# Mental Health Nurses, Physical Healthcare & People with Serious Mental Illness: A Bourdieusian Exploration

**Gearóid Kevin Brennan**

A thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy (Nursing Studies)

The University of Edinburgh

2021

# Declaration

I declare, (a) that this thesis has been composed by myself, and (b) that this work is my own, unless otherwise stated, and (c) that this work has not been submitted for any other degree or

**Signed:** Gearóid Kevin Brennan

**Date:** January 2021

# Abstract

**Background:** People with serious mental illness (SMI) die between 10-20 years younger compared to the rest of the population. They experience higher rates of physical co-morbidities. The contributing factors are multifactorial and include medication side effects, genetics and socio-economic determinants of health. This is a global problem. There appears to be ambiguity surrounding nursing roles in addressing these health inequalities. Previous studies have highlighted certain organisational and structural factors which may play a role but without significant depth of how they impact on mental health nursing practice.

**Aims/Objectives:** The aim of this study was to examine how registered mental health nurses working in one Scottish health board understood their role regarding providing physical healthcare to people of working age with SMI. In particular;

Find out how relationships and structures within the work environment impact on mental health nursing practice.

In what way do educational experiences and competencies assist mental health nurses in performing their role.

**Methods:** This qualitative study was informed by Pierre Bourdieu's *Theory of Practice*. Registered mental health nurses (n=7 inpatient, n=7 community) from one Scottish Health board were interviewed. Data was collected between January-May 2018, using semi-structured 1:1 interviews. Interviews were transcribed verbatim and analysis was informed by Braun and Clarke's (2006) Thematic Analysis. The study received a favourable ethical opinion from the author's institution and research development approval from the local health service.

**Results:** Analysis reveals that Mental Health Nurses' (MHNs) physical healthcare practices takes place in a complex field. All the participants voiced that they had a role in meeting the physical healthcare needs of people with SMI. They often did not realise that they were 'doing' physical healthcare tasks as they were embedded into their routine, every day work. Their work appears to be invisible and may not be conceptualised as physical healthcare. Several structural factors impact on participants to provide appropriate physical healthcare for people with SMI. These can be conceptualised as forms of symbolic violence. There is also tension between the boundaries of various fields that impacts on practice. It may account for nurses questioning their role. Nurses utilise many forms of capital within their field of practice, to varying degrees of success. Some of these forms of capital include the establishment and maintenance of therapeutic relationships, clinical experience, learning from peers and the development of confidence. It was clear that there was a significant emotional burden to this area of practice which is not always recognised or discussed.

**Discussion:** The study highlights various structural factors impacting on mental health nurses ability to address patients physical health needs. Services need to give

consideration as to how they are going to remove such barriers, which may help nurses to practice more competently and confidently. Specialist nursing roles may help overcome some of these barriers. Education providers and health services need to work in tandem to better meet the ongoing development needs of the workforce. In particular, education should empower MHNs to deliver health promotion in a way that is tailored to people with SMI. Pre-registration education should consider how physical healthcare can be delivered in a MH-specific context. There is need for a clear, strategic, longitudinal policy approach.

# Lay Summary

People with certain mental illnesses die between 10-20 years younger compared to the rest of the population. They experience higher rates of physical diseases. Previous research has shown that nurses are unclear about their role in this issue. Previous research has shown that certain organisational and structural factors may impact on nurses' practice. This study examined how registered mental health nurses working in one Scottish health board understood their role regarding providing physical healthcare. This study took a qualitative approach and was influenced by social theory. Mental health nurses from one Scottish health board were interviewed. Data was collected using semi-structured 1:1 interviews. This study found that mental health nurses' physical healthcare practices are complex. They often did not realise that they were 'doing' physical healthcare tasks as they were embedded into their routine, every day work. Their work was influenced by issues such as accountability, risk, support from their employer as well as other services. There were sometime tensions between nursing practice and these issues which may explain why nurses sometimes question their role. Nurses draw on their relationship with patients, their own clinical experience and that of their colleagues in order to practice physical healthcare. Nurses do not always appear confident. This study has found that organisations need to think about how they can support nursing practice. Specialist nurses may help. Nurses need more education on health promotion. There is also a need for clear policy to support mental health services in what they should be doing to help the physical health of people with mental illness.

# Acknowledgements

There are many people, whom without their unyielding support and encouragement, I would have never made it this far. I shall endeavour to thank them here;

The 14 wonderful registered nurses who participated in this study. Their honesty, sense of humour and evident dedication to their role left me feeling inspired and uplifted.

The university itself for awarding me the Principal's Career Development Scholarship. This funding made my PhD journey possible. It was a great honour to receive it on the 60th anniversary of Nursing Studies.

My supervisors, Dr Rosie Stenhouse and Professor Graeme D. Smith. You often saw me at my worse, when I felt demoralised and despondent and in a crisis of self-belief. Thank you for believing in me when I didn't believe in myself.

My examiners, Dr Colin Chandler, Professor Ben Hannigan and Professor Wendy Cross for their constructive comments but generous validation of my work. It has given me the confidence to continue to pursue an academic route.

It's said it takes a village to raise a child, and I believe the same is valid for developing an aspiring academic. There are several current and former colleagues in Nursing Studies who played their role. Special thanks to Dr Sheila Rodgers and Dr Susanne Kean for encouraging me to embark on PhD studies but for always encouraging me to continue. Professor Pam Smith MBE for telling me to trust my 'hunches.' Dr Sarah J. Rhynas deserves mention for many things; she acted as my 'critical friend' throughout the process, and her insights and suggestions proved most useful and delivered at the times I needed another perspective the most. Professor Tonks Fawcett acted as my mentor for the development component to my scholarship, doing so with her usual gusto and positivity. Dr Jennifer Tocher for giving me a push in the right direction. Dr Jessica MacLaren for introducing me to the 'opticians', for many a giggle and distracting me with debates over interior design. Professor Aisha Holloway, not least her decisiveness when issues of digital recorders or Nvivo were concerned. But also for her positively, encouragement, for 'that' cup of coffee and always championing me.

Clinical colleagues for putting up with my sheer nonsense and notions, listening to me moan, giving me the nice jobs when on shift, not sending me into ward rounds because I was never there and in general for all the laughs and giggles. Particular mention to Dr Karen Ozden and Dr Juliet MacArthur (Chief Nurses) for enthusiastic support and financial aid to attend conferences. Alan Speirs for our informal 1:1s and teaching me that you catch more flies with honey than vinegar. Graeme Haddon for many an eRoster tweek and for being an inspirational nurse. Kevin Hodgson for kindness and slagging in equal measure and Miranda Mutebuka for keeping a secret. Marjorie Purkiss for so much. Evonne Randell for always inquiring if the next chapter was written! Shona Loban for her assistance in arranging room bookings for interview

participants. Not to mention Paul Smith, Kim, Mandy, Gunn, Mike, Courts, Carley, Alex, Louise, Duncan, Mhairi T, Pam, JC, Catherine, Ross, Pringle, Fred, Mark, the two Lisa's and Jonathan.

In the final hurdle, I am appreciative of the support of my colleagues in the Department of Psychological Medicine. Your dedication to providing the best possible care simply makes work a pleasure. I am so fortunate to be in the receiving end of the kindness of Joyce Follan, Ettie Mucheke, Andrea Connolly, Lorraine MacKinnon and Claire Bashford.

Several professional services staff at the university provided invaluable support. Alison Grahamslaw for sharing a giggle. Lee Gaedeke who made me so welcome at the start. Morven Sutherland for our mutual love of kitchen shopping, *Les Mis*, a good Fringe show and listening to me moan. Nikki Pakarian for her helpfulness. Rowena Stewart (subject librarian) for her giving generously of her time when it came to literature reviewing. Dal Kang and Ian Hesketh for their calmness in the face of IT frustrations and digital recorders.

I would have never entered the nursing profession without the support of colleagues & residents at St. John of God Kildare Services. In particular friends in Carraig Beag. It was the best introduction to nursing care I could have received. Sheila Watkins provided much practical assistance to get me to this point. Liz McGuinness for her fortitude and encouraging words "off to Scotland with you!" Sarah Daly, Anne Farrell & Maria Jackman-Burke for always checking in.

Alison Connor for helping me make the unsaid said when I most needed to.

Adam Bates for whipping me into shape, so I was able to overcome the physical demands of doctoral studies.

I want to acknowledge the support of the Florence Nightingale Foundation and my fellow scholars. The WhatsApp group is a never-ending source of support. Professor Karen Strickland for her encouragement to apply and then host me. I cannot fail to mention the support of Dr. Cathy Daniel, Professor Marie Gerdtz, Raza Kabaila, Julie Ewing and Professor Brenda Happell. The experience helped me form my ideas and how things could be.

Current and former members of the mental health teaching team at Edinburgh Napier. Fiona Carver and Martin Gaughan for their unrelenting encouragement. Margaret Conlon has been one of the biggest enablers of my academic notions over the years.

Two staff from the Department of English at NUI Maynooth require special mention. Dr Oonagh Frawley for her writing guidelines which I still use today. Dr Moynagh Sullivan, who taught me not what to think, but to think. By asking me why a chair is a chair and not a table, you set an unquenchable fire for inquiry within me. You challenged me to question assumptions and I am a better academic and person because of that.

Gareth Haston, for your kindness and understanding at the start of this journey.

My wonderful fellow MNers- Megan McGrath, Allan MacRaild, Gemma Logan, Rosie Beardon and Dr Anny Chen. You are friends for life.

PhD studies proved a lonely and arduous journey. This was significantly lightened by my extraordinary peers, who accompanied me on the way. Firstly, the Buccleuch Place crew of Dr Paula Jacobs, Dr Candella Sanchez, Dr Clarissa Catherine and Dr Hyeri Choi. To some of the more experienced colleagues who made me feel so welcome at the start; Dr Susannah C. Johnstone, Dr Sarah Brown, Dr Somia Imran and Dr Eilidh Mackenzie-Smith. Special mention to Dr Lissette Aviles Reinoso, Dr Azwa Shamsuddin, Dr Iris Ho (your kindness and wisdom), Dr Roxy Hawkins, Dr Sarah Janes, Dr Katie McGooghan and Katie Gambier-Ross. You inspire me. Asaly Skrenes for always making me laugh. Emma Eliasson, aka Swedish bae- you are the ultimate coffee and distraction buddy. Thank you for everything.

I would need to define an entirely new category of luck to adequately describe how blessed I am to have the friendships that I do. Words will never fully express my gratitude for your love, kindness and empathy. From feeding me, washing and ironing, helping me move, interior design advice, heavy-duty DIY, bringing me on mini-adventures to distract me or merely checking that I was alright. This is not to mention the countless times some of you had to act as an agony aunt! Most importantly, when emotions overtook rationality, you listened. Special mention to Ciara O'Driscoll, Heather Wilson, Dr Oscar To, Lisa Theresa, Dr Darragh Hamilton, Vicky Soutar, Sarah Eley, Elle McNeely, Murray Cockburn, Conor Ellis, Nina O'Reilly, Dr Sarah Maume, Sharon Lyons, Myra Ariyaratnam, Jenny Rooney, Claire Campbell, Riona McAdden and Greg Wighton. Apologies to the people I have not seen of as a result of this endeavour. I'm sorry about the reduced frequency of baking and hope regular service will resume soon!

The week I found out I was awarded my scholarship is the same week that my niece and goddaughter came bouncing into the world and changed everything so much for the better. Thank you, Grace, and your baby sister Ella for all the fun and laughter you have created. You have provided the best distraction!

Finally, to family. To my brother Daragh and my sister-in-law Caitriona for sending me pictures of the girls, for politely nodding when I rambled and never asking too often if ‘it’ was done yet! To my Mam and Dad, Mary and Kevin; for making sure I got this far, for setting a high-value on education, for going without so we could experience the opportunities you could not, but most importantly for setting an unassailable work ethic and showing me what such endeavours can lead to. I love you very much.

# Contents

**Declaration** ........ iii
**Abstract** ........ v
**Lay Summary** ........ vii
**Acknowledgements** ........ ix
**List of tables & figures** ........ xix
**List of abbreviations** ........ xxi
**Research outputs** ........ xxv
**Preface** ........ xxvii
**Chapter 1: Introduction** ........ 1
  1.1 Introduction ........ 1
  1.2 Use of terms ........ 1
    *1.2.1 'Physical healthcare'* ........ 1
    *1.2.2 Service user, client, patient…* ........ 1
    *1.2.3 Serious mental illness* ........ 2
  1.3 Background and context ........ 2
    *1.3.1 Physical co-morbidities in mental illness* ........ 2
    *1.3.2 Personal motivations* ........ 6
    *1.3.3 Policy context* ........ 9
    *1.3.4 A role for mental health nurses* ........ 11
  1.4 Research aims and questions ........ 15
  1.5 Study approach ........ 15
  1.6 Structure of the thesis ........ 16
**Chapter 2: Literature Review** ........ 21
  2.1 Introduction ........ 21
  PART I: INTERNATIONAL POLICY REVIEW ........ 21
  2.2 Introduction to the policy review ........ 21
  2.3 Method ........ 22
  2.4 Findings ........ 24
    *2.4.1 Mental Health disorder management* ........ 24
    *2.4.2 Physical health treatment* ........ 25
    *2.4.3 Lifestyle behaviour interventions* ........ 26
    *2.4.4 Service delivery* ........ 27

*2.4.5 Social support* 27

*2.4.6 Stigma reduction interventions* 28

*2.4.7 Policy-level interventions* 28

*2.4.8 Summary* 28

PART II: EMPIRICAL LITERATURE 29

2.5 Introduction 29

2.6 Method 30

2.7 Findings 32

*2.7.1 Role ambivalence* 32

*2.7.2 Advocacy* 35

*2.7.3 Measuring attitudes and values* 37

*2.7.4 Stigma towards pSMI* 41

*2.7.5 Lifestyle choices* 41

*2.7.6 Education and training* 43

*2.7.7 Nurses involved in interventions and health screening* 46

*2.7.8 Organisational barriers* 49

*2.7.9 Specialist roles* 51

2.8 Summary 54

PART III: DISCUSSION 56

2.9 Summary 61

**Chapter 3: Theory 63**

3.1 Introduction 63

3.2 Social Theory and Nursing 63

3.3 Key concepts 64

*3.3.1 Conceptualising 'Role' and 'identity'* 64

*3.3.2 Professional role and identity* 66

3.4 Bourdieu and his Theory of Practice 68

*3.4.1 Field* 70

*3.4.2 Capital* 71

*3.4.3 Habitus* 73

*3.4.4 Interaction of concepts* 75

3.5 Bourdieu, language and meaning 76

*3.5.1 Language as capital* 77

*3.5.2 Symbolic violence* ........ *78*
*3.5.3 Translation, researcher and context* ........ *80*
3.6 Summary ........ 81
**Chapter 4: Methods ........ 83**
4.1 Introduction ........ 83
4.2 Ontology and Epistemology ........ 83
4.3 Research Design ........ 85
4.4 Ethical issues ........ 86
*4.4.1 Ethical approval and NHS access* ........ *87*
*4.4.2 Informed consent* ........ *87*
*4.4.3 Volunteerism* ........ *88*
*4.4.4 Confidentiality* ........ *88*
*4.4.5 Data management* ........ *89*
*4.4.6 Ethics of interviews* ........ *90*
*4.4.7 Insider/Outsider relationship* ........ *91*
*4.4.8 Researcher safety* ........ *93*
4.5 Research participants ........ 93
*4.5.1 Setting* ........ *94*
*4.5.2 Population* ........ *94*
*4.5.3 Sample* ........ *94*
*4.5.4 Inclusion/exclusion* ........ *97*
*4.5.5 Access* ........ *98*
*4.5.6 Recruitment* ........ *101*
4.6 Data collection ........ 102
*4.6.1 Demographic questionnaire* ........ *102*
*4.6.2 Interviews as a method of data collection* ........ *103*
*4.6.3 Pilot study* ........ *105*
*4.6.4 Conducting the interviews* ........ *106*
*4.6.5 The use of space in conducting interviews* ........ *108*
4.7 Data analysis ........ 110
*4.7.1 Familiarisation with the data & transcribing.* ........ *112*
*4.7.2 Generating initial codes* ........ *115*
*4.7.3 Searching for themes* ........ *115*

4.7.4 *Producing the report* ... 117
4.8 Quality ... 117
4.8.1 *Rigour* ... 117
4.8.2 *Reflexivity* ... 118
4.8.3 *Braun and Clarke's quality criteria* ... 119
4.9 Summary ... 120
**Chapter 5: Findings I- The Field ... 121**
5.1 Introduction ... 121
PART I ... 121
5.2 Introduction to the field ... 121
5.3 Conceptualising physical healthcare for pSMI ... 123
5.4 The burden of accountability ... 128
5.4.1 *Accountability and responsibility* ... 128
5.4.2 *Accountability for learning needs & competency* ... 129
5.4.3 *Accountability and competence* ... 132
5.4.4 *Accountability and medical staff* ... 135
5.4.5 *Task allocation & delegation* ... 137
5.4.6 *Accountability & Impact on Emotions* ... 140
5.4.7 *Discussion* ... 142
5.5 The dominance of risk discourse ... 144
5.6 Organisational Support ... 153
5.7 Change ... 157
5.7.1 *Organisational change* ... 157
5.7.2 *Changes in presentation* ... 159
5.7.3 *Change in working practices* ... 160
5.7.4 *Change in attitudes* ... 162
5.7.5 *Change in personnel* ... 163
5.8 Socioeconomic factors ... 164
PART II ... 172
5.9 Boundaries in the Field ... 172
5.9.1 *Navigating, negotiating & setting boundaries* ... 172
5.9.2 *Primary Care and Mental Health* ... 174
5.9.3 *Boundary between mental / physical health: Fields & Places* ... 177

