within the encounter [32]. In addition, many nurses have gained experiential knowledge through their own experiences of mental health problems or as a supporter to family members with mental health challenges—knowledge that can also positively benefit practice [33].

3.3 Evidence-Based Knowledge and Evidence-Based Practice

For the last 20 years, the requirement for evidence-based knowledge and evidence-based practice has increased within mental health nursing and in the mental health field in general. Procedures and standards have been developed for how evidence should be understood and applied. Sackett et al. [34] were the first authors in defining evidence-based practice as consisting of three foundations: (1) the best available research results, (2) clinical experience and expertise, and (3) the service user's wishes and values. In exploring the content of evidence-based knowledge, all these three sources of evidence-based practice are required.

Evidence-based knowledge cannot be detached from the context it arises in. The knowledge must be contextualized historically, culturally, and socially. The mental health field is characterized by contradictions, which are reflected both in policy guidelines and in professional guidelines. Some professional guidelines are based on an understanding of evidence-based practice that is closely linked to a narrow understanding of research as primarily randomized control trials (RCT) and is considered higher in the hierarchy of knowledge. However, as discussed, Aristotle in talking about theoretical, practical, and experience-based knowledge emphasized that one form of knowledge was, and is, not superior or truer than any other—they were, and are, equally worthy [35]. This idea is important in today's understanding of what is referred to as evidence-based knowledge. In some clinical contexts, theoretical knowledge may be considered higher on the hierarchy of knowledge, especially as evidence-based knowledge has precedence and occasionally a monopoly on what can be referred to as valid knowledge. The statement "This knowledge is evidence-based…" can indicate that when knowledge is developed through research-based methods, it is considered more valid than the other dimensions of knowledge.

If mental health care relies on only one dimension of knowledge, there is a risk that over time there is a gradually loss of confidence in the other dimensions of knowledge. This development can distance professionals from the service users' experiences as well as from their own experiential knowledge, which paradoxically leads to lower quality of care. Mental health nurses, including APMHNs, should allow themselves to a lesser extent to loosen this foothold and take experience-based knowledge seriously. In this sense, the development in the evidence-based movement is promising, as it incorporates service users' values, preferences, and perspectives within their conceptualization of evidence-based practice.

An interesting aspect of the development of evidence-based knowledge is the way Finlay [36] uses the concepts of *practice-based evidence*. Practice-based evidence is developed through systematic descriptions and evaluations of practices of collaborations and helpful help and seeks to provide space for the qualitative dimensions in the relationship and the collaboration that requires time and space to be developed and implemented. These systematic descriptions of practices from within or as something that suddenly appears can also be framed as evidence in that very moment. As such, the notion of practice-based evidence invites to broaden and challenge the traditional concept of evidence [19].

Another contribution to the understanding of evidence-based practice in mental health nursing is the *experience-based patient knowledge* [37]. Professionals and researchers need to promote, listen to, and create space for service users' experiences of suffering, respect, recognition, and the absence of recognition. Systematized descriptions and presentations of experience-based service user's knowledge are crucial elements in the knowledge development of mental health nursing. Listening and taking these experiences seriously will involve a fundamental shift in attention toward creating a new human professionalism in mental health nursing. Research-based knowledge shows how important practices such as respect, listen to, and speaking out are to quality care [37]. These practices are in play in every encounter of a service user and a mental health nurse but are easily eroded by systems and institutions.

The aforementioned forms and different dimensions of knowledge provide theoretical understanding on the many facets of knowledge. In everyday practice, we seldom stop to consider what knowledge is guiding our actions and practices as several forms of knowledge are there together. In all educational activities, the learning process are mutual; all participants learn from each other, although the type or dimension of knowledge may be different. For example, we can consider this from the viewpoint of APMNHs' educational activities, when translating the professional knowledge to service users and families and yet at the same time learning from their experiences on what is pertinent as helpful help and knowledge especially for this service user and for this family. Similar process could be recognized in the APMHNs educational role, for example, with students or other professionals; educational activities are mutual learning processes rather than one-sided information giving or knowledge delivery. In each of these encounters, we learn something new about the other(s) and about ourselves.

4 Levels of the Educational Practice

Concepts such as respect, recognition, confirmation, and being listened to are decisive in mental health nursing and not only in the service user-nurse relationship but also in all relationships of the mental health practice, including between professionals. These concepts can be given concrete expressions in different levels of educational practices: at the interpersonal level, the professional level and the institutional level, as well as in the different levels of health promotion. Often in everyday practice, these educational levels overlap as we move from one level to another according to who we engage with or the activities we do. For example, APMHNs in their everyday practices work alongside the service users and with families, networks, students, junior colleagues, and other professionals. Many of their educational activities will also have an influence at the community and societal level.

4.1 The Interpersonal Level

At the interpersonal level, during the encounters between the nurse and the service user, the individual person gains experiences on provided care as well as on the mental health service system. Experiences are based not only on the interpersonal encounter but also on the framework used by the APMHN, which affects the care provided. This applies to everything from the physical environment, its practical and aesthetic design, everyday life, the opportunities for peace and quiet, to how conversations about private and personal matters are framed as well as where they are conducted. Karlsson [38] demonstrates how time and conversation presuppose each other in a dynamic whole. The conversation requires time, and the time requires conversation in the form of the parties' mutual presence, openness, and authenticity. Time is needed to get to know, to be open, to express, to listen, to try to understand, and to communicate. In these encounters, the joint learning processes also become a reality, and the experience of trust can emerge: trust toward help and coping into the future [39].

Peplau's theory of interpersonal relations provides more understanding about this relationship as a joint learning and maturity process for both the mental health nurse and the patient/service user [40]. The theory identifies four sequential phases in the interpersonal relationship: *orientation, identification, exploitation, and resolution*. In the *orientation* phase, the nurse and the patient meet as strangers, and based on this encounter, the problem as well as the type of service needed by the patient is defined. The patient seeks assistance, tells the nurse what he or she needs, asks questions, and shares preconceptions and expectations based on past experiences. Essentially, the orientation phase is the nurse's assessment of the patient's health and situation [40]. This phase includes communication in which knowledge is developed and shared together. It is not only spoken information but also other kinds of knowledge gathered by observing and reflecting on these observations. Peplau reminds us that it is not only the nurse that is making observations and gathering information, but like in all human encounters, this process is mutual, as the service user is also asking questions, making observations of the nurse and reflecting on these observations, which continues throughout the whole nurse-patient relationship. Mental health nurse, in this case, the APMHN, is making the observations at a more conscious level, and the knowledge gained in this phase creates the basis for the next, and often overlapping, phases. However, this doesn't mean that the decisions for action are solely based on this phase, as they need to be flexible and follow also the person's changing needs. The second phase, the *identification phase,* includes the selection of the appropriate assistance by the APMHN. In this phase, the patient or person begins to feel as if he or she belongs and feels capable of dealing with the problem, which decreases the feeling of helplessness and hopelessness. The identification phase includes the development of a nursing care plan or a recovery plan based on the person's situation, desires, wishes, and goals. The *exploitation phase* uses professional assistance for problem-solving alternatives. This phase is the implementation of the nursing or recovery plan, taking actions toward meeting the goals set in the identification phase. When communicating with the person or service user, Peplau [40] describes that the nurse should use interview techniques to explore, understand, and adequately deal with the underlying problem. The nurse must also be aware of the various phases of communication since the person's independence is likely to fluctuate. The nurse should help the person exploit all avenues of help as progress is made toward the final phase [40]. In mental health nursing today, more collaborative terms on the identification and exploitation phase could be used to highlight the cooperative nature of the relationship. The viewpoints and experiences of the family, where possible, should also be included, when agreeing the contents of the nursing or recovery plan. While in the past the families' role used to be as information providers to professionals, similar to our work with service users, it should now be a collaborative process in which knowledge is shared and developed together and the possible needs of family members for support and care are also met [7]. The final phase of Peplau's theory is the *resolution phase*. During this phase, the nurse and the patient evaluate the situation based on the goals set and whether they were met and commence the process of terminating the professional relationship since the person's needs have been met through the collaborative process. Dissolving ties can be difficult for both if psychological dependence exists; however, during this phase, an emotional balance can be achieved, and both can become more mature individuals through the joint learning process [40].

The nurse has a variety of roles in Peplau's nursing theory. The six main roles are stranger, teacher, resource person, counselor, surrogate, and leader [40]. From the viewpoint of educational aspects of nurse-patient relationships, the roles of stranger, teacher, resource person, and counselor are important, although it should be remembered that all these roles overlap and can also work simultaneously in the practice. As a *stranger*, the nurse meets the patient/service user in the same way that the person meets a stranger in other life situations. Even as a stranger, the nurse needs to create an environment that enables trust to emerge, as trust is a crucial element of mutual learning within the relationship [39]. As trust is assessed in all encounters [41] and especially when people are seeking help, trust is important as it affects service users' decisions on what knowledge and how much knowledge is shared with the nurse [39].

Mental health nurses' second role is that of *teacher*, which traditionally means that the nurse imparts knowledge in reference to the needs or interests of the patient/service user. In today's context, the APMHN is more a facilitator of the coproduced knowledge process, and in this way, the nurse is a *resource person*, providing specific information needed by the patient that helps the patient understand a problem or situation. The nurse's role as a *counselor* also supports and helps the patient/service user understand and integrate the meaning of current life situations, as well as provide guidance and encouragement to make changes [40].

4.2 The Professional Level

In professional practice, the APMHN ability and skills for critical thinking and reflection are crucial to guaranteeing the quality of care and the ongoing professional development of the nurse. Reflection is considered an integral part and prerequisite of all learning processes. Reflection in action and reflection on action are terms introduced by Schön [42]. The first describes the reflection during some action, while the latter is reflection after the action or incident. Rolfe [43] highlights the importance of reflective practice and reflection in action, as in mental health nursing the situations are often complicated with no simple answers or solutions. These complicated wicked problems demand us to generate hypothesis, test them, and learn from them, in those very "in action" moments, together with service users in the different situations of the mental health care. This doesn't exclude reflection on action, which is frequently enacted through the process of clinical supervision [43].

The development of APMHN's skills in all educational practices could be described by adapting the ideas of Benner [44]. Benner [44] developed the concept known as "From Novice to Expert." This concept explains how nurses develop skills and an understanding of care over time from a combination of a strong educational foundation and personal experiences. The nurse can gain knowledge and skills without actually learning a theory. Benner describes this as a nurse "knowing how" without "knowing that." The development of knowledge in fields such as nursing is made up of the extension of knowledge through research and understanding through clinical experience. Benner identifies five levels of nursing experience: novice, advanced beginner, competent, proficient, and expert. The different levels demonstrate changes in the three aspects of skilled performance: movement from relying on abstract principles to using past experiences to guide actions, change in the learner's perception of situations as whole parts rather than separate pieces, and passage from a detached observer to an involved performer, engaged in the situation rather than simply outside of it. The levels also reflect movement from reliance on past principles to the use of past experience and change in the perception of the situation as a complete whole with certain relevant parts. Each step builds on the previous step as principles are refined and expanded by experience and clinical expertise.

A *novice* is a beginner with no experience. The *advanced beginner* shows acceptable performance and has gained prior experience in actual nursing situations. A *competent nurse* generally has 2 or 3 years of experience working in the same field. A *proficient* nurse perceives and understands situations as whole parts and learns from experiences what to expect in certain situations, as well as how to modify plans as needed. *Expert* nurses, who correspond to the APMHN level of practice, no longer rely on principles, rules, or guidelines to connect situations and determine actions. They have a deeper background of experience and an intuitive grasp of clinical situations.

The more expertise, the APMHN has the more they engage in collaborative practices with service users, families, and networks and in these encounters a greater variety of knowledge is valued, used, and developed together with simultaneous reflection in and on action. Cutcliffe and Goward [45] suggest that expert mental health nurses, such as APMHNs, who have extensive experience of acts of understanding with many people, are gaining tacit knowledge in these encounters, which could be described as informal, mini-phenomenological studies in themselves.

4.3 The Institutional Level

At the institutional level**,** the health care system in the Western countries appears as a complex and diverse sector consisting of different actors, professions, and conflicts of knowledge and interests. These conflicts and contradictions seem to be a structural necessity in large systems and organizations, promoting the actors' own interests. It may also seem that institutional systems, despite good intentions and goals, maintain the dehumanizing practices [31].

In different clinical practices, APMHNs will collaborate with different professionals and professions and encounter different professional knowledge. Often, these collaborations become reality in different kinds of teams. The *monodisciplinary team* consists of what is unique to each subject and each professional practice. APMHNs have monodisciplinary or subject-specific knowledge different from the knowledge of other professionals; a form of knowledge that is related to the fact that other professionals have knowledge and skills that are different from yours. In the *multidisciplinary team*, different professionals work together with an aim to accommodate the whole person, both physical, mental, social, and the existential. The multidisciplinary knowledge represents all the monodisciplinary knowledge separately and the whole through the multidisciplinary. The fact that different professionals, including APMHN, work together with their respective subject-specific knowledge aims to ensure a comprehensive care for the person seeking help. Each of the professionals gets to use their knowledge in relation to the knowledge of the other subjects. The interdisciplinary knowledge of the *interdisciplinary team* is something other than the multidisciplinary. It is something unknown, something undiscovered, and something exciting; a professional knowledge that none of the professions "owns"—it is outside and transverses specific disciplines or professions e.g., nursing, physiotherapy, social work and occupational therapy. It is an area of knowledge where the monodisciplinary identity and knowledge are put on hold. Family therapy can serve as an example of this. There are many people working there who have different educational and professional backgrounds including social workers, child welfare educators, mental health nurses, occupational therapists, and physiotherapists. Starting to train as a family therapist, you enter an unknown field with new professional codes and a new professional language. You need to put aside monodisciplinary identity and knowledge. Monodisciplinary identity and knowledge can be useful for your own professional identity as APMHN, but it can also be an obstacle to learning and being with people in new and different ways, in short, to be able to help in a new way.

The basic idea in different teams, excluding the monodisciplinary, is that something more is gained as a collective competence. However, these two, the individual and collective competence, are intertwined together as Boreham [46, pp. 14–15] describes: "*At a surface level of analysis, we can identify some competencies as individual and some as collective, but going deeper we will discover individual competencies whose purpose is to promote collective competence, and collective competencies whose purpose is to promote individual competence*." Team-based learning, in which the development of collective knowledgebase also happens, might be the way to value and utilize both types of the competence to develop more person-centered care [47]. Therefore, reflection should be not only an individual process enabling individual development but also a dialogical process, a dialogical reflection, enabling the teams and communities of practice to learn and develop together [48].

4.4 APMHNs' Educational Role in Different Levels of Health Prevention

Today, mental health nurses, especially APMHNs, are working more and more in settings other than the traditional mental health services. These settings and services demand different kind of educational approaches. A brief look to the different levels of prevention and educational implications for APMHN is important. The levels of prevention presented by World Health Organization (WHO) are guiding this discussion [49, 50].

The *primary level* focuses on promotion, meaning activities to support well-being and health, often at policy- and society-level actions, as well as supporting the health of groups. From the mental health viewpoint, this means providing and strengthening the protective factors of health and mental health, like healthy lifestyle, nutrition, and social relationships ([51], see also "Advanced Practice Mental Health Nursing and Mental Health Promotion"). Primary level activities are often conducted through different public health campaigns that provide general health information to groups, communities, and societies. In mental health field, examples of these kind of campaigns are the ones aiming at reducing stigma and negative attitudes toward people experiencing mental health challenges [52, 53]. As nurses, APMHN can adapt the knowledge from different nursing theories and have an active role in these activities alongside other professional groups and the general public [54].

At the *secondary level*, the aim is to prevent symptoms or mental health problems/disorders occurring, often by working with groups or individuals recognized to be at risk. There is a vast amount of knowledge of different risk factors for ill health and poor mental health, many of them not only at society level but also at the level of groups, families, and individuals. Unemployment, economic stress, substance abuse, and loneliness are examples of different factors affecting negatively in mental health (see "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing"). In mental health practice, different risks and protective factors should be acknowledged by all professionals, especially by mental health nurses and APMHNs who are working most intensively with persons seeking mental health support. At this level, one example of prevention is the support and care provided to children whose parent is experiencing mental health challenges. Models like “Let’s talk about children” aim at decreasing the children’s risk for mental health challenges by supporting parents to see situation from the children’s viewpoint and talk with the children about the situation (see “Collaboration with Families, Networks and Communities”). APMHNs can have a central role in working with parents and children and by educating other mental health nurses and professionals in this approach.

The tertiary level is where most of the health care professionals, including mental health nurses and APMHNs, work. This level is focused on people who are experiencing health problems, including mental health problems that led them to help seeking from health care or other services. Hence, the emphasis is more on care and prevention of relapse; however, the other levels are included in here as well. Sometimes, it is not so easy to recognize, but the work of APMHNs includes aspects of all these prevention levels, despite the working context or environment.

5 The Role of Educational Theories in APMHNs’ Skills’ Set

In different environments, with different learners and with different learning objectives, different educational theories guide the practices of APMHNs. There is no single theory that addresses all contexts, but in any other professional area, educational competence is a professional competence on its own, based on careful assessing and planning. Therefore, APMHNs need to acknowledge and critically reflect on the kind of educational competence that is needed in different situations and study different educational theories and approaches according to the learning needs. For example, the knowledge based on andragogy can give theoretical understanding to adult learning when working with adult service users, students, and other professionals [55].

Theories like Kolb’s experiential learning [56] or Mezirow’s theory on transformative learning [57, 58] could be beneficial to understand the individual learning process as well as the process of mutual learning. The ideas of critical pedagogy by Freire [59] are also important guiding principles in the collaborative learning processes, as they are based on the on the ideas of co-learning through dialogue and reflection [60]. The abovementioned are only few examples of different educational theories, which APMHNs could use to inform and underpin their practice.

6 Terms and Language of the Educational Aspects

The educational aspects of APMHNs’ work could be a more visible part of practice in the future, and specific emphasis should be put on the language and terms used about these practices. Our values, attitudes, and philosophical standpoints are reflected in the actions and the language we use. Language provides the basis for thinking, and it is through language that reality is constructed [61]. The language used can enable and support the collaboration, or make people feel excluded and powerless [14]; therefore, it is important to acknowledge the background of the terms used and critically reflect them also, in this case, in the educational context. For example, the term “psychoeducation,” a widely used term today, is often framed within a biomedical model of care [39, 62], which is a contradiction with today’s ideas of empowerment [63]. The term doesn’t reflect the value based on mental health nursing and risks making service users feel patronized or less than active participants in the care and leaning process [64]. However, as a practice, psychoeducation seems to be beneficial to many (e.g., [65]); hence, we suggest terms such as co-production or co-creation be used in conjunction with the educational aspects of the mental health nursing as they are attempting to describe more equal and collaborative ways of co-operation. Also, with these terms, there are sometimes challenges in different languages to find the right terms or translations to capture the meaning. Hence, if we want to change the educational practices of mental health nursing toward more participatory, equal, and inclusive, change in the terms we use is needed.

7 New Settings of the Educational Practices

Today, mental health professionals are working more than ever in the digital world (see “e-Mental Health and Health Informatics”). The COVID-19 pandemic has accelerated this development, and there will probably be more research in this area, also in the context of mental health nursing and, hopefully, from the viewpoints of service users, families, and mental health nurses.

From the educational viewpoint, these developments provide not only challenges but also many opportunities. There is a vast amount of knowledge and materials available online, and different digital online programs have been developed. Several of these are beneficial in many ways, but the reliability and accuracy of the information should be negotiated together with a service user and family to meet their needs. The professionals should invite service users and families in these discussions and consider the options carefully together. In the development of these new options and ways of working, APMHNs have an important role to ensure that the person-centered, humanistic approach remains intact.

Besides the digital options, there are several other settings beyond the traditional mental health services in which APMHNs could have an important role also from the viewpoint of the educational aspects. One example of these new settings are the recovery colleges, which have been established in several countries [66]. Within the recovery colleges, there is variety in how they are organized, the extent of the different provided, and who is leading the educational activities. The recovery approach itself challenge all professionals, including APMHNs to “step out of offices” and to enter environments, which might not be familiar to them, but which could be important meeting places for persons with lived experiences and their families. Such low threshold places are often based on the ideas of peer support and collaboration. These places also provide APMHNs new ways get to know people, to participate, and to learn from each other. Below, we have gathered some projects as examples to encourage the readers to think about the collaborative knowledge development beyond traditional mental health settings (Box 1).

Box 1: Projects as Examples of Collaborative Knowledge Development

From double trouble to dual recovery, increasing recovery-oriented rehabilitation (ROR), and quality of life through collaborative partnership. The project focuses on people with coexisting mental health and substance abuse problems and who live in municipal housing measures. Residents, employees, and researchers collaborate in the development and implementation of the project. The project has a collaborative action research design with both qualitative and quantitative components. The research project is funded in its entirety by the Research Council of Norway, through the program Good and accurate diagnostics, treatment, and rehabilitation.

Homepage: https://www.usn.no/forskning/prosjekter/andre-prosjekter/from-double-trouble-to-dual-recovery/

Publications:

- Ogundipe E, Sælør KT, Dybdahl K, Davidson L, Biong S. "Come together": a thematic analysis of experiences with belonging. Adv Dual Diagnosis. 2020;13(3):123–34.
- Nesse L, Gonzalez MT, Aamodt G, Raanaas RK. Recovery, quality of life and issues in supported housing among residents with co-occurring problems: a cross-sectional study. Adv Dual Diagnosis. 2020;13(2):73–87. https://doi.org/10.1108/ADD-10-2019-0014 [67].

Recovery on the pitch. The research project focuses on describing and exploring how people with substance abuse and mental health challenges experience participation in street team football. The study focuses on the participants' experiences with street football in relation to their recovery processes, their social situation and life situation, and any ideas of changes and improvements of the teams. The project was set up as a collaborative research project, whereas the players, the coaches, and the researchers developed and implemented the whole research process.

Publication:

- Ogundipe E, Borg M, Thompson T, Knutsen T, Johansen C, Karlsson B. Recovery on the pitch: street football as a means of social inclusion. J Psychosoc Rehabil Ment Health. 2020;7:231–42. https://doi.org/10.1007/s40737-020-00185-6.

The EOLAS project: EOLAS, which is the Irish word for knowledge, are a suite of education programs designed for service users, who experience psychosis and their family members. There are co-produced with service users and families and co-facilitated by peers and clinicians. They are designed to be deliver in a face-to-face group format, with the support of handbooks/manuals. The programs have been extensively evaluated using participatory methodologies, disseminated using traditional approaches such as peer reviewed papers with participants as coauthors and other less traditional approaches, such as videos and photography. The Project was funded by the Health Research Board and the Health Service Executive in Ireland. Currently, the EOLAS team are designing the programs for real-time online delivery, which includes an evaluation.

Homepage: EOLAS—Psychoeducation programmes for psychosis and bipolar disorder. https://eolasproject.ie/.
Publications:

- Higgins A, Murphy R, Downes C, Barry J, Monahan M, Doyle L, Gibbons P. Beyond the moment: influence of a co-facilitated education intervention on practitioners' recovery beliefs and practices. Int J Ment Health Nurs. 2020;29(6):1067–78.
- Higgins A, Downes C, Hevey D, Boyd F, Cusack N, Monahan M, Gibbons P. Evaluation of a peer and clinician co-facilitated information and learning mental health programme for Service Users: the EOLAS Programme. Irish J Psychol Med. 2020;37(2):89–98. https://doi.org/10.1017/ipm.2019.32. Epub 2019 Aug 7.

8 Conclusion

In this chapter, the educational aspects of advanced practice mental health nursing have been described from several viewpoints. The approach of the chapter is based on a humanistic approach toward care and learning. Throughout the chapter, these approaches are closely intertwined with an emphasis on the service user-nurse relationship, as it is in the context of the relationship that care and education happens. Issues of language, power, and the different dimensions of knowledge have been highlighted, together with different levels of educational practice: namely, the interpersonal, professional, and institutional levels as well as at the level of prevention. However, humanistic approaches and the educational competence of APMHNs are relevant in the ever-changing environments of service user-nurse encounters, such as those provided by digital solutions and other new settings.

We have expressed our concern for the understanding of knowledge referred to as evidence—or evident—in certain way. This applies to evidence-based knowledge as true and correct and has been developed with a certain methodological approach. Our starting point is a broader understanding of evidence that includes all equivalent forms of knowledge as described. Given the diversity of the areas of knowledge, they will also require different methodological approaches to make them more visible.

Reflective Questions

- When thinking about your daily practice as an APMHN, what educational aspects and dimensions of knowledge do you find there?
- What concepts do you use to describe the educational aspects of care in your practice, and what is their philosophical underpinnings?
- What are the next steps in your career as an APMHN to develop, support, and enhance collaborative knowledge development in different educational levels?

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Advanced Practice Mental Health Nurses as Leaders

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Learning Objectives

The objectives of this chapter are to enable you to:

- Understand the importance of organization-wide nurse leadership in mental health care in the current volatile, uncertain, complex, and ambiguous environment.
- Discuss why transformational and transformational-like leadership styles are most appropriate for the nursing context.
- Identify what effective leadership behaviors entail and what intrapreneurial behaviors are and more specifically how APMHNs can contribute to sustainable change by using their influence, by helping other nurses express their values and mission and inspiring them to a shared vision.
- Debate how the development of leadership of APMHNs can be realized by investing in enablers and eliminating barriers.

1 Introduction

Advanced practice nurses (APNs) including APMHNs are expected to show leadership in their advanced roles within practice settings, health organizations, and governments. Leadership is a core competency of the advanced practice nurses' role as

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is claimed by the International Council of Nurses [1–3]. Hence, nurse leadership is considered within many European countries as one of the important components and competencies included in the role of APNs [4]. Some European countries have established frameworks and regulations within their national policy, which emphasize leadership and excellence roles of the APNs [5, 6].

Mental health care is developing and fostering new ways of thinking and managing care into the twenty-first century, with both opportunities and challenges, including strong emphasis on increased community mental health delivery, telemental health and collaboration with service users on their recovery. APMHNs are expected to be on the cutting edge of knowledge and clinical skills in their professional development, which includes using up-to-date leadership knowledge and skills [7]. They must learn to be creative and innovative to be able to question constantly the care they deliver and improve their clinical practice. Furthermore, APMHNs must participate and lead transformations and become entrepreneurs or intrapreneurs in mental health care to build a creative workforce [8].

Although nobody doubts the pivotal role of nurse leadership in the healthcare system, there is still a lot of work to be realized with regard to the development and implementation of nurse leadership. The 2010 landmark report of the Institute of Medicine (IOM), The Future of Nursing: Leading Change, Advancing Health [9] states that the nurse profession should produce leaders at all levels of the organization to achieve the transformation the healthcare system currently requires. An increase of aging people and an increase in the incidence of mental health problems are seen as reasons for the needed change. APMHNs need to participate in this indispensable change and become leaders in clinical practice, management, and policy making [10, 11].

The IOM called this leadership at all levels “leadership from the bedside to the boardroom,” which refers to leadership from every healthcare worker on the one hand and leadership from people in formal, hierarchical positions on the other hand [12, p. 7]. Six years after the first IOM report, Altman et al. [13] published a new report, assessing the progress made on the 2010 recommendations. One of the conclusions made in the second report was that the availability of leadership did not meet the requirements for the current nursing context. They cite the fact that there is a looming shortage of nurses prepared to assume leadership roles. Boveda and Metz [14] relate this to the retirement of baby boomers. They also mention the fact that, at least in the United States, there is a decrease in the number of nurses represented at the executive level. Unfortunately, this is happening in other levels of nursing too. Therefore, it is crucial in mental health care to counterbalance these trends and systematically build leadership into the role of the APMHNs in all the European countries.

APMNHs are in a strong position to be leaders implementing breakthrough practices in mental health care. APMHNs in Australia [15] influenced mental health practice by emphasizing the recovery focused principles of promoting hope, autonomy, and participation to improve lives of people with mental health problems. Moreover, the ACMHN encouraged mental health nurses to establish and develop community mental health organizations/enterprises using recovery in close collaboration with their service users. These APMHNs were in a leadership and entrepreneurial role by being both managers and clinicians of their own practice [8, 16, 17]. There are exciting times ahead in mental health care in Europe as more APMHNs are establishing themselves as innovative and visionary leaders in close collaboration with the service users and mental health professionals in meeting the mental health challenges ahead [18, 19].

In this chapter, we first describe generic and specific challenges regarding APMHN leadership. New insights into traditional leadership theory are introduced, and the difference between management and leadership is explained. Then, we present what is generally considered the most important leadership theory in the nursing context, the transformational leadership theory, and we highlight the decisive influence of that theory. Moreover, we explore the opportunity for APMHNs to become entrepreneurs, which at the individual level is currently called "intrapreneurial behavior." The section on attributes and practices of effective leadership in this chapter begins with an example of how Dr. Helga Sif Fridjonsdottir, an Icelandic APMHN, demonstrated how her leadership had an impact on mental health care. We emphasize that APMHNs are change agents and have to be aware of their influence and the need to involve other nurses in the change process by developing a strong mission and a shared vision of mental health nursing for the future. In the last section, we pay attention to both barriers and enablers to APMHN leadership development before we conclude with a discussion on how much the APMHN contribution to strong leadership in mental health is needed.

2 Generic and Specific Challenges Regarding APMHN Leadership

APNs are confronted with both general and specific challenges. One of the generic challenges is that APNs struggle with defining their leadership roles in healthcare. APMHNs in mental health care seem to be struggling with the definition of the leadership role as well (Casey 2011 in [20]). The term clinical leadership is a rather new concept in nursing [21]. Clinical leadership includes that evidence-based nursing interventions are systematically applied to deliver excellent outcomes for individuals and families [22, 23]. Clinical leaders are at the heart of clinical services, they are role models in delivering quality clinical care, and they motivate others to do the same [21, 23]. Therefore, it is necessary to help nurses at all levels and within all specialties, APMHNs included, to define their leadership role in their clinical practice [10]. We continue the discussion on clinical leadership in the section on transformational leadership.

Another example of a generic challenge is the conflict between the increasing amount of care demands and the everlasting shortage of nurses. New organizational models need to be developed, and the role of mental health nursing leadership has to be given space to develop [7, 10]. Furthermore, there is a conflict between quality and safety requirements and the restricted budgets to deliver high quality and safe care. Since the influential reports "To err is human" [24] and "The Quality chasm"

[25], a healthcare system without accreditation and public reporting is unthinkable. But at the same time, nurses are faced with an aging population and its ever-increasing care needs including demand for mental health services that are often barely affordable.

An example of a specific challenge in mental health care is building safety into nursing practice, for example, by implementing clinical leadership methods. This means implementing calm and confident nursing care to prevent crisis and to manage unpredicted crisis in mental health environments [26]. Another specific leadership challenge mentioned in an interview study with nurses in adult mental health care included leadership struggles with behaviors of service users treated for psychosis and addiction. The nurses described feelings of responsibility and meaningfulness that were mixed with feelings of powerlessness and uncertainty. Also in that study, the nurses experienced feelings of being needed, being supported, and being skilled, but at the same time, they experienced feelings of moral frustration, beginners stress, and an unclear leadership mandate within their clinical practice [20].

To overcome generic and specific challenges, profound and sustainable change must be achieved. The leverage for such drastic transformation is leadership. This is not the monopolized responsibility of people in managerial positions, but of all members of the organization [27].

3 New Insights into Traditional Leadership Theory

Since the early 1960s, leadership is seen as contingent, which means that it is strongly related to the context. As contexts evolve over time, the way leadership is seen also evolves. Therefore, traditional thinking about leadership is challenged. We elaborate on that in the next paragraphs.

