Educational Aspects in Advanced Mental Health Nursing Practice

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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

[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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