*5.9.4 Workload & Time pressures ... 182*

*5.9.5 Shared Language to overcome difficulties ... 185*

*5.9.6 Boundaries between patient and staff ... 186*

5.10 Summary ... 187

**Chapter 6: Findings II- Capital ... 189**

6.1 Introduction ... 189

PART I ... 191

6.2 Therapeutic Relationships ... 191

*6.1.1 Discussion ... 197*

6.3 Specialist Nursing Roles for physical healthcare ... 201

*6.3.1 Discussion ... 204*

PART II ... 206

6.4 Knowledge gained during pre-registration education as capital ... 206

*6.4.1 Perceptions of the current programme ... 206*

*6.4.2 Tensions ... 208*

*6.4.3 Achieving competencies ... 210*

*6.4.4 General placements as a form of capital ... 212*

*6.4.5 Dual training as a form of capital ... 216*

*6.4.6 Discussion ... 219*

6.5 Knowledge gained post-registration ... 224

*6.5.1 Experience ... 224*

*6.5.2 Formal Learning ... 227*

*6.5.3 Informal learning from peers ... 228*

*6.5.4 Role modelling ... 231*

*6.5.5 Discussion ... 232*

6.6 Confidence as a form of capital ... 233

*6.6.1 Experience resulting in increased confidence ... 233*

*6.6.2 Emotional burden ... 235*

*6.6.3 Identity ... 237*

*6.6.4 Discussion ... 238*

6.7 Summary ... 246

**Chapter 7: Conclusion ... 249**

7.1 Introduction ... 249

7.2 Summary of findings ... 249
7.3 Bourdieu's contribution ... 253
7.4 Limitations ... 255
7.5 Contribution to Knowledge ... 256
7.6 Implications and recommendations resulting from this study ... 260
*7.6.1 Implications and recommendations for practice ... 260*
*7.6.2 Implications and recommendations for policy ... 262*
*7.6.3 Implications and recommendations for education ... 263*
*7.6.4 Implications and recommendations for research ... 267*
7.7 Reflection on the process ... 269
7.8 Concluding remarks ... 271
**References ... 273**
**Appendices ... 305**

Appendix A: Letter from ACCORD ... 307
Appendix B: Letter confirming favourable ethical opinion ... 309
Appendix C: Letter confirming R&D approval ... 311
Appendix D: Participant Information Sheet ... 313
Appendix E: Consent form ... 317
Appendix F: Data Management Plan ... 319
Appendix G: Recruitment Poster ... 323
Appendix H: Demographic Questionnaire ... 325
Appendix I: Interview Guide ... 329
Appendix J: Transcription Notation System ... 331
Appendix K: Diagram mapping of the field ... 333

# List of tables & figures

## Tables

Table 1: Summary of how each region scored against the WHO multilevel risk model for addressing the physical co-morbidities of people with SMI. ................................. 23

Table 2: Demographic information of sample ................................................................ 97

Table 3: Breakdown of criteria for sample....................................................................... 99

Table 4: Interview locations by participant .................................................................. 109

Table 5: A 15-point checklist of criteria for good Thematic Analysis. Taken from Braun and Clarke 2006 .......................................................................................................... 119

## Figures

Figure 1: Multilevel model of interventions to reduce excess mortality in pSMI (Liu *et al.,* 2017). ............................................................................................................ 11

Figure 2 PRISMA diagram representing search strategy ............................................. 31

Figure 3: Representation of various fields within the study........................................ 70

Figure 4: Inclusion & Exclusion criteria ........................................................................ 98

Figure 5: Prompts used to encourage analytical thinking........................................... 116

# List of abbreviations

| | |
|---|---|
| ACCORD | Academic and Clinical Central Office for Research and Development |
| ACEs | Adverse Childhood Events |
| ACMHN | Australian College of Mental Health Nursing |
| AfC | Agenda for Change |
| ANP | Advanced Nurse Practitioner |
| BMI | Body Mass Index |
| BPD | Borderline Personality Disorder |
| CASP | Critical Appraisal Skills Programme |
| CFP | Common Foundation Programme |
| CHD | Coronary heart disease |
| CNO | Chief Nursing Officer |
| COPD | Chronic obstructive pulmonary disease |
| CPD | Continuing Professional Development |
| CPN | Community Psychiatric Nurse |
| CVD | Cardiovascular disease |
| DRC | Disability Rights Commission |
| FtP | Fitness to Practice |
| GMC | General Medical Council |
| GP | General Practitioner |
| HEE | Health Education England |
| HEI | Higher Education Institution |
| HIP | Health Improvement Profile |

| | |
|---|---|
| HIV | Human immunodeficiency virus |
| ICH | International Council for Harmonisation |
| IHTT | Intensive Home Treatment Team |
| LDP | Local Delivery Plan |
| MDT | Multidisciplinary team |
| MH | Mental Health |
| MHN | Mental Health Nurse or Mental Health Nursing |
| MiND | Mental Health in Development |
| MOOC | Massive Open Online Course |
| MRM | Multilevel Risk Model |
| MWC | Mental Welfare Commission for Scotland |
| NES | NHS Education for Scotland |
| NEWS | National Early Warning Score |
| NHS | National Health Service |
| NMC | Nursing and Midwifery Council |
| NP | Nurse practitioner |
| NQP | Newly Qualified Practitioner |
| PEG | Percutaneous Endoscopic Gastrostomy |
| PH | Physical health |
| PHASe | Physical Health Attitude Scale |
| PHC | Physical healthcare |
| PIS | Participant Information Sheet |
| pSMI | Person/People with serious mental illness |
| R&D | Research & Development |

| | |
|---|---|
| RCGP | Royal College of General Practitioners |
| RCN | Royal College of Nursing |
| RCPsych | Royal College of Psychiatrists |
| RMN | Registered Mental Health Nurse |
| RN | Registered Nurse |
| ROI | Republic of Ireland |
| SAMH | Scottish Association for Mental Health |
| SMI | Serious mental illness |
| SOP | Standard Operating Procedures |
| SRN | Scottish Recovery Network |
| STI | Sexually transmitted infection |
| TA | Thematic Analysis |
| US | United States |
| WHO | World Health Organization |

# Research outputs

## International conference papers:

**Brennan, G**., Stenhouse, R., Smith, GD. (2019). What 'capital' do mental health nurses utilise to address people's physical health?' *Australian College of Mental Health Nursing 45th International Research Conference*. Sydney, Australia. 8th October 2019.

**Brennan, G**., Stenhouse, R., Smith, GD. (2019). What 'capital' do mental health nurses utilise to address people's physical health? *Royal College of Nursing 25th International Mental Health Nursing Research (MHNR) conference*. London, England. 12th September 2019.

**Brennan, G**., Stenhouse, R., Smith, GD. (2019). Mapping the field: Are organisational and structural factors impacting on mental health nurses' ability to provide physical healthcare? *RCN International Research Conference.* Sheffield, England. 5th September 2019

**Brennan, G**., Stenhouse, R., Smith, GD. (2019). The same but different: Addressing the physical health needs of people with serious mental illness: A review of nursing policy in eight English-speaking regions. *International Council of Nurses (ICN) Congress*. Singapore. 28th June 2019.

**Brennan, G**., Stenhouse, R., Smith, GD. (2019). Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Boudieusian qualitative exploration. *Trinity Health & Education International Conference*. Dublin, Republic of Ireland. 6th March 2019.

# Preface

It would be remiss of me to submit this thesis for examination and not say something about COVID-19. When 2020 was declared the *International Year of the Nurse and Midwife*, I do not think anyone had a pandemic in mind in order to make visible nursing's value and contribution to society. I have known, loved and been loved by so many dedicated nurses, medics and healthcare professionals. As much as the media and government may wish, you aren't heroes or angels. Indeed, Bourdieu would arguably have considered such language to be a supreme act of symbolic violence. Healthcare professionals are so perfectly imperfect. It's what makes you human.

It is this sense of humanity, coupled with your desire to go about your work in a quiet, unassuming manner, going above and beyond for patients every day, not just during a pandemic, that should be valued and celebrated. Thank you for what is past, passing and to come.

For this reason, I humbly dedicate this thesis to you. May the best of days be yet to come!

> "Hope is not optimism which expects things to turn out well, but something rooted in the conviction that there is good worth working for"
>
> -Seamus Heaney, inspired by Václav Havel

# Chapter 1: Introduction

## 1.1 Introduction

People with serious mental illness (SMI) die between 10-20 years younger compared to the rest of the population (Department of Health England, 2006; Firth et al., 2019; Liu et al., 2017; Walker et al., 2015; World Health Organization, 2018). This is because they are at a significantly increased risk of developing numerous physical co-morbidities (Robson and Gray, 2007). They experience a 2-3 times higher rate of cardiovascular disease (Nash, 2014b) and 3.8 times higher rate of HIV infection (Blank et al., 2013; Collins et al., 2012). One in five will go on to develop diabetes (McDaid and Smyth, 2015). They are likely to have lower levels of physical activity and poor diet (Liu et al., 2017; Nash, 2014b). The contributing factors are multifactorial and include medication side-effects, genetics and socio-economic determinants of health (Collins et al., 2012; Friedli, 2009; Liu et al., 2017; Nash, 2014b). It is a global problem, faced by health systems throughout the world (Bartels & DiMilia, 2017; Happell & Cutcliffe, 2011; Liu et al., 2017; Walker & McAndrew, 2015; WHO 2016 & 2018).

This thesis attempts to improve this situation by developing a better understanding of mental health nursing (MHN) practice and how they understand their role in meeting the physical health (PH) needs of patients. The study draws on the work of Pierre Bourdieu and his *Theory of Practice* as a theoretical lens to frame the study. This chapter serves as an introduction to the thesis. It starts with a discussion on the use of language throughout the work. It then moves to expand on some of the statistics above regarding the current PH of people with serious mental illness (pSMI). Critical to the writings of Bourdieu was the position of the researcher within the study. Therefore, I outline my personal motivations for undertaking this study. I then provide a brief overview of the policy regarding PH needs for p SMI and why MHNs have a role to play in addressing these complex issues. It ends with an introduction to the research questions followed by an introduction to my approach to the work. Finally, the chapter closes with an introduction to the remaining chapters.

## 1.2 Use of terms

### 1.2.1 'Physical healthcare'

There is no definition of physical healthcare (PHC) offered in any of the policy documents. Arguably, when one considers the World Health Organisation's (WHO) (1948) definition of health[1], then it may be a falsehood to separate the physical from the mental. However, that is currently what numerous healthcare systems do throughout the world. The definition of health also acknowledges that it is an arbitrary spectrum that moves between wellness and illness.

Before starting this study, I conceptualised PHC as a set of task-based interventions such as vital signs monitoring, wound care, food and fluid care and providing personal hygiene, as well as the management of any long term condition (LTC). I also understood it to mean providing health promotion interventions such as advice and education around lifestyle behaviours that could impact on someone's PH and help them address this.

Rather than forcing any definition on people, I decided it would be the starting point of my interviews with my participants. If there is no clear definition in relevant policies, different practitioners likely conceptualise physical healthcare differently. Conceptualisation will be discussed further in the findings chapters.

### 1.2.2 Service user, client, patient…

Many terms are used to denote people who utilise MH services. These include: 'patient,' 'service user,' 'user' 'people with lived experience' and 'consumer.'

The use of such terms has been subject to much debate in the literature (Bradstreet, 2013; Christmas, 2013; Neuberger, 1999). Such terms can have political connotations and can often demonstrate the various power dynamics at play. Indeed, the Scottish Recovery Network (SRN) argues every term is imperfect and especially any term that defines a group of people by their use of services (Bradstreet, 2013). The term 'patient'

---

[1] "[…] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

is most frequently used in the literature presented in chapter two. It would be my personal preference to refer to such people as that; people. Throughout this thesis, I have adapted the term pSMI to refer to people or persons with a serious mental illness.

### 1.2.3 Serious mental illness

Serious (or sometimes referred to as ʻsevereʼ) mental illness (SMI) is an umbrella term used to describe several specific mental health diagnoses. There is no universally accepted definition (Craig, 2006; Ruggeri et al., 2000). The label is typically used to describe psychosis; when people's sense of reality is distorted, and they experience hallucinations and delusions (Craig, 2006). The Royal College of Psychiatrists (RCPsych) (2015) consider the term to consist of three elements; diagnosis, disability and duration. The term usually implies a diagnosis of schizophrenia, bipolar or psychotic disorder. The condition causes significant disability and lasts for a significant duration, usually two years or more. They are considered to be 'serious' because of the risk that they can pose to the well-being of the person and others. Consequently, people often require high levels of care, including hospital admission or long-term follow-up with secondary care (Hardy, 2013).

## 1.3 Background and context

In this section, I provide background and context to my study. This includes providing details on the physical health needs facing pSMI. I then outline my personal motivations for choosing this topic. I provide details of the policy landscape in which this study sits. This section concludes with outlining a justification for why MHNs when it comes to meeting the PHC needs of pSMI.

### 1.3.1 Physical co-morbidities in mental illness

The links between mental health and physical health have gained considerable attention within the literature in the past decade (Firth et al., 2019; Wand, 2011). Evidence would suggest that the two domains are inextricably linked (Wand, 2011, 2013). We know that living with a LTC such as Chronic obstructive pulmonary disease (COPD) or diabetes can significantly impact on people’s mental health (Nash, 2014b). There is also significant evidence that having a long-term mental health condition is likely to impact on someone's physical well-being. Despite this, Gray (2012: 191) argues that the reality of practice has not caught up with the rhetoric of research and calls the current situation a "silent scandal."

There is no one reason to explain the current state of poor physical health for people with SMI, and there are multiple contributing factors, which interact with each other (Collins et al., 2012; Firth et al., 2019; Liu et al., 2017; Nash, 2014b). These include socio-economic issues, stigma and the side-effects of psychotropic medication to name but a few.

Cardiovascular disease (CVD) appears to be the most substantial contributor to the increased mortality rate. There are numerous risk factors for CVD including obesity, smoking, poor diet, metabolic disorders, hypertension and reduced physical activity levels (Collins et al., 2012; Robson and Gray, 2007; Ryan and Thakore, 2002). Some of these are further compounded by the side-effects of antipsychotic medication, which can result in QT abnormalities. Rates of CVD are 2-3 times higher in the SMI population (Nash, 2014b; Robson and Gray, 2007). The Disability Rights Commission (DRC) (2007) found that 31% of people with schizophrenia were aged under 55 when they were diagnosed with CVD, compared with 18% of the general population.

Respiratory disease is also a concern, with higher rates 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 gained publicity when it was published in 2015 (Gallagher, 2015). Gurillo *et al.* (2015) found that daily tobacco use is associated with an increased risk of developing psychosis and an earlier onset; therefore, a causal link between tobacco use and psychosis may exist. Alderson and Lawrie (2015) question the findings, arguing that there is an overlap between genes in psychosis and tobacco addiction. However, they conclude that the causal link warrants further research, and it may not be too long before there is conclusive evidence. Due to the link with smoking, it is not surprising that higher rates of lung cancer are found in this population group. 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 (Casey and Hansen, 2003).

The relationship between schizophrenia and diabetes has been researched and discussed more than any other co-morbidity (Robson and Gray, 2007). People with SMI experience increased rates of metabolic abnormalities, including metabolic syndrome and diabetes compared to the rest of the population (McDaid and Smyth, 2015; Nash, 2014a). Meta-analyses show that one-in-three patients with SMI met the criteria for metabolic syndrome, with one in five having significant hyperglycaemia (Mitchell et al., 2013). McDaid and Smyth (2015) found in their review that MHNs have a role to play in the early detection and monitoring of such conditions and therefore they are required to have the appropriate knowledge and skills to manage such risk factors.

CVD and metabolic abnormalities are not the only diseases with an increased prevalence rate. It is estimated that HIV is 3.8 times higher in this patient group compared to the general population (Blank et al., 2013). Higher-risk sexual behaviours are more prevalent in this group, such as unprotected sex and injecting drug use, coupled with lower rates of STI screening (Campos et al., 2010; Dyer and McGuinness, 2008; King et al., 2008). Additionally, this population group are three times more likely to experience sexual assault and abuse (NHS Scotland, 2009; Warne and McAndrew, 2005).

Some would argue that some of these risk factors are simply lousy lifestyle choices, including poor diet and illicit substance misuse (De Hert et al., 2011). This is a controversial contention, as others would argue that they are not 'choices' but instead are forms of self-medication and self-management as a consequence of having an SMI and the medication that is prescribed to manage symptoms. There is a strong link between motivation and physical health. If someone has poor physical health, it is likely to affect motivation levels (Nash, 2013, 2014b). We also know that negative symptoms of schizophrenia can make it incredibly difficult for people to remain motivated. This may impact on pSMI's ability to engage in activities that may contribute to good mental or physical health.

The literature that is presented in chapter two demonstrates that people with SMI are less likely to be offered or indeed undergo screening for a whole variety of preventable diseases (Hardy, 2013). For example, DRC (2007) estimates that women with schizophrenia are 10% less likely to have a cervical cancer smear test compared to women who do not have the diagnosis. Stein-Parbury (2012) found that patients over the age of 50 years with a diagnosis of 'schizophrenic disorder' were less likely to self-report co-morbidities in comparison to a similar group who experienced physical morbidity alone. This may be due to cognitive deficits which are evident in SMI, which may mean people are unaware of physical problems.

Biological determinates are not the only contributing factor. Inequality plays a massive role in contributing to these statistics. Marmot (2010)  argues that a critical attribute of promoting health is reducing health inequalities derived from the social determinants of health. Friedli (2009) states that social inequalities are both the result and the cause of mental health problems. While people with physical health problems are likely to experience multiple inequalities, pSMI are likely to face inequality as a consequence of their mental health, as well as having an increased risk of physical health co-morbidities (Blakeman and Ford, 2012). Such people may find it challenging to engage with services, because of reduced mobility as a consequence of multiple co-morbidities (Clifton et al., 2013). It is also likely that they will experience stigma, which can often be perpetuated by mental health services themselves (Elliott and Masters, 2009).