The world in general and healthcare in particular are often described as “VUCA” [28]. This acronym stands for volatile, uncertain, complex, and ambiguous. The COVID-19 pandemic is an obvious example of how the world was thoroughly disturbed by rapid, unpredictable changes, high amounts of uncertainty, multiple complex intertwined evolutions, and high ambiguity about the effect of actions [29]. The VUCA acronym is undeniably applicable to the mental health care system as these phenomena can clearly affect the APMHNs’ everyday work. Not only is the nature of mental health problems, diagnoses, care, and therapies complex and uncertain, but the way the mental health sector tries to find answers to the need for integration and coordination is subject to disruptive change [30, 31]. Also, in mental health, the COVID-19 pandemic demonstrated how rapid and unpredictable changes in our environment with high ambiguity affected the delivery of mental health nursing not only during the pandemic but also in the future planning of mental health services [32].

It is clear that traditional principles of organization do not offer conclusive answers to the VUCA challenges. These principles, which rely on a mechanistic view on organizations, often described by the “well-oiled machine” metaphor state that employees and teams operate in predetermined and structured patterns. Within this outdated view, managers use known solutions for known problems, assuming that those solutions are effective. This is called “linear management.” However, this linear management strategy does not offer the required answers to the complex problems healthcare has to face. On the contrary, as we stated earlier, healthcare organizations and their problems require a more adaptive and creative approach.

Therefore, for two decades, adoption of a complex adaptive system (CAS) approach in healthcare has been promoted [33]. This approach recognizes that different agents, being individuals, teams, organizations, interact and co-evolve in unpredictable ways and whose actions are interconnected so that an action of one agent causes a change in the context of other agents. APMHNs working with youth realize, for example, that they need to collaborate with several multidisciplinary domains, that is, mental health, primary care, addiction services, social and vocational services, youth services, and last but least educational provision [34]. Headspace is originated in Australia, which stands for a culture and method to work with young people in mental health [35]. It is applying the CAS thinking into youth mental health services, which disappointingly has not proven to be as successful as expected. Mental health professionals unfortunately continued to work in silos of their organization, which gives managers, policy makers, and researchers further questions to ask and reflect on [30, 34].

In a CAS approach, traditional “command-and-control” leadership is replaced by so-called “complex leadership” [36]. This refers to the “law of requisite complexity,” which states that complexity has to be defeated by complexity. Linear ways of leading, with strict rules and imposed change are replaced by organic ways of leading, with joint agreements and a lot of attention to learning, innovation, and creativity. In this approach, APMHNs like other employees are getting more opportunities to interact with each other, across boundaries of departments, and getting more involved in the decision-making processes. In other words, leadership gets shared. As employees and teams acquire more autonomy in this approach, managers are seen as facilitators of self-regulation of the employees and self-organization of the teams. Complexity leadership theory calls this “enabling leadership”: the managers enable their employees to interact and to cooperate freely with each other and other groups inside and outside the organization [36]. Those leaders promote interdependency as well as diversity and heterogeneity. By doing this, everyone’s leadership, including APMHNs leadership, can emerge as employees feel invited to take responsibility and to be accountable.

In the next section, we describe the most used leadership theory in healthcare and its effectiveness. But first, we explain the difference between management and leadership.

4 Management Versus Leadership

Although the terms management and leadership are often used interchangeably, they are different concepts with distinct and unique activities and functions. Management is mostly related to planning, organizing, budgeting, coordinating, and monitoring activities. It is aimed at reaching short-term goals, hereby avoiding risks to new initiatives and innovative behavior. It is focused on obtaining order and stability [37]. Leadership on the other hand, is mostly related to developing a long-term vision, connecting and motivating people. It is focused on adaptation and promotes more the achievement of sustainable change, which includes taking risks and coping with uncertainty.

Both management and leadership are critical for organizational success. They are distinctive but complementary. The distinction is sometimes summarized in terms of efficiency and effectiveness, efficiency describing management, the latter effectiveness describing leadership. Management requires technical, human, and conceptual skills, whereas leadership depends more on behaviors, often described as a style. It is obvious that APMHNs fulfil both managerial and leadership roles. Although they are mostly not in a formal managerial position, they have to plan, to work efficiently, and to solve problems. In the field of leadership, they are expected to challenge the status quo, to innovate, and to create change, which is pivotal in mental health care.

In that sense, and given that APMHNs often do not have subordinates, one could state that their leadership role predominates their management role. They are predominately leaders in clinical practice, which enables them to inspire colleagues and superiors, and they can play pioneering roles, even without possessing formal managerial roles [38]. Indeed, leadership is defined as a process of influencing others in order to achieve a common goal [39]. This is exactly what APMHNs aspire to: influencing and improving quality and safety of care, influencing and improving interprofessional collaboration, and enhancing the professionalism of nurses. Thus, they can be considered as transformational leaders. In the next paragraph, we elaborate on that.

5 Most Important Leadership Theory in Nursing: Transformational Leadership

Since the beginning of the twentieth century, scientific research on leadership evolved from the description of leadership traits to the investigation of leadership behaviors and styles. Similar to the general literature, the most cited, most recommended, and most researched theory in nursing is that of transactional and transformational leadership (Cummings in [40]).

In a landmark publication, Burns [41] distinguished transactional leadership from transformational leadership. In transactional leadership, followers base their behaviors upon reward for compliance. In transformational leadership, followers base their behaviors upon the need to meet higher order needs. Transactional leadership reflects to a certain extent task-oriented leadership, while transformational leadership can be viewed as relation-oriented with a focus on development and change [42].

Other relation-oriented styles often used in nurse leadership research are authentic leadership and servant leadership [43]. Authentic leaders are people with high levels of authenticity in that they are highly aware of their own perspectives, values, strengths, and also their pitfalls. They motivate and engage others by personal identification. Servant leaders are people that focus on the development and empowerment of others. They consider the psychological needs for personal growth of the followers as their main goal. Although there are differences between the cited styles, according to Yammarino [44], authentic leadership, as well as servant leadership, is essentially transformational-like in orientation, description, and application. They all have a common element that they are founded on authenticity, a characteristic that is highly associated with nursing values.

Transformational leadership has the reputation to be the most effective style; however, when used together with transactional leadership, its effect is still stronger. Transactional leadership aims to clarify expectations, to reward contributions, and is goal-oriented. Transformational leadership, as the word suggests, aims for transformation. This goes beyond changing existing situations. Transformation is more radical, old systems and habits are abandoned, and a new substantial step forward is taken. The status quo is not an option for such leaders, and they look for new avenues and alternatives and are much more focused on the future than on the past. They apply four behavioral categories, the so-called "Four I's": idealized influence, inspirational motivation, intellectual stimulation, and individual consideration [45]. The first one, idealized influence, means that the leader builds trust and confidence through socialized charisma. The leader focuses on values, beliefs, and a collective sense of mission. The second I, inspirational motivation, is about motivating and energizing people to envision attractive future states. Intellectual stimulation can be seen as challenging others to think creatively, and the last I, individual consideration, stands for coaching and supporting people on an individual basis. Cleary et al. [46] describe a set of mental health nurse leadership qualities that can easily be categorized as transformational qualities: using personal authenticity, working on trust within the group, developing a vision for better care provision, and supporting team members by coaching, teaching, facilitating.

Clinical leaders, whether they are in a hierarchical role, like nurse managers, in non-hierarchical roles like bedside nurses or in specialty roles like APMHNs, must grasp the opportunities to develop transformational or transformational-like leadership. There is a large body of knowledge about the effects of this type of leadership on both outcomes on the workforce and on quality of care, although specific research in the domain of mental health care is still lacking. The transformational-like leadership styles have, for example, shown to have a positive correlation with nurses' job satisfaction, nurses' health and well-being, and personal effectiveness [47].

We have mentioned the IOM idea of leadership from the bedside to the boardroom. Complex leadership theory calls this "emergent leadership": leadership that is not linked to assigned roles, but leadership that can arise with every employee. Therefore, it is often also called "shared leadership" or "distributed leadership." As we stated earlier, mental health care is a complex system, and that requires a new approach. Clinical change in this type of environments cannot be achieved through applying linear, top-down leadership. It requires leaders at all levels of the organization, in policy making, management, and clinical care. The administrative leaders, meaning the managers at the executive level of the organization, provide the organization with the needed vision and budgets. Their most important contribution to a new organizational model is their willingness to delegate power and to empower the clinical leaders, including APMHNs, and to create a context where they get enough opportunities to develop themselves and to become leaders [22, 48].

Later in this chapter, we describe some key aspects of leadership like influence, proactivity, and trust. But first, we describe a specific type of leadership, intrapreneurship.

6 Intrapreneurship Leadership

In a literature review on entrepreneurial nurses, Neergård [49] found two entrepreneurial nursing roles, that is, the nurse entrepreneur and the nurse intrapreneur. Entrepreneurship at the individual level is called "intrapreneurship." APMHNs who are self-employed in private practice and are acting entrepreneurially are entrepreneurs. While only a few APMHNs are self-employed, those APMHNs who are not and are acting entrepreneurially through their formal employment in healthcare are intrapreneurs. Intrapreneurship leadership means that the leader emphasizes and promotes innovative work behavior in his/her workplace [49].

According to Neessen et al. [16], the concepts that define intrapreneurial behavior are innovativeness, proactiveness, opportunity recognition, risk-taking, and networking. APMHNs embracing individual intrapreneurial behavior may affect the outcome of an organization in, for example, employers' job satisfaction and motivation. On the other hand, the emergence of intrapreneurial behavior is also dependent on the organizational context. The context includes organizational structure and management support. Intrapreneurship is a dynamic process between the individual and the organization where individuals are given the possibility to perform beyond expectations of their employers.

As the traditional way of working in mental health care is coming to an end, the need to increase innovative work behavior is becoming urgent. A transition has started with professionals and service users demanding new ways of improving mental health care [50, 51]. Entrepreneurship emphasizes the ability of an organization or individuals to transform ideas, opinions, and evidence-based knowledge into action. Moreover, entrepreneurship must integrate creativity, innovation, and risk taking at all stages of managing projects to reach the objectives at hand [52]. There is an acknowledgment of the importance of entrepreneurial methods in the European Commission, which has, among other things, influenced healthcare innovation in institutions and professional development of employers. The importance of entrepreneurship was referred to by the European Commission (EC) for the first time in 2003, and later in 2006, it was included as one of the necessary elements of a European knowledge-based society [53]. It is a challenge for APMHNS to invest in intrapreneurial behaviors and move mental health care forward.

7 Practices of Effective APMHN Leadership: A Case Example

In their work in Ireland, Elliott et al. [54] found seven key clinical leadership activities or practices of APNs, including APMHNs. These leadership activities are (1) steering and coordinating best practice in multidisciplinary teams (MDT), (2) using practice development to initiate and change service user's care, (3) taking responsibility for policy making and guideline development and implementation, (4) initiating and developing new patient/client services, (5) leading formal education for the MDT to change clinical practice, (6) mentoring and coaching the MDT in clinical practice, and (7) being a role model for autonomous decision-making in clinical work and continuous professional development. In addition, they identified three other activities what they termed professional leadership, namely, (1) contributing to policy at a national and international level, (2) engaging with professional organizations and committees at a national and international level, and (3) engaging in education outside the service at a national and international level.

The following case example about Dr. Helga Sif Fridjonsdottir shows clearly that the actions and the behaviors of an APMHN who practices leadership behaviors can have an impact on the addiction services in an entire country. It demonstrates what leadership is all about: creating effect and making a difference, in other words achieving change. We encourage the reader to keep in mind Elliotts et al.'s [54] key leadership activities mentioned above when reflecting on what leadership activities Helga Sif used in her leadership role.

Case Example

Dr. Helga Sif Fridjonsdottir, an APMHN, has changed mental health services in Iceland with her practices of effective leadership activities. In January 2021, Helga Sif was awarded the Order of the Falcon recognition by the President of Iceland for her pioneering work and contributions to the development of mental health and addiction services in the country. She introduced harm reduction methodology into the service continuum for people who need assistance because of active drug use, homelessness, or other severely marginalizing factors. She led the development of a mobile needle exchange program that is operated by the Red Cross of the capital area branch that started in 2009. This program is operated in a mobile van that goes out six nights a week where needle exchange takes place and includes wound and infections assessment. Furthermore, health assessment, supportive therapy, and harm reduction education are provided. Each night, there is a volunteer nurse, assistant staff member, driver, and a physician on call. This service has improved the health and social situation of a marginalized population significantly and has influenced Red Cross branches to create similar services in the north and south-western parts of Iceland. Helga is still a volunteer at the needle exchange program and participates actively in further development of the harm reduction services provided by the Red Cross in Iceland [55].

8 Essence of Effective APMHN Leadership

In this section, we explore the essence of leadership, namely, influence, which is often called "the working mechanism," or "the engine of leadership." Then, we focus on change leadership, and we end this section by highlighting the importance of working with values and developing a mission and a vision.

8.1 Influence: The Essence of Leadership

As we mentioned earlier and as you can see from the case study, leadership is about influencing others to reach common goals [39]. This definition holds the idea of achieving something, often improving or changing situations. In the example above, the APMHN introduced a new way of serving a minority population with a new methodology, and she continues to develop the service with her enthusiasm and motivational methods in communication. She offers continuing education courses for nurses on motivational interviewing, a useful tool to enhance or influence change behavior in people, which she applies in her work and projects. This refers to touching, to reaching the other by applying a so-called "influence tactic" [56]. Examples of positive influence tactics are rational persuasion, apprising, inspirational appeal, and consultation. Examples of negative tactics are pressure and coercion. The choice for one of the tactics is based not only on personal preferences but also on contextual characteristics like the type of employees and the concrete situation.

The effectiveness of leadership is not exclusively the result of the practices and the personal attributes of the leader. The characteristics of followers and features of the context also play a role in the effectiveness of leadership. Some of the important follower factors that influence the effectiveness of leadership include experience, competence, level of motivation, as well as others. Influencing factors within the context are organizational culture and structure.

Regarding the contribution of the leaders themselves, Kouzes and Posner [57] describe five practices of exemplary leadership, practices that must be applied to be successful as a leader. The practices are modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart. These practices include elements of both transformational as transactional leadership. Above this, their research and many other studies show that, to get people involved, integrity is the most pivotal behavioral quality of an effective leader.

Integrity is one of the three qualities people rely on to trust their leader. Also, the leader's competence as well as their benevolence determine whether someone trusts a leader or not [58]. Leaders who show integrity walk the talk; they practice what they preach. Leader's competence refers to the ability to do what he or she is expected to do and, in case of leadership, simply to demonstrate strong and brave leadership. Benevolence means that the leader is willing to take the other's interests into account. The more integrity, competence, and benevolence an employee experiences with the leader, the greater the probability that she will trust the leader.

Research indicates that a trustful relationship between leaders and followers is an important driving force for the achievement of positive service user outcomes [59]. If nurses have trust in their leader, they demonstrate more commitment and experience more safety, which is correlated with less errors and finally higher quality of care. Trust is a reciprocal process, which means that leaders also need indications of integrity, competence, and benevolence to trust their followers. Trust is a crucial component in leadership theories like transformational, authentic, and servant leadership, which again underlines their appropriateness for the nursing context.

Effective leaders focus on what Stephen Covey calls "their circle of influence" [60]. They spend their energy on trying to understand where opportunities for improvement or change appear. They are aware of their abilities and their power to exercise their influence in those areas where this influence can work. This means that they do not loose energy in phenomena outside their circle of influence. They do not make themselves dependent of the circumstances, quite the opposite; they try to change the circumstances. They replace reactive behaviors with proactive behaviors. Instead of complaining, they make choices and take decisions. By doing so, they avoid complaining and feelings of powerlessness. Effective leaders do not want to be victims. They want to be influencers.

By their position at the frontline of care, APMHNs know better than anyone else where they can put a foot in the door. They can exercise their influence, from their personal inspirational and motivating behavior and from their advanced knowledge. In this way, they can create opportunities to bring about change, which we explore in the next paragraph.

8.2 Change Leadership

Earlier we mentioned the close link between leadership and change. In fact, leadership can be seen as going forward, taking steps to improve an existing situation, breaking the status quo. Sustainable change can only be made if the leader can face the uncertainty that is associated with it. A real leader creates conditions where people feel safe enough to experiment and to take risks. They turn challenging situations into learning moments. They break large tasks down into several little pieces, offering co-workers the experience of small wins. By doing so, they avoid performance anxiety. Furthermore, they realize the importance of creating a readiness for change. Readiness for change is the capacity of co-workers to integrate the demands that a sustainable change process requires [61].

Recent research demonstrates that the principle of readiness for change is often overlooked in change management literature [61]. The first thing a leader needs to do is to *assess* the readiness for change. Assessing readiness involves investigating how the team has experienced earlier change processes, what the current stress level of the team members is, what their information and training needs are, as well as exploring how they can be supported. The second task is to *create* the readiness for change by giving extensive information, explaining the benefits and utility of the change, listening to the concerns of the co-workers, showing respect for their emotions, and above all providing enough opportunity for employee participation. In this way, people get committed. As people are willing to change but are not willing to be changed, this approach is a more effective way of leading change than imposing change and enforcing obedience.

This begs the question of how a leader can create conditions to enable people to do what they really want to do. This is what self-determination theory calls "autonomous motivation": people get motivated to grow and change when three innate and universal psychological needs are fulfilled—the needs for autonomy, belongingness, and competence [62]. The first need is fulfilled when people feel psychologically free, not controlled. The second need is fulfilled when they feel they have positive relations with other people and that they belong to a caring and sense-giving environment. The third need, the need for competence, is fulfilled when people have the perception of personal effectiveness. In terms of change management, this means that the change agent respects and even promotes the participation of every single team member, creates an atmosphere of community, and provides opportunities for the team members to demonstrate their influence. The effect of the influence is stronger when it's built on strong values, a clear mission and a shared vision.

8.3 Values, Vision, and Mission

Values are defined as "standards for action that are accepted by the practitioner and/or professional group and provide a framework for evaluating beliefs and attitudes that influence behavior" [63, p. 226]. Most nursing associations have standards of conduct, performance, and ethics for nurses and midwives representing their values in nursing [64]. The European psychiatric nurses' association, Horatio, has published position papers on their values and code of practices from different European countries on their web page [65], which most of all emphasize collaboration with service users. If nurses experience that the values they cherish align with the values of their team and their organization, their involvement will increase. It is a key leadership task to help people identify and articulate their own values as well as making the values of the team explicit. By doing so, the vision of the team can be formulated. It expresses what the team stands for and where it wants to go, and what the goals for the next period are. It is an antidote for the status quo. A vision provides the team with an image of the future. Aside from this, teams must also reflect on their mission. It defines the identity and the reason of being of the team. A mission makes it clear to people outside the team what the team does.

The more a leader can involve people in the process of developing the vision and the mission, the more it appeals to their autonomous motivation. Vision and mission originate from team conversations and joint reflections. Once again, we want to refer to the example of the APMHN Dr. Helga Sif Fridjonsdottir where she influenced the vision of the Red Cross and the Health Ministry to insert into their strategy a plan to fund the program for a population that was almost invisible previously in policy making. She succeeded in her mission of changing attitudes toward drug users in Iceland who belong to a marginalized population. In Icelandic society, most people know what she and the nurses who take a shift in the Red Cross van stand for.

Finally, to really achieve the desired results, leaders have to think about the way they implement change. What steps need to be taken, and what obstacles need to be overcome? Effective leaders enlist people in the development of the vision but also in its implementation. Vision and implementation are equally important as demonstrated by the old proverb: "Vision without action is a daydream, action without vision is a nightmare."

9 Development and Use of APMHN Leadership

In a systematic review by Scheydt and Hegedüs [66] on APMHNs' tasks and activities, they found one of the main themes being leadership and public relations. In this section, we discuss barriers and enablers of development and use of APMHN leadership. Elliott et al. [67] conducted a scoping review to identify barriers and enablers in the advanced practitioner's environment for APNs and midwifes to be able, or not to be able, to use their leadership capabilities in their role. Their review of 34 research papers found 13 barriers and 11 enablers. First, we discuss the barriers. Then, we discuss the enablers, and we end the section with a plea for empowerment of the APMHNs.

9.1 Barriers of APMHNs Leadership Development

The barrier, for not being able to enact leadership, in the APNs working environment that was most frequently mentioned in the review of Elliott et al. [67], was large clinical caseloads because of staff shortages and physicians' demands. Hughes [68] in her review on the barriers to effective nurse leadership also found that time constraints were contributing to nurses' powerlessness in developing leadership. The second most frequently mentioned barrier in Elliott's et al.'s study [67] was lack of support from nursing management and other co-workers and staff. Lack of support from managers means that APMHNs are possibly not getting enough motivation for leadership development and/or psychological safety to speak up to enact their leadership. The third barrier mostly reported was lack of administrative support in the APNs' clinical work related to their workload.

Other barriers that were found regarding the APNs role were the lack of understanding of APNs' leadership role and lack of preparation and education of the leadership role. Hughes [68] also found in her review that more availability is needed in leadership education for nurses and more structured nurse leadership pathways to empower nurses to become leaders. Moreover, other barriers that have been identified are lack of authority and lack of opportunities to work strategically within the institution [67] as well as lack of funding to support leadership development of nurses [68]. This confirms some of the study findings of Higgins et al. [69] on factors influencing advanced practitioners' ability to enact leadership within the

Irish healthcare system. The factors included the importance of APMHNs having opportunities to act as leaders and the mechanism for sustaining leadership.

9.2 Enablers of APMHNs Leadership Development

Higgins et al. [69] found in their study how important it is to have a framework and formal policy for the professional development of the APNs. The most significant enablers in the Elliott et al. [67] scoping review were situated at the organizational or institutional level. They mention, among others, the importance of APNs having the opportunity to networking with other professionals and being provided with formal mentoring support by their organization and support from senior management to do so. There also needs to be a vision of the APMHN leadership role as well as a strategy that focuses on creating opportunities for APMHNs to lead practice development and participation in research and improvement projects. To move the leadership dimension of their role forward and create a shared vision on their leadership role, it's important for the APMHNs to discuss with their managers and co-workers their understanding of their role, the complexity and challenges of it, the importance of collaboration in change initiatives, as well as how to make leadership visible.

9.3 Empowering the Voice of the APMHNs in Organizations

The findings regarding the barriers and enablers demonstrate clearly that the APMHN leadership role can and must be better supported by healthcare managers and made more visible within the healthcare system, organization, and team. Therefore, it is important that healthcare organizations, within hospitals, communities, and NGOs, include how to implement and support the leadership role use and development for APMHNs in their human resource management (HRM) strategy.

The employers of newly hired graduate APMHNs must realize the importance of mentorship of the leadership role in relation to the context of the workplace [70]. The experienced APMHNs within the workplace are valuable and key players in supporting organizational management in developing the leadership of the entire clinical team and in advancing the leadership role of new APMHNs. The modern chief nursing officer/chief executive officer wants leadership in all aspects and levels of the health organization, that is, in clinical, professional, health policy, and at systems level. The APMHNs are in the excellent position to participate in delivering quality healthcare and at the same time contribute to an improved leadership organizational culture [70, 71]. It has been suggested that when more than one APMHNs is employed within a team or organization, they support and empower each other in their leadership role, which is beneficial for both APNs and the organization [67, 69].

Besides the role organizations can play in the promotion of APMHN leadership, there is also a contribution to be made through undergraduate and graduate educational programs. The extra contribution a masters' degree can offer APMHNs is to include in their curriculum competencies, attributes, and importantly personal development of leadership behavior [71]. Successful programs have been developed recently. For example, within the University Centre for Nursing and Midwifery at Ghent University in Belgium, the Master of Science in Nursing and Midwifery program has recently been reformed to respond to the rapidly evolving field of nursing. One of the most important evolutions is the increasing development of advanced practice nursing. Therefore, a specific in-depth APN course for general healthcare and another for mental health care was organized and implemented. In the advanced practice specialization in mental health care, the students are trained to the preventive and care role and the professional responsibility and commitment of the APMHN as a leader in mental health care. In addition, the course "Internship Advanced Practice Nursing" gives the student the opportunity, under supervision and independently, to integrate the competencies as future nursing leader learned in advanced practice specialization in mental health nursing. Students deepen and broaden their knowledge and skills by, on the one hand, selecting and reviewing study materials relevant to the healthcare domain and, on the other hand, by researching, applying, and mastering the acquired insights and skills in clinical healthcare practice [72].

10 Conclusion

In this chapter, we emphasized the enormous need for strong nurse leadership in healthcare in general and, in particular, mental health care. The voice of the APMHN must be heard in relation to the VUCA context on the one hand and a list of challenges for the mental health care system on the other hand. More effective leadership at all levels of the organization is required. APMHNs play a substantial role in this evolution to improve clinical mental health practice.

The APMHNs because of their scientific background and their position at the frontline of care can become intrapreneurs, role models, who involve the caregivers and service users in a movement of innovation. Incremental change must be replaced by sustainable change in order to realize a radical transformation of the often obsolete and inappropriate ongoing practices. Both regarding the organization of care and regarding the delivery of high-quality care, there are countless opportunities for improvement that is required by international trends, tendencies, and standards.

Transformational or transformational-like leadership behaviors must be developed with leaders in the boardroom and with leaders at the level of service user care (bedside), like APMHNs. Leaders at the boardroom level of an organization must create conditions that enable the development of APMH nursing leadership. Feasible caseload and mentorship with extensive support appear to be the most important enablers in this regard. APMHNs themselves must become aware of their influence and invest in trustworthiness. By doing so, they become leading partners in the leadership system of an organization that can make a significant difference to service users, family, and population health outcomes.

Reflective Questions

- What opportunities for improvement and deep change do you see in your current situation that could be the focus of your APMHN leadership?
- How do you estimate your current level of influence? What can you do to increase it?
- Who or what can help you in your development as an effective leader?

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Part V

Advancing the Evidence-Based Practice Agenda

Knowledge Translation and Linking Evidence to Practice

Patrick Callaghan and Tim Carter

Learning Outcomes
The objective of this chapter is to enable you to:

- Examine frameworks for linking evidence to practice.
- Understand and evaluate evidence for translating knowledge to practice.
- Understand the skills and capabilities in linking evidence to practice, and enhance your skills.
- Link or translate evidence to practice.

1 Introduction

It is widely thought that the concept of evidence-based practice has its roots in the work of Archie Cochrane, after whom the Cochrane Collaboration is named. Cochrane was a Scottish doctor known for his seminal book: *Effectiveness and Efficiency: Random Reflections on Health Services* [1]. In this book, Cochrane criticised the lack of evidence being used to make important clinical decisions and advocated the use of systematic evidence reviews to address this gap. Whilst it is true that

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Cochrane's text led to the birth of contemporary evidence-based practice, the idea of using the best possible and available evidence against which to make decisions has a far longer history.

In eighteenth century, China, during the Qing dynasty, scholars to the imperial court changed the way they gathered evidence based on the principles of *kaozheng*—'practising evidential research'. Kaozheng was characterised by thorough evaluation of data that adhered to high standards of rigour and precision. The aim of *kaozheng* scholars was to base their studies not on speculation, or anecdotes, but on hard facts [2]. This is an early version of Cochrane's vision for twentieth century evidence-based medicine.

Cochrane's ideas rapidly gained traction beyond medicine to all health care, and now, the concept of evidence-based practice is widespread. The work of the Cochrane Collaboration is at the centre of global efforts to improve health care practice using the best available evidence. In nursing, the emergence of Joanna Briggs Institute, formerly Joanna Briggs Centre for evidence-based Nursing (https://jbi.global/), and the journal *Evidence-Based Nursing* have been at the centre of driving evidence-based nursing.

This chapter is concerned with APMHNs linking evidence to practice: evidence-based mental health nursing. For the purposes of this chapter, the authors' definition of evidence-based mental health nursing utilises a modified form taken from Ingersoll [3, p. 152]: '*The conscientious, explicit and judicious use of theory-derived, evidence-based information, such as published empirical research, informed, expert opinion, anecdotes, clinical case studies, service users' preferences and expert opinion in making decisions about care delivery to individual service users, or groups of service users and in consideration of their individual needs and preferences*'.

Linking evidence to practice is known more commonly as knowledge translation, or less commonly knowledge exchange. While much of the evidence that the authors cite in this chapter use the term knowledge translation, this is essentially the process of linking evidence to practice.

In this chapter, the authors will:

1. Evaluate the nature of linking evidence to practice, an essential element of evidence-based mental health nursing.
2. Show how APMHNs can link evidence to their and others' practice in creating and sustaining impact through evidence-based knowledge translation processes and the judicious use of various forms of evidence.
3. Illustrate, using case studies, how APMHNs link or translate evidence to their practice.

2 Advanced Practice Mental Health Nursing

Advanced nursing practice has been present in the United States for several years [4] and increasingly in other parts of the world [5]. Advanced practice mental health nursing has a long history. But the advent of advanced mental health nursing practitioners, at least as characterised by the ICN, is a relatively recent phenomenon.

Increasingly, advance practice roles are tending towards those that meet the International Council of Nurses' (ICN) characterisation, including those in mental health, where they are seen as central to ensuring parity of esteem between mental and physical health care [6].

Research is one of the four pillars of advanced nursing practice in the (ICN) descriptions of advance nursing practitioners [7]. Evidence-based practice is a key component of advanced nursing practice. This is apparent in the monitoring and improvement of health care quality, assessing the effectiveness of practice and using the best available evidence to underpin practice, in other words evidence-based nursing. A crucial part of evidence-based nursing is linking or translating evidence to practice.

3 Evidence-Based Mental Health Nursing

Mental health nursing is an art, science and craft. The art of mental health nursing lies in the values that drive the practice of mental health nurses. The craft of mental health nursing is evident from the skills mental health nurses use in their practice working in collaboration with people using their services, their caregivers, and representative agencies, as well as other mental health workers. The science of mental health nursing is apparent when nurses adopt an evidence-based approach showing clear clinical relevance and need, methodological rigour and varied research methods, translatable to practice, which generate theories that explain the art, science and craft of mental health nursing [8].

Values for mental health nursing are many and varied and should drive evidence-based practice. Good examples are respecting diversity, challenging inequality, practising ethically and promoting recovery [9]. In addition, the values of mental health nurses are often shaped, monitored and regulated by others, such as registration/governing bodies. To achieve and maintain their registration, mental health nurses in some countries must continue to demonstrate and uphold the values of their professional and regulatory bodies.

The use of informed, up-to-date, high-quality evidence is central to effective advanced practice mental health nursing. This ensures APMHNs can account for their own practice whilst allowing them to master the skills of evaluating all forms of published evidence and guidelines and deliver best practice [10]. As shown above in our definition of evidence-based mental health nursing, evidence takes many forms. In health care, however, evidence hierarchies have been created, invariably with high-quality meta-analytic and systematic reviews and randomised controlled trials at the peak of such hierarchies, with expert opinion at the base, and no mention of other forms of evidence, including service users' preferences [11]. Hierarchies, however, are problematic. They privilege quantitative forms of evidence above all others. In health care, good practice in decision-making requires a wide use of all available evidence (including service user preference), the judgement to make the best decision in the interests of those receiving care and the individuals and organisations delivering services [12].

Exercising context-based judgement is central to linking evidence to practice. The judgement required of evidence-based decision makers such as APMHNs includes the ability to define effectiveness, safety and acceptability; find evidence on the effectiveness, safety and acceptability of a new test or treatment; know how to assess the quality of evidence retrieved and decide whether the results are generalizable beyond the sample from which it is derived; and possess the skills to assess whether the results of the research are applicable to a particular population of interest [10]. Such judgements have always been needed. Arguably, in a pandemic era where truth and evidence are often subjugated to political and vexatious whims, the ability to judge the quality of evidence and its uses in health care practice becomes inviolate [13].

However, the skills required to evaluate evidence and apply it to practice are not straightforward. These skills require APMHNs to work in partnership with other health care professionals to create the conditions for accessing and evaluating evidence, using it in practice and showcasing its value and impact to (sometimes) sceptical others. Linking evidence to practice may seem logical, desirable, essential and ethical. It improves care, helps direct scarce resources to where they have greater benefit and advances health care outcomes [14]. However, health care practitioners can often be opposed to this because they don't know about the evidence, they do not understand it, they do not believe it, they do not know how to apply it in practice, they are not allowed to apply it and they refuse or are reluctant to apply it [15]. In addition, the changes that result from evidence-based approaches may be incompatible with health care professionals' current beliefs and working practices, increase the complexity of health care practice, clash with the views of influential opinion leaders and lead to more bureaucracy [16].