These risk factors come together to produce the mortality gap (Royal College of Nursing, 2019); the fact that pSMI are dying between 10-20 years younger than the rest of the population. However, gender also plays a role, with men with schizophrenia dying 4.1 years younger than their female counterparts (Brown et al., 2010). This is demonstrated in Scotland. While the average life expectancy has increased in Scotland in the past decade, (male: 73.3 years to 76.6 years, female: 78.3 years to 80.8 years), the gap between the most affluent and the most deprived is 7.5 years (Karanwal et al., 2015). Indeed, a boy born in Kilwinning Whitehirst Park & Woodside in North Ayrshire could expect to live for approx. 92 years. This compares to 58 years for a boy born in Greendykes and Niddrie Mains in Edinburgh. In 2010, there were 98.3 per 100,000 psychiatric inpatient admissions in Kilwinning compared with 564.6 per 100,000 in Greendykes and Niddrie Mains (Seaman et al., 2015).

Therefore, the level of need is great, and the reasons contributing to that need are multifaced and complex.

### 1.3.2 Personal motivations

> “Education without values, as useful as it is, seems rather to make man a more clever devil.”
>
> -CS. Lewis

As well as the staggering statistics discussed above, this study has been heavily influenced my own practice experiences as a student and RN. It is on reflection that I realise that the issue of people's PH needs was somewhere in my psyche even before I became a nurse.

I started off working as a care assistant while undertaking my first degree. What started as a summer and part-time job turned into a whole career. The people I cared for had learning disabilities alongside SMI and other complex needs. The experience was so formative that I decided I wanted to be an MHN. While institutional care is by no means perfect, we strived to do the very best for people and most of the day was spent off the unit on bus trips; shopping, cinema, sporting events, pubs and restaurants. The unit was staffed by RNs, nursing assistants and social care practitioners. Ground-breaking, even in this era of health and social care integration! Because of the nature of these complex needs, there was a significant amount of physical health need. Indeed, while I did not appreciate it at the time, hindsight would show that people’s physical health needs were high on the agenda; I was just not consciously aware of it. Every resident had a full physical review every year, regular review of psychiatric medication by their psychiatrist and a GP attended the unit daily. The level of co-morbidity was staggering. For example, one resident was under the care of approx. ten different medical specialities, in addition to their psychiatric issues. This is to say nothing of the level of allied health professional input. Therefore, a significant number of bus trips were to the outpatients' departments of various Dublin city teaching hospitals. Either way, I loved every minute of working with the residents and my former colleagues. I was fascinated by the mental health side of things. Nursing became a natural career choice after completing my degree.

I choose to undertake my nurse education in Scotland for two reasons; it came highly recommended by several colleges, and it was free. My perception prior to commencing my studies was that physical health skills would be high on the agenda, regardless of my field of practice and regardless of where I undertook my education. I also expected that by the end of my degree I would be well-versed in basic pharmacology and pathophysiology. I do not think I can be judged too harshly for this preconceived perception considering the experience of need I witnessed, along with hearing my friends who undertook their nurse education in Ireland.

The reality could not have been any further from my preconceived notions, and my pre-registration experience did not live up to my expectation. What was taught in university was on the whole enjoyable and well-executed. It was the content that was never taught that left me feeling unprepared and terrified of being a RN. It added a new dimension to the term ‘hidden curriculum.’ For example, I was shown how to administer insulin in the clinical skills laboratory, but never actually covered any theory on diabetes such as its aetiology, the pharmacology of insulin or what interventions we could do as MHNs to positively impact on the quality of life of someone living with diabetes. It seemed like the horse was put before the cart.

There was also an incongruence about the whole thing. We were almost constantly told that as RNs we were going to be fully accountable for our actions, and risk sanction, sanity and livelihood if we did not tackle the staggering rates of health inequalities of pSMI. Yet requests for sessions on a variety of common physical health problems were rebuked with statements about an overcrowded curriculum.

Indeed, placement became my saving grace. Firstly, it gave me evidence of the extent to which physical health problems for our patient group were a genuine and worrying concern, being made worse by the advent of the new psychoactive substances ('legal highs'). The summer I qualified as a nurse is unaffectionately known as 'the summer of legal highs' due to the sheer volume of admissions of drug-induced psychosis. Horrific physical side-effects often accompanied such presentations, not from the psychiatric treatment but the injecting of substances such as 'Burst' and 'Clockwork Orange' resulting in everything from septic groin wounds to burst veins and GI bleeds.

Secondly, I had mentors who genuinely took a holistic approach to patients and had no issue addressing their physical health, and did so confidently and competently. Within the local NHS health board, every patient has a full physical examination on admission to inpatient services, which is congruent with best available evidence and are regularly audited to ensure they are being performed (Scottish Intercollegiate Guidelines Network, 2013).

However, not all staff were so confident and often if someone required basic wound care, I would be ushered into the treatment room because I was a student and was most likely to be more up to date than colleagues. Furthermore, there are always the nurses who never did the physical observations, who regard them as irrelevant. This is despite some patients being on high-doses of clozapine[2], an antipsychotic with great clinical efficiency but with equally great physical risks. When you probe this, some staff say they did such a limited amount of physical health during their 'training' that they are just 'winging' it. Others simply did not see it as their role.

Very early on after qualifying, I made the decision that I never wanted to just 'wing it.' The reality is though that self-directed learning will only take you so far. While I very much agree with C.S. Lewis' statement about the importance of values underpinning education, I also feel that education must contain enough instrumental

---

[2] Clozapine is a newer generation antipsychotic drug. It is the only one that has proven superior efficacy over others but because of its significant side-effects, it is reserved for people deemed 'treatment resistant.' A person has usually been tried on at least two other antipsychotic medications, one of which should be a newer generation drug. Side effects of clozapine include; constipation, agranulocytosis, neutropenia, cardiomyopathy, myocarditis and metabolic disorders including significant weight gain. Therefore it has potentially life-threatening and life limiting adverse effects which require the person to undergo strict physical health monitoring including regular weekly blood tests.

knowledge about a topic, so the foundations are laid to build on this. There is no point valuing recovery-focused practice if you do not have the skills to address something that can impact so much on a patient's recovery from mental distress. I'm a (mental health) nurse; I should know what I'm doing. I went in search of some formal CPD. I looked at every single Scottish HEI's course catalogue, and not a single one offers a module on physical health in mental illness.

Digging deeper, it would appear that the content is 'embedded' within pre-registration courses, yet no credit-bearing module exists in Scotland at this level. This is in contrast to institutions south of the border. So this whole thesis is my attempt to indulge my curiosity of not just why our patients face these increased inequalities, but why some MHNs see physical healthcare as essential to practice and for others, it merely does not cross their mind. Gray (2012) postulates that if life expectancy was falling in any other area of healthcare, it would be a national scandal and on the front of every newspaper. This thesis is my contribution to advocacy, and I hope that it will highlight this issue on a broader scale. It is my greatest hope that this work might go in some way to improving the physical well-being of patients and go some way to compensate for my own professional anxieties.

### 1.3.3 Policy context

There has been an expansion of policies as more attention has been focused on the health inequities faced by pSMI. This is often presented using the term 'parity of esteem'. The RCN (2019: 4) define it as "an absolute need to equate the importance of mental health and mental health service provision with physical health and physical health service provision". This has become the theme for the RCN's current programme of work around addressing the mortality gap. They hope the parity of esteem programme will work collaboratively with others to address the issues. It is hoped that as a result people will be given equal access to care and treatment, the same levels of dignity  and quality of care to pSMI and in doing so reduce. Essentially people with a mental health issue should have the same access to healthcare as those with physical health needs (RCN, 2019).

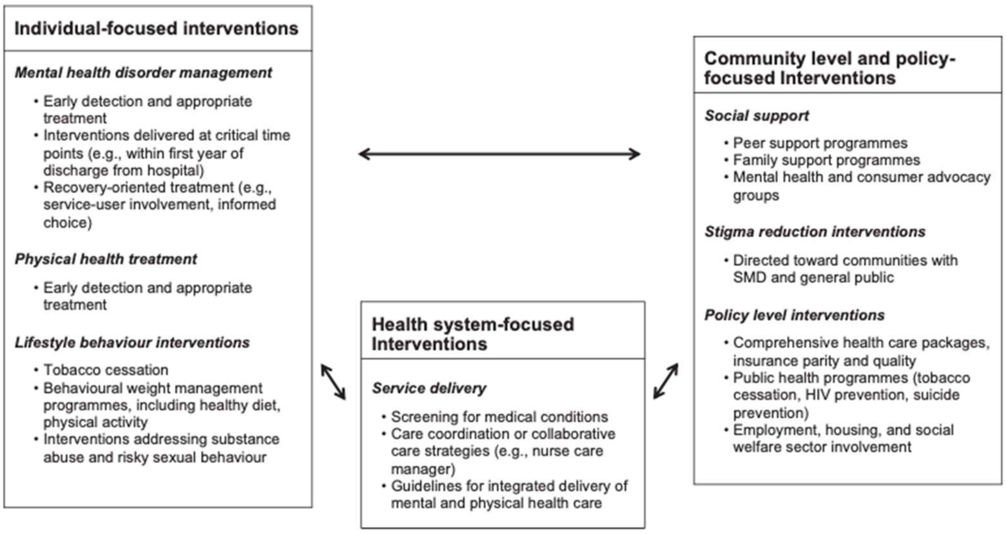
The physical health needs of pSMI has become an increased focus over the last two Scottish Government mental health strategies (Scottish Government, 2012, 2017). In 2012, the government committed that every patient would have a physical health assessment every 15 months. Most recently they are aiming for "equitable provision of screening programmes" so that people with SMI take up the offer of screening as much as those without a diagnosis. However, the strategy lacks detail on how this is to be achieved as well as who should be responsible for doing the work.

The Academy of Medical Royal Colleges (2016), including the RCN have written a joint report and policy paper addressing the physical health needs of pSMI. This is in an attempt for a 'systems approach' to tackling the issue. By doing so, this recognises that multiple professional groups are involved including dentists, public health, GPs, pharmacists. However, it does not make any novel recommendations, some of which it does make regarding nurse education were already being considered, and indeed were already evident in the NMC (2010) standards.

In recent years, the gravity of the situation has been highlighted by the World Health Organisation (WHO). The WHO recognises the excess mortality of pSMI as a global issue requiring targeted intervention. They have developed guidelines for the management of physical health conditions in people with SMI (World Health Organization, 2018). This has come about from previous work which the WHO has done to gather evidence and develop a strategy to help clinicians, policymakers and researchers address the mortality gap (World Health Organization, 2015, 2017b). This earlier work has led to the creation of a multilevel risk model (MRM) (See Figure 1). This model underpins the 2018 guidelines. It is meant to help all interested parties to think about what is required when designing, implementing and evaluating interventions aimed at reducing the mortality gap (Liu et al., 2017; World Health Organization, 2018).

In essence, the model is about taking a 'whole government' or systems approach to tackling the mortality gap. Often interventions have been limited with poor evidence bases and delivered in 'generic' manner without considering the unique needs of pSMI. This has resulted in a focus on a single or limited number of risk factors when we know that it is the combination of multiple risks that are contributing 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 this to be successful, governments will be required to adopt this approach for policy development, as well as providing clear financial investment. Additionally, it will require a longer-term view beyond the life cycle of most governments. The model forms the basis for the international policy review presented in chapter two.

**Figure 1: Multilevel model of interventions to reduce excess mortality in pSMI (Liu *et al.*, 2017).**



### 1.3.4 A role for mental health nurses

Scottish MHN policy also emphasises the importance of MHNs being able to address the physical health needs of patients  (Scottish Executive, 2006). The Scottish CNO review of the profession, *Rights, Relationships and Recovery* asserts that doing so is an essential component of recovery-focused practice, the prevailing ethos of MHNs in Scotland. This requires nurses to take a holistic approach, working alongside people rather than 'doing *to* or *for*' people. As part of this, the *Ten Essential Shared Capabilities* (10ESCs) (NHS Education for Scotland, 2011), which are the ten values developed jointly with patients and professionals, are embedded in education and MH services. One of the 10ESCs is 'challenging inequality.'

This is not just a policy mandate but is considered an imperative by the nursing regulator, the NMC. The NMC (2010) published 22 MHN-specific competencies in their *Standards for Pre-registration Nursing Education*. One of these requires MHNs to "promote mental health and well-being, while challenging the inequalities and discrimination that may arise from or contribute to mental health problems" (Nursing and Midwifery Council, 2010: 23). A similar message is detailed in the Scottish MH nursing policies. Similarly, *The National Framework for Pre-registration Mental Health Nursing* lists 18 specific criteria under the banner of 'promoting health and well-being' (NHS Education for Scotland, 2012). Collins *et al.* (2012) articulate that the 2010 standards are more explicit about the role MHNs have in addressing the physical health needs of pSMI, but also state that more needs to be done for staff in practice, whose education may have neglected this area.

The 2010 standards have become obsolete as new standards have come into effect from 2019 (Nursing and Midwifery Council, 2018). These new standards require registrants to possess a greater understanding of pathophysiology and pharmacology, so pre-registration students are more readily able to extend their skills to prescribing post-registration. The standards contain a detailed list of skills, known as annexes, which all nurses must be able to practice competently at the point of registration. Whether this list of tasks mean mental health nurses are more likely to tackle patients physical health is unclear. It is also possible that not all the skills are needed to address the physical needs of pSMI. If it's mainly non communicable diseases as a result of lifestyle behaviours and socioeconomics, it may be more prudent that MHNs are facilitated to develop expertise in health promotion and the necessary communication skills to utilise them in practice.

It is also interesting to note that the NMC has toned down the large mantle mandates regarding challenging inequalities in both the latest version of the Code of Conduct (Nursing and Midwifery Council, 2015b) and the new standards (2018). This may not be a bad thing as several authors have suggested that the practicalities of 'challenging inequalities' are somewhat intangible (Clifton et al., 2013; Conlon et al., 2015; Elliott and Masters, 2009). As a student nurse, Elliott and Masters (2009) paper made a real impact on me. Perhaps because it 'chimed' with my sense of justice and desire to challenge inequality. They suggested that one way MHNs could meet their policy and regulatory mandates was to address physical health needs. It legitimised my view that physical health was within my scope of practice as a RMN and permitted me to do so;

> "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" (Elliott & Masters, 2009, p.767)

Indeed, Collins *et al.,* (2012) argue that we need to move past the rhetoric and begin to take practical steps by establishing an evidence base, identify examples of good practice and areas where improvements are needed. Nurses are the most prominent professional group working in mental health services across the globe (World Health Organization, 2020). Therefore, we are in a unique position to address these deficits in practice and make a positive impact on the well-being of people with SMI through practice, education and research (Robson and Gray, 2007).

In the same vein, several academics have called for MHNs to show leadership in this area of practice (Gray and Brown, 2017; B Happell et al., 2011; Wynaden and Heslop, 2016). They are all clear that MHNs skillset allows for us to make such a contribution. MHNs embrace the philosophy of recovery; therefore, a role in physical healthcare would allow them to more generously embrace holistic care (B Happell et al., 2011). MHNs have a broad overview of services that allows them to tailor care in a very individual manner for patients, which they can do for physical health interventions. This is in addition to collaborative care, empowering self-management and promoting self-efficacy (Gray and Brown, 2017).

Wynaden and Heslop (2016) take an ethical stance to justify MHN role; MHNs administer medications with well-documented side-effects and therefore have a professional and moral obligation to monitor this as well as provide interventions to counteract these side-effects.  They state that nurses are 'closing their eyes' and pretending the problem does not exist. They call on MHNs to determine what level of accountability and ethical responsibility they have in addressing outcomes such as life expectancy, screening rates, and health promotion interventions (Wynaden and Heslop, 2016).

For all these reasons above, I would support Wynaden & Heslop (2016)'s call but caution it. If nurses do not see physical healthcare as their role in the first place, they will be unable to fulfil any leadership role. A bottom-up approach to tackling the issue alone may fall on deaf ears unless nurses in established positions of leadership and responsibility use their influence to change the culture. It will require such nurses to view physical health screening and intervention as a 'core' role and like Nash (2011) recommends, put in place appropriate infrastructure and resources.  This is similar to the view called for by the WHO (2018) and the MRM discussed above.

It is with the same view that the RCN (2019) undertook a literature review on the role of the MHN in providing physical health care. They found that the principal role was one of assessment and monitoring of physical health. However, there are many barriers including how services support nurses to do so, a consistent approach to competency with scope to develop and maintain competency along with clear and consistent policy.

There are much broader debates about what do MHNs 'do', what is their role and purpose beyond the above literature review. Gray (2012, p.191) surmises eloquently by saying "our job is to promote health and enable the people we care for to lead full and productive lives" (Gray 2012, p.191). Therefore it is clear that MHNs have a role in providing physical care. Nevertheless, how that role is enacted and supported in practice is unclear. It is unclear what helps MHNs enact this role as well as what prohibits their practice.

## 1.4 Research aims and questions

With this in mind, this study proposes to address the following question;

How do registered mental health nurses working in one Scottish NHS board understand their role regarding providing physical healthcare to people of working age with serious mental illness?

This study aims to:

- Find out how relationships and structural issues within the work environment impact on mental health nursing practice.
- Find out in what way do educational experiences and competencies[3] assist mental health nurses in performing their role.

## 1.5 Study approach

This study takes a qualitative approach, informed by the writings of Bourdieu. This is outlined further in chapter three and four of this thesis. This approach allows the consideration of the larger socio-economic factors such as the organisation of the NHS, health policy and education concurrently with the individual factors and experiences.

Bourdieu calls on the researcher to take a reflective approach, acknowledging where relevant their own position within the research. It is for this reason I have outlined my personal motivations for undertaking this study in this chapter. It is evident, as a registered mental health nurse, I did not come to this study with an empty mind; This will be made explicit throughout the thesis.

---

[3] This is more than just technical skill but rather meaning to encompass knowledge, skills, attitudes and values.

## 1.6 Structure of the thesis

This thesis is divided into seven chapters. This first chapter has provided an introduction to the topic of physical healthcare for pSMI, including providing an outline of the policy landscape, my personal motivations for undertaking the study as well as a justification for why MHN. I also outline the research aims and questions.

In chapter two, I present the relevant literature on the topic of MHNs and physical healthcare for pSMI. This is to provide an academic and international context for the study. The chapter is presented in three parts; The first is a review of international policy. The second presents a review of the empirical literature and finally, I present an integrated discussion section which should make it clear to the reader how my research questions formed as a result.

Chapter three is the first of two methodology chapters. The first provides the reader with details on the theoretical perspectives which I have utilised in conceptualising this study. The chapter opens with my rationale for drawing on social theory to study nursing practice. I then outline how I conceptualise ‘role’ and ‘professional identity.’ I then detail my use of Bourdieu’s writings and his key concepts which make up his *theory of practice*; 'field', 'capital' and 'habitus' and how they relate to the context of this study. This chapter concludes with a detailed discussion on Bourdieu's view of language and the implications this has for meaning within my study.

Chapter four is the second of two methodology chapters. This chapter provides a detailed outline of the approach I undertook in conducting the study and the justification for the decisions made during this process. I begin this chapter by outlining my ontological and epistemological position before moving on to provide my justification for pursuing a qualitative approach. I discuss and reflect on the various ethical issues which occurred as part of this study, in particular, the ethics of qualitative interviews and having a pre-established professional relationship with participants. I also provide the reader with details on the study setting and in particular, my approach to recruiting participants and the criteria I used to reach my sample of 14 registered nurses. I then provide a detailed account of my data collection methods, namely a short demographic questionnaire and semi-structured interviews. This account includes my rationale for choosing interviews as my method of data collection as well as the role of space and place in conducting them. I then move on to discuss how I answered the research questions via analysis. This includes a discussion on the process of transcription as well as how I arrived at two findings chapters which are centred around Bourdieu's concepts of 'field' and 'capital.' The chapter concludes with an outline on how I ensured quality throughout the research process.

Chapter five is the first of the two findings chapters in this thesis. This chapter focuses on issues relating to the field of physical healthcare practice for MHNs. The chapter is divided into two parts. The first part (Part I) examines the structural issues apparent in the field. The second part (Part II) is an analysis on some of the boundaries and tensions within and between the fields of study. Part I opens with a brief overview of what constitutes the issues within the field across both the inpatient and community setting. I then outline how my participants conceptualised physical healthcare and relate this to pSMIs' understandings. I then go onto discuss several structural issues impacting on MHNs physical healthcare practice. These include the burden of accountability, discourse on risk management in mental health, organisational support, change, and socioeconomic factors. In Part II, I discuss the boundaries between different fields, the actors within them and how this tension demonstrates issues of power.

Chapter six is the second findings chapter and again is divided into two parts. Both parts present an analysis of the capital MHNs utilise in their physical healthcare practice or lack of capital in certain circumstances. Similar to the previous chapter, it is presented in two parts for ease of reading. Part I examines the role of therapeutic relationships (TR) and specialist nursing roles within the field. In the section on TR, I discuss how MHNs go about using TR as the basis for all interventions, how it is the basis for building trust with people so difficult and sensitive topics, such as physical healthcare can be raised. It is, therefore a valuable form of capital that participants use to function within the field. I discuss the challenges of MH legislation and how physical health issues could pose a threat to TRs, which are primarily focused on assessing and supporting people's MH. The section ends with situating these findings within my own institution's cannon of research on TRs in MHN practice. In the next section, I discuss how specialist roles carry capital with both other nurses and more importantly, pSMI. I present data showing how participants feel such a role should exist for meeting the physical healthcare needs of pSMI. I then go onto explore the specifics of how this may occur. This section concludes with situating these findings in relation to recently published evaluations of similar roles.

The second part of chapter six examines different forms of knowledge and contains three sections; (1) knowledge gained during pre-registration as a form of capital, (2) knowledge gained post-registration and (3) confidence as a form of capital. The first part starts off by presenting data regarding pre-registration experiences. This moves onto discussing the divide and power dynamics between HEIs and their NHS practice partners, with placements being the site where these tensions play out. I then move onto exploring the issue of achieving competency and how this may be difficult if MHN practice is currently invisible. I then explore how both general placements during pre-registration, as well as the concept of dual training. The section concludes with a discussion of these issues and explores who has the capital within the field. This discussion is situated with the historical context of nurse education of the past thirty years as well as drawing on the seminal work for Patricia Benner’s (1984) *Novice to Expert* study.

The next section in part II explores capital gained post-registration. This capital or knowledge takes different forms, the most important being knowledge gained from experience. This appears to have the most effective form of capital and is once again discussed in the context of Benner's work. This section moves on to look at the role of both formal and informal learning, and the value both have within the field. Lastly, this section concludes by examining role modelling and its role in knowledge development.

The final section in this chapter explores the vital role of confidence in MHN executing their role in physical healthcare. I explore the critical role of experience in increasing confidence and an important form of capital in progressing within the field. I then explore the impact of a lack of confidence and how it is contributing to an emotional burden for MHN. I then move onto discuss the role of confidence and identity as a MHN before briefly looking at how a lack of confidence can also act as a motivating factor. This section concludes with a discussion section where I endeavour to unpick the interplay between 'competence' and 'confidence.' While these terms are not mutually exclusive, the literature points to a complex dynamic. This has led me to conclude that not enough focus is paid to developing confidence. I provide a critique of competency and competency-based education and how its focus on nurse education may explain some of the tensions discussed regarding pre-registration education. I discuss the difficulty in maintaining competency and how this has been ignored by the regulator and the NHS. I also discuss how the focus of competency is short-sighted in the context of MHN value on therapeutic relationships, their complexity and is contributing to the invisibility of MHN knowledge and practice.

The final chapter in this thesis is a summary chapter. I outline a summary of my findings. I then discuss how these findings contribute to knowledge. I also discuss the limitations of my approach. I detail the implications of the findings for MHN practice, policy, education and research. I conclude this thesis with some reflections on my doctoral journey.

# Chapter 2: Literature Review

## 2.1 Introduction

In this chapter, I present the relevant literature on the topic of MHNs and physical healthcare for pSMI to provide an academic context for this study. The chapter is divided into three parts; the first is a review of international policy. The second presents a review of the empirical literature, and in the final part, I present an integrated discussion section which should make it apparent to the reader how my research questions were formed.

## PART I: INTERNATIONAL POLICY REVIEW

## 2.2 Introduction to the policy review

This policy review aims to set this thesis within an international context. I do so by reviewing the MH strategies of seven English-speaking regions across the globe. I have chosen to review MH strategies as they should articulate a government's vision for services and provide a strategic overview of the priorities for services. It should, therefore, drive service provision and innovation as well as determining what services will be financially prioritised in delivering any vision. As such, they should indicate where physical healthcare for pSMI sits within the broader strategic picture and the importance a jurisdiction places on tackling the health inequalities faced by people using MH services. As I have already outlined in chapter 1, the mortality gap for pSMI is a global issue. Therefore, the findings of this review will help situate my study within a broader international context.

The seven regions reviewed are; Scotland (UK) (Scottish Government, 2017), South Australia (Government of South Australia, 2010), British Columbia (Canada)

(Government of British Columbia, 2017), South Africa (Department of Health South Africa, 2013), Nigeria (Federal Ministry for Health Nigeria, 2013), Republic of Ireland (Department of Health ROI, 2006) and Singapore (Ministry of Health Singapore, 2007).

These regions were chosen as they are geographically diverse. They also represent a mix of socioeconomic statuses. The regions were also selected because they are all English-speaking or English is used as a *lingua franca*. Due to the nature of doctoral studies, I did not have resources available to have documents translated. The reason for English being a common factor is also because the regions are all former British colonies and so are likely to share some cultural similarities.

## 2.3 Method

This review has drawn on the methods of two previous policy reviews undertaken on this topic. In order to locate the relevant MH strategies, I accessed the WHO's database of mental health policy, known as Mental Health in Development (MiND) and the WHO Mental Health Atlas (2017a). Mugisha *et al.,* (Mugisha et al., 2017) used the same method when reviewing policy in sub-Saharan African countries. The databases were accessed in April 2019. Happell *et al.,* (2015) conducted a policy review on the topic of co-occurrence of physical and mental illness in Australia and used the WHO (2012) mental health action plan as an evaluative framework. I have similarly used a WHO strategic document as a framework for critiquing the MH strategies, the WHO multilevel risk model (MRM) (Liu et al., 2017; World Health Organization, 2018) which was presented in chapter 1.

I have chosen the MRM as it was developed specifically to tackle the high rates of physical co-morbidities and mortality gap experienced by pSMI. This framework should guide all governments when considering physical healthcare for pSMI, as it sets out the key issues and the underpinning evidence for interventions. I used the framework's seven core interventions as a benchmark to measure each strategy against the framework. A summary of how each strategy addresses each aspect of the WHO MRM is summarised in Table 1. If the region's mental health strategy covers an aspect of the model, it is given a 1 and coloured green. If it is absent, it is scored 0 and shaded orange, to give a total score out of a possible 17. This is to act as a blunt measure of how each strategy fairs in comparison to the model.

**Table 1: Summary of how each region scored against the WHO multilevel risk model for addressing the physical co-morbidities of people with SMI.**

| | Scotland | Republic of Ireland | Nigeria | South Australia | British Columbia, | South Africa | Singapore |
|---|---|---|---|---|---|---|---|
| Individual focused interventions | | | | | | | |
| (1) Mental Health disorder management | | | | | | | |
| Early detection & appropriate treatment | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Interventions delivered at critical time points (eg within first year of discharge from hospital) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Recovery-orientated treatment (service-user involvement, informed choice) | 1 | 1 | 0 | 1 | 1 | 1 | 0 |
| (2) Physical health treatment | | | | | | | |
| Early detection and appropriate treatment | 1 | 1 | 1 | 1 | 1 | 1 | 0 |
| (3) Lifestyle behaviour interventions | | | | | | | |
| Tobacco cessation | 1 | 0 | 0 | 0 | 1 | 0 | 0 |
| Behavioural weight management programmes including healthy diet & physical activity | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Interventions addressing substance abuse & risky sexual behaviour | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Health system-focused interventions | | | | | | | |
| (4) Service delivery | | | | | | | |
| Screening for medical conditions | 1 | 1 | 0 | 0 | 1 | 1 | 1 |
| Care co-ordination or collaborative care strategies (eg nurse care manager) | 1 | 1 | 0 | 0 | 1 | 1 | 1 |
| Guidelines for integrated delivery of physical & mental healthcare | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Community-level & policy-focused interventions | | | | | | | |
| (5) Social support | | | | | | | |
| Peer support programmes | 1 | 0 | 1 | 1 | 1 | 1 | 0 |
| Family support programmes | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| Mental health & consumer advocacy groups | 1 | 0 | 1 | 1 | 0 | 1 | 0 |
| (6) Stigma reduction interventions | | | | | | | |
| Directed towards communities with SMD & general public | 1 | 0 | 1 | 1 | 1 | 1 | 1 |
| (7) Policy level interventions | | | | | | | |
| Comprehensive healthcare packages, insurance parity & quality | 1 | 0 | 1 | 1 | 1 | 1 | 1 |
| Public health programmes (tobacco, HIV, suicide) | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Employment, housing and social welfare sector involvement | 1 | 1 | 1 | 1 | 1 | 1 | 0 |
| Score: | 14 | 8 | 9 | 11 | 12 | 15 | 7 |

## 2.4 Findings

I will now present a detailed critique of the seven regions under the seven core headings used in the model; (1) Mental Health disorder management, (2) Physical health treatment, (3) Lifestyle behaviour interventions, (4) Service delivery, (5) Social support, (6) Stigma reduction interventions, and (7) Policy level interventions.

### 2.4.1 Mental Health disorder management

This entails planning for early detection and treatment of mental disorder, as well as interventions being delivered at critical points such as perinatal, early childhood etc. It also involves services taking a recovery-orientated approach. The majority of regions scored very well across the three criteria in this domain, with a clear focus on promoting good mental health and preventing mental illness.

All strategies had a clear focus on investing in early intervention services and taking an ‘across the lifespan’ approach. Scotland stood out for several reasons. The Scottish strategy contains many actions set to improve mental health from perinatal right through to college/university students. The first 9 of the 40 actions set by the strategy are related to children and young people's mental health. The strategy also wishes to set up and fund a managed clinical network to address perinatal mental health issues (Scottish Government, 2017). A lot of this early intervention work is focused on schools, including ensuring all children are given mental health training as part of their formal schooling. Similarly, in Singapore, their strategy has several workstreams around early intervention, including in-reach for schools and workplaces.

In contrast to other regions, the Republic of Ireland (ROI) strategy, while referring to the need to develop early intervention services, does not offer specific details (Department of Health ROI, 2006). This is despite it being the most extended document, at 288 pages. In contrast to other regions, the ROI strategy is organised along the lines of 'services' and uses sub-specialities typically used in psychiatry.

Nigeria and South Australia are notable for their clear statements regarding mental health being a human right. Health, including mental health, is considered an inalienable right of every citizen (Federal Ministry for Health Nigeria, 2013; Government of South Australia, 2010). South Australia takes this further with a clear commitment to recovery-focused practice, including detailing what they mean by this. In contrast, only Nigeria and Singapore fail to mention about recover-orientated approaches.

### 2.4.2 Physical health treatment

All regions recognised the importance of early detection and appropriate treatment to meet the physical healthcare needs of pSMI. Indeed, Nigeria's strategy makes it explicit that parity of esteem must be achieved, with people with SMI having the same right to healthcare when physically unwell as other citizens (Federal Ministry for Health Nigeria, 2013). Singapore was the only country not to offer any detail for this category.

Scotland's strategy makes specific mention for the need to address the physical health needs of pSMI through screening (Scottish Government, 2017). However, it does not state who should do this work, who should carry out the screening or indeed how the government is going to ensure equitable provision for any screening programmes that are routinely offered to members of the public who do not have a SMI. Similarly, the ROI strategy mentions throughout the increased physical co-morbidities experienced by pSMI but is very non-specific in what actions are required. The main recommendation is that everyone, including those in long-term mental health care, is registered with a GP in order to meet their physical health needs (Department of Health ROI, 2006). There is no mention of the nurses' role. There is a focus on GPs working in partnership with community MH services in order to meet these aims.

In contrast, South Australia calls on mental health services to identify, prevent and reduce the harm associated with psychiatric treatments (Government of South Australia, 2010). There is also a commitment to making physical monitoring a priority in primary care services. Similarly, South Africa's strategy recommends that there are routine screening and treatment of physical health in all consultations for pSMI (Department of Health South Africa, 2013). Similar to other regions, it appears superficial and not detailed enough to state who should undertake the work.

Both ROI and Nigeria's strategies focus on physical health monitoring in inpatient settings, recommending that psychiatric inpatient facilities take account and record people’s physical health status. This could be in recognition of very hospital-centred health systems within these two regions.

Several regions (ROI, South Australia, British Columbia, South Africa) attribute the increased physical co-morbidities to medication side-effects. It appears this is the primary driver for increased screening within these regions’ strategies. British Columbia, in particular, calls for the need to provide "evidence-based medication" and monitoring (Government of British Columbia, 2017). While this assertion is true, WHO are clear that medication alone is not the root cause of the low physical health status of pSMI (Firth et al., 2019; World Health Organization, 2018). Nigeria stands out in this regard, recognising that physical monitoring for pSMI should act as a driver for broader health promotion.

### 2.4.3 Lifestyle behaviour interventions

This category deals specifically with tobacco cessation, behavioural weight management, healthy diet, physical activity programmes and interventions addressing substance abuse and risky sexual behaviour (Liu et al., 2017). The majority of regions scored badly in this category. No region met all three sub-categories, with Scotland scoring the best with two out of the three, followed by British Columbia and South Africa scoring one each.

The Scottish Government (2017) has committed to supporting the physical activity programme which has been developed by the third-sector organisation, the Scottish Association for Mental Health (SAMH). Along with British Columbia, Scotland also recognises the large portion of pSMI who smoke and the need for tailored interventions for this population. However, it does not deal with other lifestyle issues. Only South Africa details the need to tackle high-risk sexual behaviours as part of improving mental health (Department of Health South Africa, 2013). Surprisingly, Scotland, with its high drug-related mortality rate (National Records of Scotland, 2019) has not recognised this within its strategy. Similarly, Nigeria's mental health strategy considers mental, neurological, and substance misuse all under the one umbrella term yet does not address any of the three sub-categories.

### 2.4.4 Service delivery

This fourth category within the framework considers screening for medical conditions, care co-ordination or collaborative care strategies and guidelines for the integrated delivery of physical and mental healthcare (Liu et al., 2017). Most regions scored well, with four scoring three out of three (Scotland, British Columbia, South Africa and Singapore). Nigeria and South Australia scored the worst, with both only scoring for guidelines on integrated delivery.

Numerous countries discuss the need for physical health screening. Scotland stands out for committing to ensuring the equitable provision of national screening programmes so that pSMI access such intervention as much as those who do not have a mental health diagnosis. ROI strategy makes similar calls, but like Scotland, it does not state how this should happen or what specific programmes should be prioritised.

All countries scored for integrating the delivery of physical and mental health care. In the strategies, this is about recognising that those with LTCs have increased mental health needs. Scotland hopes to achieve a more integrated approach to physical and mental healthcare by increasing the workforce, so there is a mental health worker in every GP practice, A&E department and expansion of liaison mental health services within general hospitals. Singapore calls for a similar approach, where GPs are encountered to deliver more integrated care. Other regions make similar calls but often lack the detail of how this will happen.

### 2.4.5 Social support

South Australia and South Africa were the only two regions to score three out of three. Singapore and the ROI both scored zero, with their respective strategies not discussing the role of peer support, family support or mental health consumer advocacy groups. Throughout most regions, the strategies contain vague statements about the need for such social supports but with little detail of how that will look. South Australia provides detailed content on supporting family and carers.

### 2.4.6 Stigma reduction interventions

All regions recognised the need to reduce stigma, both regarding mental health within the general public but also stigma that is directed towards those with pSMI. All regions detailed the need to establish anti-stigma campaigns.

### 2.4.7 Policy-level interventions

This category details the need for regions to have comprehensive healthcare packages, insurance parity and quality, public health programmes tackling tobacco use, HIV, suicide as well as policy interventions that address issues of employment, housing and social welfare involvement (Liu et al., 2017). In this regards, this may be the most critical set of interventions, as WHO (2018) has called for a 'whole government' approach to tackling the physical health outcomes of pSMI. As discussed in chapter 1, many of the contributing factors are due to socio-economic inequalities. Only South Africa scored three out of three within this category. Singapore only scored for comprehensive healthcare packages and insurance parity. The remaining regions all scored zero for public health programmes that tackle HIV & suicide.