Thinking of how best APMHNs can link or translate evidence to practice requires an understanding of the obstacles and methods for overcoming these. These include developing skills in searching, retrieving and appraising evidence; accessing mentors and clinical supervisors; promoting and providing access to evidence sources; having time in workloads to undertake the work of linking or translating evidence to practice; and joining networks of like-minded people, working with potential adopters, whilst prioritising which barriers to address [10, 17]. Knowledge mobilisation approaches are one response to these challenges [18].

4 Knowledge Mobilisation

Knowledge mobilization is essentially a process for linking evidence to practice. It is often referred to as knowledge exchange or transfer. APMHNs can use knowledge mobilisation as a means of working collaboratively with colleagues and service users to link evidence to their practice.

Knowledge mobilisation often includes using appreciative inquiry (AI). AI is a strength-based, action research approach to enable behaviour change in organisations [19] and has been used in many domains including nursing [20], medicine [21], education [22] and management [23]. At the heart of AI is putting frontline

Table 1 Using appreciative enquiry to assist APMHNs link evidence to practice

Facet	Question	Response
Define	What is the inquiry?	For example, how best to implement changes to service user safety assessments based on the latest evidence
Discovery	What has worked well before and why?	For example, educational outreach visits to service users and clinicians as it allowed a co-creation approach to emerge, and there is a robust evidence base for this approach
Dream	What would we love to see happening?	For example, improved safety assessments helping enhance service users' safety
Design	What must we do to make our 'dream' a reality?	For example, introduce a safety assessment tool to replace our risk assessment tool
Delivery	What is our success indicator?	For example, fewer service users' self-injury episodes

staff and service users working in partnership at the heart of the change process [24]. There are five facets to AI; in Table 1, we illustrate how an AI approach using these facets can help link evidence to practice in advanced mental health nursing practice. The task set is facilitating the implementation with staff and service users of a new intervention to improve service users' safety assessments.

Despite its benefits enabling APMHNs linking evidence to practice, appreciative inquiry has its drawbacks. It is often criticised as overtly positive in its approach [25], evangelically so, according to some [26]. Much of the evidence of the approach in health care relies on observational studies. However, it has been tested in quantitative experimental and qualitative studies [27–29], and its effects are summarised in empirical and conceptual reviews [30]. What we can take from these studies in the real world of advanced practice mental health nursing, is the likelihood that AI produces transformational change, that is, improvements that completely alters the organisation's culture and the behaviour of people within the organisation. AI can also enable local improvements and better organisational performance, arguably a key role for APMHNs. In the example shown in Table 1, the language of risk implies danger, rather than vulnerability; a focus on safety may be more reassuring to service users that their vulnerability will be better addressed to enable their safety. Despite the possibilities of AI contributing to APMHNs' efforts to link evidence to practice, it sits alongside more targeted interventions, whose aim is solely focussed on how best to transfer evidence to practice. We will examine these interventions next.

5 What Works in Linking Evidence to Practice?

We have established that APMHNs have an important role using the best available evidence in their own practice and facilitating evidence-based nursing in others. Effective methods for translating evidence into practice have been studied extensively, and these studies have produced conceptual frameworks as well as robust empirical evidence for what works, what matters and how best to link evidence to practice.

From a conceptual viewpoint, the PARIHS: *Promoting Action on Research Implementation in Health Services* framework, which was produced by nurses [31], recognises the relationship between key components of the nature of the evidence, the context in which knowledge translation occurs and facilitation: factors that enable the linking of the evidence into practice and the likelihood of low or high implementation of the evidence in practice.

In relation to the nature of the evidence, three things affect the likelihood of implementation: the quality of the evidence such as well-conceived, well-designed and well-executed research that is relevant to clinicians and involved service users at the outset. In relation to context within the PARIHS model is a culture of reflection on practice, transformational leadership, and regular evaluation of methods and processes designed to link the evidence to practice. A form of continuous performance improvement, again involving service users is linked to high levels of implementation.

Finally, in relation to facilitation, enablers of high implementation are having systems and mechanisms for change in place, taking an adult learning approach to education on change mechanisms and co-critical evaluations and reflections of what works and what matters.

The PARIHS framework has been developed by Rycroft-Malone and colleagues in subsequent papers [32, 33]. In the latter paper, the authors demonstrate the conceptual integrity of the framework, as well as face and concept validity. However, it had not been tested empirically at that point. A recent citation analysis of PARIHS [34] shows that 367 papers used the framework in various ways in low-, medium- and high-income countries in different parts of the world. The use of the framework varied from full use to mostly partial use, but its use was mostly ill-defined. Sixty-five percent of papers had nursing as their professional focus.

It is hard from the citation review to glean reliable evidence of the effectiveness of PARIHS, largely because it has not been tested directly, but more in explaining how data were analysed. Nevertheless, some studies reported its feasibility, predictive and explanatory value and theoretical and global inclusiveness. However, it was less adept at identifying how to address barriers to implementation. Arguably, it fails to show, empirically at least, what works best in linking evidence to practice.

Possibly, some of the most influential sources of empirical evidence for delineating the best evidence for linking evidence to practice is the work of Bero et al. [35], Grimshaw et al. [17] and Cheung et al. [36]. The results of this work is summarised in Table 2.

The focus of these studies [17, 35, 36] of linking evidence to practice is addressing five key questions: (1) *What knowledge should be linked*? (2) *To whom should evidence be linked*? (3) *By whom should evidence be linked*? (4) *How should evidence be linked*? (5) *With what effect should evidence be linked*?

5.1 What Knowledge Should Be Linked?

Two key points are apparent in addressing this question. The first refers to the nature of the evidence being transferred. The authors privilege high-quality systematic

Table 2 Interventions for linking evidence to practice

Consistently effective interventions	Interventions of variable effectiveness	Interventions with little or no effectiveness
• Educational outreach visits (face-to-face visits by healthcare professionals to colleagues, and we argue, service users at their own place of work) • Reminders (manual or computerised) • Multi-facetted interventions (two or more of the following: audit and feedback, reminders, local consensus processes, or marketing of the evidence seeking to translate into practice) • Interactive communication applications (use of applications with an interactive component) • Tailored interventions (those matched to the needs of clinicians and service users.	• Audit and feedback • Local opinion leaders • End user-mediated interventions (Information gleaned from health services users) • Decision aids (supporting consumers to make better choices among treatment options) • Coaching	• Educational materials (clinical guidelines, audio visual materials or electronic publications) • Didactic educational approaches (lectures)

reviews, including well-designed studies, as well as large, well-designed randomised controlled trials. Few would argue with privileging this sort of evidence, but only for answering specific research questions around efficacy and effectiveness of interventions. Other forms of quality evidence will be more relevant for answering different but equally relevant questions [12], such as exploring peoples' experiences of health care. Whatever the type of evidence, the point is well made about focusing on *quality* evidence, but how is quality determined?

In the UK Research Excellence Framework (REF), a quinquennial assessment of the quality of research in UK universities, variations of which are also used in other countries including France, Germany, New Zealand, the Czech Republic, Romania, Finland, Holland, Sweden and Denmark [37], the quality of research is determined by its originality, significance, rigour and impact.

Originality is assessed as evidence that generates important and innovative knowledge, produces and interprets new empirical findings or materials; engages with new and/or complex problems; develops innovative research methods, methodologies and analytical techniques; shows imagination and creativity; provides new arguments and/or new forms of expression, innovations, interpretations and/or insights; collects and engages with novel types of data; and/or advances theory or the analysis of doctrine, policy, or practice.

Significance is assessed as the extent to which the research has influenced or has the capacity to influence knowledge and scholarly thought, or the development and understanding of policy and/or practice.

Rigour is assessed as the extent to which research demonstrates intellectual coherence and integrity and adopts robust and appropriate concepts, analyses, sources, theories and/or methodologies.

Finally, impact is assessed as the effect of the research on, change or benefit to the economy, society, culture, public policy or services, health, the environment or quality of life, beyond academia.

Table 3 The overall ratings of quality of research outputs REF panels use

Rating	Originality, significance and rigour	Impact
4 star	World leading in terms of originality, significance and rigour	Outstanding in terms of reach and significance
3 star	Internationally excellent in terms of originality, significance and rigour	Very considerable in terms of reach and significance
2 star	Recognised internationally in terms of originality, significance and rigour	Considerable in terms of reach and significance
1 star	Recognised nationally in terms of originality, significance and rigour	Recognised, but modest in terms of reach and significance
Unclassified	Falls below the standard of nationally recognised work. Or work that does not meet the published definition of research[a] for the purposes of the REF assessment	Little or no reach and significance, or the impact was not eligible, or the impact was not underpinned by excellent research

[a] 'A process of investigation leading to new insights effectively shared: disseminated within the wider academic domain' [38]

The overall ratings based on these assessments are shown in Table 3 [39].

As APMHNs are expected to conduct research, and/or link the evidence this research generates to practice the REF definitions of what is quality evidence can be used by APMHNs to improve the quality of their research or appraise published evidence they are seeking to use in practice. For APMHNs who do not conduct research, but use research evidence in their practice, the REF quality assessment criteria will allow them to distinguish between poor- and high-quality evidence. However, the REF assessment criteria are not the only tools for assessing the quality of evidence; see Ma et al. [38] for an excellent review and description of quality appraisal tools used for different types of studies used in health care research. These tools are used mostly to assess the risk of bias of studies included in systematic reviews and are potent sources for assessing evidence that APMHNs might use in practice. Commonly used tools are the Cochrane Risk of Bias (RoB) tool and PEDro: the Physiotherapy Evidence Database for assessing the quality of randomised controlled trials. The Risk of Bias in Non-randomised Studies-of Interventions (ROBINS-I) tool is used for non-intervention studies, the Newcastle-Ottawa Scale (NOS) is useful for cohort studies, and AXIS is good for appraising cross-sectional studies. Joanna Briggs Institute's critical appraisal checklist for qualitative research is used commonly for qualitative studies.

For APMHNs who conduct research and seek to publish their research findings, the Enhancing the QUAlity and Transparency Of health Research (EQUATOR) network: https://www.equator-network.org/ [40] showcases an extensive list of reporting guidelines for reporting different types of studies. Journal editors increasingly require authors to use a relevant guideline to ensure their manuscript meets the journal's requirements for reporting. Commonly used guidelines include various CONSORT statements for reporting RCTs, STROBE for observational studies, PRISMA for systematic reviews, SPIRIT for protocols, CORE-Q for qualitative studies, AGREE for clinical guidelines, SQUIRE for quality improvement studies and CHEERS for economic evaluations. APMHNs can access these at the EQUATOR website, link above.

The second issue in answering the first question—what knowledge should be linked—is focussing on the key message of evidence and tailoring this message to the audience. The key message may be different for different types of audiences; how it is delivered may also vary. For example, we conducted a randomised controlled trial [41] with embedded qualitative [42] and health economic evaluations [43] of the effect of exercise on adolescents living with depression. Adolescents living with depression and clinicians thinking of using exercise in their practice are more likely to be interested in whether exercise improves their depression (RCT) [41]. Adolescents might focus also on how well it does this (the qualitative component) [42]. Whilst these issues will be of interest to clinical managers and policy makers, the key message for these groups may be the cost-effectiveness of the intervention [43]. So, what has this to do with APMHNs? Notwithstanding that the authors do not wish to do the thinking for APMHNs, who are, after all, advanced and often highly educated practitioners, APMHNs might find the following helpful.

The authors have established that an important part of the APMHNs role is linking or translating evidence to practice. Therefore, taking the example of the exercise and depression studies, if APMHNs working in the field of child and adolescent mental health care wanted to link this evidence to practice, and based on what we have thus far discussed, we suggest APMHNs:

1. Assess the quality of the evidence the authors present in the papers: the Cochrane RoB, or REF criteria can help in this. PEDro would be of help with the RCT paper, the JBI critical appraisal tool is relevant for the qualitative paper, and the CHEERS tool can help appraise the quality of the health economics paper.
2. Using an AI approach, set up educational outreach sessions, see Table 2 with colleagues, organisational leaders, policy makers and mindful of the PARHIS framework, ensure that children and young people and their parents are included.
3. Consider how you present the key messages of the papers. The children and adolescents might respond more to an interactive app or flyer summarising the key messages, clinicians might prefer an educational outreach visit, while organisational leaders may be more persuaded by hearing the results from a local opinion leader—the APMHN may be that person. Policy makers may want a more formal, scientific presentation.
4. If all involved agree that exercise should be incorporated into the range of interventions on offer to the service users, evaluate the impact on meaningful outcomes for the service, the young people, their parents or guardians, managers and policy makers.
5. Finally, following these sessions, the APMHN may want to publish the results of the evaluation. Depending on the design of the evaluation, APMHNs might find it helpful to use an appropriate reporting tool, available from the EQUATOR network (see above).

5.2 To Whom Should Evidence Be Linked?

The scientific elements of the research may be of more interest to researchers. The clinical element of the evidence may be better suited to service users, and the public health elements will be of interest to policy makers.

5.3 By Whom Should Evidence Be Linked?

This will vary, but the credibility of the messenger is key. Linking evidence to practice skills is important, and training may be required. Local opinion leaders, such as APMHNs, could fulfil this role and may be best suited for it as they may be the most effective at influencing local opinion, and they may be viewed as credible given their experience, qualifications, subject discipline expertise, and close links to practice. As argued above, APMHNs may be well placed to use knowledge transfer infrastructures, technical or otherwise, such as knowledge mobilisation approaches—see the example in Table 1. Given the research expectations of their role, APMHNs may have better access to online systems and platforms, such as the Cochrane database [44], Rx for Change and Health Systems Evidence [45] and Joanna Briggs Institute [46], which are good sources of quality evidence. The latter includes a helpful manual for different types of evidence syntheses. APMHNs can use AMSTAR [40] to help them assess the quality of systematic reviews, as well as help others in practice do likewise. Having access to systematic evidence syntheses and other forms of evidence (see above) is a key first stage in linking evidence to practice.

Of course, opinion leaders, or local influencers as they may sometimes be called, are not the only individuals or group by whom evidence could be linked. Opinion leaders will include other members of the clinical team, those in clinical/academic roles, those at the forefront of practice, as well as service users. The success of opinion leaders is not solely rested upon the roles they hold, but their expertise in shaping practice, the skills in negotiating and facilitating practice change, so further education and training in these areas may be necessary. Service users are often designated as ‘experts by experience’ and are often called upon to help link evidence to practice. In the United Kingdom, the shift from the use of first to second generation anti-psychotic drugs was attributed by then UK Government Mental Health Director to service users’ experience of these drugs and their increasing refusal to use these drugs because of their more toxic side effects.

5.4 How Should Evidence Be Linked?

Table 2 shows the effectiveness of different methods of linking evidence to practice. These, however, tend to focus on individuals, groups and organisational behaviour change. They also ignore the role of systems, processes within systems, context, provider and service user preferences, stakeholder involvement and are overreliant on traditional randomised trials. An implementation science [47] approach is recommended as a means of addressing these challenges [48].

Implementation science is defined as the '*scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care*' [49, p. 1]. Implementation science approaches rely on implementation studies and are characterised by real-world studies of effectiveness using inclusive pragmatic methods that will appeal to practitioners as samples in such studies are more representative of those attending health care services. These studies usuall employ mixed methods, assess and develop logic models and use process evaluations to understand mechanisms of action and change processes. They take account of contextual factors influencing change, such as service user and provider preferences and capture wider community and policy perspectives. They are theoretically driven and use interdisciplinary and multidisciplinary approaches [49]. Implementation science recognises the complexity of linking evidence to practice and researchers' design studies to address this complexity. In 2006, the journal *Implementation Science* was established to promote and publish studies using implementation science approaches and is a relevant source of quality evidence on how best to link evidence to practice.

5.5 With What Effect Should Evidence Be Linked?

The Cochrane Collaboration has an Effective Practice and Organisation of Care (EPOC) group. This group supports others to conduct reviews synthesising evidence of the effect of interventions to improve healthcare systems and the frontline delivery of healthcare, the goal of translating/linking evidence to practice. Grimshaw et al. [35] present an impressive list of reviews of these interventions with data showing the magnitude of their effect (effect size), from 363 studies of 37,977 participants. Overall, the effect sizes Grimshaw et al.' report was medium. In one review, the authors reported a pooled odds ratio of 1.52. This means that the odds of a positive outcome using the knowledge translation intervention is one and a half times the odds in a control intervention.

The Cochrane Collaboration also has a Consumers and Communication Review Group. This group also supports systematic reviews, but its focus is interventions to enhance consumers' knowledge, decision-making, health services use, their experience of using services and its effect on their health and well-being. Grimshaw et al. summarise the results of 7000 randomised studies of 37,566 participants, 35 systematic reviews and one overview of systematic reviews. The evidence that Grimshaw et al. report shows mixed effects for various interventions. Table 2 summarises the overall findings of these studies showing consistently effective interventions, that is, multifaceted interventions and those of variable effectiveness: decision aids. Effect sizes, which were small to moderate, did not appear to increase with the number of interventions used [50, pp. 26–32].

Another important effect of linking evidence to practice is it its role in creating impact, (see below) and changing policy. For APMHNs, this may be healthcare policy.

The current Chief Medical Officer of England and the UK Government's Chief Medical Advisor, Professor Chris Whitty [51], discusses how to best influence policy makers such as himself. He highlights the important of good quality reviews as an excellent source of evidence to persuade policy makers: '*If the academic community (as a whole) could do one thing to improve the pathway from research to policy, it would be to improve the status, quality, and availability of good synthesis*' [51, p. 4]. We have discussed how to assess quality, and the resources available to APMHNs. While the Cochrane Collaboration focusses on evidence syntheses in relation to health and health care, the Campbell Collaboration [52] generates evidence syntheses of social science studies. Both Cochrane and Campbell collaborations focus on quantitative evidence syntheses. In contrast, the Joanna Briggs Institute includes a much wider range of evidence syntheses, including qualitative, opinions, psychometrics, implementation methods, scoping reviews and mixed methods reviews. The JBI approach reflects the importance of using different types of evidence to guide health care and the rejection of evidence hierarchies.

Aside from the use of quality evidence syntheses, Whitty offers other tips to influence policy makers and possibly contribute to changing health care practice. These include stating the policy problem explicitly, suggesting solutions and leaving the policy makers to determine what are the policy implications.

In sum, we have discussed what works in linking evidence to practice and how this evidence might be used by APMHNs. The next section examines other important and widely used sources of linking evidence to practice, namely, clinical (practice) guidelines, [53], and care pathways [54].

6 Clinical Guidelines and Care Pathways

Clinical guidelines were designed to reduce variations in health care outcomes, to help APMHNs and other clinicians better link evidence to practice and facilitate informed decision making between clinicians and service users [55, 56]. Care/clinical pathways are used commonly in health care systems to also improve the quality of care. APMHNs provide direct clinical practice and will often use pathways to guide their care and ensure it is evidence-based. The use of evidence synthesis reviews is common and recommended for the development of effective clinical guidelines.

In relation to clinical guidelines, a systematic review reported that strategies improving clinicians' use of guidelines positively improved clinicians' behaviour 86% of the time. The overall medium effect sizes showed a 10% improvement, although included studies were weak methodologically [56]. The strategies used were educational interventions, such as presenting audit data, interactive and experiential educational sessions, service-user focussed sessions based on their preferences, and how their preferences can be addressed: these were consistently effective. Sending reminders to professionals was the most used, but their effect was moderate; a combination of several interventions showed modest improvements.

A Cochrane systematic review of the effect of clinical/care pathways containing 27 studies of 11,398 participants comparing pathways with usual care [56] reported they improved documentation, reduced in-patient care complications, length of stay and the costs of care. There was no difference between readmission and mortality rates. Seven studies included pathways as part of multi-facetted interventions with no evidence of effect.

Clinical guidelines are used extensively in many parts of the world, and standards for their development are produced by a range of organisations such as the Institute of Medicine (IOM) in the United States [57], The National Institute of Health and Care Excellence in the United Kingdom (NICE) [58], the World Health Organisation (WHO) [59], the Australian National Health and Medical Research Council (NHMRC) [60] and the Guidelines International Network (GIN) [61]. But the quality of some guidelines, as assessed by the AGREE criteria, see the second paragraph on page 11, has been questioned as a result [62], and more than 50% do not use systematic evidence syntheses in their development. Notwithstanding these concerns, the use of clinical guidelines remains a common and successful approach to linking evidence to practice, but guideline developers must improve the quality of evidence underpinning them.

7 Improving APMHNs Capability to Translate or Link Evidence to Practice

Earlier in this chapter, we reported on the ICN characteristics of advanced nursing practice and the importance of APMHNs having research skills and capability for linking evidence to practice. The ICN recommends a master's degree as the preferred qualification for APNs. This differentiates advance practice from the bachelor's degree commonly required for entry level admission to the profession in many countries. With master's degrees, APMHNs more likely to have experience of advanced research methods necessary for linking evidence to practice. We also reported earlier a key barrier linking evidence to practice being the capability of clinical staff. The master's preparation for APMHNs should help remedy deficits in their capability. Increasingly, we are seeing more APMHNs undertaking doctoral degrees. The latter, however, can be costly and time-consuming for hard-pressed APMHNs. Therefore, opportunities and support to pursue these degrees are essential.

In 2007 in the United Kingdom, the UK Clinical Research Collaboration for nurses, midwives and allied health professionals published a report with recommendations for preparing and supporting APMHNs [63]. A significant recommendation that emerged from the report was the development of fully funded, competitive research training awards including master's degrees in Clinical Research, PhDs (and latterly other doctorates), post-doctoral junior and senior clinical fellowships. The Department of Health accepted these recommendations, and the organisation and processing of these awards was overseen by the UK National Institute for Health Research. The first author was a member of the master's and doctoral degree funding panels and chaired the junior and senior leadership panels. Many of these fellowships were awarded to APNs as well as APMHNs.

These opportunities, where they exist, expand the range of opportunities available to APMHNs. Where they do not exist to the same degree, in the UK, existing masters levels courses were amended to ensure they offered a focus on developing the clinical and research capability of APMHNs, and other nurses. In addition, the emergence of clinical/professional doctorates in the United Kingdom and elsewhere in Europe expanded the range of options for APMHNs looking to increase their clinical and research prowess, whereas PhDs are focussed mostly on improving research capability.

In the first ten years of the UK research training programmes, the number of awards and funds allocated increased significantly, making a huge contribution to building nurses' research, clinical capacity and capability [64]. In addition, the fellowships increased recipients' research activity, gave them clarity in pursuing a clinical academic career and enabled more integrated working between clinical and academic departments [65]. The additional capability these fellowships provided has enabled APMHNs to improve the originality, significance, rigour and impact of their research. The final part of this chapter will examine how APMHNs can best create impact from the research they conduct; this is entral to linking evidence to practice.

8 Creating Impact from Research

The originality, significance and rigour of APMHN research is necessary but insufficient in creating impact., that is, getting others to notice and use the research to change practice. Earlier we discussed the definition of impact as used in the UK Research Excellence Framework. Without evidence of impact, undertaking and publishing original, significant and rigorous research are best understood as esteem indicators, that is, they may enhance APMHNs' reputation but contribute little to changing practice. Bayley and Phipps [66] provide helpful examples of what impact *can* be, but not what it is, while McKenna [37], the panel chair for the unit of assessment that includes nursing in three successive REF exercises, provides excellent examples of what impact is.

In McKenna's view, creating impact is a moral imperative and an important feature of showcasing the value, and value for money of research, if its benefits to others are evident. Increasingly many research funders expect to see pathways to impact narrated in research bids as a condition of funding and are willing to pay for this.

To enable APMHN (and others) create impact, McKenna [37, p. 3] provides helpful questions to guide their thinking, and these are shown in Table 4.

Table 4 Questions to ask to help create research impact

1. Who are the actual and potential research users?
2. Who, among your colleagues, are already working with them?
3. Where are the actual and potential research users?
4. When is the best time to engage with them?
5. What are their interests, priorities and needs?
6. What is in it for them; how will they benefit?
7. What are your objectives from this engagement?
8. What methods will you use to access and engage with them?
9. What resources will you need to create meaningful engagement?
10. How do you align your objectives with their priorities?
11. What are the main barriers to successful engagement?
12. How do you ensure long-term engagement?

Table 5 Examples of toolkits to enable pathways to research impact

Economic and Social Research Council ESRC toolkit https://www.ukri.org/councils/esrc/impact-toolkit-for-economic-and-social-sciences/
Canadian Knowledge Mobilisation toolkit http://www.kmbtoolkit.ca/the-toolkit
Health Foundation toolkit https://www.health.org.uk/publications/communicating-your-research-a-toolkit
Fast Track Impact https://www.fasttrackimpact.com/resources
National Institute of Health Research (NIHR) toolkit https://openlearn.nihr.ac.uk/course/view.php?id=707
United Kingdom Research and Innovation (UKRI) toolkit https://www.ukri.org/councils/nerc/guidance-for-applicants/what-to-include-in-your-proposal/pathways-to-impact/

Additionally, Bayley and Phipps [66] suggest a six-stage approach to creating impact: (1) engaging service users to ascertain their perspectives and interests; (2) cultivating partnerships with people who may want to champion APMHNs' research; (3) understanding the context where APMHNs may be attempting to create impact; (4) tailoring materials and means of communication of their research to the intended audience, (5) considering the best approach to impact; and (6) considering the best time to start their impact activity, during or after the study's completion.

In addition to the Bayley and Phipps' approach, many funding bodies also provide toolkits to enable APMHNs to create impact pathways; links to some of these are shown in Table 5.

Thus far in this chapter, the authors have examined advanced practice mental health nursing, evaluated the nature of evidence-based nursing, shown how APMHNs can link evidence to theirs and others' practice, and discussed how they can create and sustain impact through knowledge mobilisation processes and the judicious use of original, significant and rigorous evidence. In the final section of the chapter, the authors present two case studies showing examples of advanced practice mental health nursing.

9 Case Studies Linking Evidence to Practice

Case Study 1: Using Advanced Practice Communication Skills to Work with a Disengaged Service User: A Solution-Focussed Approach

The scenario: Mary has been a long-standing client of the community mental health team. She has a long history of self-injury, mainly cutting her arms when distressed, and this has caused her significant injury. She struggles to engage with the team, believing that most team members are too young and inexperienced to help her. The service asks the APMHN, an experienced clinician, to work with Mary. The APMHN, mindful of Mary's reluctance to engage and her distress leading to significant self-injury, decides on a solution-focussed approach.

The evidence being linked to practice: A solution-focussed communication style emphasises the notion of *solution building* by looking at a person's existing resources and future hopes. It is goal focussed; the better the clarity of the service users' goals, the more likely will be a solution to those goals. The solution-focussed approach has produced small, but positive effects on anxiety and self-concept and improved service users' self-esteem. The potential efficacy of the approach can be assessed in several ways: the use of Mary's responses to the 'miracle' questionnaire and her assessment of her actual and ideal state, both illustrated in the next paragraph, and using other standard measures of the desired outcomes agreed between the APMHN and the service users with whom they are working.

The APMHN intervention: The four key tasks of a solution-focussed communication approach are as follows: exploring what Mary was hoping to achieve from the encounter with the APMHN. What are you hoping to achieve from our session today? The second task was exploring with Mary what life would be like if she realised her hopes: Imagine you wake up tomorrow and you have realised all your hopes; what do you think would be different? This is the 'miracle' question. The third key task was exploring what Mary was doing now, or had done before, to realise her hopes—a strength-based approach: think of a time when you have realised your hopes in the past. What did you do then? Finally, the fourth key task was exploring what might be different if Mary took a small step towards realising her hopes: What things would you, or those close to you, notice if you realised some of your hopes? In addition to these key tasks, the APMHN also ask Mary to assess, more formally, her current and ideal state by marking 0 = the worst-case scenario, 3 = where Mary was presently, 7 = a good, but realistic outcome, and 10 = the perfect solution.

Over the course of five encounters, the APMHN worked with Mary on a range of advanced nursing interventions: problem-solving skills training, a strengths and solutions exercise, to enable Mary to identify and use her existing strengths.

Evaluation: The APMHN used a before and after assessment of Mary's hopes and self-reported problem-solving skills. At the end of the final session, the APMHN re-ran the 'hope' exercise and used a problem-solving skills' follow-up self-report assessment and found improvements in Mary's hopes as shown by her responses to the strength-based hope tool and her self-report of her problem-solving skills.

Case Study 2: Using a Behavioural Activation Intervention to Support a Service User with Severe Depression

The scenario: John (45 years, male) had experienced depression for most of his adult life and had been prescribed several anti-depressant medications over the previous 20 years, with limited effect. Presently, John was unemployed having not worked for 10 years, lived alone and had limited contact with friends and family. In the past, John had attempted suicide on two occasions and had been admitted to an inpatient unit following each attempt. Presently, John was receiving care from a community mental health team for treatment and support for severe depression, with an emphasis on changing his medication regime.

The evidence being linked to practice: The community APMHN assigned to work with John adopted a behavioural activation approach to support John with his depression. Behavioural activation is an active approach to treating depression with a foundation in cognitive behavioural therapy but guided by behavioural principles and learning theory. Behavioural activation has a strong evidence base as a treatment for depression [67, 68] and can be delivered effectively by non-therapist mental health practitioners. The primary focus of behavioural activation is to support the person to establish a weekly routine, reduce avoidance, re-engage with activities that provide a sense of achievement and pleasure, restrict the opportunity for rumination and move towards living a meaningful, valued life.

The intervention: The intervention was delivered in the following sections, each being delivered in a separate meeting with John, usually with 1 week in between each meeting:

1. Initially, the nurse formulated John's experiences using a five areas model to explore with John how his behaviours, thoughts and feelings were linked. The emphasis here was to demonstrate how the behaviours that John engaged in (avoidance, withdrawal, rumination) served to make him feel worse and think more negatively and ultimately lead him to more unhelpful behaviours.
2. The next step was for John and the nurse to agree collaboratively a weekly routine focused on when John would to go to bed, when John would get out of bed and when John would eat each day. Additionally, they worked

together to identify all the activities that John was avoiding or had withdrawn from recently and historically due to his depression. Following this, the nurse explored John's values in life, and they identified new activities that might allow John to encounter these values.

3. John was guided to start scheduling the identified activities into his week. This was undertaken carefully, ensuring John only undertook a limited number of activities to begin with (this was limited to three activities in the first week). John was directed to specify the exact time and place each activity would take place and then to engage in the activity even if he did not want to at the time (this process is designed to show the patient the unhelpfulness of allowing behaviour to be dictated by mood state).
4. The next four meetings with John were used to review each of the weekly activities that John engaged in (with a focus on exploring the impact that doing the activities had on his mood and motivation). John and the nurse also worked together in each meeting to plan the following week's activities—gradually increasing the number and range of activities each week.
5. As John's mood and motivation improved, he was encouraged to start planning weekly activities on his own and to start planning activities that might bring him into contact with his life values (John's values were having meaningful friendships, doing something of value to others and being in nature).
6. *Evaluation*: The APMHN used a well-validated measure of depression—the PHQ-9 [69]—to explore the impact of the intervention on John's symptomology. The PHQ-9 was administered at all meetings with John, and it was found that John's depression reduced from the severe to the moderate range over the course of 10 weeks. John was also engaging in much more activity, had a stable sleep and eating routine, had started to engage in voluntary work at a local charity shop and had re-connected with some of his family.

Both case studies show how APMHNs can incorporate evidence-based interventions into routine, daily mental health nursing practice, with significant improvements for and with service users.