All regions, except Singapore, recognise that many contributing factors to poor mental health are socially determined and therefore sets out a 'systems' approach that will involve social, housing and employment support. Additionally, Nigeria has a focus on reducing poverty, which should help improve overall health and not just mental health (Federal Ministry for Health Nigeria, 2013). There is a focus on developing healthy attitudes and positive health, including paying attention to the social-cultural impacts on mental health. However, Singapore does mention the need to have a workstream focused on people returning to employment. South Africa deserves praise in this category for a detailed strategy which includes setting out the responsibilities of each government department in achieving the aims of the strategy. It is the only region where there is a specific focus on the association between mental illness and HIV, TB and substance misuse.

### 2.4.8 Summary

This is the first of three parts of this literature review. This first part has presented the findings of an international policy review on physical healthcare for pSMI. The MH strategies of seven English-speaking regions were reviewed against the WHO MRM (Liu et al., 2017; World Health Organization, 2018). The review has been organised around the seven core interventions used in the MRM; Mental Health disorder management, Physical health treatment, Lifestyle behaviour interventions, Service delivery, Social support, Stigma reduction interventions, and Policy level interventions. The implications of the findings will be discussed in Part III of this chapter.

# PART II: EMPIRICAL LITERATURE

## 2.5 Introduction

In part II of this chapter, I present a review of the international empirical literature. The review aims to present an overview of what is already known within the field and to allow the reader to situate the findings of this thesis. This review helped shape this study, and its research questions by demonstrating the 'gap' in the existing knowledge. This section starts with details of the systematic search I undertook, before discussing the literature in greater detail.

The findings suggest that nurses are ambivalent regarding their role in addressing the physical health needs of pSMI. Nurses cite excessive workloads and lack of organisational support, though attending to physical healthcare was seen as providing holistic care. The advent of generic workers may not contribute to reducing the mortality gap as some professions will not have the key physical healthcare skills. MHNs occupy an advocacy role, ensuring patients access relevant services. Studies show that MHNs generally have positive attitudes to physical healthcare. Regions where there is a specialist MH qualification or register, the attitudes are better. There is an incongruence between self-reported positive attitudes and recorded practice revealed in documentation audits.

Stigma can impact on role performance, with some research samples reporting negative attitudes towards pSMI. Lifestyle and illness factors such as medication side-effects and negative symptoms can impact on pSMI to live a healthy life. Nurses have voiced strife between practising in a recovery-orientated manner that respects people's lifestyle choices while at the same time promoting best possible health. A large number of studies show that education can improve nurses' knowledge. However, the studies have been poorly designed, relying on simple same-day pre-/post questionnaires. We do not know how participants utilise this knowledge when they return to practice. Screening has attracted much attention within the literature, with numerous studies reporting positive outcomes with the adaption of the Health Improvement Profile (HIP), though the positive attitudes were not universally held. There are several organisational and structural barriers to improving practice. These include lack of integrated record systems, inconsistent data collection as well as lack of equipment. There is an emerging evidence base for a specialist physical health nursing role within mental health services. Studies have shown that such roles can impact positively on a range of outcomes. However, the evidence-base is confined to Australia.

## 2.6 Method

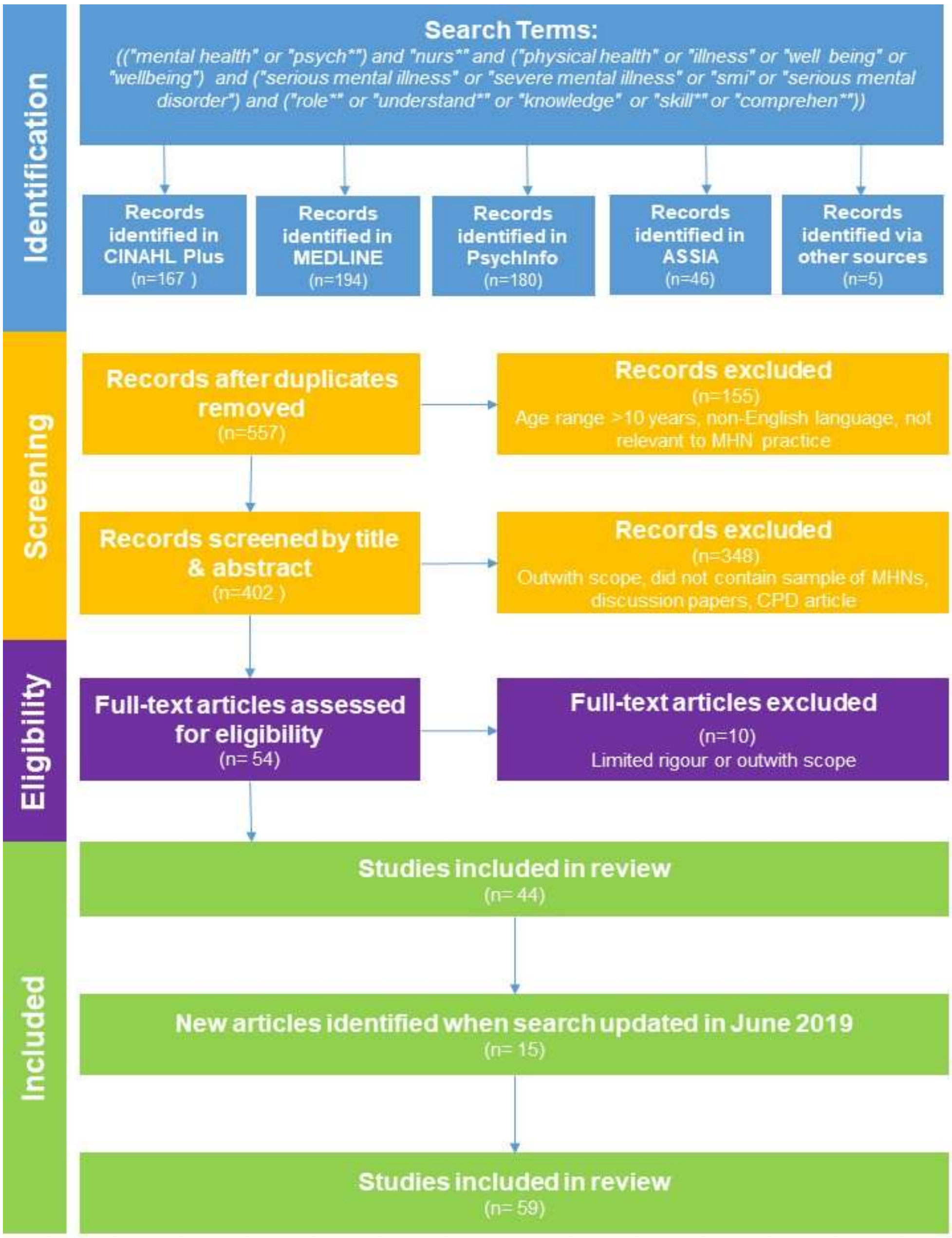
In order to understand the colour and texture of the landscape of this topic, a narrative review of the literature was conducted. I developed key terms[4], guided around wanting to discover the existing knowledge on what role MHNs play in the physical healthcare of pSMI. These were developed and entered into the following health-related databases; CINAHL Plus, MEDLINE, PsychInfo, ASSIA. I took a broad view when considering studies to include. For studies to be included they had to deal with an aspect of physical healthcare practice and contain a sample of nurses. Papers from the previous ten years were accessed along with only those published in English. There was no geographical limitation set, though it is likely that there is relevant work published in other languages. However, it was beyond the scope and resources to get papers translated. Papers were excluded if they did not contain relevant information about nursing practice. This search was conducted in late 2016. After duplicates were

---

[4] *(("mental health" or "psych*") and "nurs*" and ("physical health" or "illness" or "well being" or "wellbeing") and ("serious mental illness" or "severe mental illness" or "smi" or "serious mental disorder") and ("role*" or "understand*" or "knowledge" or "skill*" or "comprehen*"))*

removed, 402 papers were screened by title and abstract. A total of 54 were accessed and read fully. A total of 44 were included in the review. The search was repeated in June 2019 in order to update the review. At this point, a further 15 studies were identified as relevant. This is displayed in the PRISMA diagram in Figure 2.

**Figure 2 PRISMA diagram representing search strategy**



The studies were appraised using the Critical Appraisal Skills Programme (CASP) tool. This was chosen as it is a well-established tool used for appraising and evaluating studies (Long et al., 2020). It is also considered user-friendly and suitable for the novice researcher. CASP has also been endorsed by Cochrane and the WHO (Hannes and Macaitis, 2012; Noyes et al., 2018)

The findings of the review are presented under nine themes. These are; role ambivalence, advocacy, measuring attitudes and values, stigma, lifestyle choices, education and training, interventions and screening, organisational barriers and specialist nursing roles. Throughout many conflicts appear to occur between role and policy.

## 2.7 Findings

### 2.7.1 Role ambivalence

Several studies show that MHNs are ambivalent in their role in this area (Blythe and White, 2012; Collins et al., 2012; Cunningham et al., 2013; Ezell et al., 2013; Gray and Brown, 2017; Gronholm et al., 2017; Happell, Scott, Platania-Phung, et al., 2012b; MacNeela et al., 2010; Shuel et al., 2010; Tranter et al., 2012).

Happell *et al.,* (2012b) undertook focus groups with 38 nurses in a regional public mental health service to elicit their views on the physical health of their clients, who had responsibility for this area of practice and what was patients' engagement and motivation regarding their physical health. In general, there was a mixed response and ambivalence towards the role. The study did provide good demographic detail on the participants and setting that allow for comparisons to be made.

It is apparent that all nurses do not hold this view. The nurses interviewed by Gray and Brown (2017) did not consistently consider service users physical health to be a priority. It is unclear if nurses are motivated to take on this role or unclear why they lack motivation  (Gray and Brown, 2017). This qualitative study provides useful insight as it draws on nurse (n= 18) and patient (n= 15) participants. It is one of a few UK qualitative studies included in this review and one of only two Scottish studies. While the sample size is appropriate for a study of this kind, how the participants were selected are not detailed, expect that the nurses helped recruit patients. There is no demographic information on participants provided. While the authors cite this was done due to issues of confidentiality, it does not provide context for the study.

Nurses have asserted the negatives of an increased role, including the risk of excessive workloads and lack of time in clinical settings. They also cite the issue of pre-registration education lacking robust curricula that can empower nurses to do adequate physical health screening (Happell, Scott, Platania-Phung, et al., 2012b)

MacNeela *et al.*, (2010) utilised a delphi survey technique to gain consensus about what are the core elements of MHN in the Republic of Ireland. While the researchers report a large sample in the first round (n=150), they do not document the sample size in the subsequent two rounds. Items were drawn from a review of the literature and focus groups with nurses (n=115). Consensus was reached at 75%. The researchers report that the ratings assigned by participants towards physical health difficulties demonstrate that they are not viewed in biomedical terms or given a high priority, with only a few receiving a substantial rating to progress for consideration in round three of the study. Participants rated five items as essential to their clinical practice. These include; nutrition, hygiene needs, physical side effects, sleep disturbance and fluid balance. However, some of these such as sleep disturbance and hygiene needs are related to psychosocial elements such as assisting with mood and anxiety and promoting self-care. The authors argue that the MHNs in their Delphi study might not have rated physical health tasks as 'core' because nurses did not see their role through simply a biomedical lens (MacNeela et al., 2010).

Gronholm *et al.*, (2017) interviewed care coordinators (n=7) working in a London trust about physical healthcare in one London community team, four of whom were from a nursing background. They felt that their role was overall co-ordination of global health with a firm view that GPs were responsible for physical health monitoring, although they acknowledged that this does not always happen. However, they did support physical health as part of their role of co-ordinating overall health- including social, mental health and family. Participants reported that they often stepped outside their role to ensure patients received holistic care, including attending exercise classes with patients.

The literature offers many examples of nurses discharging their role to other members of the MDT, suggesting role ambiguity and uncertainty. Gray and Brown (2017) reported that nurses felt more was required of dieticians in supporting patients weight management. Nurses voiced frustration that smoking cessation was not integrated into their routine clinical work, but instead this was undertaken by a specialist role, who they felt did not communicate or share with them what was going on for the patient (Gray and Brown, 2017). Australian nurses questioned if it was not the role of other members of the MDT such as the GP in primary care or the junior doctor on the ward to undertake the role (Happell, Scott, Platania-Phung, et al., 2012b).

Cunningham *et al.,* (2013) present a narrative review, arguing that the move to ‘generic' caseworkers within MH services may mean a blurring of responsibilities and consequently workers who do not have the appropriate skill set to address patients physical health needs. For example, in teams made up of generic 'caseworkers', who have a variety of backgrounds (social work, occupational therapy, nursing etc.), not every caseworker will possess proficient physical health skills. This simply may be because such skills were not traditionally considered core competencies of certain professional groups. The administrators interviewed (n=21) as part of Ezell *et al.,* (2013) study reported that if a patient has been allocated a therapist for psychological work, it is difficult to expect the therapist to monitor physical health when they lack the clinical knowledge and skills to identify issues.

Shuel *et al.,* 's (2010) Scottish study further demonstrates this tension. The authors used qualitative methods to evaluate a physical health clinic for people with SMI, that used the Health Improvement Profile (HIP) screening tool. The nurses (n=9) in the clinic who were using the HIP were optimistic about its clinical utility and were clear and confident in their role and responsibilities. In contrast, the nurses (n=8) who had not used it questioned whether it was their role to be carrying out this screening and expressed concern about whose responsibility it was to follow-up on the findings (Shuel et al., 2010). Similarly, GPs (n=12) expressed some ambiguity and confusion over 'who should do what' but welcomed the idea of monitoring and were optimistic about the tool. The psychiatrists interviewed (n=4) in the study were very positive and made no comments about roles and responsibilities (Shuel et al., 2010). This study suggests that such a screening tool being embedded in practice may contribute to MHNs seeing this as part of their role (Shuel et al., 2010).

It is clear from the studies that if nursing staff embrace their role and responsibilities for physical health care, they appear to hold positive attitudes, which in turn are appreciated by patients. In Shuel *et al.,* (2010) it is unclear if the nurses using the tool did so because they were positive about this area of practice already. Perhaps nurses accounts of feeling other members of the MDT have a role to play is in response to the traditionalist view that the nursing profession is oppressed and cannot find its voice. It may also be due to discourses surround task shifting, extended roles and what constitutes nursing work versus that of medical colleagues. The nurses advocating for others to take responsibility could be a form of empowerment, where nurses are simply highlighting an already burdensome workload. The argument regarding generic workers is a prevalent one when we consider the current demands on NHS resources in the UK and calls for a more 'flexible workforce' to meet the demands of the public. In Scotland, health and social care integration is currently being implemented, where there will be a pooling of financial and human resources. In an attempt to make services more 'joined up' or flexible, teams may lack the necessary skills to address people's needs entirely unless there are clear criteria and job descriptions.

While the studies in this category identify that nurses are ambivalent towards addressing patients' physical health needs, none of the studies identifies why they feel this way and the mechanisms that are driving this ambivalence on a day-to-day basis.

### 2.7.2 Advocacy

The concept of MHNs undertaking advocacy is peppered throughout the literature (Doherty and Gaughran, 2014; Ezell et al., 2013; Happell, Scott, Platania-Phung, et al., 2012b; Nankivell et al., 2013).

It is argued that nurses may be able to tackle this issue through a human rights lens (Nankivell et al., 2013). Despite identifying the barriers to accessing appropriate physical health care, none of the nurses in Nankivell *et al.,* (2013) mentioned their role in either contributing or tackling the issue of access. This paper is based on the qualitative focus group interviews carried out by Happell *et al.,* (2012b). While this is one qualitative data set, from one regional service in Australia, the demographic data provided does allow us to draw comparisons with the UK. Arguably, the data would not be much different. This is worrying that this issue was not viewed in explicit human rights terms when we consider that MHN policy has called for a rights-based approach to care for over a decade.

While nurses appeared to be annoyed at these barriers, none of them appeared to view it as a human rights issue (Nankivell et al., 2013). Participants voiced that they had a role to play in advocating for their patients by ensuring that they were registered with a GP, as well as raising concerns regarding adverse side-effects (Happell, Scott, Platania-Phung, et al., 2012b). This sense of advocacy is also seen in Ezell *et al.,* (2013). Ezell *et al.,* (2013) carried out semi-structured interviews clinicians (n=25) and administrators (n=21) in a variety of settings (clinical, social projects etc.) in the state of New York in order to examine current practice and barriers to addressing the physical health needs of people with SMI who are also classified as belonging to a minority ethnic group. Administrators interviewed as part of the study described the efforts that clinicians would go to ensure people received appropriate support. They labelled staff as ‘navigators’ for their clients, helping them find their way in a fragmented system (Ezell et al., 2013).

Doherty and Gaughran (2014) discuss in their narrative review this issue through a medically-orientated approach and suggest very clearly that it is the responsibility of psychiatrists to address people's physical health needs without considering the role of nurses (Doherty and Gaughran, 2014). However, they conclude by suggesting that MHNs role may be to advocate for SUs to have access to physical healthcare and assess what support they need, rather than doing the screening (Doherty and Gaughran, 2014).

It is unclear why Doherty and Gaughran (2014) take this view. It is likely influenced by traditional power dynamics, that place the doctor as 'in charge' of the patient's care. This power dynamic is legitimised under current mental health legislation in both England and Scotland, where consultant psychiatrists are deemed the 'Responsible Medical Officer,' legally accountable for the person's care and treatment. While there have been moves to reform this role in England to allow a broader range of professionals to take up this mantle, it is still widely undertaken by medics (Veitch and Oates, 2017). Therefore discharging physical health screening to other professionals may raise strife for the medical profession who may view themselves as being vulnerable for any possible litigation.

### 2.7.3 Measuring attitudes and values

Several studies have taken a quantitative approach to elicit MHNs attitudes to their physical healthcare role (Bressington et al., 2018; Haddad et al., 2016; Happell, Platania-Phung, et al., 2013a, 2014; Howard and Gamble, 2011; Knight et al., 2017; Robson et al., 2013; Robson and Haddad, 2012; Wynaden et al., 2016)

Except for one of these studies (Howard and Gamble, 2011), they have all utilised the Physical Health Attitude Scale (PHASe), developed by Robson and Haddad (2012). PHASe is a 28-item questionnaire that aims to measure MHNs’ attitudes towards the physical healthcare of people with SMI. The different studies report on different samples and settings. The PHASe was originally developed using data from RMNs (n=585) participants, working in one large English mental health service (52% response rate) and was found on statistical analysis to be valid and reliable (Robson et al., 2013). The items contained within the questionnaire were all derived from the available literature. While government policy identifies developing MHNs’ knowledge and skills in this area (Department of Health England, 2006; Thomas, 2016), nurses’ attitudes are likely to affect their behaviour and willingness to engage in new ways of working, including increased physical healthcare activity.

Researchers at the University of Central Queensland, Australia conducted a comprehensive online survey of MHNs in Australia to ascertain their views and current practice on delivering physical health care to pSMI. Topics surveyed include attitudes, training needs, confidence levels and role perception. The invitation to complete the survey was sent to all 2852 members of the ACMHN. The survey received a response rate of 22% (n=643). While the response rate is low, the researchers note that from analysis of demographic information, participants were a good representative of the Australian MH nursing workforce (Happell, Platania-Phung and Scott, 2013a)

While in different geographical regions and health systems, the data shows some noteworthy similarities between the UK and Australian data. Overall nurses in both countries were optimistic about this area of practice. Nurses in the UK had more positive attitudes with higher levels of involvement reported in UK participants in all areas of practice, except one. Australian nurses who held the official credential from the ACMHN reported giving advice more regularly, helping reduce drug and alcohol use and ensuring patients were registered with primary care (Happell, Platania-Phung, et al., 2013a). Additionally, the longer qualified as an RN correlated with giving advice on sexual health, hygiene and dental issues (Happell, Platania-Phung, et al., 2013a). Analysis of data shows that specific post-registration education on physical health or an additional 'general' nurse qualification (RN/RGN) was significantly correlated with positive ratings on the PHASe. However, in the UK data, this was not the case; dual qualified staff did not have more positive attitudes but did report more confidence (Robson et al., 2013).  There was a positive correlation between the frequency of discussions with colleagues and self-reported direct actions with patients (Happell, Platania-Phung, et al., 2014). Both studies found that if nurses held the attitude that they should be involved in the physical healthcare of people with SMI, and then it resulted in more frequent self-reported physical healthcare delivery. The minority of MHNs in this sample had undertaken training in the five years before data collection (Robson et al., 2013).

Wynaden *et al.,* (2016) administered the same survey across three sites in a public MH service in Australia. They hypothesised that leadership would impact on the attitudes of the nurses. Half of the nurses on site 2 (compared to <30% at Site 1 and 3) reported that it should not be the MHNs' role to check if a client had a cancer screening. Less than a third of nurses at site 1 felt confident in advising which psychotropic medication cause cardiovascular problems. This compares with more than half of nurses at the other two sites. Thirty-seven percent of nurses at site 1 believes clients were not interested in their physical health. This compares to 56%  and 66.1% at sites two and three (Wynaden et al., 2016). It is unclear what other variable factors may contribute to the diversity of outcomes. Perhaps due to confidentiality and disclosure, it would be inappropriate to explore the leadership style of each site in an explicit manner.

Bressington *et al.*, (2018) administered the PHASe to nurses across three Asian countries; Hong Kong (n=143), Japan (n=200) and Qatar (n=138), resulting in a total of 481 completed surveys. Findings are broadly in line with results from other regions. While nurses in the Asian sample were generally positive, their attitudes were less so when compared to UK data. Indeed, more nurses in this study felt that mental illness itself was a barrier to implementing physical healthcare and a third from Hong Kong, more than 50% in Qatar and 80% in Japan felt that a patient's mental illness drove physical health concerns. This indicates that attitudes and values may result in high levels of diagnostic overshadowing. Nurses from Japan reported less confidence compared to other countries in providing all aspects of care. However, the authors stipulate that this could be a cultural phenomenon associated with the Japanese culture of modesty.

Regardless of country and type of nurse registrations, there was a perception of requiring more education & training. This mirrors earlier studies from the UK and Australia. All participants in Hong Kong were registered psychiatric nurses, while only 9% in Japan had a specific MH qualification and none in Qatar. Nurses in Hong-Kong (who were all registered psychiatric nurses) were significantly more likely to report workload as a barrier to engaging in health promotion for patients. The authors recommend that further studies take greater account of the organisational dynamics, which may inhibit MHNs from addressing physical health.

Knight *et al.,* (2017) administered the PHASe to 154 nurses via the American Psychiatric Nurses Association. The results were similar to other regions. Haddad *et al.,* (2016) administered it to nursing staff working (n=57) in one forensic long-stay unit in London, as part of a pre/post educational intervention. Changes were positive on the whole but with only modest increases. There was a more robust agreement that involvement in physical care is part of the nursing role compared to previous studies. However, there were lower levels of confidence in differing care with greater acknowledgement of potential barriers.

Seventy-five per cent (75%) of respondents in Howard and Gamble's (2011) quantitative study, which explored the views, practices and training needs of nurses (n= 37, response rate 47%) in one acute trust in England reported that addressing physical health needs of people with SMI was 'important' and 19% rated it as 'very important' The sample perceived most of the 41 health tasks to be within the role of the MHN. MHNs rated activities like blood pressure, weight and side effects monitoring as within the scope of the MHN but less so for actual physical health screening. Seventy percent perceived lifestyle assessment (Howard and Gamble, 2011) (smoking, nutrition) to be within the role of the MHN. Eighty-nine percent were either 'very confident' or confident in assessing side effects but not with the use of structured screening tools such as LUNSERS and GASS (Howard and Gamble, 2011). They also reported very low confidence levels for checking blood and ECGs. Additionally, screening sexual health was considered low and instead was seen as the role of medical staff.

The researchers carried out a documentation audit afterwards. The audit demonstrated a gap between self-reported endorsement of the role and actual nursing activity. Over 50% of the case notes reviewed had no nursing entry for 39 out of the 44 physical health activities. For example, blood pressure which nurses reported high confidence levels, was only recorded in 57% of the case notes. Some checks, such as urinalysis were never recorded. Seventy-five percent of the sample reported that they had not received any training on physical health care since working for the organisation (Howard and Gamble, 2011).

This highlights the issues and bias inherent in self-reported questionnaires. There is a clear gap between how nurses perceive their role and how they actually perform it in practice. This study also highlights the tension between nurses requesting more training but showing an evident ambivalence and not performing skills in practice. It is unknown if this is because nurses in this sample lack the confidence and skills in the first place, hence avoid physical healthcare or they do not do it in practice and therefore perceive themselves as lacking confidence. It may also be that participants are not realising that they are engaged in physical healthcare activity and therefore not recording it in their notes.

### 2.7.4 Stigma towards pSMI

Stigmatising attitudes towards pSMI may also be impacting on role performance (Bressington et al., 2018; Hardy, 2012).

Hardy (2012) reports on the evaluation of training sessions for practice nurses (n=8) in the use of a physical health screening tool in the context of mental health. Prior to undertaking the training, participants reported high rates of misconceptions of people with SMI. These misconceptions could be impacting on mental health nurses as well too. It is unclear if this is the case. (Hardy, 2012). The mean number of nurses answering correctly about misconceptions was 2 (SD 3.17) pre-test and 6 (SD 0.92) post-training (P=0.00, CI 0.41). Training is likely successful in modifying attitudes. Results also suggest that participants were more motivated to work with people with SMI and with CMHTs as a result of the training (Hardy, 2012).

This appears similar to Bressington *et al.,* (2018). Participants from the three Middle Eastern and Asian countries reported poorer attitudes towards those with SMI. These poorer attitudes may act as a barrier to addressing the physical health needs of pSMI.

### 2.7.5 Lifestyle choices

Staff attitudes to lifestyle choices may also impact on MHNs perception of their role (Gray and Brown, 2017; Happell, Scott, Platania-Phung, et al., 2012b; Verhaeghe et al., 2013; Wynaden et al., 2016).

Verhaeghe *et al.,* (2013)'s Belgian study was set in sheltered accommodation. After conducting numerous focus groups with MHNs (n=17) and patients (n=15), researchers found that SMI affected people's energy and motivation levels and therefore impacted on their ability to engage in health-promoting activities. Furthermore, participants voiced that antipsychotic medication and its harmful side-effects also impact significantly on activity levels as well as contributing to excessive eating. The nurses raised provoking ethical issues. They questioned if it was their role to assist patients to change their lifestyle behaviours, because it could be paternalistic, which would evoke power dynamics and undermind the patients' autonomy (Verhaeghe et al., 2013).

Similarly, nurses reported that if they were to tackle patients' lifestyle behaviour, it would make their job difficult in an inpatient setting. They reported that they did not want to be the one to say no to patients ordering takeaways or smoking. There is a sense that such interventions may impact on therapeutic relationships. Australian nurses also voiced the same concerns (Happell, Scott, Platania-Phung, et al., 2012b).

Additionally, patients identified the importance of healthy eating and physical activity. Patients appeared to value the input from nurses regarding lifestyle choices and identified the need for nurses to do so (Verhaeghe *et al*., 2013, Gray and Brown 2016). Nurses report that their own eating and physical activity habits might impact on their ability to support patients in this domain (Verhaeghe et al., 2013). This was a particular issue when it came to smoking. This issue is evident in other studies. Wynaden *et al.,* (2016) reported that 45.3% of participants reported that they did not believe clients should be banned from smoking on all healthcare premises (Wynaden et al., 2016). This may be due to the staff's own attitudes to their smoking habit.

There is an apparent tension between respecting a person's autonomy and providing care that promotes positive health. This demonstrates some of the inherent tensions in recovery-focused practice. On the one hand, clinicians need to respect that individuals can exercise choice and sometimes these choices are not what we would want for the person or ourselves. However, nurses also have a professional obligation to promote the best possible health and wellness. Wellness is considered a key concept in recovery (Crowe and Deane, 2018). Clearly, nurses in the above studies are struggling with these ethical dilemmas and questioning at what point do you intervene and override the person's autonomy.

This raises a number of issues regarding nurses conceptualisation and operation of recovery-orientated approaches. Firstly, recovery could be used by nurses to absolve them of their professional obligations or as a defence mechanism to avoid work that they find potentially very distressing. Secondly, nurses may be using ‘recovery’ to cover up their lack of motivation and competence in health promotion skills.

### 2.7.6 Education and training

A large number of studies deal with issues of education and training for nurses regarding physical healthcare for pSMI  (Blythe and White, 2012; de Mey et al., 2016; Gray and Brown, 2017; Happell et al., 2013; Happell, Platania-Phung, et al., 2013c; Hardy, 2012; Hardy and Huber, 2014; Hemingway et al., 2013, 2014, 2015; Hennessy and Cocoman, 2018; Howard and Gamble, 2011; McDaid and Smyth, 2015; Mwebe, 2017; Nash, 2010; Ramluggun et al., 2017; Robson et al., 2013; Terry and Cutter, 2013; White et al., 2014). The majority of studies focus on the educational needs of RNs but some involve samples with pre-registration students.

The literature suggests that a lack of education and training may be contributing to nurses not seeing physical healthcare as part of their role (Cunningham et al., 2013; Happell et al., 2013; Happell, Platania-Phung, et al., 2013c; Happell, Scott and Platania-Phung, 2012). MHNs knowledge and skills around diabetes and metabolic disorders are poor, with nurses lacking opportunities for education and training (McDaid and Smyth, 2015; Nash, 2014a). No universal measurement of obesity hampers some of this, therefore nurses may not be accurately identifying at-risk people. The definition of metabolic disorder varies from country/guidelines; therefore nurses may be misidentifying people (McDaid and Smyth, 2015).

Nurses who have undertaken some form of post-registration education on physical health topics have more positive attitudes to the role (Robson et al., 2013). Several quantitative studies substantiate this. Robson *et al.,* (2013) found that 80% of respondents wanted more training in diabetes management, cardiovascular health, and nutrition. Happell, et al. (2013c) survey results, 70% of participants wanted more training on physical health, except for areas of smoking and healthy eating. 65% of participants viewed education as having a 'significant value' in tackling the physical health needs of patients. Indeed, across studies, most participants reported they were optimistic about further education and that they needed to develop more skills (Blythe and White, 2012; Happell et al., 2013; Howard and Gamble, 2011). However, this was not universal, and some felt that their skill set was enough for their role (Gray and Brown, 2016).

Many studies report on education interventions to increase nurses' knowledge and skills. Terry and Cutter (2013) report on a mixed-methods evaluation of a degree module for post-registration participants (n=15). A lack of evidence for the use of education improving outcomes could result in staff questioning their role in this area (Terry and Cutter, 2013). Overall, confidence levels improved by the end. However, participants' confidence levels varied depending on their career pathway and experience (Terry and Cutter, 2013). Participants reported increased confidence in screening tools of medication and side-effects, and this may be due to the availability of such screening tools in practice  (Terry and Cutter, 2013).

Nash (2010) carried out a brief pre-training questionnaire of participants' propositional knowledge, who were engaged on a training day on the physical health needs of pSMI. Propositional knowledge is defined as knowledge which "relates to facts found in textbooks and research literature" (Campbell and Leathard, 2000: 373). Nash (2010) argues that if nurses' propositional knowledge is lacking, then it is a risk factor for patients' physical health needs. Participants (n=88) were asked to complete a 12-item questionnaire prior to the training. Answers to each question were then covered throughout the session. All questions were based on a review of biological sciences taught in the common foundation programme[5]. While the study has a few apparent limitations (small sample size, lack of a control, format delivery) Overall, the study showed that nurses' propositional knowledge needed to improve. Some lacked appropriate clinical terminology which could impact on communication in the practice setting. Only four could correctly explain how to calculate BMI correctly (Nash, 2010). The brief questionnaire also demonstrated a lack of awareness about units of measurement and standard definitions. Newly-qualified staff within the sample remarked how much they had forgotten in a short space of time. The study has several limitations, notably that the pre-/post-testing occurred on the same day. It also does not consider different learning styles and how participants put new knowledge into practice.

---

[5] Implemented as part of Project 2000 nursing education reforms, the common foundation programme (CFP) consisted of the first 18 months, where students undertook common subjects in life sciences, social sciences & fundamental nursing care. While no longer officially a feature, many courses in the UK & ROI still have a CFP where students have shared classes prior to undertaking their field-specific preparation.

The University of Huddersfield has published several studies reporting on training that was developed by the University of Huddersfield and South West Yorkshire mental health NHS trust (Hemingway et al., 2013, 2014, 2015; White et al., 2014). Each paper reports on a different component of the same data set. Several interactive training workshops were developed for registered (n=89) and student nurses (n=115). The workshops covered areas such as intramuscular injections, diabetes care, oral care, wound care and the HIP. All workshops used a pre-/post-test evaluation, asking participants 13 multiple-choice, equally-weighted questions. Pre- and post-questionnaire were matched and statistically analysed. Completion of the questionnaires ranged between 78% to 100% over the five workshops (Hemingway *et al.,* 2014). Each workshop showed a statistically significant improvement in pre-and post-testing. Like Hardy and Huber (2014), the pre-/post-test evaluation occurred on the same day as the workshop, and therefore we do not know if this improved knowledge translates into practice.

The authors comment that a lack of RNs at the training sessions shows either a lack of interest on the part of RNs to develop their knowledge and skills or else a lack of organisational support in affording nurses with opportunities to gain this knowledge. Small sample sizes make the findings difficult to generalise. We do not know if these improvements were sustained when practitioners returned to their clinical areas. The inclusion of students may alter or skew the results as they are more likely to be up to date with knowledge and skills (Hemingway et al., 2013).

de Mey *et al.,* (2016)'s Dutch study examines oral health education sessions and interventions for both patients and nursing staff in a mental health setting. The educational session was developed by oral hygienists and researchers and consisted of a brief 20 min PowerPoint presentation. The study utilised a pre-/post study knowledge questionnaire. In contrast to previous educational interventions, the researchers administered the post questionnaire five weeks after the delivery of the presentation. The sample of nurses included n=27. Analysis of the questionnaire using t-tests showed a significant increase in knowledge [ $t(27) = -5.26$, $p<.001$, $d= 1$ (The Cohen's d)]. However, very few actively participated in promoting good oral health among patients and participated in the patient arm of the study, which involved providing motivational and behavioural interventions for patients on their oral health.

Mwebe (2017) conducted semi-structured interviews with inpatient nurses (n=11) in London on their physical healthcare practice. Findings indicate that the sample had a clear commitment to meeting the holistic needs of patients and that physical health practice was essential to achieving this. However, they cited a lack of education and training opportunities as a significant issue.

Ramluggun *et al.,* (2017) conducted a qualitative study in an English university, who is a large provider of pre-registration nurse education. They conducted a focus group with final year MHN students (n=10) to explore their preparedness for meeting the physical health needs of patients with SMI. The results of this led to conducting further in-depth individual interviews (n=7). Participants reported that the content of the first year (anatomy and physiology) was too generic and could not be applied to the needs of pSMI. They also reported that content tapered off as they progressed. They also identified gaps in content in terms of physical and neurological observations and pharmacology. They also felt the content was then jammed into the final year as opposed to consistent intervals throughout the programme. While students were positive about this aspect of care, they reported a lack of confidence.

A number of the studies included in this review include either implicit or explicit debate regarding how do we best educate and prepare nurses for their role. Some general nurses felt that specialist nurses are not equipped to care for people's physical health (Happell, Scott, Platania-Phung, et al., 2012b). However, nurse participants who had undergone accreditation by the ACMHN were also more likely to self-report higher incidents of physical health activity. They also demonstrate more confidence in discussing difficult topics such as sexual health with patients (Happell, Platania-Phung, et al., 2013a).