10 Conclusions

Advanced practice mental health nursing is an art, science and craft. Linking evidence to practice is a key part of advanced mental health nursing and requires APMHNs to adopt an evidence-based approach. This means undertaking and/or using research that is methodologically rigorous and clinically relevant. There are conceptual frameworks and a wealth of empirical evidence from creditable sources from which APMHNs can draw to assist them link evidence to practice. This evidence describes interventions that are consistently effective, those which are of variable effectiveness and those which are ineffective. Linking evidence to APMHN requires an array of skills and capabilities. These include skills in assessing the originality, significance and rigour of evidence and creating impact using established criteria and toolkits, as well as skills in overcoming obstacles linking evidence to practice. Using structured impact pathways will enable APMHNs link evidence to practice and show how their research is changing practice. Finally, showcasing examples of how APMHNs are linking evidence to daily, routine mental health nursing practice highlights the benefits for users of mental health nursing practice.

Reflective Questions

- Compare and contrast the PARIHS and AI framework for linking evidence to practice.
- Read Bastounis A, Callaghan P, Lykomitrou F, Aubeeluck A, Michail M. Exploring students' participation in universal, depression and anxiety, prevention programmes at school: a meta-aggregation. School Mental Health. 2017;9:372–85. Using one of the interventions described in Table 3, describe how you would use that intervention to work with colleagues to use the Bastounis et al. findings in practice.
- Critique the quality of Bastounis et al. paper cited above using the UK REF benchmarks of originality, significance and rigour.

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Advocacy and the Advanced Nurse Practitioner

Mick McKeown

No voice is too soft when that voice speaks for others.

—Janna Cachola (Janna Cachola is an actor, singer and author. This quote of hers has been taken up by numerous advocacy organisations, e.g. https://borgenproject.org/tag/quotes-about-advocacy/.)

Learning Objectives
The objectives of this chapter are to enable you to:

- Develop a critical understanding of the need for advocacy grounded in a complex of crises of legitimacy facing mental health nursing.
- Appreciate the distinction between nursing advocacy and independent advocacy.
- Develop a critical understanding of how best to advocate for individuals' self-defined interests and to support the work of independent advocates in this regard.
- Become interested in broader social justice advocacy and the idea of a radical professional identity suited to pursuing this.

1 Introduction

This chapter discusses the importance of advanced practice mental health nurses (APMHNs) being knowledgeable, skilled and supportive of other key colleagues in the context of advocacy. Advocacy in the health-care context can be thought of as a

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skilled intercession to ensure that an individual service user has their voice heard or is supported to speak for themselves. Different people can take on an advocacy role. In mental health service contexts, this can be professionals or informal carers, including nurses, or people external and independent to services, including citizens, peers and professional advocates. More often than not mental health advocacy involves supporting people to express their views and wishes or secure rights and entitlements. Political or policy advocacy moves beyond a focus on individual rights to advance collective mental health interests, such as campaigning for resources or against stigma. Arguably, mental health nurses have an important stake in advocacy at all levels.

APMHNs should recognise themselves and their role in generic references to 'mental health nurses' throughout the chapter, acknowledging that certain key messages must extend to all nurses. Moreover, APMHNs are well placed to assume leadership and educative roles in relation to advocacy. Advocacy on behalf and for persons engaged in the mental health system has a proud international heritage. Nurses have been prominent as advocates in developed Western nations across North America, United Kingdom, the antipodes and Asia-Pacific region and Europe [1]. More broadly, in the context of a global mental health movement, interest in advocacy related to equal access to mental health care has extended to the global south [2]. The necessity of policy advocacy to promote human rights and fight stigma has been taken up globally by the World Health Organization [3].

There is a long history of advocacy in the mental health context [4], and a number of nursing scholars have blazed a trail of interest in advocacy (see [5–8]). Indeed, early in mental health nursing's emergence as an academic discipline, crucial pioneers such as Annie Altschul [9] were publishing about the importance of nurses respecting and attending to the patient voice. That said, other international nursing scholars have found that mental health nurses have not always had advocacy foremost in their mind when contemplating their role and professional identity [10]. Generally speaking, scholarly interest in the development of nurse advocacy began in the United States in the 1970s. This can be tracked to other jurisdictions from this point with the International Council of Nurses (ICN) adopting advocacy into its code [11]. The interest in advocacy paralleled a progressive shift from obedience to institutional power and subordination to biomedical orthodoxies towards a more patient-centred orientation. This in turn was linked to empowerment ideals and, arguably, consumerism [12]. A recent international study of student nurse attitudes across Europe and Australasia showed high levels of acceptance of the need for nurses to be advocates [13].

In my career, I have been fortunate to have interacted with some notable advocates of advocacy, such as the late great pair David Brandon [14] and William Bingley [15]. These two men balanced critique with support for professions navigating the fine line between helping and hindering patients' rights and autonomy under mental health care. Nursing and other psy-professions have arguably had a chequered history with regard to advocacy. Such groups face a seeming paradox: charged with a duty to provide advocacy whilst their practice often precipitates the need for advocacy in the first place. Their role and the social-relational context they operate in can be complex. Possessing limited professional autonomy within prevailing managerial and clinical hierarchies, mental health nurses, including APMHNs, can lack the authority to meaningfully challenge psychiatric systems whilst also being mandated by other colleagues to 'do the dirty work':

> *Mental health nurses are required to be involved in removing human rights, but don't have ultimate power over these decisions. Therefore, they must be competent to advocate for patients and force discussion on actions and consequences using the language of ethics and human rights. The need for moral courage is great, because, as social animals, things are often left unsaid for fear of social repercussions within both institutional and relational hierarchies. The ethics of self-preservation over doing the right thing need to be exposed and challenged* [16, p. 1].

Such observations firmly place the context of mental health practice in a field of morality and ethics and, arguably, the political field of psychiatric contestation. For as long as there has been an occupation of nursing, there has been an interest in notions of advocacy, and mental health nursing has required its own advocates. Indeed, the very establishment of a mental health nursing professional identity can be seen to have resulted from concerted lobbying and persuasion by key individuals in the course of history. For mental health nurses, the assumption of fully fledged professional recognition was delayed in relation to other fields of nursing, including having to struggle against the opposition of already recognised and regulated professional nurses. This reflected the lack of esteem in which nurses working in asylums were held. The establishment of a register of professional nursing occurred in 1919 in the United Kingdom and was largely associated with established training schools for general nurses. Mental health nursing did not secure a place on the register until 1923. This early history of mental health nursing informs our understanding of the present. As asylum attendants adopted the title nurse and achieved professional regulation in their own right, they did not escape subordination to, and control by, psychiatrists [17].

The development of an engaged and politicised nursing identity is arguably congruent with professional pedagogical aims to produce nurses who can sustain autonomous critical thinking [18]. Latterly, various critically minded nurses have collectively addressed a range of political issues and have explicitly called for more of their nursing colleagues to be involved and embrace a more radical, engaged professionalism [19–25]. This has explicitly counteracted an unhelpful stereotype of nurses as politically passive. Nurses are not alone in such endeavours, and many critical practitioner groups have formed over time and produced radical ideas for the reconstitution of mental health care (see [26–30]). Latterly, the Critical Mental Health Nurses' Network[1] has formed to take forward such a radical agenda amongst mental health nurses.

Perhaps the ways in which a mature profession of mental health nursing negotiates its future regard for and relationship to advocacy will assist in evading the more obvious traps inherent in inter-professional and service-wide power relations. Primarily, this must involve asserting and identifying with a notion of mental health nursing as relational, person-centred practice. Arguably this cannot be achieved

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[1] https://criticalmhnursing.org/.

without also attempting to renegotiate mental health nursing's relationship to psychiatry. Ideally getting out from under hierarchies of subordination ought to be a key goal. Lastly, but very importantly, we must challenge the oppressive influence of a neoliberal political economy. Neoliberalism has dominated global economic policies since the late 1970s, and it is characterised by commitments to diminishing the role of the State, placing political faith in free markets, deregulation and privatisation. Amongst other negative impacts, this constrains resources and, hence, nurses' collective ability to enact compassionate and consensual care. Jenkins et al. [21] make a passionately and eruditely argued case for nursing leadership to prioritise a practice of 'truth-telling' in seeking a more just society and exposing the adverse consequences of neoliberal capitalism.

2 The Contested Mental Health Service Context

Historically, the negative implications and impacts of psychiatric services, and their enmeshment with wider systems of governance and control, have furnished a cogent but somewhat disparate challenge to psychiatric legitimacy. Various fairly recent developments vie with a more longstanding critique, urging mental health services and the practitioners who work in them to think more critically about their own practice and the context within which they work. This involves consideration of the location of mental health practice at a nexus of health care, governance and social control. As such, working with mentally distressed individuals may never be as simple as just meeting their needs. Matters of public protection and risk management have become increasingly prominent concerns, whilst ideologically driven austerity regimes cut services. In tandem, these policies damage and deprive communities, employment opportunities and welfare support, creating more mental distress for services to deal with, but with less resources. Moreover, under this neoliberal malaise, some outcomes are valued more than others. For example, whilst service users may value personally defined recovery outcomes, ultimately under neoliberalism, work capability is most valued [31].

Furthermore, the social and community relations of people in contact with mental health services are bedevilled with stigma, moralising judgementalism, exclusions and discrimination. These in turn intersect with other matters of identity and disadvantage. It can appear to people who use or refuse to use mental health services that their choices are limited. Dissatisfaction is intensified in contemplation of the dominance of an arguably too narrow biomedical framing of mental distress that restricts available care and treatment options. This curtailment of choice persists despite recent turns in policy and philosophy oriented towards:

- Psychosocial, trauma-informed and recovery orientations.
- Person-centred care.
- Democratic coproduction.
- Efforts to redeem the medical model from overly simplistic or partisan criticisms (see [32, 33]).

All of this, together with the inescapable fact that services are typically replete with a range of restrictive practices, compulsion and coercion [34], brings a need for advocacy into the foreground of mental health care.

Germane considerations include the challenge to reappraise the supposed evidential basis for certain forms of practice and the conceptual frameworks underpinning them. The absence or imperfection of advocacy has been implicated in various failures of services, and the establishment of better advocacy has been likewise recommended as a remedy. Broad failings across health-care systems include the consolidation of substantial health inequalities, even within rich Western nations able to support well-resourced welfare systems. Specifically, there have been catastrophic failures of care and compassion, with neglect and abuse of vulnerable patients. These faults have damaged public faith in the leadership and institutions of health care, leading to a crisis of legitimacy [35]. Disquiet has flowed from the exposure of various recent scandals, such as in the United Kingdom at Mid Staffordshire Hospital and Winterbourne View. Sadly, the relevant events are not unique in terms of history or national context. In the United Kingdom, they were preceded by no end of other failings, provoking a series of damning service reviews and public inquiries. Elsewhere in the world, mental health service scandals have occurred wherever one cares to look, with institutionalised abuses of children, the elderly and disabled, women, ethnic minorities and indigenous peoples. Prominent examples include the Oak Ridge social therapy unit scandal in Penetanguishene, Ontario, where psychiatrists subjected inmates to degrading treatment amounting to physical and psychological torture.[2] The Council of Europe has also reported levels of neglect in parts of Eastern Europe, such as Bulgaria, which also amount to torture. In the latter case, patients were forced to live in filthy conditions and sleep on rusty beds, with individuals found ‘covered in flies’.[3]

I have personal experience of least two public inquiries which bookended the time I spent working at Ashworth High Secure Hospital [36, 37]. These inquiries reported a number of shocking abuses that were able to exist within the closed confines of a totalising institution that proved, initially, fairly nimble at closing down the scrutiny of whistle-blowers and advocates. Consequently, key recommendations from the first public inquiry were for the establishment of effective independent advocacy and the dismantling of managerial systems which had been blind to nefarious practices and ineffectual at addressing complaints [38].

The specific legitimacy crisis facing mental health nursing is predicated upon a triad of issues. The key points of contention are (1) a supposed deficit of compassion, (2) the neglect of the physical health care of mental health patients and (3) complicity in the broad harms associated with biomedical dominance. All these issues suggest substantial detriments of service, for which mental health nurses whilst not singularly blameworthy must take their share of responsibility. Taking them in turn, we can see that nurses have at the very least been operating in a system

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[2] https://globalnews.ca/news/7132762/psychiatrists-ontario-liable-patient-abuse/.

[3] https://www.coe.int/en/web/human-rights-rule-of-law/-/council-of-europe-anti-torture-committee-issues-public-statement-on-bulgaria.

that visits significant harm upon individuals using services. Furthermore, the threats to nursing legitimacy, whilst well-defined, are not necessarily independent of each other. First, the noted scandalous systems failures have generally implicated nurses in scenarios where compassion is alleged to be compromised or lacking altogether [39]. This has led to a raft of mass media and social media amplification, much soul searching within the profession and policy turns in nurse education designed, but not guaranteed, to address identified failings [35, 40]. Second, people using mental health services, especially those with more serious mental health problems, suffer profoundly increased levels of morbidity and mortality for treatable physical health conditions [41, 42]. Amongst the reasons for this is the iatrogenic effect of long-term medication regimes that nurses mainly administer [43]. Finally, a wide-ranging critique of the knowledge base of mental health care has coalesced around criticism of a prevailing biomedical orthodoxy and how this is wrapped up with increasingly coercive and restrictive service provision [44–47]. Notably, in this era of the *Black Lives Matter* movement, amongst universal detriments, there are particular differential negative impacts for people of colour (see [48]).

Flowing from such disquiet and contestation, recent propositions for reforms of mental health legislation have identified coercive and restrictive practices and various institutional biases, not least regarding race, for critical attention.[4] The alternative Power Threat Meaning Framework begins with a rejection of a narrow biomedical episteme [49] and has been welcomed by progressive nurse educators [18]. Notably, a historical contribution brings together the famous critics tagged as an anti-psychiatry movement in the 1960s and 1970s, but also the arguably more sophisticated critique of Peter Sedgwick [50] and sundry others going back to the birth of psychiatry. Earlier, critical voices such as Frantz Fanon [51] laid foundations for more nuanced objections to a simplistic medical model and also presaged later calls for more culturally sensitive care practices on the one hand and, alternately, more radical demands linked to abolition democracies (see [52, 53]). This politics of abolition emerged out of criticism of the treatment of black people in the US penal system prompting Angela Davis [54] to connect this experience to the horrors exposed at the Abu Ghraib prison during the American occupation of Iraq and the movement to end slavery. For critically engaged scholars like Davis and activists in related movements such as Black Lives Matter, the goal is not merely simplistic abolition of oppressive systems and institutions. Rather, attention is focused on perceived causes and even the causes of causes of injustice. Hence, applied to psychiatric injustices, an abolition democracy might seek upstream solutions to arrive at a perspective whereby a coercively organised system no longer makes sense. Latterly, these critical voices have been joined by scholars and commentators offering a mad studies perspective [55] and others best described as a re-emergence of anti-psychiatry [56]. These critical perspectives have always crucially involved a mixture of scholars, practitioners and service users, refusers and survivors, and one of Sedgwick's valuable intercessions was to call for building cross-sectional political alliances in the quest to transform psychiatry [57].

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[4] https://www.gov.uk/government/consultations/reforming-the-mental-health-act.

A common feature of many of the more progressive alternatives urged upon psychiatry is a commitment to equalise or democratise the relationships between care providers and recipients. A notable relatively recent innovation is the Open Dialogue approach (see [58]). This emphasises democratic communication and achieves impressive outcomes with minimal use of medication. The World Health Organization has also identified a range of mental health initiatives deemed to be more person-centred, respectful of human rights and recovery focused.[5] Democratic communication is also at the heart of authentic efforts towards coproduction of care. Similarly, the therapeutic community tradition is effectively grounded in a commitment to interpersonal democracy. Sedgwick himself worked in the famous therapeutic community at Grendon Underwood Prison and was politically the consummate democrat, seeking democratic transformations of psychiatry and society as a whole. Interestingly, advocacy can be viewed as one remedy for insufficient democracy within the system, attempting to support service users to have their say when aspects of the system have quietened their voice. For all the potential of democracy, a fundamental democratisation of care is some way off.

Socialisation into occupational roles results in practitioners taking for granted how services operate, however damaging this might be. Opportunities for imaginative contemplation of alternatives can be thoroughly curtailed. One aspect of this is the incorporation and co-optation of a series of ideas for change without achieving anything like a transformation of the orthodoxy. Ideas such as recovery, user involvement, shared decision-making and coproduction have been wheeled out in turn. Despite certain improvements, these ideas have not yet proved to be transformational (see [59]). The relative failure of progressive ideas to gain meaningful translation from policy rhetoric into practice echoes Ahmed's [60] critique of non-performativity. A policy is seen as non-performative if it substantially fails to achieve its stated objectives.

3 Nurses as Advocates

Acknowledgement of the complexities of care provision highlights nurses' often paradoxical positioning in relation to advocacy. Whilst often desirous of change and seeking to advocate on behalf of service users or professional progress, nurses can lack effective power and be complicit in structures and practices that precipitate the very need for advocacy in the first place. Despite this, amongst other health and social care practitioners, nurses have long claimed an advocacy dimension to their role in supporting vulnerable service users [8, 61–64]. Furthermore, this is often mandated by regulatory authorities and reflected in codes of professional conduct [65].

Juggessur and Isles [1] outlined several models for nursing advocacy. Most of these emphasise the human rights of service users, a moral or ethical framing of nursing and

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[5] See WHO: https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services.

the desirability of individuals' voices being heard within the care process and, crucially, decision-making about the care and treatment provided. Thus, Curtin [5] made a case for advocacy within a rights-based philosophy of nursing: the object of nursing being the assistance of other human beings who are entitled to human rights. Similarly, Gadow's [6] existential advocacy offers a humanistic understanding of nursing's advocacy role, integral to broader nursing practice. This involves respecting individuals' autonomy by working alongside them easing access to and explaining information, listening to individuals and assisting appreciation of their values and beliefs. Ultimately this involves supporting individuals' appraisal of alternatives enabling them to make choices. When this works well, nurses can be seen to be effective advocates for improving individuals' welfare and experiences of services. APMHNs can play a key role in facilitation, supervision and education of other practitioners.

Nevertheless, support for nurses taking on an advocacy role is not unequivocal, and appropriate education and preparation may be necessary. This might helpfully include appreciation of moral and ethical issues. Nurses and other practitioners interested in their potential advocacy contribution have been cautioned to be conscious of and guard against possibilities for paternalistic judgements, such as considerations of clinical best interest or irrationality overriding individual patient autonomy [66]. The fact that nurses are able to be advocates for individuals receiving care, and that this can on occasion require substantial courage or even heroism, does not obviate the appreciation that nursing advocacy is fundamentally different to forms of independent advocacy which also ought to be available. Nurse advocates are never truly independent of the care teams they belong to and the system that employs them. Moreover, it is a rare practitioner who is willing or able to put aside care team views of individuals' best interests. In this way, the limitations of nursing advocacy become apparent, either in the inevitable conflicts and contradictions between what service users and staff judge to be good for them and/or the constrained capacity to realise individuals' demands which may be contra to legally legitimated restrictions. The latter issues become hugely significant with regard to curtailed liberty or forced treatment.

4 Blowing the Whistle and Other Acts of Resistance

The practice of nursing advocacy can, on occasion, concern itself with illegitimate practices and the illegitimate consequences of legitimated practices. It can also be prompted by a more general awareness that the system is replete with crises of legitimacy. That is, nurses and other mental health practitioners can experience forms of moral injury that flow from dissonance between their hopes and aspirations for their professional role and identity and the knowledge that the public and service users may actually see them quite negatively. Because of the nature of this moral, ethical and politicised territory, such concerns might inevitably situate mental health nurses in opposition to prevailing neoliberal or biomedical hegemony. This is most obviously apparent when such contradictions and dissonances of conscience lead to acts of whistle-blowing, such as bearing witness to unacceptable care or misconduct

[67]. The personal cost borne by notable whistle-blowers serves to emphasise the limitations of nurse-initiated advocacy. These include the pressures of facing up to managerial and interdisciplinary hierarchies with split loyalties between colleagues and clients, inconveniently exposing discrepancies between avowed professional ideals and recognisably poor practice [68].

Most acts of whistle-blowing, however, are indicative of the failure of systems to correct highlighted shortcomings through ordinary channels, including responsiveness to advocacy. The act of blowing the whistle thus represents a profound distillation 'of professional values and raises questions about the responsibilities nurses have to communities and clients, the profession, and themselves' [69, p. 51]. Typically having exhausted available processes for raising and escalating concerns, whistle-blowers can pay a personal price that highlights some important limitations for nurses' assumption of an advocacy role [1]. Notable nurse whistle-blowers, including courageous student nurses, have often faced an uphill struggle to make themselves heard and then face adverse repercussions. Many have found themselves ostracised or lost their jobs in the process [70]. As a consequence, nurses caught up in dilemmas of conscience regarding practice concerns are urged to follow defined procedures and seek the support of representative organisations such as trade unions. In the United Kingdom, for example, Unison [71] has produced helpful advice for negotiating whistle-blowing policies. Similarly, despite misgivings concerning adequacy of protections, the Canadian Union of Public Employees has been prominent in campaigns to establish legislation to safeguard whistle-blower rights.[6]

Despite the value of nurses providing sometimes heroic forms of advocacy, there is a fundamental difference between this and the advocacy performed by independent advocates. Nurses working within health-care systems cannot be truly independent of these systems. It is inevitable that they will be, whether by association or complicity, responsible for endorsing or sustaining a clinical team perspective regarding what is, or is not, deemed in a person's 'best interest'. Unavoidably, substantial numbers of people using services will contest and resist such views of what might be good for them. The inevitable existence of such tensions makes the case for independent forms of advocacy.

5 Independent Advocacy

Mental health law in Scotland, and England and Wales[7] provides for a right to independent advocacy for users of mental health services who are subject to compulsion into services. Independent advocates are employed outside of the mental health service, so they have no conflict of interests. All persons sectioned under mental health law have a right to an independent advocate. The legal entitlement to independent advocacy also came with certain formal expectations for nurses and other practitioners to actively support this right to advocacy and ensure service users are able to

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[6] For example, http://www.archives.gov.on.ca/en/e_records/sars/report/v5-pdf/Vol5Chp7.pdf.

[7] Scottish mental health law is distinct from that in England and Wales.

access advocates. Practitioner staff such as nurses must facilitate these rights. There are other forms of advocacy such as citizens advocacy, peer supported advocacy, advocacy tailored to ethnic minorities and more generic advocacy which all can have a degree of independence from services but are not necessarily legislated for. Various international jurisdictions also have systems for independent advocacy, but this isn't always legally mandated.[8] The desirability of independent advocacy is implied by different national disability rights instruments and widespread adoption of the UN Convention on the Rights of Persons with Disabilities (see [74]). Across Europe, though most nations have some form of mental health legislation, only 65% are fully compliant with human rights instruments. The WHO Mental Health Atlas describes 30 European countries having some degree of relationship with independent advocacy groups, though this may be more at the level of policy engagement rather than individual advocacy for service users [75].

A research team I was involved in, inclusive of a number of co-researchers with lived experience of using mental health and advocacy services, undertook a large-scale evaluation of independent mental health advocacy (IMHA) services across England [76]. This project, in conjunction with the Social Care Institute for Excellence (SCIE), also produced various resources[9] designed to promote better understanding of the independent advocacy role. The resources were collaboratively created by a collective of advocates, service users, practitioners, researchers and commissioners and provide information in different media. These include compelling short films produced by the service user-led company 'Flexible Films'. Such resources are intended to aid practitioners fulfil their obligations to support independent advocacy and also inform service users of their statutory rights [77].

Whilst the statutory right to independent advocacy for individuals subject to the Mental Health Act was to be welcomed, questions remained, about the extent to which such entitlements are supported by appropriate resources. Similarly, the establishment and privileging of IMHA may have been to the detriment of more generic advocacy, inclusive of voluntary patients, for example, and more specialist advocacy, for example, targeting Black, Asian and minority ethnic (BAME) communities and other minority groups. In the case of the former, the operation of de facto compulsion as experienced by notionally voluntary patients raises substantial ethical concerns about their exclusion from a formal right to independent advocacy. In the latter case, the well-documented anomalies in the care and treatment of BAME communities (e.g. [78–81]) suggest a powerful argument for culturally sensitive independent advocacy support. Furthermore, the individualised case-based model underpinning statutory IMHA services, framed by notions of independence, may be somewhat incongruous with considerations of interdependence within certain BAME communities [82, 83]. For example, in particular ethnic minority cultures people may expect or insist on more involvement of families or wider

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[8] For example, the Australian State of Victoria has been urged to follow the English model (see [70]); also see, Canada [71].

[9] https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-users/.

community in the advocacy process or mental health care, but most Western systems rely on a more individualised framing of needs and problems.

Our study showed that staff and services can be anxious that access to independent mental health advocacy raises the potential for complaints about nursing practice and practitioners. This is, however, a mistaken view as problems are much more likely to be resolved without recourse to formal procedures when independent advocacy is involved. The intercession of advocates can support and improve communications to the overall benefit of care, including communication within teams or between practitioners and service users, where matters of trust can be compromised by other aspects of services such as coercion. Such communication issues can often be at the heart of service users' concerns, and staff can welcome the input of advocates, such as in this contribution to our research:

> The essence of our job is to have a meaningful dialogue with our service users... it's fantastic from my point of view that an advocate helps the staff have a dialogue with a patient. So we should always see that as a huge opportunity, as a huge benefit. [77, p. 1].

Moreover, independent advocacy can be better placed to exert influence and make demands on resources where staff interventions have failed to gain traction or are more easily rebuffed within cost-conscious organisations.

Notwithstanding the opportunity for nurses and other practitioners to see the value of independent advocacy, a number of tensions exist between nurses and advocates within the routine operation of services. To some extent this may reflect misunderstandings of the independent advocacy role and an uneasy juxtaposition with nurses' own perceptions of themselves as advocates. There are, perhaps, certain deeper issues, and certain of these were revealed in the research study. For example, we found variable appreciation of the value of independent advocacy or knowledge of statutory duties to provide support for independent advocates amongst practitioners [84].

Routine monitoring by the UK Care Quality Commission (CQC) has highlighted gaps in universal access to independent advocacy alongside ever-increasing levels of coercion and compulsion. Mental health professionals, including nurses, can become somewhat aggrieved or upset if service users appear to go outside of the care team to seek support for issues the team feel should be their business to sort out [85]. Our research discovered that services and the staff in them related to independent advocacy in distinctly different ways. To a large extent, the prevailing orientation to independent advocacy depended upon a complex of affinity for the value of independent input and knowledge of what independence means in the context of mental health services. Figure 1 represents a matrix of relationships between independent advocates and practitioner staff, mainly ward-based nurses, derived from our research.

As the matrix suggests, the ideal set of working relationships was, perhaps unsurprisingly, predicated on a positive appreciation for independent advocacy alongside practitioner staff possessing excellent knowledge of the independent advocacy role. This allowed for development and maintenance of healthy boundaries between independent advocates and care team staff within which staff were able to understand and fulfil their statutory obligations to support independent advocacy and

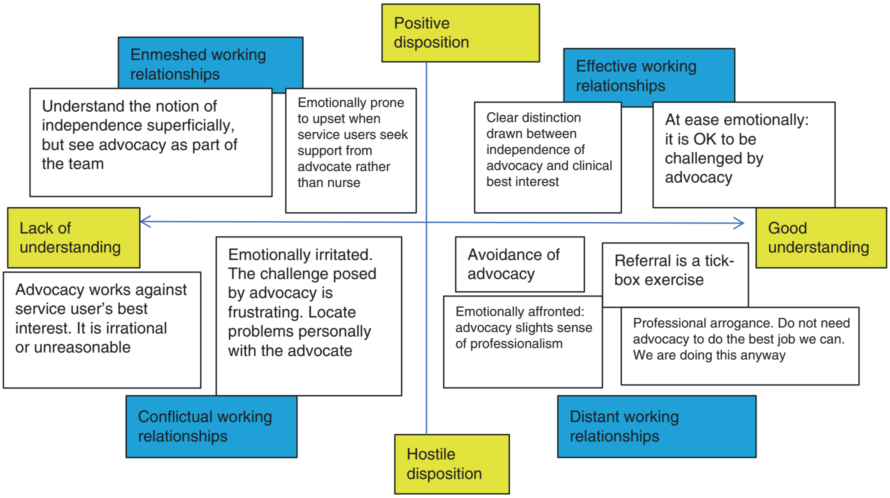

Fig. 1 Working relationships matrix

make appropriate referrals to IMHA. Less than ideal relationships could also flow from a positive disposition towards independent advocacy if this was not supported by adequate knowledge of the importance of independence in the advocacy role. This could result in nursing staff trying to become too close to the advocates or include them as an adjunct member of the care team, thus compromising the advocates' independence. Alternately, the nature of independent advocacy can be fully comprehended, but the value of such independent input is not appreciated. Under such circumstances, practitioners can fail to support, or resist, the input of independent advocates, typically feeling themselves to be better placed to fulfil any necessary advocacy role. This results in poor compliance with statutory duties to support IMHA and a distant or avoidant disposition to advocates. Lastly, perhaps the worst scenario, antipathy towards independent advocacy co-exists with poor understandings of it. This almost inevitably predicts hostile and conflictual relationships with advocates, and our research identified some particularly vexatious examples of this where working relationships had almost completely broken down.

At its simplest, problems in relationships were due to staff ignorance of the value of an independent advocacy perspective and the necessary measures required to maintain and render visible this important independence. For example, staff could misunderstand advocates' attempts to balance the desirability of open communication with teams alongside keeping a degree of distance in their relationships to protect their independence. Thus, independent advocates must both relate and communicate with teams but always be separate from the team. An uninformed reaction might be to see the advocate as unfriendly or purposively avoidant of friendly gestures. However, the flip side could also be true, with equally misguided staff attempting to incorporate advocates into their sense of team, trying to involve them within team decision-making, with this sort of enmeshed relationship undermining independence.

Arguably, to enhance appreciation and knowledge of independent advocacy, practitioner staff, including APMHNs, ought to be better educated about the value of independent advocacy. Such a view is not new, and much earlier research also highlighted ignorance and opposition to the role of previous forms of independent advocacy (i.e. not legislated for), suggesting the need for staff training [86]. Importantly, this must include improving understanding of the benefits for both service users and care teams that can flow from staff support for an independent advocacy role and acknowledgement of the limitations of practitioner advocacy.

6 Survivor and Staff Movements for Change

The provision of independent advocacy for individuals engaged in mental health services resonates with the representation provided by trade unions for nursing staff and others. Union representatives are trusted because they are independent of employers. Similarly, union case work and bargaining can be understood as a distinct form of 'advocacy'. Trade unions practise this advocacy as part of a wider social movement, which sustains itself through solidarity and an appeal to civil and employment rights won through historical struggles. Likewise, we can view independent advocacy through an historical lens of service user and survivor struggles to secure and defend their rights within mental health services and wider society. Mental health service user and survivor movements have long campaigned for independent advocacy, the aim of which is to ensure individuals' voices are heard when they are caught up in the psychiatric system. Ultimately, this is best achieved by forms of self-advocacy and mutual assistance organised by and for survivors themselves [87, 88]. Particular forms of mutual-aid and self-advocacy may be required for specifically marginalised or oppressed groups, such as ethnic minorities [89] whose interests have not always been best served within the mainstream survivor movements [88]. The similarities in objectives between survivor movements and trade unions were briefly recognised in the 1970s in the United Kingdom with the establishment of a Mental Patients Union, but this was not allowed to affiliate to the Trades Union Congress (TUC), the umbrella organisation for UK labour unions, in an arguably short-sighted judgement of what constitutes a legitimate trade union [90].

Regardless of such tensions between different movements, progressives within survivor and employee movements have previously called for cooperation in the quest for positive changes in the system of mental health care [91, 92]. Such cross-sectional alliances could support and create the space for nurses, amongst others, to make their voice heard in a context of social justice advocacy within a broader politics of mental health. In the wider health context, unions have internationally organised in coalitions of citizen, service user and disability groups [93]. In the United Kingdom, the trade union Unison has shown some interest in two recent areas of mental health contestation and campaigning: grassroots approaches for truth and reconciliation [94] and conscientious objection to forced treatment [52]. APMHNs need not shoulder all responsibility for such politicking but may find themselves well-placed to contribute because of the relative esteem and opportunities accruing to more senior roles.

The adoption of, or engagement in, a more radical politics need not be the enemy of professionalism. Indeed, it has been argued persuasively that if nursing is to make further advances as a profession, then a more radical professional identity is one clear route for such advancement. To take up this challenge, nursing may have to shake off a degree of individual and collective timidity, including challenging bias and prejudice against notions of radical professionalism. Certainly, in society the very idea of being a radical or militant has, for many, assumed a pejorative meaning. The notion of being a radical is so denigrated, for instance, it has been co-opted in the field of terrorism prevention, that we have lost track of the idea of radicalism as a positive force for driving social justice. If we are to adopt a more radical professionalism, we may first have to reclaim a valuing of radical identities and ideas [23, 95, 96].

Nursing as a profession and the user and survivor movement make demands on the polity, on government and governance systems. Some salient demands in the context of the critique expressed in this chapter might include but not necessarily be exhausted by examples such as:

- Nurse education not merely aiming to produce critical thinking nurses but also including within the learning much more critical and political theory, ideas and practices. How can nurses be true advocates within a challenging environment without learning how to accomplish this most effectively?
- The nursing profession engaging in a concerted effort to reclaim and reconstruct the language of madness, militancy and radicalism and recognise the legitimacy of resistance to many orthodox psychiatric practices.
- The practices of mental health care becoming much more authentically consensual, cooperative and non-violent.
- In alliance with others, nurses collaboratively shaping better places and spaces of care provision within which to realise these essential goals.

Frederick Douglass [97], the famous anti-slavery campaigner pointed out the reluctance of the powerful to conceded anything at all without there being a clear demand, and the need for dynamic action to realise this. Writing about how merely being affronted by injustice and rhetorically appealing for a more just alternative will be insufficient to achieve real change, he states:

> *The whole history of the progress of human liberty shows that all concessions yet made to her august claims have been born of earnest struggle. The conflict has been exciting, agitating, all-absorbing, and for the time being, putting all other tumults to silence. It must do this or it does nothing. If there is no struggle there is no progress. Those who profess to favor freedom and yet deprecate agitation are men who want crops without plowing up the ground; they want rain without thunder and lightning. They want the ocean without the awful roar of its many waters. This struggle may be a moral one, or it may be a physical one, and it may be both moral and physical, but it must be a struggle. Power concedes nothing without a demand. It never did and it never will, (p. 7–8).*

Despite all good intentions, a commitment by nurses to fulfil an advocacy role or support the practice of independent advocacy may not alone be sufficient to ensure individuals in receipt of services have their rights and entitlements protected nor on a broader canvass might nursing's embrace of a more politicised professional advocacy realise intended goals. At the level of patient care, ingrained power imbalances and epistemic domination can conspire to neuter the impact of advocacy. There can also be a seemingly paradoxical outcome, whereby a commitment to good practice in advocacy, an essentially relational set of processes, does not achieve, or does not immediately achieve, the wishes of service users. Instead, the experience of being listened to and having one's voice valued is welcome. This assists individuals to reconcile themselves to a system that now seems to recognise their individuality and desires to be heard. That is, people appreciate the process of advocacy but may not achieve the outcomes they initially asked for. With colleagues, I have made sense of such limitations with recourse to Goffman's [98] account of the 'cooling out' of people subject to life's disappointments via an analogy of the confidence trick [99]. That is, the relational experience of advocacy is appreciated. Being listened to and respected is a positive experience, regardless of the result. This is a state of affairs redolent with earlier critique of the incorporation threats to innovations ostensibly designed to achieve more fundamental change. Brandon [100] famously called attention to such circumstances in his book *Innovation Without Change*, highlighting the need for genuine service user involvement to ensure progress in service developments. Recognising the potential for such traps can sharpen up our commitment to improve and transform services.

7 Conclusion

High-quality nursing care and support of individuals in mental distress is obviously the aim of APMHNs. These professionals also have regard to a whole team and systems approach to maximising the quality of individuals' experience in a context of coproduced, person-centred care. Recognising the complexities of a mental health-care system operating within broader systems of social control and governance and facing various crises of legitimacy, the notion of advocacy is hugely important. APMHNs must be both competent advocates in their own right and supporters and allies of independent advocacy. Moreover, because of a contested politics of mental health, all mental health nurses ought to consider a new radical professionalism and an ideal of social justice advocacy within the political realm, as a means of advancing the interests of nursing and service users alike. Because of the undoubted need to speak truth to power implicit to advocacy within the mental health system and the interrelationships between knowledge and power, advanced nurse practitioners might appropriately involve themselves in a triad of activity: take on an advocacy role for themselves, support independent advocacy and play a part in relevant education, for themselves and other nurses.

Successful advocacy can often go unremarked, subsumed amongst the complex inputs that create a journey towards positive outcomes. Nurses may be more likely to experience or enact advocacy from within more negative circumstances and with less appreciated outcomes. In the face of systemic injustices, nurses may find that advocacy has its limits. No voice may indeed be too soft at such times, but maybe we ought to raise ours, and then raise them again, in the pursuit of more just ends.

Reflective Questions

- What changes might you make to your own practice to better fulfil a nurse advocacy role?
- How might you reflect upon your own disposition towards and understanding of independent advocacy to improve care team relations with independent advocates?
- As an APMHN how might you be involved in the education of nurses and other colleagues to become more aware of a politics of contestation in the mental health field?
- How might you engage with communities or social movement organisations, for example, trade unions or service user/survivor groups, to pursue social justice advocacy?

Case Study

My name is Joe. I have had a complicated relationship with mental health services for a substantial portion of my adult life and have experienced a number of compulsory admissions to the hospital under the powers of the Mental Health Act. Typically, these have involved lengthy periods of detention because I refuse to voluntarily take antipsychotic medication which I don't feel I benefit from and causes me to feel ill and too tired to do anything useful. To be perfectly honest, I dislike any medication that affects how my brain and body functions, and I fear this might destroy my sense of who I am. I am very clear about my mistrust of medication, and this is written into an advanced directive that I have had drawn up with the help of an advocate. Despite this, on most of my recent hospital admissions, I have been held down and forcibly injected. This is also despite me cooperating with all other aspects of my admission, including agreeing that I needed to be away from home and in a place of sanctuary. The only thing I won't do is take medication, but this results in strained relationships with staff and lots of conflict between us, including violence; when they approach me with a needle, I fight back.

Some of the nurses on the ward tell me they disagree with the use of force to administer medication but feel they have no other option. I tell them they could just leave me alone and that I will become more my usual self in time. They respond that it is their duty to give me the medication and they believe it will 'make me better' quicker. Despite an advanced directive, they also say that the medication prescription and the requirement for this to be given against my wishes is deemed to be in my best interests and is mandated by the psychiatrist. I do not dislike these nurses, and I can recognise they are sincere and have a genuine kindness towards me and the other patients. I just think they don't think deeply enough about what they are doing and do not offer sufficient challenge to what I see as obvious unfairness.

I have a good relationship with a specialist nurse who sees me for weekly sessions, and we talk about distressing experiences I have had in my life and how these might be linked to my current problems. She speaks about a trauma-informed care approach, and there is a poster about this on the wall. I find these sessions difficult but helpful and I appreciate the efforts this nurse makes. I also argue with her about, in my view, the absurdity of her talking to me about trauma whilst the service continues to violently force me to take medication. The act of doing so revisits some of my earlier traumatic experiences, replete with degrading exposure, violation, shame and powerlessness. I can see in her face when we talk that it is also difficult for her to deal with this, and I suspect she disagrees with this use of force. But it seems, she isn't able to say this. She does ask me to consider cooperating with the medication so as not to be subject to force. She doesn't yet see that this capitulation is also a form of re-traumatisation. I can see her logic. But I feel viscerally disempowered. This nurse says she will make sure my views and experiences are heard within the care team and she will advocate for a change of approach. She also says I should make use of the independent advocacy service and makes a referral.

This advocate visits the ward once a week. Again, she is a lovely, compassionate person and I enjoy spending time with her. But she is really powerless to make the changes that I ask her to take to the care team. Everything boils down to power, and the law is clear – my care team are able to override my wishes if, in their clinical judgement, it is in my best interest to do so. It is a huge irony to me that I am not seen as the best judge of my own interests. There is nothing the advocate can do about this beyond stating my view and making sure this 'is heard'. This is scant consolation to me.

So, my hospital admissions follow a predictable pattern. Conflict and violence move to eventual 'cooperation' and 'compliance'. I agree to take oral medication. I get discharged (eventually). I stop taking the medication.

Ultimately, what I want is a different sort of mental health support. One which can accommodate me when I am at my worst ebb of distress, without rushing to medicate me. One which allows me to have ups and downs. One which doesn't want to, and doesn't, bring a fight to me. Coercive care is not care at all. Why cannot services truly hear my voice and work with people like me to design the sort of services we would gladly come into and cooperate with?

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Enhancing the Quality of Care Through Participatory Generation of Evidence

Sabine Hahn and Peter Wolfensberger

Learning Objectives
The objectives of this chapter are to enable you to:

- Understand the process of evidence generation as an ongoing process that is needed for developing interprofessional and nursing practice and the discipline of nursing and health-care systems.
- Know the different ways of evidence generation to improve quality of care.
- Value the important role of service users in the participatory process of evidence generation and know the important promotors and barriers of service user involvement.
- Have an insight into the role of Advanced Practice Mental Health Nurses (APMHNs) in the process of evidence generation and practice development.

1 Introduction

Evidence generation is an ongoing, demanding and reflective process in order to improve the quality of treatment and care. It normally starts with a critical reflection about what we already know about a certain problem or a phenomenon of interest. To answer this question, a literature review, an expert survey or another form of investigation can provide us with the needed insights into the state of the art in practice and science in the examined topic. If, for example, there are guidelines nurses and health professionals should be following, audits may give us insights if the professionals are doing what they should be doing or if there are problems in following the guidelines. Such knowledge allows a clearer problem definition. In the next step, we must think about the best course of action: Do we need a research

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project and a scientific method to fill the knowledge gap, or do we need to conduct a service evaluation about the quality of nursing care? In case of a research project, we usually have to work step by step until a feasible intervention can be developed, implemented and validated. If it is about a service evaluation, it brings us to a spiral process, with sometimes non-linear forward motion to generate new knowledge in order to improve the quality of treatment and care. This is all part of the generation of evidence, which is a continuum. Either way, it is imperative to involve those affected the most, the service users. However, enhancing quality of care through service user-centred evidence generation is not only an intellectual and scientific challenge but also a very practical, hands-on adventure and an enriching journey. Advanced Practice Mental Health Nurses (APMHNs) are in an excellent position to support evidence generation in their field of practice and expertise. Together with service users, they can support researchers or conduct applied research to generate useful, practice-relevant evidence and improve nursing and health-care practice.

Service users should participate in quality development and the design of health care: this is a demand that is increasingly voiced by politicians, scientists and stakeholders [1]. However, service user participation (also referred to as co-participation, co-production or co-design) in health and nursing care processes and evidence generation, like in complex intervention models [2], is hardly realized [3, 4]. There is a lack of important foundations for the elaboration of beneficial service user participation [5, 6]. Nevertheless, participatory developments such as co-design, co-production, etc. in research and practice are promising and indicate that health care is of higher quality when it is promoted involving service users and stakeholders. According to Pearce et al. [6], there is a lack of consensus to the definitions of co-participation, co-production or co-creation. After a comprehensive literature review and analysis, they propose to use the term co-creation if new knowledge regardless of the user (researchers, service providers and public health policy practitioners) is developed and implemented. They propose the following definition:

> The generation of new knowledge that is derived from the application of rigorous research methods that are embedded into the delivery of a program or policy (by researchers and a range of actors including service providers, service users, community organizations and policymakers) through four collaborative processes: (1) generating an idea (co-ideation); (2) designing the program or policy and the research methods (co-design); (3) implementing the program or policy according to the agreed research methods (co-implementation), and (4) the collection, analysis and interpretation of data (co-evaluation) [6, p. 11].

Later in this chapter, we will explore what this can mean for our practice as APMHNs and how the experiential knowledge of service users and stakeholders can be incorporated into the treatment and caring processes or in research and development projects. We propose, depending on the problem to be solved, different stages of involvement in the process of evidence generation, with the aim to broaden not only the perspective of health professionals and make them work more efficiently but also to reduce workload through needs-based communication, interventions and clear processes [7, 8]. Despite the knowledge of the benefits of service user involvement, the requirements or hurdles to implement more user involvement in health care still seem to be too high. Perhaps it is just a question of attitude towards service users or lack of understanding. The fact is that in many countries, service user involvement or participation in health-care quality development has not yet been implemented [9]. APMHNs do have a key role to improve this situation in the field of psychiatric and mental health care. It is important for the development of the discipline of mental health nursing, to enhance not only nursing care and treatment but also the education of future health professionals. Overcoming the barriers of service user involvement is a central precondition, in evidence generation. Still too often there are organizational barriers (lack of policies, lack of financial resources, time restrictions) or professional barriers (prejudices about the reflective capacity of people with mental illness, lack of methodological skills that allow the success of co-creative processes, restrictive rules and procedures of scientific community) hindering professionals to involve service users and stakeholders in practice development projects or in research and curricular projects. Also, service users' own barriers can hinder the involvement, like lack of confidence about their personal experiences or lack of trust that their voices will be heard. The different stages of involvement are not only methodologically challenging but also a chance to reflect critically and rethink the current paradigm of evidence generation in mental health care. Therefore, advanced practice in evidence generation means collaborating with service users in different roles in the process of evidence generation as informed users, sounding board members, members of project steering committees, collaborators or even project leaders. It also means transforming research methods, research practice and the whole evidence generation process in a collaborative friendly process allowing democratic teamwork for all stakeholders [10, 11].

In this chapter, we will first address the topic of quality of care and quality of nursing care, because the understanding of quality is important in the process of evidence generation. Secondly, we will focus on the process of evidence generation and different methods in the practice field of APMH nursing. However, as this is not a research methods chapter, we only give an overview and try to convey methodological ideas. In the subsequent sections of the chapter, we will further elaborate the topic of service user and stakeholder involvement and co-creation processes.

2 Quality of Care and Quality of Nursing Care

According to Donabedian [12], quality is usually classified according to structure, process and outcome. Many definitions of quality of care are discussed within the literature. The Institute of Medicine (IOM) defines quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990 as cited in [13, p. 1]). In more recent work, the IOM focuses on the conceptual components of quality of care rather than on the health outcomes and describes quality of care as being safe, effective, person-centred, timely, efficient and equitable [14]. The IOM's definition of quality of care implies that there are several relevant perspectives when determining quality of care. Connecting quality of care to patient-centredness, efficacy, effectiveness and equity leads to the appreciation of quality of care by health-care providers and service users. However, until today, quality of care is typically assessed from a provider's perspective. In mental health this usually means using objective quality indicators such as aggressive incidences, coercive measures, readmission rates or even the degree of compliance with medical prescriptions and therapies. At present, there is no binding or uniform international standard on how to describe the quality of nursing care, and there is yet no recognized reference framework for describing and reviewing the quality of mental health and psychiatric nursing care. Neither important stakeholders in nursing or nursing science nor organizations dealing with aspects of nursing quality (providers of quality measurements, professional associations for quality development, patient safety efforts, etc.) have developed a corresponding quality model so far. This is despite an undisputed need for standardized information to describe and assess the quality of nursing care [15, 16].

From a scientific point of view, valid and reliable measurements and indicators are of interest in addition to well-founded concepts and models that form the theoretical background for quality efforts. Overall, however, there is a lack of concepts and models to represent the quality of nursing care [17, 18]. As described, standardized measurements often focus on outcome indicators that intend to stimulate the evaluation of structures and processes in the organization. However, it is still not sufficiently taken into account that quality measurements can also help to keep service users better informed about their own progress and to better inform the public about the impact of nursing care [15]. Yet another complicating factor for the description of quality of nursing care is the fact that it often represents only a part of the overall quality of treatment and care.

In the scientific literature, quality of care is no longer seen as a strictly linear process based on structures, processes and outcomes but is viewed within a dynamic and multi-relational system of several levels of analysis and specifications [17, 19]. In addition, an expansion of the quality dimensions to include the service user and the family perspective is recommended [20]. Likewise, the quality of relationships and actions should be taken into account, which are primarily concerned with soft, social factors, such as dealing with service user, service user-centredness and the relationship between professionals [15, 21]. Such descriptions should increasingly include the perspective of service users and their subjective assessment of quality (subjective quality indicators) in quality measurements, which is still insufficiently taken into account [22], although studies show that service users have a comprehensive understanding of care quality [23]. Therefore, it is important that quality of care is understood and described as a multidimensional concept. Quality of care should encompass both the provider's and the service user's perspective and include both objective and subjective quality indicators (see Table 1). Objective indicators are usually measurable and quantifiable and are therefore less focused on the individual, whereas the subjective indicators focus on personal experience and feelings, aspects that do not have to be measurable but nevertheless have high relevance for treatment and care. All perspectives must be included on both sides. Professionals also have subjective experiences and feelings, and these can also influence the quality of care.

However, it should not be forgotten that patient-reported outcome measures (PROMs) are still poorly developed, researched and validated. Also, the communication of PROMs and other quality data for empowerment and shared decision-making with service users are yet in their infancy. Still neglected is also the

Table 1 Examples of objective and subjective quality indicators in mental health care

Quality indicator	Objective	Subjective
Aggression and coercion	• Prevalence of aggressive incidences and type of aggression • Number and type of coercive measures • Structural prevention measures • Availability of expert support from professionals and service users	• Quality of de-escalation strategy from viewpoint of the patient (experience measures) • Reasons for coercive measures from viewpoint of patient and professionals
Quality of care	General quality of care indicators measurable on the basis of: • Effectiveness • Efficiency • Accessibility • Acceptability • Equitability • Safety	Personal and individual assessment and evaluation based on own experiences and/or values and attitudes, as well as corresponding expectations (patient and professionals)

development of patient-reported experience measures (PREMs). In collaboration with service users, knowledge and practices from the fields of communication science, nursing and psychiatry, the development of process indicators to promote safe, high-quality mental health care should be improved. Such developments can improve the urgently needed quality of shared decision-making processes, service user safety and empowerment [24].

3 Evidence Generation

Evidence generation is a continuum reflecting the state of evidence based on the methodologic approaches that can be used to support clinical decision-making and best practices. To adopt and implement evidence-based practice, we need to understand the different forms of evidence generation that are necessary to contextualize the results of different types of research. It is equally important to know the difference between health services evaluation and research. According to Twycross and Shorten, nursing research is about finding the answers to the questions "what nurses should do to help patients", while audit examines "whether nurses do [what they should be doing] and if not, why not", and evaluation asks about "the impact of care on patient experience and outcomes" [25]. Research, audits, and evaluation are all important to generate knowledge for better practice and care. All these different approaches should be viewed as mutually enriching, depending on the context, and the problem, and on a continuum of knowledge generation. Despite their differences, there are clear similarities between service evaluation, audit and research. Each approach starts with asking what is already known and what data we need to answer the question. All use a systematic approach and sound design. In addition, similar methods are used to evaluate practice or measure outcomes. The differences in approach relate mainly to project scope and objective or intent [25]. Table 2 summarizes the key criteria that will help to select the right approach for different types of clinical projects in the continuum of evidence generation.

Table 2 Key criteria in selecting approaches for clinical projects based on [4, 25] and the continuum of evidence generation

Stage on the continuum	Aim	Example of methods	Possible result	Advantages
Formulate the problem/ topic of interest	The problem/ topic definition is formulated based on already existing evidence.	Literature review Expert view (nurse, service users, etc.), e.g. interviews or survey	Available evidence is described. Knowledge gap is described.	The boundaries of the problem are described. Care is taken to focus on the meaning and importance of the problem as perceived by service users, caregivers, nurses, etc. The risk of trivializing or even misunderstanding the problem can be reduced by involving service users and professionals.
Problem analysis	Find the next methodological step depending on problem description, available knowledge and information (data).	Stakeholder discussion Systematic literature review	Enough knowledge allows decision about the next methodological step.	Needs and problems are described from the perspective of the literature and from those described by service users, nurses and other health professionals. Available data for problem analysis are recognized.
Need for more information	Based on the lack of information/ knowledge, additional analysis is executed to describe the problem for the next methodological step.	Qualitative descriptive methods like observation, document analysis and stakeholder interviews Quantitative methods like questionnaire-based survey, standardized observation and statistical analysis of routine data	Enough knowledge allows decision about the next methodological step.	Problem needs more precise description through descriptive research describing the problem more in detail.

Table 2 (continued)

Stage on the continuum	Aim	Example of methods	Possible result	Advantages
Conduct research	To generate new knowledge, add new knowledge to the body of knowledge.	Qualitative study design (e.g. grounded theory approach, ethnocratic observation, thematic interview and analysis) Quantitative study design (survey, Delphi study, intervention study, randomized clinical trial, etc.)	Description of a situation, new theory, new or advanced intervention, etc.	Systematic and comprehensible development of new knowledge
Perform audit	Audit of current practice	Structured assessment, routine data analysis and audit interviews	Measurement of clinical practice against a standard	Systematic and comprehensible audit of current practice
Evaluate system	Evaluation of impact of care	Quality measurements out of routine data, process evaluation, stakeholder surveys, quality of service	Judgement of the quality of the current practise	Systematic and comprehensible evaluation of practice and possible developments

In the field of advanced nursing practice, it seems obvious that evidence generation is based on clinical data from real practice and real world. This means that for a lot of topics or knowledge gaps, we do not have to generate a lot of additional data with, e.g. surveys or specific assessment instruments, interviews, etc., because they are already there. To generate evidence, we can often use data from routine daily practice, e.g. from electronic patient records and documentation systems; from patients' health application software (apps) such as step tracker, sleeping patterns, medication reminders, etc.; or from observations during clinical practice. Another important aspect in evidence generation is service user involvement. There is substantial evidence that service user involvement for problem-solving (e.g. what data are relevant to investigate in a topic) improves treatment planning, processes and procedures and reduces costs [8]. Not only complex problems can be solved better but extremely difficult to grasp "wicked problems" that cannot be "solved", but effectively "improved", through iterative processes such as those used in co-creation. Wicked problems, as the example of aggression or coercion shows, can only be tackled in the evidence generation through the commitment and efficient collaboration of many stakeholders, specifically including service users, taking into account the different objectives and priorities, as only joint consideration opens up possible solutions [26]. It is this kind of knowledge that should inform evidence-based practice. Rose, Thornicroft and Slade discuss and challenge the common concept of evidence-based practice. They criticize that research often does not reflect or consider if an evidence-based intervention is the best possible solution for the service user or if it is even inappropriate [27]. For example, randomized controlled trials (RCT) carry the risk of allowing only probabilistic conclusions that are of little use to the individual. This criticism is linked to a critical position towards RCT for evidence generation. Nevertheless, RCTs are considered as gold standard in research providing the strongest evidence for the validity of interventions. The complex intervention model, a framework for the development and evaluation of RCTs for complex interventions, is proposed to improve the quality of RCTs [2]. And still, RCTs have serious limitations when developing knowledge for use in clinical practice. van Meijel et al. [4] list the following limitations: RCTs

- Are often not developed with service users or stakeholders.
- Do not provide evidence for general laws; they allow only probabilistic conclusions.
- Do not demonstrate that something is true for any given case, but for a number of general cases.
- Do not really allow testing variations in the intervention. This is also true if a factorial design is used, because it is not possible to test all the decisions that must be made about how to mould the intervention.
- The interventions usually have limited generalizability, and after adapting an intervention to the own context of practice, it is not clear if the evidence is changing.
- Sampling and strict focus on one patient group may further limit the validity of the results of an RCT for other patient groups.
- Subgroup analysis is only possible if the number of participants in the subgroup is sufficiently large and the variables that may affect the outcomes associated with the intervention are conceptualized and measured.
- Without adequate attention to subgroup analysis, the RCT may lead to false positive or, more often, false negative conclusions.

All these limitations show that RCTs have a good internal validity but that the external validity may be limited. More important is that evidence generation should have the aim to assess relevant quality preferences of service users to ensure that service users get the treatment and care that is right for them and supports their quality of life. However, until today, this is not yet realized in a satisfactory way. Therefore, future evidence generation offers the opportunity to clarify, when deciding on the evidence of an intervention, to what extent the service user perspective is included. As APMHNs work closely with service users and have an extended practice role with insight into the activities of daily living and personal matters of the service users, they can systematically adapt or improve evidence, with for example observational studies, participatory action research, qualitative studies or other approaches. This way APMHNs may generate easier to implement interventions in practice and new research hypotheses for future clinical trials with active involvement of service users. To strengthen the continuum between data, information and knowledge, APMHNs, in their central role and in interprofessional collaboration, can produce and synthesize, together with service users, high-quality evidence and can support knowledge translation into practice.

4 Service User Orientation

Orientation towards the perspective of service users means dealing with the diverse and individual experiences of people affected by mental health problems and their relatives in depth and at equal level. In mental health-care service, users have gained extensive expertise in dealing with impairments and illnesses and managing them in everyday life. People with mental health problems often deal with issues of autonomy, self-determination or self-management due to stigmatization, exclusion and dependence on others, such as being dependent on support from relatives or professionals. Inclusion and collaboration improve the knowledge of service users as well as of professionals. Everyone in the system, both service users and professionals, become more competent. People see each other with different eyes, and this changes hearts, minds and attitudes. The value of the respective point of view is recognized. Particularly among service users, self-confidence increases, and new competencies and action skills can be built up. Also, the quality of evidence generation improves. This is especially true since blind spots in research can be illuminated and the whole research process from design to dissemination enhances [8, 28].

The inclusion of service users as equal partners offers professionals and especially APMHNs the opportunity to learn from their expertise and experience and to derive measures for nursing care practice from it. Also, service users are learning in such trustful relationship. Therefore, it is a continuous process of exchange, reflection and learning. Methodologies practised in action research or co-design and co-creation with orientation towards the experience of service users are innovative and can further develop the health-care system as well as psychiatric care in a beneficial way. On one hand, inclusion on an equal level in collaboration means that APMHNs as highly experienced professionals meet service users with curiosity, openness and an attitude of recognition and appreciation. On the other hand, APMHNs must actively seek the experiential perspective by building a trusting relationship, also with relatives, and communicating with a person-centred attitude. This also means that the experiential perspective is given the same importance as one's own or external expertise. To advance this attitude and enhance quality of care, service users may, for example, be involved in the development of new offers in the area of housing, psychoeducation programmes, in the training of caregivers or also in the development of projects on the topic of anti-stigmatization [8].

However, service users currently have limited opportunities to influence the health services they need. This also has to do with the fact that health-care organizations have become increasingly bureaucratized and professionalized [29, 30]. The lack of democratic processes in public health institutions and organizations has led to an intense international debate about the need for and impact of service user-driven processes. Furthermore, the importance of such collaborative processes in health policy and the different service areas of health care, including research, has been increasingly discussed [31, 32]. With all these proven positive results of service user involvement, the question is why don't we put more emphasis on service user involvement and just do it? APMHNs, and not only those with close contacts with service users, should refocus all their work and efforts towards close cooperation with service users and, therefore, practise real service user involvement.

5 Service User Involvement

Even though service user involvement may sound easy to accomplish, it has benefits and challenges. Most often it is a lack of preparation and insufficient conditions to anchor service user involvement systematically in the organization. However, meanwhile a lot of evidence generation projects are conducted in the field of mental health and psychiatry. Nevertheless, modern psychiatry and mental health nursing has also disregarded the voice and rights of its service users for decades. This has triggered a massive countermovement and rethinking of psychiatry in the last 20 years. This rethinking has enforced constant change in the care landscape in psychiatry and mental health. For example, there are many training programmes for service users who represent other service users as peer-support workers (peers) in clinical practice. Peers now work within in- and outpatient settings and help strengthen the views and perspectives of the service users and their relatives more clearly into care and treatment processes [33, 34]. The recovery movement also demands the acceptance of personal recovery paths in individual care plans. And professional congresses and conferences without the participation of service users and the inclusion of their important experiences, in addition to research-based knowledge, are hardly conceivable in psychiatry these days.

Nevertheless, in many organizations the engagement of service users as peer-support workers (peers) is voluntary and non-paid work. Depending on the health and social care financing system, this may be important, in order not to jeopardize the financial security of service users through social security benefits. More likely, however, it is that no financial compensation is possible because the system does not have sufficient resources. In view of a cooperation and collaboration on an equal footing and the principle of normalization, it is important though to rethink this practice and to remunerate the work and expertise of service users appropriately. Therefore, a goal- and task-oriented concept of service user involvement is highly recommended [35]. Appropriate concepts should anchor service user involvement in the organization and improve the commitment from supervisors and the management of the organization. APMHNs, when developing such concepts, should take into account the following aspects: Firstly, what structures do service users and professionals need to enable active participation in evidence generation? Secondly, what competences and/or support do service users and professionals need in order to learn from and with each other and to make this knowledge usable for evidence generation? Thirdly, which service users should be involved, in what role or way and what are the employment and compensation conditions?

6 Structures Enabling Service User-Driven Evidence Generation

Involvement and collaboration between service users and professionals need concepts, rules and contracts. Before the collaborative work can start, a clear implementation or embedding in the strategy of an organization is important. This enables leaders to allocate enough resources for a successful development of the collaboration. Of high priority are job and activity profiles by the organization (depending on the level of involvement and the experience background, professional qualifications as well as the possibilities within the service users' own illness trajectory). According to these profiles and tasks, the requirements and competencies of the service users are formulated and recorded in contracts, and the compensation is agreed. A possible model to describe different job profiles could be based on the "Ladder of Citizen Participation" by Arnstein [36], which is frequently cited in the literature. Even though the model is quite old, it still seems highly usable and adaptable to current APMHN practice fields. Service users can participate in different functions and areas of research and development, depending on their personal expertise and professional qualifications. Our suggestion, based on our experiences in research, practice and education, is to organize the collaboration in three levels (see Table 3): level

Table 3 Level of service user involvement (compare [38, p. 7])

Level	Collaboration	Competences
1	Employment contract and job profile for professional role in service user-driven evidence generation, involvement in planning, implementation and evaluation of research and development projects and opportunity for professional development	University degree or equivalent, completed peer training, good computer skills (Excel, Word, PowerPoint), presentation skills and experience with project work
2	Contract on an hourly wage basis, for example, in the role of collaborator and co-worker, sequential assignments in research and development projects	Possibly peer training and basic computer skills (Word, Excel, PowerPoint)
3	Irregular individual work on a fee-based and/or voluntary work if interested in networking, no contractual commitment (e.g. participation in a service user group, round table discussion, etc.)	Personal experience of mental impairment, in- and outpatient treatment experiences, possibly peer training, interest in networking and exchange (sufficient distance to personal experience of impairment and health/illness trajectory)

1 refers to service users with academic training and professional experience in project management. Service users with these qualifications may be employed as researchers in projects with a contracted workload, as needed. Specific training (e.g. peer training) or a reflective examination of one's own experience with illness is required as an important foundation. At level 2, service users can be recruited on an hourly wage basis for smaller, time-limited assignments. In addition to good language and communication skills, these individuals should have computer and digital skills and an interest in working in teams and with other service users. Level 3 involves individual assignments of service users as part of projects. For example, this could be in the context of surveys, interviews, workshops, roundtables or reflection groups. Assignments at this level could be compensated, e.g. through vouchers or on an hourly wage basis [35]. These definitions of roles enable to recruit and select service users targeted for specific topics in the evidence generation. However, we learned that it is also important to reflect on issues such as how close service users are to the system or topic under development? And, to what extent can they contribute critically and support service user-driven evidence generation? Greenhalgh et al. [37] have systematically reviewed frameworks for supporting patient and public involvement specifically in research and suggest that instead of developing one's own framework, it is useful to consider the use of an existing one that might only have to be adapted to the relevant circumstances.