### 2.7.7 Nurses involved in interventions and health screening

Several studies explore nurses' role in delivering interventions to improve physical health. The majority of these interventions are health screening (Howard and Gamble, 2011; Organ et al., 2010; Shuel et al., 2010; Thongsai et al., 2016; Tranter et al., 2012;

White et al., 2009). It is not always clear if nurses see this as their role (Happell et al., 2013; Tranter et al., 2012).

Tranter *et al.*, (2012) review of innovations to improve physical health found three themes; assessment, health education/promotion and multimodel interventions. No one intervention results in improvement but usually a combination of education, health promotion, exercise etc. Often the sample sizes in the studies are too small to make generalisable statements. The evidence to support assessment and screening is more substantial than the other two themes. If people are screened, it is the first essential step in identifying potential issues and therefore, appropriate interventions (Hardy, 2012; Tranter et al., 2012). They demonstrate that in the health education and multimodal approach, the outcomes are variable and at times contradictory throughout the literature. Also, such studies use different outcomes and measurements of health. No study had a follow-up period, so any improvements in health may have been limited to the intervention period (Tranter et al., 2012). This severely limiting the evidence.

It appears that the most popular intervention is screening. This is despite limited evidence to support the widespread adoption of screening tools, or evidence to support their effectiveness (Collins et al., 2012; Firth et al., 2019; Tosh et al., 2014; Welsh and McEnany, 2015). It is also unclear which member of the MDT has responsibility for screening & assessment (Collins et al., 2012). Patients (n=13) generally viewed screening as positive and welcomed the additional information about their well-being, and liked being informed (Organ et al., 2010; Shuel et al., 2010). However, rates of screening vary. For example, in one study, researchers audited 618 clinical files examing the preceding 12-month period. Rates of screening varied from 7% (waist circumference) to 63% for cholesterol and 60% blood sugar (Organ et al., 2010).

The HIP, discussed previously, has garnered frequent mention in the literature. The HIP was developed by Hardy *et al.*, at the University of Northampton. It consists of 28 screening health parameters that have all been identified as health priorities for people with SMI from the relevant literature. A manual with evidence-based follow-up has also been produced so practitioners can act upon health risks (White et al., 2009). Patients in one outpatient clinic were very optimistic about the tool (Shuel et al., 2010). Nurses appeared to support the concept of physical health screening and acknowledged it as an essential first step in establishing any diagnosis or decision regarding treatment. This view is also echoed by Australian nurses (Happell et al., 2013).

The tool has also been adapted for Asia, including Hong Kong and Thailand (Bressington et al., 2016; Meepring et al., 2018; Thongsai et al., 2016). Thongsai *et al.,* (2016) observational study reports on the use of the tool in a Thai outpatient psychiatry clinic. 44% of the sample of 105 participants (n = 105) had unhealthy BMI measurements despite desirable levels of exercise and a healthy diet. It suggests that health interventions will not be universal and must take into account the needs of the population, based on the socioeconomics of the region. The authors conclude that some of the outcomes are due to prescribing practices, and therefore MHNs in this region would benefit from paying attention to medicines management interventions to support patients.

Howard and Gamble (2011) found that 70% perceived lifestyle assessment (smoking, nutrition) to be within the role of the MHN. 89% were either 'very confident' or confident in assessing side effects but not with the use of structured screening tools such as LUNSERS and GASS (Howard and Gamble, 2011). They also had very low confidence levels for checking blood and ECGs. Additionally, screening sexual health was considered low and instead was seen as the role of medical staff.

However, participants in some studies felt that they took on enough responsibility for patients’ health and questioned if it was their role (Happell et al., 2013). In particular, nurses expressed that any screening tool could turn into another bureaucratic and time-consuming process. Nurses were particularly concerned regarding screening but questioning who was responsible for follow-up or actions as a result of any screening (Happell et al., 2013). This is a valid ethical point. Arguably, nurses should not be facilitating screening if they do not have the knowledge and skills to follow up on identified issues, or indeed if other members of the MDT also lack the competence and resources to put in place appropriate care plans.

In contrast, Bressington *et al.,* (2016) undertook descriptive qualitative interviews with community nurses (n=11) in Hong Kong regarding their perception of the HIP. It was generally reviewed positively. In particular, the use of the tool increased their motivation to provide physical healthcare for people. It was viewed as feasible in their day to day practice. It reminded CPNs of the importance of providing holistic care. It also highlighted gaps in nursing knowledge which encouraged staff to source further learning and training. Nurses in this study reported frustrations in referring and accessing appropriate services in order to meet patient needs.

### 2.7.8 Organisational barriers

A number of studies refer to organisational barriers to role perception but do not explore them in great detail (Björk Brämberg et al., 2018; Blythe and White, 2012; Chadwick et al., 2012; Ezell et al., 2013; Gronholm et al., 2017; Happell, Scott, Platania-Phung, et al., 2012a; Lawn et al., 2018; Mwebe, 2017; Nankivell et al., 2013; Organ et al., 2010).

Collins *et al.,* (2012) found that in general, a lack of clear organisational guidelines and policy were impacting on poor physical health, which results in only small pockets of good practice. They question if the culture of MH settings are leading to nurses questioning if this topic is within their scope of practice (Blythe & White, 2012, Collins *et al.,* 2012). This would appear to have merit when examining other studies.

Regardless of the country, patients voiced barriers to accessing appropriate physical healthcare. These include mistrust of services, low competency of staff, and lack of consideration given to patient's mental state, lack of co-ordination between primary and secondary care, poor staff attitudes and diagnostic overshadowing (Björk Brämberg et al., 2018; Blythe and White, 2012; Chadwick et al., 2012; Ezell et al., 2013; Mwebe, 2017). Nurses identified several barriers, in particular, access to GPs. They reported that some GPs would not accept patients because the patient had a SMI or would not allow them to 'bulk buy appointments'[6] (Happell, Scott, Platania-Phung, et al., 2012a). In rural areas, some patients were reported to lack access to transport so they could not attend GP appointments (Gronholm et al., 2017; Nankivell et al., 2013).

---

[6] A system of payment in place in Australia and some US states. It allows patients to claim for appointments through the public system.

Nurses identified discrimination and poor physical health outcomes without using terms such as discrimination or human rights. Nurses did not mention how they might address these barriers (Björk Brämberg et al., 2018; Gronholm et al., 2017; Happell, Scott, Platania-Phung, et al., 2012a; Nankivell et al., 2013).

Fragmented services resulted in an inconsistency in basic data collection and health parameters. Only essential health monitoring (weight, vital signs) that did not require much expertise was recorded. This made monitoring quite difficult as data might be collected multiple times in different services, but clinicians might lack the ability to compare and measure progress (Ezell et al. 2013). An Australian study involved a review of 100 patients chosen at random from a possible 900 in the community service hard copy and electronic patient record (Lawn et al., 2018). It found that physical monitoring was occurring, but it was patchy. 76% of patients in the sample were on clozapine and therefore would have a greater need for close physical monitoring including regular bloods, often on a weekly basis, but this was often not recorded. It was found that documentation on physical health was buried within case notes and not clear or consistent. Often when there was known physical co-morbidity, the case notes did not reflect a more targeted or concerted effort but instead was a quite generic response. These findings are similar to Howard and Gamble's (2011) documentation audit.

Nurses cited a lack of organisational support to undertake further training, particularly in rural areas (Happell et al., 2013; Happell, Scott, Platania-Phung, et al., 2012a). Staff also reported that the lack of equipment and time were barriers to implementing any physical health improvement. Staff also reported that collaborating with primary care services was a significant issue (Mwebe, 2017; Organ et al., 2010). Patients identified lack of energy and motivation, which nurses found to be a time-consuming endeavour (Haddad et al., 2016; Mwebe, 2017; Verhaeghe et al., 2013). Patients reported that nurses were too busy to help address health behaviours, and this is substantiated by nurses (Gray and Brown, 2017).

Brämberg *et al.,* (Björk Brämberg et al., 2018) conducted semi-structured interviews in a western region of Sweden. 50 participants were interviewed, drawn from patients (n=14), carers (n=15), and clinicians (n=21 of which registered nurses accounted for n=8) across inpatient and outpatient settings. The main barrier was the gap between organisation of the health system and the patient need. The system depends on patients' ability to initiate contact, which is not always possible in this patient group. The services were often fragmented with little communication between them the services.

Gronholm *et al.,* (2017) found that lack of adequate computer systems meant that sharing information was difficult. As people were identified as 'care coordinators' and not by their professional background i.e. registered nurse, occupational therapist, not everyone will have the clinical skills to provide physical health monitoring. This echoes the point articulated by Cunningham *et al.* (2013). Participants in the study also reported that systems such as performance review and care programme approach, where the focus was on completing documents acted as a trigger to complete physical health needs, but often it was completed due to external motivations such as external monitoring and not out of patient welfare. These processes were seen to contribute to the heavy workload

### 2.7.9 Specialist roles

There is a growing body of evidence that supports a specialist nursing role for physical healthcare for pSMI. Such a role was seen as one way to address patient need while also having a role in bridging the gap between different services (Blythe & White, 2012). However, the evidence base is geographically narrow, and all reside in Australia.

Numerous state governments in Australia introduced the Mental Health Nurse Initiative Programme. This programme paid for a MHN to be integrated into primary care services. The programme was found to be very successful in addressing people's needs (Happell, Scott, Platania-Phung, et al., 2012a, 2012b). Participants described a sense of having a positive role and where their knowledge and skills were respected in the primary care setting. Nurses regularly discussed the health of patients with GP and other professionals (Happell et al., 2013; Happell, Platania-Phung, et al., 2013a). MHNs seemed positive about this role and screening for physical health. They described their role in flexible terms in order to meet patient need (Happell, Platania-Phung, et al., 2013b).

Happell *et al.,* (2013) surveyed members of the ACMHN about the possible introduction of the Cardiometabolic specialist nurse role into services in Australia (Happell et al., 2013). 77% of nurses surveyed agreed that a specialist role would help improve patients' physical health. 81% felt it would lead to an increase in assessment and screening, and 83% reported that they believed it would lead to increased monitoring and follow-up over time. 32% neither agreed nor disagreed that the role would increase prevention. While these figures are promising, the qualitative analysis undertaken by the same team shows that nurses were generally ambivalent about the role, and expressed fear regarding role fragmentation, dilution of role and a clear opinion that responsibility should remain with the wider team (Happell, Platania-Phung, Stanton, et al., 2015). This ambivalence appears to have subsided after a 6-month trial of the role within a mental health service, with nurses being overwhelmingly positive about the role and its impact on practice (Happell, Stanton, Hoey and Scott, 2015). While it was suggested that the development of a specialist physical health role was good, some pSMI disagreed, fearing it would be used as a substitute for lack of GP services (Gray and Brown 2017).

Happell *et al.,* (2014) reports on a trial of a Cardiometabolic Nurse in providing physical health monitoring and intervention. The qualitative study is in the form of an exit interview with the person who undertook the role during the study. However, it shows some of the organisational and structural issues apparent in such a role. Support from organisation was vital to its establishment and embedding in practice, in particular knowledge among frontline staff that such a role exists. This was not always the case during the implementation.

McKenna *et al.*, (2014) reports on a retrospective cross-sectional comparison study, where some community MH teams were provided with a specialist physical health nurse role, and others were not. It found that those with a specialist role had increased rates of metabolic screening (78% versus 3%) compared to when the case manager alone was doing the screening. It also found that the specialist role resulted in more varied referrals for pSMI for follow-up.

Furness *et al.,* (2019) reports on a proof-of-concept study which evaluated the role of a nurse practitioner (NP) in improving the quality of physical healthcare for pSMI in one community MH setting in the state of Victoria, Australia. The study took a mixed-methods approach involving data collection 12 months pre- (period 1) and post- (period 2) the introduction of the role as well as qualitative interviews with pSMI (n=10). During the 12-month period, the number of metabolic monitoring assessments rose from n= 55 in period 1 to n = 146 in period 2 ($P < 0.01$, $v^2 = 41.20$).

What is arguably more impactful is the results of the qualitative data from interviews conducted with pSMI. This data showed that pSMI placed a high value on the role. They found the person to be helpful and the relationship they formed resulted in improvements in both their physical and mental health. They reported that the NP provided verbal and written advice about healthy eating, weight loss, increased physical activity as well as being able to provide advice about managing the side-effects of psychotropic medication. Those interviewed reported that they were able to implement the health promotion advice offered, and this resulted in lowered blood pressure, blood glucose levels, and cholesterol; and improved mood and social relationships. Additionally, participants reported greater energy levels and sustained and manageable weight loss.

Brown *et al.,* (Brown et al., 2018) report on the outcomes of a similar role in an inpatient setting, again within the state of Victoria, Australia. They used a similar design and found similar findings but over a six-month period. Preventative physical screening and clinical assessment undertaken by an NP resulted in an increase in referrals to primary and secondary care for appropriate follow-up. A total of 497 patients (n=497) were admitted to the MH inpatient unit's intensive care area across the two 6-month data-collection periods. Prior to the NP role, only 2% of consumers had their body mass index (BMI) risk calculated; less than 1% had their waist circumference measured, and no abnormal results were referred to a GP. After the NP role commenced, BMI risk was calculated for 67% of consumers, waist circumference recorded for 68%, and referrals for abnormal results were forwarded to 37 consumers' GPs. Similar to the NP in Furness *et al.,* (2019), they were involved in conducting physical health screens, liaising with other members of the MDT, developing care plans, ordering investigations and making referrals as well as reviewing physical health medication.

Numerous studies conclude that guidelines for the monitoring of physical healthcare for pSMI have minimal impact on their own (Ezell et al., 2013; Furness et al., 2019; Organ et al., 2010). Rather, key personnel such as a specialist nurse is needed to help implement and co-ordinate the guidelines. As well as providing this leadership, the authors also conclude that nurse-led roles are required with the advanced scope of practice, so pSMI receive holistic care, and there can be comprehensive assessment and intervention.

In contrast to specialist roles, Jones *et al.,* (2016) trained non-government (unregistered, non-nursing staff) to conduct physical health checks due to the shortage of registered nurses in rural Australia. The qualitative study in the form of a focus group with the workers (n=7) found that the lack of clinician training was an enabler to use the HIP as opposed to a barrier as participants felt they could align themselves more with patients and not assume to know in a way that clinicians often can. Use of the tool enabled structured conversations which in turn led to patients accessing healthcare as a result. A limitation of this approach was that the backgrounds of participants not explored.

## 2.8 Summary

Part II of this chapter has presented findings from a review of the empirical literature. The findings of the review are presented under nine themes. These are; role ambivalence, advocacy, measuring attitudes and values, stigma, lifestyle choices, education and training, interventions and screening, organisational barriers and specialist nursing roles. Throughout several conflicts appear to occur between role and policy. The findings suggest that nurses are ambivalent regarding their role in addressing the physical health needs of pSMI. Nurses cite excessive workloads and lack of organisational support, though attending to physical healthcare was seen as providing holistic care. The advent of generic workers may not contribute to reducing the mortality gap as some professions will not have the critical physical healthcare skills. MHNs occupy an advocacy role, ensuring patients access relevant services. Studies show that MHNs generally have positive attitudes to physical healthcare.

Regions where there is a specialist MH qualification or register, the attitudes are better. There is an incongruence between self-reported positive attitudes and recorded practice revealed in documentation audits. Stigma can impact on role performance, with some research samples reporting negative attitudes towards pSMI. Lifestyle and illness factors such as medication side-effects and negative symptoms impact on pSMI's ability to live a healthy life. Nurses have voiced strife between practising in a recovery-orientated manner that respects people’s lifestyle choices while at the same time promoting the best possible health. A large number of studies show that education can improve nurses' knowledge. However, the studies have been poorly designed, relying on simple same-day pre-/post questionnaires. We do not know how participants utilise this knowledge when they return to practice. Screening has attracted much attention within the literature, with numerous studies reporting positive outcomes with the adaption of the HIP, though the positive attitudes were not universally held. There are several organisational and structural barriers to improving practice. These include lack of integrated record systems, inconsistent data collection as well as lack of equipment. There is an emerging evidence base for a specialist physical health nursing role within mental health services. Studies have shown it can impact positively on a range of outcomes. However, the evidence-base is confined to Australia.

# PART III: DISCUSSION

This review has some limitations. Firstly, it is part of a Ph.D. study and therefore cannot for pragmatic reasons contain every paper or policy. The policy review had a narrow focus and therefore included a limited number of documents. Some of the issues faced by pSMI may be detailed in other government policies out with MH strategies. The review does not take into account other policies which are published by professional bodies and other organisations involved in providing care and support to pSMI.

Secondly, Some may question why a systematic review was not carried out. However, such a methodological approach to reviewing the literature would have resulted in excluding some studies discussed above that add a level of depth and further the knowledge base. Instead, this review was conducted in a systematic manner in order to identify a large body of literature. It contains a comprehensive overview of the landscape on MHNs role in physical health care.

Thirdly, all of the policies reviewed were produced before the publication of the WHO MRM (Liu et al., 2017; World Health Organization, 2018) and therefore it may have been considered an unfair framework to use for evaluation. However, this review may demonstrate where current gaps are regarding the unique physical health needs of pSMI and prompt governments to review their strategies in the future in light of new WHO guidelines. Considering the scale of the mortality gap, it would be pertinent of governments, to carry out specific action on the physical health needs of pSMI including details on who, how and what is to be achieved.

The policy review can be summarised in one sentence; the same but different. That is because, despite the diverse geographical, socio-economic and political context of the regions, most of the documents contain similar recommendations, such as a focus on early intervention and social determinates of health. This, along with the 'whole-government' approach is to be welcomed, as it takes into account the reality and complexity of the issue (Firth et al., 2019; Liu et al., 2017; Tranter et al., 2012). The focus on early childhood is welcome, considering the link between Adverse

Childhood Events (ACEs) and significantly poor physical and mental health. It is clear that by focusing on early intervention, the physical health issues faced by pSMI may not develop in the first instance and therefore would negate the need for specific strategies to improve their physical health. The broad focus in the strategies on positive mental health and health promotion is welcome. A number of the factors which contribute to good mental health are congruent with the interventions recommended in the WHO MRM.