7 Resources and Competences Needed to Support Service User-Driven Evidence Generation

Based on our own experiences in projects, it was important to consider that working with service users on different competence levels may need more time as working within an exclusively professional team [39]. A service user may have health problems in the trajectory of his or her health state. Issues to consider include possible sick leave, time pressure in research projects, support needs and disclosure/management of identity. It is important that service user be fully accepted as researchers in the team. The extent to which service users discuss their own experiences with mental impairment and the mental health-care system should be left up to them. However, sometimes this process requires exchange with supervisors and colleagues [40]. Also, the whole team may require more time to discuss topics from different perspectives and within the different experiences. Therefore, when planning projects, with teams with service users as researchers, additional time needs to be planned. More time is needed for project management tasks and consultation, as well as to cover sick leave. Coaching by the organization is also important, i.e. institutional, and additional time and accordingly more financial support to compensate for these special conditions. However, all of these extra needs could happen in other projects without service users as well. It seems that service user involvement helps organizations to be better prepared for the extraordinary.

Also, professionals involved in such projects and especially the project leaders may need additional training or support, and their roles must be clearly defined.

Suggested training needs are on techniques to improve collaboration between service users and professionals, such as co-design, facilitation methods or open dialogue. Clarity about the role is especially important for APMHNs who might otherwise work with service users as patients. In an evidence generation project, however, it is a work relationship with the service user and not a therapeutic one. Nevertheless, support or coaching for service users, staff and other involved persons should always be available by superiors or the organization. In some projects, e.g. if the transition between clinical setting, home care setting and integration into the community needs to be improved and social integration strengthened, it might be important to work with service users who are still vulnerable due to their experiences or illness and not with highly trained and fully adapted peer-support workers (peers). Only these vulnerable persons may give the right information and can evaluate if the process is feasible. However, this could mean that a service user cannot take over the responsibility for a whole working package due to poor health or a health crisis (which can also happen to any team member) and the team is dependent on substitutes. Therefore, for a well-functioning service user-driven evidence generation, it is useful to have several people available to replace someone at short notice if necessary.

8 Stages of Involvement in Service User-Driven Evidence Generation

There are different stages of involvement in the evidence generation process (see Fig. 1). Evidence generation can be a complex process, and clear stages of service user involvement can be very useful, if chosen consciously. The first stage involves

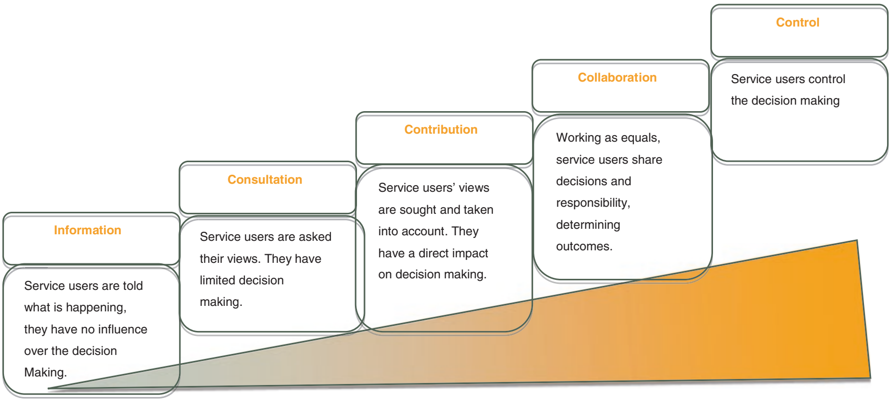

Fig. 1 Stages of involvement in the evidence generation process

service users only to the extent that they are well informed about the project. There is no real collaboration. Service users are participants in the evidence generation and in this role as informants, e.g. in discussion groups, interviews or as questionnaire respondents. They have no further influence on the product or what happens next. An example of such a study is Wolfensberger [41], who investigated the experiences of people living with mental illness. Service users participated in this study as interview partners and to a certain extent as critical feedback partners, which was due to the chosen research method. The second stage allows service users to have minimal influence in bringing in their knowledge and expertise as consultants. Their views are recorded and valued, but it remains unclear how much influence they have. This is, for example, the case in the study of Zuaboni et al. [42] and Burr et al. [43] about recovery orientation of patients and nurses after an intervention to improve recovery orientation on acute psychiatric wards. In the third stage, service users' contribution and their views are clearly sought and considered. On this stage service users typically work in parts of a project, e.g. at the beginning, to define a problem or to describe project goals, in supporting data generation and assisting data analysis, or to draw practice-relevant conclusions out of research results. Therefore, in this stage they have direct impact on the decision-making in evidence generation. This was the case in the project PIONEERS (pioneers of a new paradigm in psychiatric nursing and care) by Gurtner et al. [38] in which together with service users and stakeholders they developed an understanding of service user involvement in research, practice and education and how they would like to work together. In this project two service users worked as team members of the research team. The information presented in this chapter about service user involvement have been generated in this and further projects. Since then, service users are full staff members of the research team and enable stage four. In the fourth stage, service users are working as equal collaborators. They are part of the team, critically bring in their expertise, discuss, share decisions, take over responsibilities and determine outcomes. In the fifth stage, service users control the decision-making as project leaders or co-leaders. This is the case in a project called Chapp-U about the use of digital application in the treatment of persons with mental health problems. Already the topic of the project was generated by service users, and the project runs under co-lead of service user researcher and health-care researcher [44]. In what stage of evidence generation service users are involved depends on their personal expertise and professional qualifications. In the fourth and fifth stages, service users act as bridge builders between research, practice and society. They do this, for example, by translating complex questions into easily understandable language for potential study participants or by contributing new impulses for research projects from society or as collaborators in research projects [45]. In doing so, they contribute to an increase in research relevance and efficiency [7]. The stage of involvement depends on the level of involvement and the role service users can take over. However, with this being said, we have to face another challenging question: who decides on the stage or level of involvement in order to avoid paternalism? There are very helpful toolkits to reflect on this and other questions [46].

9 Considering Barriers of Service User-Based Evidence Generation

What are the barriers of service user-based evidence generation? There are positive experiences and challenging situations reported [47–49]. One of the main challenges, from our experiences, is how to find the “right” service user. What is the required experience background, who is the right person for that and how can she or he participate without coming under too much stress? At the beginning of the cooperation in a project, all team members (professionals and service users) are on unusual terrain, which must be accepted and acknowledged. A high level of reflection is required of superiors, service users, professionals and especially project leaders. They have to reflect if they have the necessary techniques, procedures and competencies to lead a diverse project team because, before complexity can be reduced, it supposedly increases and sometimes it is really difficult to understand each other. This happens especially in teams with very different backgrounds (in terms of academic and professional background, as well as the background of experience). Another relevant aspect within service user-based evidence generation is also professionals’ attitudes towards service user involvement [50], which could be a barrier in collaborative work. Professionals and service users need to be aware of their own prejudices and stigma towards each other. Therefore, high interpersonal skills are required from professionals and service users. In addition, a very competitive world of quality improvement and evidence generation in research and practice with high pressure on scientific performance, time constraints and financial restrictions limits the opportunities for cooperation or collaboration with service users. Nevertheless, service user-driven evidence generation should take a critical stance on such competitive and therefore excluding and limiting research practices, support the reflection on these barriers and stimulate a change of paradigm towards a more inclusive and democratic behaviour recognized in the scientific world.

10 Summary

Evidence generation is an ongoing, demanding and reflective process. To enhance the quality of care, evidence generation should have the aim to assess relevant quality preferences of service users to ensure that service users get the treatment and care that is right for them and supporting their quality of life. To realize this in a satisfactory way, the APMHNs are in an excellent position. APMHNs in their extended practice role with close contact to service user and other health-care providers can systematically adapt or improve evidence involving all relevant stakeholders and can support knowledge translation into practice. Generating such evidence needs not only scientific and project management skills, it also requires high level of reflection techniques, procedures and competencies to lead a diverse project team. It also needs concepts, rules and contracts to work in a collaborative and professional team-oriented way.

Reflective Questions

- What is the level of preparation, and what are the conditions to anchor service user involvement systematically in my organization?
- What structures do service users and professionals need to enable active participation in evidence generation in my project/organization?
- What competences and/or support do I need in order to learn from and with service users and to make this knowledge usable for evidence generation?
- Which service users should be involved and in what role or way in my project?
- What are the employment and compensation conditions for service users in my project/organization?

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Maintaining Professional Competence

Ben Hannigan and Hazel Powell

Learning Objectives
The objective of this chapter is to enable you to:

- Understand the importance of pushing the boundaries of advanced mental health nursing knowledge and skills.
- Explore approaches to the enhancement of competence and capability likely to be of value for advanced practitioners.
- Appreciate the variety of opportunities available to mental health nurses concerned with developing practice beyond the level associated with initial registration.

1 Introduction

This chapter addresses strategies for advanced practice mental health nurses (APMHNs) to maintain, and develop, their personal knowledge, skills and values. It also considers approaches that advanced practitioners might use to support the development of others, including less experienced members of the interprofessional team. The chapter opens with an examination of the word 'competence' and related terms including 'proficiency', linking these to global and European standards and directives surrounding the work and regulation of registered professionals. The chapter then moves to an exploration of selected approaches which APMHNs can

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use to further their (and their colleagues') practice, including: preceptorship, mentorship and coaching; clinical supervision; post-qualification education and training; professional networking; supporting others; and research, and service and quality improvement. At the end of each section, we highlight key messages for mental health nurses everywhere, which we also summarise in a separate figure presented at the chapter's conclusion along with a series of reflective questions.

2 Competence for Practice

Four key themes are identified in the World Health Organization's (WHO) global strategy for nursing and midwifery, with the first making the case for a workforce which is educated, competent and motivated [1]. In a review of recent achievements within nursing and midwifery, the WHO also identifies two key developments within the education domain: first, the move towards competency-based education and, second, shifts towards the recognition of advanced practice [1]. Published in the International Year of the Nurse and Midwife, the more recent WHO *State of the World's Nursing 2020* report uses the word 'competencies' no fewer than 23 times, including in a sentence which outlines the policy goal of ensuring that education programmes for nurses equip practitioners 'with competencies to deliver high-quality, integrated, people-centred services' [2]. Within Europe, similar references to the importance of 'competence' can also be found, including in the European Union's (EU) directive on the recognition of professional qualifications [3]. It is this document which specifies that nurses responsible for general care educated in member states must have 4600 hours of preparation, with the theoretical component comprising at least one-third and the clinical component at least one-half of the minimum duration of programmes overall. This same EU directive also makes general reference to 'regulated professions' and 'professional qualifications', with the latter serving as an 'attestation of competence' [3].

'Competency' is, therefore, clearly an important concept within the global and European nursing community. It is also a contested term which historically has evaded consensus definition [4]. In the United Kingdom, current *Future Nurse* education standards for pre-registration nurses published in 2018 by the national regulatory body make reference to the achievement of 'proficiency' [5], replacing references made in previous sets of standards to 'competence' [6]. Other words, like 'capability', also have considerable currency within the health and social care professions [7]. There is undoubtedly a debate on language to be had here, but our choice is to sidestep this in this chapter in favour of treating words like 'competency', 'proficiency' and 'capability' as all broadly referring to the knowledge, skills and values characteristic of regulated, professional, practitioners. Beyond this, our focus in this chapter is firmly on the strategies which mental health nurses might adopt to promote their (and their colleagues') practice at an advanced level. 'Advanced practice' is a term used in different ways in different settings, though a recent attempt at clarifying what the phrase means in a global context has been provided by the International Council of Nurses (ICN) [8]. In this document, the ICN acknowledges the grounding advanced nurses must characteristically have through education completed at master's degree level or higher (and therefore beyond the level required at initial registration) and how advanced nurses possess competencies which exceed those specified for new registrants.

We observe that mental health nursing is a modern profession, its rise to this position speaking to its success in capturing a body of knowledge and associated practices sufficient to underpin a place in complex systems of work in which roles are also fulfilled by psychiatrists, psychologists, social workers, occupational therapists, pharmacists and others [9]. Within the ecologies of which they are a part, professions can be recognised by their institutional structures, including the presence of their educator and knowledge-creator members in universities, their awarding of degrees to new entrants, their formation of profession-oriented societies and by their founding of discipline-specific journals and conferences [10]. The professions, nursing included [11], are also highly regulated. They limit entry only to those who meet certain criteria and permit ongoing registration only to those whose behaviours reflect agreed codes of practice in which, frequently, are included obligations to maintain professional competence over time. Indeed, written into the EU's common provisions on professional preparation is the expectation that, 'continuing education and training shall ensure that persons who have completed their studies are able to keep abreast of professional developments to the extent necessary to maintain safe and effective practice' [3].

Against this background our starting position in this chapter is to recognise that all registered mental health nurses need to maintain and demonstrate their continued competence. Knowledge advances over time, often driven by new insights generated through research. Professional and health system standards and expectations are also liable to change. In this context, for ethical and evidence-informed reasons, practitioners have obligations to keep up-to-date. In the mental health field, an illustrative example of change is the shift towards 'recovery', an orientation to mental health care which challenges narrow, reductionist approaches concerned only with treatment and cure [12]. Knowing something of the idea of recovery, and indeed critiques of it, seems to us to be a key competency for mental health nurses everywhere. We recognise that the demonstration of ongoing competence in this sense is increasingly linked to the periodic re-registrations, or revalidations, to which nurses across Europe are required to submit. In the United Kingdom, all registered nurses revalidate with their regulatory body the Nursing and Midwifery Council on a 3-yearly basis, as part of which declarations must be made on minimum practice hours, continuous professional development, receipt of feedback from others, reflection and discussion with a registered colleague [13]. However, in the context of this chapter, we also recognise the professional and personal imperative which exists for many to advance their practice (and that of others) by pushing the boundaries through developing new capabilities and through fulfilling roles with leadership and influencing potential. Taken together, this concern with both maintaining and advancing practice is consistent with Europe-wide aspirations. Whilst preparation for mental health nursing practice differs markedly across European countries, a position paper produced by Horatio: European Psychiatric Nurses makes the case for all mental health nurses to have access to continuous professional development and clinical supervision and to have opportunities to benefit from advanced education and to become advanced practitioners [14]. Having made this case for the importance of advancing professional competence, in the remainder of this chapter, we explore a number of different, but complementary, strategies to accomplish this which are open to mental health nurses across Europe.

3 Preceptorship, Mentorship and Coaching

All of us need support in the workplace, but the kind of support we need or seek out may change at different stages of a career trajectory. Whilst initial registration is a signifier of having demonstrated competence to practice, increasingly, it is recognised that newly registered nurses need support at the commencement of their post-qualification careers to consolidate and grow their skills and confidence [15]. Preceptorship aims to do exactly this and involves employing organisations putting in place programmes of structured support for new registrants to assist their transition from student to qualified practitioner. Recognising the particular complexity of orientating and acclimatising to being a newly registered practitioner, examples include NHS Education for Scotland’s *Flying Start NHS* programme which is for newly qualified practitioners (NQPs), specifically nurses, midwives and allied health professionals who are about to undertake their first year in practice [16]. This is intended to help NQPs make the step from student to assured and capable, registered health professional in their first year of practice. A learner-directed programme, the NQPs, with support from their *Flying Start* facilitator and line manager, are responsible for identifying the best way in which to approach and complete the programme. For APMHNs, an important role is in supporting newly registered colleagues through facilitating preceptorship in this way.

Beyond the first 6–12 months of registered practice supported through preceptorship, mentorship provides another route to the consolidation and extension of capabilities for practice. The United Kingdom’s Nursing and Midwifery Council has announced the introduction of ‘academic assessors’, ‘practice supervisors’ and ‘practice assessors’ in replacement of traditional mentorship, with these roles applying to all learners following professionally approved programmes of study at both pre- and post-registration levels [17]. Mentors and subsequently assessors and supervisors play a vital role in the practice-based preparation of students of nursing and (as a recent guiding framework from Ireland identifies) are also able to assist more experienced nurses in solving problems, exploring new ways of working and developing expertise [18]. Mentoring is considered the support and guidance of a person by a more experienced professional [19] and, therefore, is a role which all APMHNs are able to fulfil as the ICN recognises [8].

As careers progress further and as experienced nurses move into positions of greater responsibility, mentorship may be replaced by a coaching relationship. Coaching is particularly designed to support leadership development, with its essence in helping others unlock their potential [20]. As such, coaching for (and, in turn, provided by) APMHNs is likely to be a helpful strategy for practitioners whose roles carry significant responsibility for people and resources. Coaching, it is suggested, can lead to increased self-awareness, improved relationships and decision-making and better team performance [21]. All of these are key attributes for mental health nurses working in advanced practice roles. Further, mental health nurses operate in a complex environment with a significant number of interrelated factors of which they must take account. Whilst both preceptorship and mentorship may also help achieve clarity and direction within this ambiguous and often liminal space, for nurses in positions of seniority, coaching is likely to play a particularly important role.

Our **key message** in this section is that the type of individualised support which mental health nurses may find useful is linked to their career trajectory, beginning with preceptorship for those who are newly registered and expanding onwards to include mentorship and coaching as (many) nurses assume positions of increasing influence and responsibility.

In Case Study 1 below, Sherrie Stewart, who works as a Consultant Nurse and Responsible Clinician (a role carrying specific responsibilities under the Mental Health Act for England and Wales), writes about her experiences working in an advanced role. Sherrie writes particularly about how she keeps her practice up-to-date and how she supports others in their development.

Case Study 1: Sherrie Stewart

I currently work as Consultant Nurse in the capacity as a Responsible Clinician/Approved Clinician in a community mental health team traversing both primary and secondary care outpatient clinics. This holistic role had developed from my advanced clinical practitioner role within an inpatient and community setting leading to transforming the client journey through community services from outpatient clinic assessment, review, diagnosis, treatment and therapeutic intervention. The role includes acting as an Approved Clinician supporting clients on Community Treatment Orders in the community thus effectively forming pathway links with the GP, primary care, home treatment teams, liaison and generic community and inpatient services together providing a seamless service for the client.

As Consultant Nurse, I complete a self-certification of my competency on a yearly basis ensuring that I keep up-to-date with knowledge, educational updates, guidelines and skills within my area of practice and generic practice relating to my clients. I also keep abreast of new and advancing treatment options, and I continually research for the client to ensure best practice and care delivery that is evidence-based. I continually strive to achieve the core pillars of clinical practice, research, leadership and education in which my advanced practice is embedded, and this is added onto my portfolio. This allows me to maximise my role and add value to what I do for clients and the service so that I am practising as a ‘maxi nurse’ not a ‘mini doctor’.

A large part of being a Consultant Nurse is facilitating the development of others by enabling their capabilities within their role and creating enthusiasm about developing a career pathway that is clinically based through education or dynamic clinical practice for clients. This involves creating interprofessional/interagency educational opportunities, providing clinical and peer supervision opportunities so that this generates a desire to learn together and from each other. It is important as a Consultant Nurse that I lead by example being actively involved in team skill, values, attitude and knowledge development. It also involves creating an understanding of my role and how this can have a positive impact on general team cohesion which supports change and maximises the value of the nursing role. Roles are continually evolving, extending and expanding; therefore I see my role as instilling a culture that embraces change and supporting this.

As a Consultant Nurse, collaboration and sharing are a key attribute for networking and liaison which helps my practice. The role allows for co-production with clients and carers in the development of services with all key stakeholders. I am also involved in networking across Consultant, Advanced Nurse Forums and other NHS and Social Care Organisations nationally to benchmark good practice. I also act in a consultancy capacity in primary and secondary care, and across all departments.

As a Consultant Nurse, being involved in research at an organisational level and as part of my development is imperative as this allows the role to be fluid, dynamic, innovative and creative. My area of interest is social prescribing for mental health well-being, and I am currently researching as part of my Professional Doctorate how ecotherapy in the form of a guided walking group can impact on mental, physical, social and spiritual wellbeing of clients in the community who experience mental illness. I am also one of the leads on developing the My Physical Health Monitoring Journey for clients with mental illness in Betsi Cadwaladr University Health Board, which is about transforming the care and service delivery in mental health creating a mind-body synergy.

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Consultant Advanced Clinical Practitioner
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4 Clinical Supervision

Within mental health nursing, the promotion of clinical supervision as a reflective, supportive and quality-promoting activity dates back at least to the 1990s, with particular initial interest being shown in a model (developed by Brigid Proctor) which emphasises its formative, normative and restorative dimensions [22]. Notable early contributions to the evidence base include an evaluation in England and Scotland which concluded with recommendations for investment in both clinical supervision and mentorship [23] and research in Wales which demonstrated an association between effective clinical supervision and lower levels of burnout in mental health nurses [24]. In Australia, high levels of support for clinical supervision continue to be demonstrated through the existence of a special interest group in this area organised under the auspices of the Australian College of Mental Health Nurses, with a cross-college position paper outlining the case for supervision as an accepted norm for all nurses and midwives [25]. This same position paper reiterates the idea of clinical supervision as a formalised process, involving pre-arranged meetings in which a supervisee has opportunities to critically reflect on their work, in a setting which is confidential within established legal and ethical boundaries. However, decades after the initial wave of interest in clinical supervision for nurses, an overview of research in this area characterises this as more descriptive than evaluative, with many of the claims made regarding supervision's presumed benefits (particularly in the areas of quality of care and outcomes for people using services) unproven [26]. Recent evidence also suggests that, in England at least, clinical supervision may over a period of time have become a form of performance management or management supervision [27]. Both management supervision and clinical supervision have a role to play, but they are very distinct entities, and if clinical supervision does morph into a form of performance management, we will have lost an important approach that not only supports professional development and clinical practice but also supports nurses' well-being. For APMHNs, fulfilling supervisory roles with practitioner colleagues in ways which are separate from the provision of managerial supervision is one way of preserving this kind of distinction.

In recent years there has been a focus on midwifery supervision that may provide learning across the nursing profession. As a consequence of investigations into maternity services at Morecambe Bay NHS Foundation Trust in England, the UK Parliamentary and Health Service Ombudsman (PHSO) recommended that midwifery supervision and regulation be separated and that the Nursing and Midwifery Council should be in direct control of regulatory activity [28]. Following publication of the PHSO recommendations, the Nursing and Midwifery Council commissioned the King's Fund to review statutory supervision in the United Kingdom which supported the recommendation that statutory supervision should end [29]. A new 'Future Proofing' model for statutory supervision of midwives in Wales was developed by the Local Supervising Authority (LSA), Directors of Nursing, Heads of Midwifery, Nursing and Midwifery Council (NMC), Welsh Government and the Royal College of Midwives and involved clinicians and service user representatives [30]. This has led to an all Wales 24-hour on-call rota for regulatory advice and guidance and supervisors providing supervision through clinics/surgeries for midwives, students and user group forums. The overarching purpose of change was to improve the quality of supervision in Wales through the appointment of full-time supervisors of midwives on a rotational 18-month cycle with support from two full-time local supervising authority midwifery officers. As part of the new model, Wales concluded it is vital that women's (service users') voices are also heard. All midwives must undertake clinical supervision activities for four hours per year—two hours of which must be undertaken in group supervision.

Our **key message** in this section is that advanced mental health nurses should have access to clinical supervision as a matter of course and in reciprocal fashion should also act as supervisors providing reflective space for their colleagues. Having a clear and mandated focus on clinical supervision in this way, separate from management supervision, is important in making sure nurses benefit from its restorative and supportive dimensions and its capacity to promote reflection and growth. Through the activation of the normative dimension of clinical supervision, the aspiration is also that attention is paid to the promotion of quality and safety with direct benefits to service users.

5 Postgraduate Education and Training

Advancing competence means engaging in continuous professional development, and in many jurisdictions the completion of a minimum number of hours of learning over a prescribed number of post-qualification years remains a requirement for ongoing professional registration [13]. Beyond this general principle of the importance of lifelong learning, post-qualification education and training for mental health nurses across Europe is set against the background of two distinctly different approaches to initial, pre-registration, nursing preparation: generalist education and education which prepares newly qualified practitioners for work in mental care specifically [31]. Few countries use the second approach (the United Kingdom and Ireland being amongst those which do), and for nurses whose pre-qualification programme has been a generalist one, a route to developing competence can mean engaging in post-qualification study and practice leading to recognised specialist psychiatric/mental health nursing status. The position of the Europe-wide organisation Horatio: European Psychiatric Nurses is that all nurses working in mental health settings should have opportunities of this type to develop core and advanced skills and knowledge for their chosen field of practice and that universities should be proactive in offering programmes of this type linked to academic awards up to and including doctoral level [14]. In this context, the eMenthe project was notable as a Europe-wide initiative which aimed to bring together, online and in open access format, learning materials to support postgraduate education for mental health nurses [32]. Internationally important examples of routes to the development of specialist mental health nursing skills and knowledge in countries with generalist approaches to initial preparation can also be found outside of Europe. ‘Credentialing’ in Australia [33] and ‘certification’ in Canada [34] both enable nurses to secure recognition in psychiatric and mental health nursing, following periods of specialist post-registration work and study.

In Wales’ *Framework for Mental Health Nursing*, the idea is put forward that the importance of investing in mental health nurses beyond their initial qualification cannot be overstated [35]. In addition to maintaining the competencies needed to keep up-to-date with professional development, this framework identifies how postgraduate provision for mental health nurses should focus on advanced evidence-based practice and interventions that improve outcomes for people who use services. An example of APMHN education of this type is in the development of high levels of competency in psychosocial interventions for people with severe mental health problems [36]. Further examples include advanced education in different models of psychological therapy and in medication management and prescribing. The framework adds that all mental health nurses need to be research-minded and some need to be research leaders. This means creating opportunities for growing numbers of mental health nurses to develop their formal research skills far beyond the level acquired during undergraduate education and to grow towards research independence.

It is not always easy for mental health nurses to get clear information on what additional competencies they need to enable them to make progress in their careers. This can be compounded by variation, both within and across individual countries, in mental health nursing postgraduate education and training. National competency and career frameworks are one approach to trying to support more clarity in this area, with Health Education England publishing a framework of this type in 2020 that aims to identify core competencies across the career framework [37]. This is organised around four pillars of practice and is specific to mental health nursing, enabling nurses to view the required core competencies and education requirements at each level of the framework, to be able to plan careers and to identify continuing professional development and education and training needs.

Reflecting the multiplicity of practice areas in which mental health nurses work, formal programmes of study can also be found supporting advanced practice in specific fields: for example, with people experiencing psychosis, people using mental health services in the community, children and young people and older people with dementia and their carers. A first notable example is the Thorn initiative, this being an internationally acclaimed post-qualification programme in the United Kingdom which supported nurses (and other mental health practitioners) to develop specific skills and knowledge in the care of people with severe mental health problems, involving modules in case management, family interventions and cognitive behavioural therapy for psychosis [38]. A second example is the Admiral nurse initiative, which set out to develop expertise in mental health nurses to work specifically with people with dementia [39]. Preserving and protecting post-registration programmes of education which specifically are aimed at enhancing the skills and knowledge of mental health nurses can be a challenge, and in our experience are vulnerable to being lost in favour of modules and courses which are more generic. Innovative ways of teaching and learning, including greater use of online delivery, may be one way of helping here.

Finally, the environment in which APMHNs work is an interprofessional one. An important component of post-registration education and training is therefore the opportunity to study and learn alongside members of other professional groups fulfilling roles in the mental health care system. The Thorn initiative, referred to above, is an example of a skills-based programme which was open to all practitioners working in the mental health field.

Our **key message** in this section is that learning is for life and that APMHNs should have access to (and engage in) ongoing postgraduate education and training relevant to their specialist field.

6 Professional Networking

Engaging with professional associations, special interest groups and other networks and participating in conferences and seminars are all ways of both advancing practice and influencing the field. As an example, the All Wales Senior Nurse Advisory Group for Mental Health brings together representatives from health providing organisations and universities and in recent years has produced a national framework for the profession. As a group that reports to the Office of the Chief Nursing Officer at Welsh Government, this group is an example where mental health nurses work nationally and have a significant role in shaping, and responding to, national policy as well as providing an interface between practice, education and research [35]. Mental Health Nurse Academics UK brings together representatives from some 70 higher education institutions, providing a forum for educators, researchers and others to meet, share good practice and act as a source of advice and expertise for others [40]. At a Europe-wide level, Horatio: European Psychiatric Nurses brings mental health nurses together across the continent via conferences and other meetings and lobbies for the field at the international level [14]. These groups support and develop the influence of mental health nursing as they can give a space for sharing information and healthy debate. They collectively speak on behalf of their memberships to provide a voice for mental health nursing that can, and does, influence at national and European levels.

Participating in groups and networks enables mental health nurses to engage on a larger stage and develop strategic skills. The level of change and uncertainty in contemporary mental health nursing underlines the importance of critical and strategic thinking. The ability to look ahead and read the landscape, anticipate change, align stakeholders, learn lessons and challenge assumptions to make decisions is a key skill at any level within the organisation [41]. Organisations, including those we have listed above, will always be open to welcoming new and engaged members and are typically keen to involve those who come forward. In our experience participating in networks also provides an important way of identifying mentors and coaches, a source of support which we have addressed earlier in this chapter.

Our **key message** in this section is that advanced mental health nurses should, as a matter of course, involve themselves in the work of field-specific groups and organisations with the purpose of collaborating, sharing good practice, influencing and leading.

7 Supporting Others

The possession of advanced knowledge and skills gained through postgraduate education, mentorship and clinical supervision brings with it obligations to help less experienced colleagues progress in their development. APMHNs are ideally placed to nurture future generations of practitioners, and this orientation to the support of others reflects important professional and ethical commitments. Integral to the advanced practice role is the facilitation of clinical supervision, the offering of mentorship and preceptorship, contributing to the formal education of both pre- and post-registration students and more. In a reciprocal fashion, all of the activities which enable advanced mental health nurses to progress their competencies are activities which, in turn, they should support for others.

Our **key message** in this section is that APMHNs have professional and ethical obligations to support the development of competence in less experienced nurses and other members of the interprofessional team.

8 Research, and Service and Quality Improvement

All mental health nurses are able to engage with research as a route to maintaining and developing competence, fulfilling roles as utilisers, evaluators, producers, implementers, teachers, supervisors, managers, influencers and/or leaders [42]. APMHNs are well-placed to expand their roles towards research influencing, producing and leadership through links which they forge with local universities and their membership of dedicated research groups and project teams. Service improvement is another field of activity through which advanced mental health nurses can bring to bear their expertise, grow their confidence and skills and enhance the quality of care provided to people using their services [43].

As Wales' *Framework for Mental Health Nursing* makes clear, it is important to support nursing research, to promote the use of research in practice and to support nurses to become more involved in research whilst remaining in clinical practice [35]. Research is a route to the production of knowledge, and (as outlined at the start of this chapter) knowledge is essential for any profession. Research can create an evidence base for clinical mental health interventions and generate new understandings of how mental health care is organised, delivered and experienced. The products of research are vital in informing developments in standards and services and in underpinning advances in professional practice. Within nursing, relatively little progress in many countries has been made in growing and sustaining clinical academic careers, through which people might sustainably combine work which straddles combinations of practice, research and education. Our view is that this remains a challenge yet to be met. In the meantime, advanced practitioners have opportunities to participate in international, national and local conferences, to join and lead seminar groups and journal clubs and to forge links with local universities.

As members of one of the professions with the most contact with people accessing mental health services, APMHNs are in a key position to apply a systematic approach to secure positive change to the care and support that is provided to and with people. Quality improvement is about continuous learning [43] and relies on all mental health nurses considering opportunities to improve what they do. It is dependent on the support and infrastructure and training that leaders can provide, but it is most reliant on mental health nurses on the frontline (including advanced practitioners) working in partnership with people accessing services to develop new solutions to achieve positive change.

In Case Study 2 below, Richard Jones (who like Sherrie Stewart, introduced in Case Study 1 above, works as a Consultant Nurse and Responsible Clinician) writes about his experiences working in an advanced role. Richard writes particularly about how he keeps his practice up-to-date through networking, service evaluation and research and supporting others.

Case Study 2:

Brief description of my role:	Responsible Clinician for Psychiatric Intensive Care Unit. The term 'Responsible Clinician' means that I am approved by Welsh Ministers as an Approved Clinician who can act as the Responsible Clinician for patients detained under the Mental Health Act. That means having responsibility for their detention and the care and treatment decisions for all detained patients under my care. In practice that means leading the multidisciplinary team on the psychiatric intensive care unit (PICU) in all aspects of care and treatment. I also take a lead role in the routine management of the ward, working collaboratively with the ward management team, to ensure that the ward meets national standards for PICU care Directorate lead role on workforce, research, audit and professional role development
How as an advanced mental health nurse do I maintain, and develop, my personal knowledge, skills and values?	• Regular attendance at postgraduate centre training • Peer-reviewed journals • Relevant conferences • Peer support groups (ANP peer group, Psychiatric Medical Staff Committee) • Discussions with senior colleagues • Discussions with consultants in other specialities • Ensure that I retain a 'buddy system'. I recommend this for all advanced practitioners and indeed all consultant colleagues. Being able to access a senior colleague is vital when faced with complex clinical situations not only for ensuring that clinical decision-making is correct but also as a means of sharing a burden at times. In the advanced practice role that I have occupied since 2013, this has necessarily always been a consultant psychiatrist
What approaches as an advanced practitioner do I use to support the development of others, including less experienced members of the interprofessional team?	• Chair an advanced nurse practitioner (ANP) peer group that meets weekly to ensure ANPs have adequate support in place. This ensures that all ANPs within the directorate are linked and can receive mutual professional support and peer supervision. It also ensures that ANPs, who tend to sit outside neat structures of management and nursing, can receive timely updates on policies, procedures, service developments, etc. via me • Development of a system of identifying potential new advanced practitioners and providing appropriate advice and guidance for their professional development • Regular supervision and feedback to members of the multidisciplinary team who work with me
How as an advanced mental health nurse do I collaborate, share good practice, influence and lead?	• Member of peer groups • Give presentations to a variety of audiences, locally, nationally and internationally • Contribute to Health Board and national strategy • Lead on workforce development for the Mental Health and Learning Disabilities directorate • Chair of professional nurse forum within MHLD directorate

How as an advanced mental health nurse do I contribute to both research production and service and quality improvement?	• Conduct own original research and publish findings • Development of a MHLD research and innovation group • Member of Health Board research, development and innovation sub-committee • Member of directorate quality and safety group

Richard Jones
Nurse Consultant/Responsible Clinician
Hywel Dda University Health Board, Wales, UK

Our **key message** in this section is that all mental health nurses have opportunities to enhance their capability through research utilisation and that APMHNs have particular opportunities to contribute to both research production and service and quality improvement.

9 Conclusion

In this chapter we have made a case for the importance of advancing professional capability and competence, which we see as an ethical imperative connected to meeting service users' needs and promoting mental health nursing practice. Our key messages, summarised from each section, are brought together in Fig. 1 following which we offer some reflective questions for aspiring or established advanced mental health nurses.

Our identification of these six strategies to support this is not intended to be exhaustive; rather, these are offered as exemplars of a generally proactive, outward-looking approach to professional practice across the span of a mental health nursing career. We encourage nurses to make, and take, opportunities to develop their knowledge and skills and through this to advance the boundaries of practice in pursuit of excellent care for people living with mental health difficulties.

Reflective Questions

- What can you do to promote supervision as a restorative, supportive and quality-promoting activity?
- As an advanced mental health nurse, what strategies do you use to network with colleagues beyond your immediate workplace?
- How do you lead and/or influence service improvement and research in your organisation?

Approach to the enhancement of capability	**Key messages**
Preceptorship, mentorship and coaching	• All nurses need support in the workplace • The type of individualised support which mental health nurses may find useful is linked to career trajectory, beginning preceptorship for new registrants and moving onwards to mentoring and coaching for nurses engaged in increasingly advanced levels of practice
Clinical supervision	• All APMHNs should have access to clinical supervision as a matter of course • APMHNs should also act as supervisors for others, supporting personal reflection, growth and the promotion of quality
Postgraduate education and training	• A hallmark of APMHNs is their participation in postgraduate study, and their access to ongoing education and training relevant to their specialist field
Professional networking	• APMHNs should make and take opportunities to involve themselves in the work of field-specific groups and organisations with the purpose of collaborating, sharing practice and influencing
Supporting others	• Supporting colleagues in their professional development, through mentoring, supervising and educating, is a key function of APMHNs
Research, and service and quality improvement	• Capability can be enhanced through research utilisation, with opportunities also existing for APMHNs to influence research, produce research, and join and lead research teams • APMHNs are ideally placed to develop their capability and competence through leading improvements in services

Fig. 1 Key messages for advancing practice mental health nursing

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Part VI

Emerging Issues and Challenges

e-Mental Health and Health Informatics

Maritta Välimäki and Kirsi Hipp

Learning Objectives
The objectives of this chapter are to enable you to:

- Explore the meaning of concepts related to e-mental health.
- Discuss examples for complex health technology applications and explore how they are currently being used in mental health services.
- Recognize the opportunities, usage, and limitations of health technology applications in mental health services.
- Be motivated to implement and test the health technology application in mental health services as part of the role of an advanced practice mental health nurse.

1 Introduction

Mental health problems are common worldwide; one out of four people experience a mental health disorder at some point in their lifetime [1]. At least 10% of the global population is affected by a mental, neurological, or substance use disorder [2]. The impact of mental health disorders on individuals includes morbidity and mortality, low productivity, social unrest, poverty, inequality, dropout from education, and unemployment [1]. On a societal level, mental disorders contribute to

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economic output losses of US $2.5–8.5 trillion every year, and these costs are increasing [2].

The key hindrance to the progress of addressing mental illnesses lies in the structural imbalance between an inadequate capacity to extend support and the high growth rate of individuals requiring treatment. Despite research advances and a significant body of evidence, mental health services still lack both availability and quality, especially in low- and middle-income countries. Mental health conditions could be treated at relatively low costs, but effective treatment coverage has remained inadequate. According to the Organisation for Economic Co-operation and Development (OECD) [3], 80% of people with a common mental disorder and half of those with a severe mental disorder do not seek or receive treatment. As good mental health refers to a state of well-being in which an individual realizes their own abilities and is able to cope with the normal stresses of life, work productively, and contribute to society, it is important to make easy-to-use, low-threshold interventions available to everyone globally.

Various applications of mental health technologies have been developed and hold promise in addressing the different dimensions of global mental health challenges. To increase awareness of these technologies and to support the role of Advanced Practice Mental Health Nurses (APMHNs), in this chapter, we describe how different technologies are currently being used to respond to mental health challenges in a wide array of contexts. We first offer definitions for e-mental health. After that, we give some examples of e-mental health applications, as well as their opportunities, usage, limitations, and needs for further development. In addition, the role of the APMHN in supporting the usage of mental health technologies is discussed. This is particularly important because of the significant impact that digital technology currently has on societies, including its impact on the mental health and well-being of individuals, and the growing importance of digital technology in societies and, in particular, health services. The World Bank [4] has stated that a subset of challenges and barriers associated with the prevention and treatment of mental disorders could potentially be reduced through the application of select technologies. Therefore, every APMHN should be interested in this topic and prepare themselves to take a leading role in designing, implementing, and evaluating the impact of health technologies on the well-being of individuals and groups in mental health services.

2 Definitions Related to Health Informatics and e-Mental Health

In the literature, a variety of definitions are used to describe health informatics and e-mental health. Although the content, structure, and connotations may vary, these terms and concepts are closely related and indeed overlap.

Health informatics refers to the applications of computing methodology and technology in healthcare information systems. This concept integrates healthcare sciences, computer sciences, and cognitive sciences in the management of healthcare information. The Royal College of Nursing in the United Kingdom [5] has specified that health informatics is a science that generates, records, classifies, stores, retrieves, processes, analyzes, and transmits health information.

e-Mental health refers to the information and digital technology that is used to promote, prevent, or assist in mental health recovery [6]. *e-Mental* health applications can also be used to deliver mental health information [7]. These technologies can be delivered via the Internet or other electronic communication technologies [8]. *e-Mental* health can be used as stand-alone self-help interventions, or it can be combined with conventional therapies.

According to the European Commission, *e-health* comprises the following four interrelated categories of applications: (1) clinical information systems; (2) telemedicine and home care, personalized health systems and services for remote patient monitoring, teleconsultation, telecare, telemedicine, and teleradiology; (3) integrated regional/national health information networks, distributed electronic health record systems, and associated services such as e-prescriptions or e-referrals; and (4) secondary usage of nonclinical systems, such as specialized systems for researchers, or support systems such as billing systems [9]. The WHO [10] has classified digital health interventions into those targeting clients, healthcare providers, health systems or resource managers, and data services.

The content of e-mental health applications varies. A systematic rapid review by Lal and Adair [11] identified e-mental health applications addressing four areas of mental health service delivery: (1) information provision; (2) screening, assessment, and monitoring; (3) intervention; and (4) social support. The Mental Health Commission of Canada [7] has listed and defined some examples of e-health technologies such as instant messaging, portal/electronic medical records, smartphones, social media, telehealth, virtual reality, and websites. Other examples of e-health solutions applications used in mental health are listed in Table 1.

Table 1 Examples of e-health solutions

Reference	*E-health* solutions
Mental Health Commission of Canada, 2014 [12]	Computerized interventions, resources, and applications; telehealth and telemedicine; wearable computing and monitoring; big data; virtual reality; peer support through social media and other technologies; robots; gaming
Mental Health Commission of Canada, 2018 [7]	Self-help tools: smartphone interventions, web-based management interventions, personalized monitoring/support, virtual online community Human-supported interventions: delivery of telemedicine-supported services, automated home messaging devices, access to mental health services
The Royal Australian College of General Practitioners, 2015 [8]	Instant messaging or video-based counselling services (also known as telehealth, telemedicine, or telepsychiatry); consumer information portals; online support groups, forums, and social networks; online assessment or diagnostic tools; blogs and podcasts; therapeutic gaming programs, robotic simulation, and virtual reality systems

3 e-Mental Health Technologies

In this section, we focus on e-mental health and describe some commonly used e-mental health applications. These include websites and portals, social media, apps and smartphones, chatbots, videoconferencing, wearable sensors, and virtual reality and gaming.

3.1 Websites and Portals

Websites and portals are e-mental health technologies that use the Internet to deliver mental health promotion and interventions [13]. Users can access web-based interventions via a computer, a laptop, or any other Internet-enabled device [14]. Web-based mental health interventions can be offered at healthcare organizations, in community settings, at schools, or in healthcare services [15].

Websites and portals have the potential to reduce the gap in mental health services as they can reach people who lack access to traditional mental health services [13]. Web-based interventions have been developed to improve mental health literacy [16], to promote mental health and prevent mental disorders [13, 17], and to provide mental health treatment [14]. Some web-based solutions are designed to manage physical conditions and healthy lifestyle, such as promoting physical activity and smoking cessation [14, 18]. Web-based interventions can be used to deliver treatment without a physical appointment [18]. Other benefits include convenience, privacy, and anonymity [17]. People can seek support without being stigmatized [14, 16]. Web-based interventions are stated to be cost-effective [13]; however, evidence of their economic benefits is still lacking [15].

Websites and portals have targeted the general population [16], young people [13], and university students [17]. They have also been developed specifically for persons experiencing depression [15, 18] and schizophrenia [19]. Other target groups include people with anxiety, social phobia, posttraumatic stress disorder, and binge eating disorder. Healthcare professionals have recommended the use of web-based therapies only for service users with low-risk diagnoses, strong motivation, the ability to use a computer, and a low need for tailored content [20].

Web-based interventions include a wide range of websites, portals, platforms, and apps. Websites can include text and multimedia such as images, animation, music, and videos [17]. There is also a wide variance in the contents of web-based interventions [15]. A review by Brijnath et al. [16] found interventions ranging from linear, statistic websites to highly interactive interventions.

Web-based intervention programs have different theoretical approaches guiding the content and structure of the intervention. Typically, interventions are based on cognitive behavioral therapy (CBT) [13, 17]. Several other approaches have also been reported, such as interpersonal psychotherapy, psychoeducation, and techniques to change health behavior [14].

The content of web-based interventions can be well structured with evidence-based material and can be designed to target the general population or specific groups. Web-based interventions can also be tailored based on users' needs, and its interactivity can support experiential learning. Välimäki et al. [15] found in their review that interventions for young people included different tasks, like exercises, quizzes, and questionnaires. Web-based interventions can also be "stand-alone," with no human support and independent work by the user, or they can include human interaction with professionals, peer supporters in face-to-face contact, phone discussions, or email support [14]. Other interactive methods supporting interventions are chat rooms and videoconferences in small groups or privately between a mentor and a participant.

In general, users' acceptance of web-based mental health programs is good [13, 17]. Still, some studies have reported high dropout rates and nonadherence among users [13, 14]. The reasons for this vary and may include participants lacking time or interest, psychiatric symptoms such as hallucinations or restlessness, technical problems, or participants perceiving the intervention to be unnecessary or noneffective. To promote adherence among participants, different solutions have been reported such as improving the quality, design, and usability of the interventions. Reminders and alerts or scheduled tracking have also been added to intervention platforms to increase more active participation [14]. Recently, gamification elements have been appearing more often in web-based interventions, meaning that interventions are using the elements of game design. Examples of gamification include playfulness, progress monitoring, increased challenges to maintain interest toward participation, automated feedback, and rewards, badges, or points with which participants can follow their own improvement [14].

Studies have found promising results using web-based mental health interventions for university students [17], adolescents with depressive symptoms [15], and adults with or without mental health problems [16]. However, the current evidence is vague due to their high risk of bias [13, 14, 17]. Reviews have also reported heterogeneity of the interventions and study methods [13], which make it difficult to compare the impact of different study results. In addition, evidence on the long-term effects of these interventions is lacking [15]. Healthcare professionals often have doubts about these types of interventions as they require extra training and organizational support. Healthcare staff also have concerns about confidentiality and security of client data in web-based interventions [17].

3.2 Social Media

Social media is defined as an application used to create and exchange user-generated contents [21]. Typically, social media in western countries refer to platforms such as Facebook, Instagram, Snapchat, and Twitter [22], but blogs, Wikipedia, and content communities such as YouTube are also included in the family of social media [21]. The opportunities for the utilization of social media are many. For example, it has been utilized to screen and identify individuals with mental health problems [21, 22]. For young people, social media is a natural tool to use to search for information about mental health and to seek support [23]. Its benefits are easy to access due to its nearly unlimited availability. Social media can also reach individuals with whom are otherwise hard to engage [21]. It can easily connect people with the same agenda to offer peer support [22]. Typically, social media interventions have been found to be usable, engaging, and supportive for young people [23]. Various social media applications have been used for persons with symptoms of depression or anxiety [24] and young people with symptoms of depression or psychosis [23].

Based on a systematic review by Ridout and Campbell [23], mental health interventions in social media can be purpose-built games or social networking environments created around mental health issues. Interventions can also be conducted in a closed Facebook group where members can post educational material, hold discussions based on daily prompts, and communicate with each other. For example, social media sites have been developed for individuals with suicidal ideation to provide information, instant chat, and online forums [21]. The interventions can have scheduled discussions, or they can provide working material with which users can proceed at their own pace [23]. Social media can also be used as part of wider interventions [24]. Analysis of social media profiles can provide a way to detect depression [22] and prevent suicide attempts [21]. This is possible as some social media applications can use artificial intelligence to detect depression, provide information on treatment, and monitor the course of treatment [22].

Limitations related to social media applications include ethical and practical concerns [21, 23]. For example, automatic detection of social media profiles raises privacy concerns if persons are not fully aware of these activities. Detection may also involve screening errors, and a person's situation portrayed on social media can be more or less erroneous [22]. Other challenges reported include difficulties in controlling member participation and accurately assessing the emotional state of participants online, as well as the potential for technological problems [21]. Peer support may also lead to sharing misleading or unreliable information [23] or dissemination of hurtful comments [22, 23]. People can also share risky behaviors such as justifications of and means for suicide [21, 22]. Social media interventions have therefore used expert moderators with clinical experience, peer moderators, and auto-detect risk management systems to ensure safe and supportive environments [23]. However, the emotional burden on volunteers needs to be acknowledged [21]. There is also a risk that people use social media platforms instead of offline help, and this can result in marginalization from mainstream society [21]. In addition, the effectiveness of social media interventions should be studied further. For example, a systematic review and meta-analysis conducted in 2016 found numerous published reports, but only two randomized studies published on the effects of social media interventions for people with schizophrenia [24].

3.3 Apps and Smartphones

e-Health apps refer to software applications that provide tools, processes, and communications to support electronic healthcare; they have been used within healthcare systems, but apps today are mainly geared toward smartphone and tablet users. In a survey conducted in 2015, the WHO identified 15,000 disease-specific mobile health apps, of which 29% focused on mental health [25].

A wide range of apps has already been developed in the field of mental health. In 2013, there were more than 3000 mental health apps for Android, Apple, and Microsoft freely available for download [26]. The development of mHealth apps was originally driven by commercial and economic rather than scientific research motivations. Since then, apps have been found to have the potential to overcome barriers in accessing treatment. Today, smartphone apps hold promises in monitoring health status and running interventions, such as cognitive behavioral therapy for social anxiety [27].

Typically, the development of mHealth apps has targeted either the general public or specific groups. Apps aimed at the general public have focused on issues such as stress, substance use, or quitting smoking [26]. Alyami et al. [27] found in their systematic review that over 95% (36/38) of apps focusing on anxiety targeted the general public, whereas only 2 apps out of 38 were directed at healthcare professionals. Apps are already designed for particular groups, for example, adults with anxiety [27].

The main purpose of apps have thus far been to offer psychoeducation, symptom management, treatment, self-assessment, or supportive resources. Apps can be used for treatment interventions, assessment, monitoring, self-management, social support, or as a platform for receiving positive feedback from a coach or peer supporters. Peers can share their lived experiences in apps that can help others navigate their daily life and solve issues that they may face during the course of illness. Users with depression have found that cognitive behavioral therapy (CBT) apps can play an active role in supporting their mental health. Ideally, apps should be evidence based; incorporate appropriate therapies (e.g., CBT); provide validated mental health information; have utility for real-time engagement, gamification, or reminders; and be easily found and accessed [28].

Typically, media used in apps includes text, audio, a combination of text and audio, or visual elements with text. To be effective, apps should combine evidence-based treatment options and support self-management skills to implement the intervention impact into practice [27]. However, not all apps are based on evidence or are validated treatment elements. It has been found that publicly available mental health apps for depression and anxiety ($n = 27$) often do not include empirically supported treatment and lack evidence-based content [29]. On the other hand, users may have different opinions on the impact of the evidence-based and non-evidence-based features. Qualitative analysis revealed that users may find non-evidence-based techniques incorporated into apps to be helpful if they distract the user from negative thoughts and feelings and help them to function by decreasing the disorder's symptoms in the moment. Still, the quality and content of apps are important as apps classified as non-evidence-based have found to have lower user ratings, and a larger percentage of users found these apps non-beneficial [30].

Various limitations have been found in existing mental health apps. For example, a great number of apps do not report their content sources. Apps are seldom found to be robustly evidence based [29]. In one study, only 4% of the participants used the apps for more than 15 days, implying that users self-manage their condition in real-world settings in ways that differ from what the intervention developers intended [31]. In addition, the effectiveness of apps is seldom evaluated in published studies [27]. If it is assessed, it is only on a short-term basis. Therefore, based on the current evidence, sustainability of results regarding the effectiveness of these apps cannot yet be determined [26].

3.4 Chatbots

Chatbots are digital tools capable of holding conversation with natural language mimicking humanlike behavior. They can be software programs with artificial intelligence [32] or rule-based chatbots that offer responses to conversations based on predefined rules or decision trees [33].

In the area of mental health, interest in chatbots is growing. Chatbots are used as diagnostic tools for monitoring mental health conditions and treatment methods to relieve psychiatric symptoms, psychological distress, loneliness [32], and stress [33]. Chatbots can also be used to facilitate psychoeducation and self-management, therapies [32–34], and suicide prevention [34]. In addition, chatbots are used to offer social companionship [32].

Chatbots have been used to target persons with any kind of mental health disorder but also persons with specific disorders, such as anxiety, depression, and phobias [32, 33]. Chatbots have been found to be promising in reducing psychological distress and symptoms [34]. The strengths of using chatbots include accessibility, flexibility, and interactivity; they are not dependent on time, place, or duration. They also enable synchronous two-way communication without specific support from experts [32]. In addition, chatbots have been used in community and educational and clinical settings, and they are usable in anonymous social interaction for individuals who are not comfortable seeking help for mental health [33].

Interventions using chatbot platforms vary in their content. They can be accessed through apps, computer programs, or virtual reality [32]. From the 12 studies included in a review by Abd-Alrazaq et al. [33], half of the chatbots were web-based and the other half stand-alone software where users communicated with chatbots using written, spoken, or visual language. A conversational agent can be embodied as a visual character such as a 3D avatar [33, 34]. Physical presence can also be offered using robots [32]. Studies on chatbots have reported user satisfaction [32]. They have been found helpful and easy to use [34]. Responses among chatbots can be structured to reply with pre-scripted statements and to replicate an empathetic response appropriate to the participants' inputted emotion or concern. For example, if the person has endorsed loneliness, the chatbot may reply "I am so sorry to hear that you are feeling lonely."

Despite the substantial development and achievements regarding chatbots, especially in the last decade, some concerns have also been raised. Users have found the content of chatbots repetitive. Voices of chatbots have been of poor quality, and their conversational skills have been limited [32]. On the other hand, contradictory concerns have also been reported in their lack of empathetic and humanlike behavior [34], and relationships with chatbots have been reported to be shallow or superficial. Other limitations regarding chatbots are related to their usage. Participants have dropped out from chatbot interventions due to technical problems or their mental health status; they have felt a lack of engagement if the intervention period has been long or too demanding [32].

Concerns have also been raised about the possible risks of the use of conversational agents. For example, chatbots may produce inappropriate responses to users' suicidal ideation [32]. However, Vaidyam et al. [34] concluded that the risk of harm was low based on their study results as only 1 out of 759 participants expressed harm in the form of paranoid thoughts. On the other hand, safety issues in chatbot studies are rarely assessed. In addition, a systematic review and meta-analysis focusing on the effectiveness of chatbots found that the evidence on effectiveness is weak and the results were conflicting [33].

3.5 Videoconferencing

Videoconferencing is a technology that allows concurrent sharing of audio and video across geographical distances [35]. Videoconferencing is used to deliver different therapies to service users by connecting service providers and patients in different locations [36]. In the literature, videoconferencing has been included under the concepts of e-therapy [37] and telepsychiatry, which refers to remote provision of healthcare through the use of information technology [38]. In their review, Backhaus et al. [35] found 65 studies that focused on videoconferencing psychotherapy.

Videoconferencing interventions typically follow standard treatment procedure, but the delivery media is based on information technology between the service user and therapist [36]. Videoconferencing psychotherapy can be used for individual therapy as well as family and group therapy [35]. Videoconferencing has also been used to provide mental health services for refugees with a wide range of diagnosable mental health disorders [39]. Some service users may feel more comfortable using videoconferencing in their therapy, as they can participate from the comfort and privacy of their own home [38]. Videoconferencing has been used to conduct therapy for various mental health problems, such as eating disorders, mood disorders, anxiety disorders, addiction issues, and psychophysiological issues [35].

It has been found in the literature that therapeutic relationships and alliances can be achieved in e-therapies [37, 38]. Therapy conducted via videoconferencing has been found to be as effective as in-person therapy [35, 39]. Studies have also provided evidence of long-term effects of videoconferencing for posttraumatic stress disorder (PTSD). Videoconferencing has been found to be more cost-efficient than face-to-face therapies due to the reduced need for travel and accommodation, although the results of the economic analysis cannot be generalized to all settings [38]. Although videoconferencing requires professionals to conduct the therapy, it overcomes other problems such as access barriers like transportation, disabilities, or absence of available services [36]. These are important benefits for groups with barriers to seeking treatment for their mental health issues, including time constraints; online therapies can be more easily accessible.

Videoconferencing has been found to be a feasible method of providing psychotherapy with high user satisfaction [35]. In contrast to, for example, phone or messaging, videoconferencing is synchronous, and verbal cues are not missed [37]. However, even though both users and providers have been satisfied with videoconferencing, they tend to still prefer face-to-face treatment [39].

3.6 Wearable Sensors

Information about well-being has typically been collected with paper surveys or diaries. However, this information often lacks accuracy and depends on recall ability and willingness to share inner thoughts. Currently, unobtrusive monitoring using wearable technology to assess behavioral (i.e., sensors), physiological (i.e., biosensors), and cognitive/emotional outcomes (i.e., self-reports) is a usable method for providing new information about elusive psychological constructs under measurement.

Wearable technology has been used for diagnostic purposes due to the dynamic nature of mental states and various individual needs, and this technology has the ability to increase a more accurate diagnostic process. The benefits of using modern electronic devices compared to conventional data collection methods are that modern technology allows for the automation of data collection and prompting features, the combination of different features, less effort needed by the users, real-time data, and an increased self-management ability [40]. Wearable technology can also offer continuous monitoring of specific symptoms over time, and it can link the monitoring to specific interventions, predict short-term mood changes, detect the worsening of symptoms, and support continuous communication between clinicians and service users. Further, daily monitoring and symptom self-ratings could provide low-cost assessments, overcome recall bias, and capture the dynamics of human functioning in daily life that cannot be detected with traditional tools [40].

Various assessment approaches and interventions are being carried out with wearable technology. These include, for example, ecological momentary assessment (EMA) and ecological momentary intervention (EMI). The term *ecological* refers to the environment in which the data are collected, while *momentary* refers to the focus of the assessment [40]. Thus, EMA involves data collection on repeated occasions, in real time and in the context of daily life. EMA uses digital technologies with automated delivery and recording of data. These include smartphones for prompting and recording and passive capture of ambulatory physiological data using actigraphy to measure heart rate or sleep patterns [41]. EMA has been used, for example, to assess symptoms, identify and monitor signs of relapse, and monitor treatment effects for people with mood disorders, anxiety, and stress [40]. Fewer studies have been conducted on people with schizophrenia. However, Tahmasian et al. [42] reviewed and found 66 papers related to psychotic disorder. The authors concluded that actigraphy allowed the objective evaluation of sleep habits and circadian rhythm disorders among persons with schizophrenia. It also helped to clarify and compare sleep and activity patterns in people with severe psychiatric disorders like schizophrenia.

EMI uses repeated prompting to provide treatment to people during their everyday lives in real time and in natural settings. The technology used in EMI includes palmtop computers, mobile phones, smartphone apps, or SMS text messages to deliver statements or instructions for promoting positive behaviors and coping when needed [42]. Other uses are illness self-management through momentary reminders or instructions for promoting medication adherence, management of symptoms and psychosocial impairments, daily living skills, and goal achievement [41].

The use of wearable technology has revealed similar limitations to other technology-oriented, repeated real-life interventions, such as poor rates of adherence among both consumers and practitioners [41]. Other limitations reported include a lack of standardization of the objective features collected, the assessment methodology, and the statistical methods applied [43]. In addition, there is a lack of standard and validated sets of items that have been developed for assessment, which raises the problem of context validity. Moreover, further research should be conducted to improve user compliance and reduce dropout rates.

3.7 Virtual Reality and Gaming

Virtual reality (VR) is a computerized real-time technology that uses graphics, sounds, and other sensory inputs to create an interactive computer-mediated world. Interactivity is enabled by sensors that track the user's position and orientation so that the user can respond to the VR environment. As virtual reality can include gaming features, in this section we discuss gaming and virtual reality together.

Virtual reality can represent social environments that trigger responses, reactions, and emotions in a person's mind that are equivalent to what a given context in the real world would create. Virtual persons (avatars) elicit reactions similar to those evoked in real life. Virtual reality can be categorized into four groups depending on what real and virtual objects are presented in the image: (1) reality, the real world; (2) augmented reality, in which computer-generated data are merged into a real-world image; (3) augmented virtuality, in which real-life data are merged into a computer-generated world; and (4) virtual reality, in which the world has been created entirely by a computer [44].

Typically, VR includes characters or any conversational agent (avatar, a virtual person), which is an image that is programmed to interact with the user. These characters were originally implemented as immersive two-dimensional figures on a flat screen. Currently, virtual reality can be a fully immersive computer-simulated experience consisting of the development of a three-dimensional virtual environment, around an individual through a head-mounted display (HMD). The environment allows the user to look around and move in any direction and to interact with the environment through inputs given via a controller or keyboard or, with the most advanced VR technology, through tactile gloves or body motion detection techniques. To offer the feeling of being immersed in a virtual space, the user's motions are continuously detected to adjust the 3D environment accordingly. Modern VR kits are designed to be integrated with personal computers, gaming consoles, or smartphones.

Active games are considered game modalities combining technology and physical activity that have been developed for children to improve their mental health. They seem to be suitable for persons in a wide range of ages because they combine a fun use of technology with the benefits of physical exercise and psychological elements [45]. Active games have recently gained an important role in increasing physical activity and promoting physical and mental health [45].

Virtual reality has been used in the treatment of various participant groups, including persons with posttraumatic stress disorder, anxiety, flying phobia, arachnophobia, agoraphobia, and schizophrenia [44]. Brown et al. [14] reviewed the interventions using gamification for common mental disorders and found 82 randomized controlled trials. These interventions were most frequently designed to treat depression ($n = 30$). Virtual reality with gaming elements is also potentially beneficial for elderly people with cognitive deficits in supporting their physical activity at home [45].

Although virtual reality with avatars has become popular with users, only a few studies have been carried out on the topic. A Cochrane review [46] described the effectiveness of avatar therapy compared to treatment as usual and was supported by three short-term studies ($n = 195$). The authors found that the evidence from the trials was not high quality. Although some positive effects were found, the results included considerable risk of bias. The authors were also worried that there was just as much risk of avatar therapy causing problems to people as there was a chance of it being beneficial. Therefore, information is not conclusive and more studies in this area are needed.

Horigome et al. [47] concluded, based on their systematic review, that the quality of virtual reality studies is not high. This technology might be suitable for persons with anxiety due to the opportunity to tailor specific features based on participants' needs. The dropout rate is also low, and participants can control their reality (e.g., the number of participants in the audience when practicing a speech). In addition, VR can create a real feeling of presence, which is missing in many other technology-based interventions. On the other hand, optimal dose amounts to increase positive results are not clear as structures and content of VR interventions vary. It is also unknown whether VR increases participants' anxiety levels. Therefore, more studies in this area are still needed.

Especially in Asian countries, an effort has been made to understand the prevalence and negative effects of gaming and Internet addictions. The reason might be that the prevalence rates of gaming disorders appear to be higher in Southeast Asia than in other world regions [48]. It has also been found that Internet addiction is associated with increased suicidality, even after adjusting for potential confounding variables including depression. Therefore, family members in Asian countries do not always favor gaming interventions as part of mental health services [49]. To better understand long-term impacts of gaming and Internet use related to mental health, prospective studies are necessary.

4 The Future Developmental Needs

4.1 The Future Developmental Needs of e-Mental Health

Despite the wide variety of target groups using e-mental health, older adults still seem to be underrepresented in the literature. More studies in this area are needed as global healthcare challenge is common especially in aging population. Many e-mental health programs are conducted in high-income Western countries. At the same time, the biggest gap in mental health services is in low- and middle-income countries. Future studies could therefore examine whether the results of previous studies are generalized for different cultures and contexts and establish new e-mental health solutions in these areas.

Current literature on the topic describes the importance of *how* e-mental health technologies are implemented in daily practices. Contrary to general assumption, the use of health technology itself does not automatically make the work of healthcare professionals easier, less time-consuming, safer, less costly, more productive, or more effective. It is therefore very important to understand, first, which treatment processes are to be replaced, changed, or left out due to new technological solutions. By doing this, it might be possible to avoid overwhelming extra workloads due to implementation of new technological solutions without changing old work processes. It is also essential to ensure that the technology does not increase staff's workload and burden.

The literature describes how some of the e-mental health products were originally developed for commercial use. Therefore, the public should be educated on how to identify evidence-based mental health technologies out of all of the non-evidence-based content. Another area that needs to be taken into account when using new e-health technologies is safety. One important future step should be to establish guidance and regulation for conversational agent interventions. It is also important to further discuss the ethical and safe use of different mental health applications and their relationship with clinical mental health services [44]. To address the needs of users, greater collaboration is needed between professionals in computer science, mental health services, and end users.

4.2 The Future Developmental Needs for e-Mental Health Research

Our introduction of e-mental health technology is mostly based on systematic reviews, and the amount of research knowledge in this area is enormous. Although the number of research results related to e-mental health applications are numerous, there is still space for future studies. First, the quality of the current evidence is low, or the results are contradictory, which makes any recommendation of the technology use difficult. Second, the content of the intervention including e-mental technology varies depending on target group, length of the interventions, structure, different components, follow-up times, etc. A variety of these elements make it difficult to combine the results to show evidence of the effectiveness of each intervention. In addition, if the intervention is very complex and requires wide preparatory training and reorganization of work, it is hard to draw conclusions about which ingredient affected the outcomes. Therefore, researchers should use more time to describe carefully the intervention elements, which might make the comparison of the studies easier.

Third, the use of most e-mental technologies is limited due to low user engagement in developing the interventions. Perhaps, therefore, e-mental health technologies do not fully fulfill users' needs. Even though satisfaction studies have given positive feedback on e-mental technology, neither the participants nor the healthcare staff have been eager to use them in real-life environments. Dropout rates are also high in all of these interventions due to a variety of reasons. More insight should be offered on how interventions are used (or not used) and why. In addition, future studies should ensure healthcare staff's attitudes and competence regarding their use of new technology-based interventions and explore how interventions may best be integrated into routine practice. Although there are a great number of studies focusing on healthcare staff's attitudes and competence regarding their use of information technology, the best methods to support staff's use of e-mental technology has not yet been determined.

4.3 The Future Developmental Needs for the Role of APMHNs

e-Health technology can offer several opportunities for APMHNs to deepen their knowledge and skills about the need for new treatment and educational approaches in their daily practices. Web-based interventions include a wide range of websites, portals, platforms, and apps. At the same time, APMHNs need to have a variety of new skills so that they can offer the best possible clinical and technological support to e-health users. In addition, various therapies, such as cognitive behavioral therapy [13, 17], interpersonal psychotherapy, and psychoeducation, as well as techniques to change health behavior [14], can be offered using technological application. Therefore, APMHNs can widen their expertise in how to flexibly use technological tools in the application of different mental health interventions.

Using new technology-based interventions may also be challenging for advanced nurse practitioners. Communication between patients and nurses has traditionally been conducted face-to-face. Current web-based interventions can include discussions between peer supporters, phone discussions, email support, chat rooms, or videoconferences in small groups. Therefore, APMHNs need to be able to manage different communication methods for supporting and engaging participants in online interventions. As technological interventions may not suit everyone, APMHNs need also be able to recognize those who might benefit from using e-health and those to whom technology use may cause harm (e.g., persons with a gaming disorder). Nurses need new skills to assess accurately the emotional state of participants online, as well as the potential for technological problems. New questions regarding privacy, confidentiality, and nurse responsibilities need to be taken into consideration. Thus, APMHNs should be aware of ethical codes and national legislation related to health technology use in healthcare settings.

The role of the APMHN aims to meet service users' individual and complex mental and physical health needs holistically [50]. This role needs to lead the development of new requirements for the structure and content of university curricula, to ensure that APMHNs have the skills needed to manage in work contexts that are more complex and unpredictable and that require new strategic approaches. By taking these requirements into consideration in the learning objectives, APMHNs can more effectively take responsibility for contributing to professional knowledge and mental health practice in the future. Therefore, every APMHN should be interested in the topic of e-health technology in mental health and prepare themselves to take a leading role in designing, implementing, and evaluating the impact of health technologies on the well-being of individuals and groups in mental health services.

5 Conclusion

We can conclude that e-mental health applications are already widely developed and used for various purposes, target groups, settings, and environments. Definitions of e-mental health technologies vary. Some commonalities between technologies can be found, while some features overlap. Still, the overall purposes of the e-mental health applications are to support health and mental well-being by assessing, monitoring, supporting, offering treatment, and evaluating treatment outcomes. e-mental health technologies have been used for many purposes in various target groups with different ages, backgrounds, environments, and countries. This has developed new challenges and also opportunities for the role of APMHNs in the field of mental health.

Reflective Questions

- Based on your experiences or attitudes, what are the main pros and cons of using e-health technologies in mental health?
- What new knowledge might you need to enable you to facilitate technology-based interventions in mental health services?
- Which factors could support the use of e-mental health in your daily practice?

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Into the Future: Challenges and Opportunities for the APMHN Role

Agnes Higgins, Nina Kilkku, and Gisli Kort Kristofersson

Learning Objectives

The objectives of this chapter are to enable you to:

- Reflect on the changing expectations, challenges, and opportunities facing APMHNs into the future.
- Identify areas for further development of the APMHN's role.
- Articulate strategies for overcoming challenges in implementation and sustaining the APMHN's role into the future.

1 Introduction

In recent years there is a growing evidence and policy base documenting the challenges facing mental health services, including the rising mental health morbidity rates, the ageing population, the many rights violations perpetuated within the mental health system documented in many international reports, and the mortality gap between those experiencing mental health problems and those without, to name but a few. As the nursing profession, in many countries, constitutes the largest and possibly the most accessible cohort within the healthcare system including the mental

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health system, there is growing recognition that if the policy imperative, to deliver accessible, affordable, safe, quality, and rights- and recovery-based care, is ever to be realised, engagement with the nursing profession must take place. While all nurses can make a critical contribution to the reform agenda, nurses who occupy advanced roles, because of their expertise and position within the team, are ideally placed to initiate, innovate, lead, and drive organisational change. Not only can APMHNs provide a rights- and recovery-based approach to care, but they can shape how mental distress is understood and how care is delivered by others without losing sight of nursing values, such as people-centred care, the primacy of the therapeutic alliance and relationship, and importance of viewing the person in the context of family, community, and the wider sociocultural context.

While APMHNs are critical in any future workforce plan, Allabyrne et al. [1] note that there has been little or no attention given to the role outside the USA. In this book we endeavoured to address the various dimensions of the APMHN's role while moving beyond the biomedical way of codifying mental distress. We are mindful that the ever-changing sociocultural, economic, demographic, political, policy, technology, and practice contexts demand that APMHNs, throughout their career, hone and perfect their knowledge, skills, and practice through the process of reflection and informal and formal learning. We are also aware that there are many issues not addressed in the book, and while crystal ball gazing is often a futile sport, this chapter focuses on some of the future challenges and possibilities facing APMHNs, including challenges in shaping and informing policy, supporting service reform, working across service and disciplinary boundaries, shaping and generating evidence, as well implementing and sustaining their role into the future.

2 Inputting into the Reform: Securing a Place at the Policy Table

As there is no health without mental health and mental health is not just a personal issue but a societal asset that is central to the social and economic prosperity of a country [2, 3], there is growing recognition that to improve a population's mental health there is a need to address the social and economic disparities that give rise to mental health problems. As discussed in the chapter "Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing", the need to address 'the causes of the causes' or what are sometimes called upstream issues is not new. Over the years numerous World Health Organization's (WHO) and European documents have made a case for such an approach. Documents such as the WHO's Mental Health Declaration and Action Plan for Europe [3], the European Commission's Green Paper 'Towards a strategy on mental health for the European Union' [2], the 2020 version of the Mental Health Atlas [4], and the recent WHO's 'Guidance on community mental health services: promoting people-centred and rights-based approaches' [5] all make the case for health and social care professionals to be involved in addressing the social determinants that impact people's mental health. In addition, they stress the importance of addressing the multiple barriers that people living with mental health problems face when accessing education, employment, housing, and social benefits: problems which lead to further exclusion, poverty, isolation, and discrimination. Given the complexity of health and mental health, these policy aspirations will only be achieved through a broad inclusive approach that incorporates the nursing voice.

The 2020 State of the World's Nursing report, by the World Health Organization, describes how nurses can contribute to the achievement of the Sustainable Development Goals and Universal Health Coverage [6]. However, when thinking about policy, Wignall and Mason [7] suggest that nurses tend to gravitate towards practice-level policy or policy that affects the immediacy of care. Not surprisingly, the International Council of Nurses (ICN) [8] and numerous writers are requesting nurses to extend their gaze and get involved in policy development and advocacy beyond the workplace (see "Advocacy and the Advanced Nurse Practitioner"). APMHNs, because of their level of education, continued grounding in practice, and clinical expertise in the area of mental health and mental distress have advanced knowledge about social, economic, and cultural determinants of health and are therefore ideally positioned to act as change agents at the policy table. However, this will require APMHNs to amplify their voice and move beyond being merely policy implementers to being proactive in the policy development arena at local, national, and international levels. It will also require APMHNs to widen their focus beyond issues that impact the immediacy of care and take a wider and more encompassing approach that incorporates all sectors of society.

Increasing the wellbeing and health of people across the life course and securing a place at the policy table is not without its challenges. The barriers to APMHNs being more involved are complex and vary from country to country (see [9]). Involvement not only depends on APMHNs' competence and confidence but also on the positions they hold within organisational and interorganisational networks. Although the importance of networking is known, this may not always be supported by senior managers, including nurse managers who tend to give primacy to the APMHN's clinical role. While this aspect of the role is crucial, senior managers, irrespective of discipline, also need to act as a 'leadership brokers' and provide APMHNs with opportunities, to enact their leadership potential, by nominating them as representatives of the profession and/or organisation onto strategic committees. Indeed, Elliott et al. [10], in their scoping review, clearly identified that a key enabler to APMHNs acting as change agents at clinical, operational, and strategic levels was senior management's willingness to share leadership tasks, as well as mentoring and supporting APMHNs to be involved in networks and committees within and outside their organisation and discipline. Engaging with practice- and policy-focused networks not only enables APMHNs to have access to those who form policy and control the flow of resources, but it enables them to acquire a 'global' view and a particular type of power-knowledge, which helps and supports them to 'speak truth to power'. APMHNs also need to be proactive in this space and actively seek opportunities to express their voice on behalf of service users, families, and the profession of nursing as opposed to passively waiting for an invitation.

Without this there is a risk that the potentially strong voice of nursing and all that APMHNs have to offer will remain absent.

3 Democratising Services: Engaging with Peer Roles

Over the years there has been a vast amount of literature written on power within the psychiatric/mental health services, from Foucault's [11] comments on the panoptic to current commentaries on the power of practitioners to engage in restrictive and coercive practices. Not surprisingly, in recent years we have seen increasing calls to involve mental health service users in mental health policy and practice. Proponents of inclusion argue that engagement with diverse and critical perspectives rooted in self-experience is paramount to facilitating meaningful change within services. In addition to enhancing the quality and array of services offered to service users, the development and inclusion of peer services and roles within mental health services is viewed as one way to disrupt traditional power relationships and challenge traditional epistemology that underpins mental health discourses.

While peer support is not unique to mental health services and has been used within physical health care in areas such as health promotion, disease prevention, and illness management, it is now viewed as a critical component of recovery-oriented mental health services [12, 13]. Emerging from sociopolitical movements that were rooted in people's shared experiences of mental health problems, including negative experiences of mental health care and treatment [14, p. 4], the importance of both formal and informal peer support now features prominently in international mental health policy. Although definitions vary peer support usually refers to support that 'occurs between people who share similar life experiences and as a result can provide each other with reciprocal support, advice, empathy, validation, and sense of belonging and community, which professionals and/or others who have not endured the same difficult situations may not be able to provide' [15, p. 441]. In a recent document, the WHO [16, p. 2] wrote that 'as experts by experience, peers … serve as compassionate listeners, educators, coaches, advocates, partners and mentors'.

Indeed, some APMHNs who have self-experience of mental health problems may as 'wounded healers' use their experiential knowledge in a relational manner to enhance empathy, model self-disclosure, enhance hope, provide insights into the recovery process, and destigmatise attitudes [17, 18]. Notwithstanding this fact, and while not wishing to perpetuate a 'them and use' scenario, it is now widely accepted and what some might call a 'universal truth' [19], that people with self-experience of mental health issues, including people currently using mental health services, should be involved in all aspects of care, including service delivery. Despite developments varying across systems, services, and countries, in response to the 'nothing about us without us' slogan and ever since the World Health Organization incorporated recovery-oriented care within their 2013–2020 Mental Health Action Plan [20], we have seen a growth in the development of intentional or formalised peer support services within and outside mainstream mental health services [21]. We also see an ever-increasing number of peer support models including, but not limited to, individual and collective models that can be face-to-face or online. Peer services are now enacted within peer-run organisations as well as within mainstream statutory mental health services. Within mainstream mental health services, peer support or peer workers are becoming part of the multidisciplinary team or crisis management team in emergency department, community, and inpatient settings [21–23]. In these contexts, they support people in transitioning from hospital to community, provide education, are part of employment support, and engage in advocacy work, such as advocating for the inclusion of the person's voice in care and treatment [24–26]. While the evidence in relation to peer support is in its infancy or mixed in relation to impact on clinical indicators of recovery such as reduced psychiatric symptoms, relapse, and hospital readmission [27–29], there is evidence that peer workers within the mental health system enhance service users' confidence, autonomy, self-efficacy, self-management, and recovery opportunities [30]. If the service user's right to choose from a continuum of services is to be respected, APMHNs need to engage with this group of workers. APMHNs, as leaders within services, have a part to play in enabling and supporting peer workers to become integrated into the systemic, cultural, and organisational structures of services. In order for the potential benefits of peer support workers to be realised, APMHNs need to challenge professional centric attitudes and practices that either perpetuate the exclusion of peer workers or take a tokenistic approach towards their inclusion within the multidisciplinary team [31]. In addition, APMHNs need to be reflective and mindful of not using their position to co-opt and colonise peer voices, voices that if nurtured and heard can 'fundamentally challenge the very basis of traditional psychiatric theory and practice' [32, p. 15].

The democratisation of mental health services is also dependent on the democratisation of the educational process of practitioners, including APMHNs. In this regard there is a growing expectation that people with self-experience are provided with meaningful opportunities for involvement in the formal education of practitioners. In the last number of years, various initiatives and pedagogical approaches have been developed, ranging from service user academic positions to the involvement of people with self-experience in curriculum design and classroom discussions on recovery process and outcomes. Systematic reviews of the evidence in this area suggest that students not only gain an insight into the service user perspective but that service user involvement also helps to develop self-awareness, reflection, and empathy [33, 34]. While there is no doubt that these formal opportunities are important, and APMHNs are in an ideal position to support service users in taking up these opportunities, involving services users in this manner is only part of the process. If services are to develop more shared and collaborative ways of working, it is crucial that ways are found to empower frontline staff to accept the value of user and family expertise and support them to listen and share power. In this context, APMHNs are ideally positioned to role model real-life examples of partnership working. By engaging with, listening to, and learning from service users and family members in the day-to-day practice, APMHNs are heightening other practitioners' awareness of the importance of respecting the centrality of the lived experience of service users and families. By routinely asking service uses and families to provide feedback on the care they provide and by acting on that feedback, APMHNs are also modelling how to treat service users and family members not as service receivers but as ‘citizens as equals’ [35]. APMHNs are also ideally positioned to open a dialogue about service user/family engagement and ensure that each discipline, multidisciplinary team, or mental health service has a formal process in place that not only incorporates and listens to feedback from service users and family members but a process that is designed by service users and families. We believe that this form of inclusion is far more likely to challenge the traditional epistemology that underpins mental health discourses, democratise service provision, and, in the long run, help to embed recovery-oriented practices into the infrastructure and operational spaces of mental health services.

4 New Spaces and Places: Expanding the Clinic to the Marketplace

As discussed, developing the wellbeing and health of the population requires a broad inclusive society-wide approach towards mental health, an approach that extends beyond the mental health services to incorporate all sectors of society. In this context the spheres of education, work, housing, and leisure all become sites of mental health practice. They become sites for the promotion of mental health, sites for the strengthening of resilience at an individual and community level, sites for supporting recovery through enabling each person to secure stable housing or employment, and sites for tackling issues of loneliness and isolation through helping the person to reengage with everyday social networks and activities. Indeed, as discussed in chapter “Perspectives and Frameworks Underpinning the Practice of Advanced Mental Health Nursing”, the bidirectional relationship between education, (un)employment, housing, and mental health is well recognised within the literature. Not only do these sociodemographic factors build social networks that enhance mental health, through contributing to a person’s identity and sense of self-worth, but for people who experience mental health problems, access to these aspects of life and living is ‘intrinsically linked to recovery’ [5, p. 144]. Indeed, the increase in loneliness and isolation experienced by a huge number of people during the SARS-CoV-2 virus (COVID-19) pandemic, as a result of the public health interventions imposed by governments to prevent the spread of the virus, forefronts the importance of supportive interaction through work, leisure, education, and the wider social context [36, 37]. This experience serves to remind all mental health nurses, including APMHNs, of the important role they play in the promotion of mental health through nurturing people’s everyday relational interactions and engagement with family, friends, and the wider social community networks.

While the pandemic amplified the importance of everyday human engagement, the loneliness, isolation, trauma, and grief experience also had a significant impact on the psychological wellbeing of people right across the age continuum. The emerging literature suggests that we are seeing an increase in depression, anxiety, stress, panic PTSD, sleep disorders, suicidal behaviour, and many other mental health problems among people, including healthcare workers [38–40]. This increase will no doubt add another layer of challenge to an already burdened and stretched mental health service, requiring the mental health service and APMHNs to respond in innovative ways.

In addition to engaging with the wider sectors of society and supporting the 'natural' relations between people, APMHNs also need to look towards peer-run services. In recent years we have witnessed a growth in peer-run services such as 'recovery colleges', 'wellness cafes', 'crisis houses', 'nature-based interventions', as well as peer-led services and groups for people experiencing a range of mental health problems [41–47]. While holding the therapeutic relationship and space at the core of their work, these changes will require APMHNs to expand the clinic into the 'marketplace' and to cultivate and generate relationships with a range of different people and services. As well as appreciating the value of work, leisure, education, housing, and social networks in people's recovery, APMHNs need to recognise that peer services within and outside mainstream mental health services are often an untapped resource that needs to be integrated as appropriate into the care offered. Indeed, it is often through equal and reciprocal interaction within the peer context that people are enabled to reconnect with their own resources and rebuild connections with others within and outside the peer context [48]. Engaging with the wider sector of society requires APMHNs to have the confidence to cross the boundaries of organisations, sectors, and locations of delivery to solve problems. This type of thinking also requires APMHNs to work collaboratively with people from diverse backgrounds and disciplines to provide comprehensive and responsive care and support.

The use of computer-mediated technologies, which accelerated during the COVID-19 pandemic, has many positive outcomes including increased access to online services delivered by professionals and peers, and increased access to information which means that the information service users and family members have access to and bring to the nurse-client relationship is changing (see "e-Mental Health and Health Informatics"). While services and information may no longer be bound by a 'premise', 'office', or geographic location, technology has also given rise to a whole new set of challenges for service users, family members, and practitioners. While access to the Internet has empowered service users and family members to become a more informed user of mental health services, the increased availability of information also makes distinguishing between information that is reliable and valid and information that constitutes 'fake news' an issue for discussion within the therapeutic space. In addition, there is a risk that the Internet is not universally accessible to all; thus APMHNs need to be mindful that they do not replicate within mental health services the 'technology divide' that is already present within society. Irrespective of the location or nature of the 'clinic', APMHNs in the future will also be challenged to address an ever-increasing array of other problems arising from technology. There is a growing concern about the impact of cyberbullying and cyber-shaming on people's mental health as well as the increase in online addictions such as gambling, gaming, and sexual addictions [49, 50]. The emergence of unregulated and uncontrolled online spaces, such as those that encourage self-harm and eating disorders, as well the potential for vulnerable people to be exposed to criminal behaviour such as online grooming requires APMHNs to be mindful of the changing nature of the technology milieu and its harmful impact. In this virtual world, the APMHNs of the future will be challenged to keep abreast of these rapidly changing landscapes and develop the skills to respond through ongoing professional development.

5 Rights-Based Approach to Mental Health Care

While people experiencing mental health problems have the same civil, political, social economic, and cultural rights as everybody else, individuals with mental health problems are subject to many forms of rights violations outside and within the mental health system, as documented in many international reports [51–53]. Research study after research study over the past 20 years indicates that people with mental health problems experience high levels of stigma, discrimination, victimisation, harassment, as well as financial exploitation and challenges in securing stable employment and housing. Depending on country and context, many encounter restrictions on their ability to exercise their political and civil rights, including their right to participate in decision-making processes on issues that affect them. In addition, worldwide there are constant failures to provide rights-based and recovery-oriented mental health services, especially services that respect people's right to self-determination and offer legal protection from coercive interventions of uncertain or questionable benefits [51–53]. As a result, nurses around the world still engage in practices that infringe people's human rights, irrespective of whether they work within the mental health system in a high-, middle-, or low-income country. For example, the harmful impact of legally sanctioned restrictive practices such as seclusion, physical restraint, and the coercive and forceful use of medication and other treatments (Electroconvulsive therapy) against people's will are well documented [54–57]. Despite the robust evidence demonstrating the effectiveness of a range of psychological and social interventions that can transform lives, service users do not have access to these interventions, with some services continuing to be dominated by the medical discourse and pharmacology [5, 52]. The right to physical health care is also brought into stark focus when the mortality and physical health morbidity rates among people with mental health problems are explored (see "Interface between Physical and Mental Health"). In addition, more subtle forms of rights violations and the asymmetry of power relationships are evident in the reported failure of nurses to support people to be involved in decision-making about their care such as their failure to provide adequate information and education to service users on the treatment options available, including the side effects of medication. Gabrielsson et al. [58, p. 977] suggest that these practices are 'driven more by the short term needs of the organisation' than by the needs of people using the mental health services.

APMHNs have a responsibility to respect and protect the human rights of each person with whom they engage within the mental health services. The International Code of Ethics for Nursing adopted by the International Council of Nurses (ICN)

[8] states that nurses' primary responsibility is to people requiring care. Inherent in nursing is the respect for human rights, including cultural rights and the right to life and choice, to dignity, and to be treated with respect. Nursing's key professional values are respectfulness, responsiveness, compassion, trustworthiness, and integrity. Therefore, it would be remiss of us to close this book without returning to the issue of a rights-based approach to mental health care. Indeed, in a recent United Nations document [52, p. 3], the Special Rapporteur stated 'the global message is clear: there can be no good mental health without human rights'. The Convention on the Rights of Persons with Disabilities (CRPD) [59] offers a chance for all stakeholders including APMHNs to rethink conventional wisdoms, address power imbalances, and implement innovative practices to address the issues. As the prevalence of rights abuse cannot also be explained by a mere lack of resources, APMHNs as key leaders and champions of change need to use the CRPD not just to argue for a greater investment of human and financial resources but use the framework to drastically reduce nonconsensual practices with a view to their elimination within the mental health system. To achieve a mental health service free from coercion, APMHNs need to raise their voice and challenge the acceptance of coercion within services and have the moral courage to speak out about human rights violations perpetuated within teams, units, and services.

6 Moving Beyond Being Adopters to Shaping the Evidence Agenda

As key members of the healthcare team, APMHNs have a critical role to play in delivering evidence-based care to people experiencing mental health challenges, as well as advancing the evidence base in relation to nursing care of people experiencing mental health challenges. While some documents on advanced practice nursing emphasis research, we choose to talk about evidence and evidence-based practice as it emphasises the importance of clinical decisions being informed by primary research, systematic reviews, clinical guidelines, clinical expertise, and most important service user preferences. As discussed throughout the book (see "Role and Competencies of Advanced Practice Mental Health Nurses"), there is a growing consensus that nurses at advanced practice level need to be 'knowledge brokers' [60], 'opinion leaders' [61], and 'transdisciplinary team leaders' [62] in linking evidence to practice. In addition to using evidence to underpin their own practice, APMHNs had a key role to play in reducing the time lag between the evidence generation and the implementation of evidence in real-world settings by influencing frontline nursing staff's views and use of evidence [63]. APMHNs also have a responsibility to generate evidence through research and audit and disseminate within and beyond their own practice context. Although Clarke et al.'s scoping review [62] highlights that Advanced Practice Nurses (APNs) value evidence-based practice and believe it to be important in standardising care, implementation of evidence-based practice was relatively low, with APNs reporting experiencing similar barriers to EBP implementation as do nurse generalists, such as lack of time, lack of support from colleagues and managers, and inadequate resources. In addition, Clarke [62] also noted that APNs in some studies expressed reservations about their skills to critically appraise and interrogate research findings, especially statistical information and language used in quantitative research, suggesting a need for further education in these areas.

While having the knowledge and skills to search for, appraise, translate, and use evidence to underpin practice is critical to quality service provision, APMHNs in the future must also move beyond being adopters and implementers of evidence produced by others and become involved in the generation of evidence to support their practice. Within a recovery-oriented service, this means moving away from the traditional top-down research approach to doing research 'with and for' people as opposed to 'on people', in other words, shifting to a philosophy of co-production and power sharing (as discussed in chapter "Enhancing the Quality of Care Through Participatory Generation of Evidence"). Co-production supports meaningful collaborations in mental health research and conceptualises research as a shared project in which experiential knowledge and scientific expertise are required and valued. While this approach is not only more respectful, it also has the potential to disrupt traditional hierarchies of knowledge, including the framing of distress as illness; produce better research and outcomes for practice; and address epistemic injustice, whereby people who experience mental health problems were excluded from being contributors to knowledge generation (i.e. from priorities setting to dissemination).

In addition, to coproducing evidence to support practice, as healthcare costs are ever-increasing, the drive to demonstrate a cost benefit from the APMHNs role, in terms of service user and service outcomes, is also critical. While a significant body of evidence exists on the positive impact of the APN role outside the mental health area, there is a need for far more research into the impact and effectiveness of the APMHN role on service user, family, and health system outcomes. If APMHNs wish to shape the research questions asked about their role and their nursing value/utility, they need to become more engaged in the evidence agenda. Equally if they wish to have an input into the way evidence is generated, they need to develop partnerships with clinical and service user researchers and become vocal about the nature and type of research conducted in their area of expertise. As much of this evidence required to evaluate their role will come from practitioner-generated outcomes, there is an urgent need for APMHNs to consider what types of data best demonstrates their impact. Without this type of engagement by APMHNs, there is a risk that others outside of nursing will define the nursing outcomes required to produce evidence of utility, impact, and cost-effectiveness.

In addition to co-producing evidence on the positive impact of the therapeutic (clinical) dimension of the role on health and service outcomes, including 'value for money', APMHNs need to consider how best to demonstrate impact of the other dimensions of their role. Given the scarcity of evidence around the leadership, education, advocacy, and evidence-based practice dimension of the role (as discussed in chapter "Role and Competencies of Advanced Practice Mental Health Nurses"), a greater focus on these areas is clearly warranted. Such evidence will be critical to support policymakers and funders' decision-making into the future.

7 Implementing and Sustaining the APMHN Role into the Future

Providing quality mental health care is premised on having a multidisciplinary skilled workforce. As such the APMHN role will be core to the future configuration of the mental health service and teams. However, implementing and sustaining the role into the future is a complex social process that requires negotiation and the development of a shared understanding of the role, including managing the barriers that continue to exist at many levels. Studies have identified several barriers to role preparation, transition, and implementation. Nurses have described the transition from being an experienced nurse in a previous role to novice in a new APN role as being 'overwhelming' [64]. The fact that some employers provide minimal support for training and clinical supervision or expect APNs to develop their role while continuing in their current role and 'being counted in the nursing numbers' [65] is also a challenge. Additional issues that plague the APN role internationally include role territory, such as concerns by medical colleagues about nurses' competence to undertake roles that are considered the remit of other disciplines, such as medication prescribing [10, 66], lack of consensus about the level of autonomy APNs should have [67], a lack of awareness of the role and acceptance of the role from medical doctors and other health professionals, and the expectation of services that clinical and administrative activities take precedence over other dimensions of the role [68, 69]. The lone practitioner model, where a team has only one APMHN, not only leads to role isolation, but it also creates challenges to continuity of care and service provision if the APMHNs is absent for an extended period of time. These coupled with a lack of time and infrastructural supports, such access to technology and an online library means that APMHNs are challenged to carve out time for all pillars of their role, including the research, audit, and advocacy dimensions.

If mental health nurses are to be attracted into and sustained in the APMHN role and provide flexible and responsive health care, these challenges to implementation and sustainability need to be addressed. Support for the role at organisational and individual levels is paramount. Strong nursing leadership is required to ensure adequate planning and resources to support the development, transition, and integration of APMHNs into the role, team, and service. Clarity around what is expected of the APMHN role [70], including the difference between expanding and extending the role, is also critical (see "Role and Competencies of Advanced Practice Mental Health Nurses"). Such conversations would help APMHNs to stay focused on the development and advancement of mental health nursing for the benefit of service users and family members as opposed to the unquestioning and uncritical adoption of new roles to fill gaps resulting from the shortage of other professionals.

If APMHNs are to find the time to engage in every dimension of their role as well as finding the cognitive and emotional energy to take a long-term perspective and create a vision for advanced practice nursing within the mental health services, infrastructural barriers need to be removed. Resources in the form of mentorship, clinical supervision, training, education, and continuing professional development are essential if APMHNs are to flourish and grow within their role, team, and organisation. APMHNs also need to be enabled to find the space and time to develop disruptive and innovative ways of thinking about mental health and distress, as well as new ways of using all the technological tools and theoretical models available. Without strong disciplinary leadership that strengthens the supports and resources for APMHNs, there is a risk that nurses will not be attracted to the role, and consequently nurses will not practice to their full scope of education and expertise, or APMHNs will merely replicate traditional ways of thinking and doing mental health care, and as a consequence aspirations to be a truly transformative force in changing the mental health services will be diluted.

Succession plans, including what Delaney [71] refers to as the 'educational pipeline' for future APMHNs, also need to be considered. Given the variation in education requirement and preparation of APMHNs across Europe, further discussion is required on master's level education and whether APMHN preparation should move to doctoral level programmes. Irrespective of the level, there is an urgent need to discuss how, within content-laden curricula, a discipline-specific mental health nursing focus, including a focus on therapeutic competencies, can be maintained. Indeed Woods [72, p. 50] argues that maintaining nursing as the focus is 'a moral imperative in nurses' ethical and social contract with society'. The future also requires consideration of suggestions that the academic nurse educator role should be designating as an APN role with an appropriate educational pathway to help alleviate the nurse faculty shortage [73].

8 Conclusion

There are many challenges, known and unknown, facing the mental health system into the future. APMHNs, both individually and collectively, are key players in supporting development and innovation to address the ever-changing needs of service users and families. However, the ongoing challenge for APMHNs will be to resist falling back into old ways of thinking and doing and develop disruptive and innovative ways to implement comprehensive interventions using all the technological management and interpersonal tools and models available. Using their own resourcefulness, as well as empowering all nurses to have a voice in the transformational changes, will enable the delivery of safe, quality, and rights- and recovery-based care. To do this APMHNs need to take charge of this change and create their own future; otherwise there is a risk that the systems will force them into new roles that do not take proper account of the core values of mental health nursing. While expanding one's scope of practice and being flexible and adaptable to the changing nature of health and the healthcare environment are important goals, APMHNs need to be reflectively cautious and mindful not to lose sight of the caring values that underpin nursing practice, namely, the therapeutic alliance, people-centredness and rights based care.

Reflective Questions

- How might you generate enablers to support APMHNs to become more involved in influencing mental health policy?
- What strategies would you use at an individual, team, and organisational level to increase peer involvement within services and education?
- What are the challenges and risk APMHNs face in expanding their scope of practice while maintaining their focus on the therapeutic alliance and relationship?

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