While this focus on social determinants within policy is congruent with what research calls for, this is not always the case. Several regions which detail this approach, appear to attribute medication side-effects as the sole cause of the mortality gap when this is not what the evidence would suggest. It should also be noted that affluent regions are not fairing any better than developing regions.

While regions may appear to score well against the model, actions speak louder than words. A lot have aspirations which are yet to be realised. Numerous regions provide little to no detail on how they are going to achieve the goals. It is often only fleetingly mentioned. In the case of when PH needs of pSMI are made explicit, it does not detail which professional group or section of the health service should provide the physical health interventions such as screening. There is often no mention of the quality, breath or intensity of intervention, which makes measurement and further evaluation a challenge.

I would also add my own experience. While Scotland scores highly throughout, I know first-hand that the current MH strategy is aspirational, with no clear delivery plan. This trickles down to on the ground. In contrast, having used my Florence Nightingale Foundation scholarship to visit Australian services, I witnessed the level of strategic importance physical healthcare is given within mental health services and the subsequent practice development.

There is little mention of specific public health issues. For example, the WHO recommends that HIV, tobacco and suicide are addressed as they are significant contributors to the morality gap for pSMI. In scoring the public health programmes in table 1, a country only scored the 1 point if all 3 were present, and 0 if incomplete.

So while some countries addressed suicide or tobacco only, South Africa acknowledged all three.

There is a notable absence of nursing across the MH strategies reviewed. This may not be surprising when we consider that of the 22-member group who developed WHO's (2018) guidelines, only one was a nurse. Hopefully, with the recent publication of the *State of the World's Nursing Report* (World Health Organization, 2020), this position may change, and nurses will no longer be invisible in policy documents. The report highlights that nurses make up over 60% of the global healthcare workforce. Furthermore, it articulates that nursing's contribution has a significant positive impact on achieving the sustainable development goals. The empirical evidence does show that despite the limitations and ambivalence, nurses have a significant contribution to make to tackling the inequalities of pSMI.

Empirical evidence would also suggest that public health programmes should include healthy eating and physical exercise considering the rates of cardiovascular and metabolic disorders prevalent in pSMI. Often when there is mention of interventions such a tobacco cessation, there is little mention of how this will be tailored or explicitly targeted to pSMI as it is recognised that many of the interventions will need to be adapted to take account of cognitive and psychological problems as a result of living with a SMI (Firth et al., 2019). There is no detail on how recruitment to such public health screening is going to increase pSMI participation.

The methodologies of the studies discussed in part II contain some limitations, which in themselves contribute to why further research needs to be undertaken to understand this issue better. A large number of quantitative studies rely on self-reported questionnaires, which are prone to bias. This is demonstrated best by Howard and Gamble (2011), who showed the gap between nurses' self-reports and their actual practice. While nurses' might report positive attitudes, this does not mean that they perform their role competently in practice.

Similarly, a large number of studies rely on a pre-/post- test analysis. While convenient and feasible for collecting data, it tells us very little about how nurses' are going to translate newly-acquired knowledge into routine clinical practice.

The empirical literature throws up a very interesting position regarding how we prepare nurses. It was the regions with a specialist mental health registration or qualification that had better attitudes to physical healthcare. This would go some way to prove that the generic preparation called for in the *Shape of Caring* (Willis, 2015) review is iniquitous. Indeed, Happell and Cutcliffe (2011) argue against comprehensive nursing education programmes. The authors argue that they are not adequately preparing people for working in mental health services and has not resulted in any improved outcomes. They point to evidence that shows that since the introduction of comprehensive education, there is no evidence to suggest that nurses are better able to care for people's physical health problems. Nurses voice a lack of confidence in caring for pSMI's physical health and not seeing it as their job. Despite suggesting that such training would help improve attitudes towards people with MH problems, evidence suggests that there has not been a change in attitudes and stigma has not reduced. It appears it is the nurses with the specialist mental health qualifications that self-report more positive attitudes to physical healthcare. It is unclear why this is the case and requires further exploration.

On the other hand, it is unclear if pre-registration education has the impact that is desired. It is clear that even in the 'fields of practice' system in the UK, nurses are given basic physical health knowledge and skills. Nevertheless, it appears that this is not being put into practice. Similarly, in other countries that do not have a specialism, the physical health outcomes are no better, and nurses are struggling to use their education to address patient needs. It is unclear why this is the case and how helpful educational experiences are for nurses once they qualify.

It must also be acknowledged that the studies in this review are geographically narrow and dominated by Australian and English studies. There are only two Scottish studies. This is surprising when one considers the higher level of health inequalities evident in the Scottish population.

Qualitative work included in the review is excellent at highlighting some of the contributing factors that influence MHN role in physical healthcare. However, with the exception of work undertaken by Happell et al., a number of the studies do not provide demographic detail about their sample or inform the reader how the study was conducted. This can, therefore, call into question the trustworthiness of the findings and their implications for practice. In addition to lack of detail, a number of the studies appear to lack a theoretical framework to help contextualise their work. This may explain why most of the qualitative work is descriptive in nature. While it is excellent that the issues are so well articulated, the current body of knowledge can only allow us to speculate why nurses are ambivalent. While it is essential to know that education plays a part in forming roles, we do not in this instance, know how and why or if education is helping or hindering the current situation. Similarly, some of the organisational factors that influence nurses' role are identified and numerous, but we are currently unsure how and why this is the case. Much of the studies have referred to other members of the team and a jarring of roles and responsibilities. This, along with organisational factors, may be down to the culture of practice settings, and this is worthy of further exploration.

A number of the studies cite a lack of time and overwhelming workloads as a reason for why MHN are not adequately addressing people's physical health needs. A recent critique of MHN argues that the profession subscribes to several practices such as care planning, not because they are useful but because of the neoliberalist nature of the health system that values system processes and ‘box-ticking’ over therapeutic engagement (McKeown et al., 2017). We know that MHNs are skilled communicators who can draw on many different interventions to help their patients, including motivational interviewing, CBT and solution-focused therapy. MHNs have experience in encountering less than ideal behaviours and understanding these from a biological, psychological and social perspective. However, it is apparent that nurses may not be utilising their skills fully and not applying them to help their patients improve or manage their physical well-being.

While there is a clear tension between current mental health ethos and wider UK government agenda (Conlon *et al.,* 2015), it was heartening to see that several studies in this review mention therapeutic relationships and how tackling a person's physical health may affect this. On the one hand, the UK government wishes MHNs to practice in a recovery-orientated way, but also wish them to implement policies such as smoking cessation, which could be viewed as a potential threat to therapeutic work. Therefore, there is a clash between the individual and larger structural systems.

As a result of the gaps that were evident within the existing literature and in particular, the many unknowns as to how and why MHNs feel ambivalent or impacted by organisational factors, I posed the question;

> How do registered mental health nurses working in one Scottish NHS board understand their role regarding providing physical healthcare to people of working age with serious mental illness?

Due to much of the qualitative work within the review being rather descriptive in nature and not explaining the underlying mechanisms, the first study aim developed was to;

> Find out how relationships and structural issues within the work environment impact on mental health nursing practice.

As education and learning was a significant theme in the review, I wished to explore this further and how this impacted on participants. In particular, I wished to also move the debate beyond pre-registration and also ascertain what within the practice setting was helping or hindering MHNs. It is for this reason that the phrases 'educational experiences' and 'competencies,' are used, in order to acknowledge that not all learning is formal. Therefore, the second study aim developed was to;

> Find out in what way do educational experiences and competencies[7] assist mental health nurses in performing their role.

## 2.9 Summary

This chapter is presented in three parts. In part I, I presented a review of international policy, critiquing the MH strategies of seven English-speaking countries against the MRM. In part II, I presented a review of the empirical literature in order to ascertain the colour and shape of the landscape regarding MHNs and physical healthcare. In the final part, I present an integrated discussion section which should make it apparent to the reader the basis for how my research questions were formed.

---

[7] This is more than just technical skill but rather meaning to encompass knowledge, skills, attitudes and values.

# Chapter 3: Theory

## 3.1 Introduction

This is the first of two chapters, outlining my methodological approach to answering the study aims. This chapter focuses on the theoretical perspectives that I have drawn on in conceptualising the social phenomenon under investigation. It opens with a justification for my utility of social theory in order to investigate nursing practice. I then outline how I conceptualise ʻroleʼ and ʻprofessional identity.ʼ I then move on to discuss my use of Bourdieu's writings and in particular his *Theory of Practice*. This is the primary theoretical lens for my study. I discuss the key concepts which make up his theory; 'field', 'capital' and 'habitus' and how they relate to the context of this study. There is a detailed discussion on Bourdieu's view of language and the implications this has for meaning within this thesis. There is particular reference made to what he coined ʻsymbolic violence.ʼ

## 3.2 Social Theory and Nursing

Blaikie (2000) argues that the use of theory is essential as phenomena are often so complex that we require theory to aid our understanding. The question becomes ʻwhat theory should I use?ʼ Lipscombe (2017) asserts that nurses are not appropriately educated in theoretical ideas and their application to research. Due to the demands of routine clinical practice, social theories are not the first or even second priority of nursing staff.

However, I would argue that the role of social theory is to give the researcher tools to illuminate things that actors in the field may not be consciously aware of, but which still influence and impact on their practice. Purkis and Ceci (2017) articulate that social theory has an important role in illustrating and highlighting what good nursing practice looks like. Embracing outside theories which may be unfamiliar, allow me as a researcher to step outside my own context and examine practice in a manner which may not be possible if I was to adopt a purely nursing theory. Tilley (2005) articulates that the very existence of MHN knowledge is a disputed concept, and drawing on such theory is unlikely to gain the insights I require to answer my research aims. Hence my decision to step out of my own disciplinary canon.

Nursing practice is a social activity carried out by a social group. Therefore the use of social theory seems entirely appropriate. Bourdieu's writings allow for the concurrent examination of both the structural and interpersonal aspects of nursing practice; the structures in which nursing operates in and the 'craft of caring.' While other theories were considered, such as self-determination theory, I came back to Bourdieu, for the ability to use his writings to illuminate processes such as cultures, traditions and structures.

## 3.3 Key concepts

### 3.3.1 Conceptualising 'Role' and 'identity'

It would be difficult to discuss mental health nurses' role without first conceptualising 'role'. Role is a "set of characteristics associated with a social position" (White and White, 2006). All roles are independent of the person's individual characteristics. Roles are socially constructed by the social expectations of others (Thoits and Virshup, 1997). These expectations are guided by a person's attitudes, values and behaviour (Ellmers *et al.*, 2002, Jackson and Hogg, 2012). This can mean people occupy different roles or positions at the same time but may privilege certain roles over others depending on the context (McCall and Simmons, 1978). Therefore, roles form a hierarchy of importance that reflects the relative value of a particular role identity has for an individual's self-concept. Self-concept is defined as "our personal understanding of our perceived attributes (as a social, physical and cognitive person)" (Marsh and Scalas, 2010: 660). Essentially self-concept is about how one thinks and feels about oneself including an attribution on their self-worth, self-esteem and confidence.

Identity is the effect of cognition, affect, and personality traits on social interactions as well as the meaning people attribute to themselves while performing a role (McCall and Simmons 1978, Thoits and Virshup 1997). Like role, it is socially constructed and formed over time through interactions with others. Jenkins (2008: 17) articulates that "[…] all human identities are, by definition, social identities." This is because they are the result of meaning-making practices. Identity is closely linked with language use and discourse, as it is language that helps us make sense and form meaning (Gee, 2014). Language offers us an 'identity kit' which in turn provides us with a way of thinking, speaking, acting and valuing that makes us recognisable to others. Simply put, while roles are about functions, identifies are about meaning (Castells, 2010). Roles are context-specific conditions to develop and express identity.

MHN has developed and shifted identity over the years. This is from one of custodian and prison-officer like role to one of a therapeutic agent who embodies person-centred and recovery-orientated practice (McCrae and Nolan, 2016). With that, the expectation of MHN has evolved as society expects more than just containment from nurses.

Sociological and psychological theories of role are concerned with how role is constructed and performed, as well as how we take on the role of the 'other' and manage expectations associated with role (Thoits and Virshup, 1997). Two such theories are Goffman's (1959) *Presentation of self in everyday life* and Butler's (1990) performativity of gender outlined in their text *Gender Trouble*.

Goffman believed that the best way to understand human action was to view people as actors on a 'social stage' (Goffman, 1959). We are expected to act various roles on this stage and interact with the other actors joining us on stage. Goffman argues that performances are viewed as being either sincere or contrived. By contrived, some people do not believe the parts they are playing reflect their true selves, but they must play the part to achieve another end. This could be true for nurses, who perform the role of the nurse, despite perhaps not wanting to interact with other actors, or indeed who disagree with the stage layout yet must do so because their 'true self' is that they want to help people, or simply have a family to support. Because as we must take on multiple roles, these roles may come into conflict with each other (e.g. nurse and manager). The possible impact on this study is that linked to identity hierarchies, MHNs self-perceived role conflicts with the demands placed on them by wider systems and structures.

Lawler (2014) argues that Goffman and Butler have much in common, in that they both argue our identity is something which is performed as opposed to being something intrinsic. Arguably we do not have a choice. The concept of nurses having agency is eroded by the social expectations of nurses in their roles. Nurses are nurses simply because they perform being nurses based on societal expectations of what nurses 'do' and 'are'.

While Goffman argues that there are correct and incorrect ways to act, based on the expectations which society places on us, Butler tries to move beyond Goffman's thinking to explore why the social world creates identities at all. Butler (1990) uses the example of gender and argues that there is no natural sex distinction, but instead, gender is a social construct placed upon girls and boys. She argues that despite biological differences, there is no reason why we must distinguish by these. Children are 'girled' and 'boyed' on a continuous process growing up, destined to 'become' a boy or girl. The child accepts this destiny and performs their gender according to social norms, and therefore recognise themselves as their prospective gender, thus actively participating in their own gendered identity (Butler, 1990). This may explain why nurses 'conform' to roles and why there may be an unquestioning and uncritical tone from nurses to the question 'what do nurses do?'

### 3.3.2 Professional role and identity

MHNs will occupy a professional role identity. There are many definitions of what constitutes a profession (Kulick, 2006). They share several common criteria which have developed over the years. Durkheim (1893) considered a professional to be members who shared a body of knowledge and moral commitment. This was developed further by Carr-Saunders and Wilson (1933) taxonomic approach, who were concerned about the difference between an occupation and a profession. They considered there were certain criteria such as technical knowledge and specialised training to be hallmarks of professions. In turn, Wilensky (1964) examined the transition from occupation to profession. Freidson (1970) moved away from a focus on processes to how different professions interacted with each other. He argued that well-established professions such as medicine dominated and subordinated other occupational groups who did similar work. He argued that one way to define a profession was by the amount of power they yielded.

Building on the concept of power, Abbott (1988) argued that the process of professionalisation was not about going through linear steps, but rather an occupation became a profession by gaining jurisdiction over types of work. Jurisdiction is the power to produce knowledge (Abbott, 1988). He viewed professions as being interdependent and a change in jurisdiction for one had an impact and on the boundaries of others. Abbott's theory is useful for this study, particularly when examining mental health nursing in the context of a biomedically-dominated practice setting. It is particularly helpful in framing how the roles of nurses have evolved due to changes in medicine and psychiatry. Professionalism is also concerned with the provision of altruistic service to society and autonomy over work, and work conditions (Liaschenko and Peter, 2004). This is important to consider, as data that will be presented in the findings chapters show that participants in this study did not always feel like they had autonomy over their work and indeed, their working conditions.

Professional identity, therefore describes how the members of an occupational group can fulfil and maintain these criteria and as a result, how they perceive themselves and perceived by others. This means how an occupational group is perceived to have authority and autonomy over its knowledge and function within its societal context.

Tajifel and Turner (2019) proposed a theory of social identity. Society identity theory hypotheses that the self-concept of an individual or group, such as nurses, is derived from the perceived image of the group by society; if society thinks well of the group this enhances the group's self-concept. Johnson *et al.,* (2012) found that professional identity in nursing is intertwined with theories of self-concept as discussed above. Professional identity relates to just one component of one's overall identity and attributed to their position within society. This supports other work in this area, which links self-image and self-esteem as core to one's professional identity (Öhlén and Segesten, 1998; Piil et al., 2012). In a review of self-concept and professional identity in nursing, Hoeve *et al.,* (Hoeve et al., 2014) found that professional identity is reflected in nurses' self-concept which is based on the general public view of nurses.

When considering professional identity, then one also needs to consider Wenger's (1998) views. Wenger (1998) links professional identity to learning, arguing that learning and education transform individuals. It provides them with the skills to perform a role, and therefore learning is an identity-shifting experience. It is not just the acquisition of skills and knowledge but something more profound, as it fundamentally shifts the person's identity, who they are and what they can do. This is similar to Bourdieu (1984, 1992d, 2006), who believed that participation in practice and learning processes develops people's dispositions and therefore, their identities. Therefore knowledge is linked to identity. This may not be just formal knowledge but also experiential knowledge that is learned in practice and which also contributes to a process of socialisation.

## 3.4 Bourdieu and his Theory of Practice

This study is framed and influenced by the writings of Pierre Bourdieu. His writings provide a theoretical lens through which to view the social phenomena of MHNs and physical healthcare. In the following section, I provide background on Bourdieu and his theory of practice. I then outline his key concepts including field, capital and habitus and how they apply to this study. It is important to note that these concepts are in a dynamic interdependent interplay, but in order to articulate their value better, I discuss them individually before discussing how they interact. This is due to their often complex nature that can make them difficult to grasp.

Pierre Bourdieu (1930-2002) was a French philosopher, anthropologist and sociologist. His writings focus on trying to understand how people make sense of their social world. His work focuses on the relationship between social structures, power, agency and in particular the hidden processes at work (Bourdieu, 1977, 1990; Grenfell, 2012a; Nairn and Pinnock, 2017). Bourdieu argued that people's actions were influenced by cultures and traditions, such as their background and personal values, as well as objective structures within society (e.g. their employer, central government) (Bourdieu, 1977, 1990).

He was particularly critical of the divide within the social sciences between Positivism and Interpretivism, especially believing that the world is a social construct. He attempts to move past the subjectivism/objectivism binary by viewing them as "modes of knowledge"(1990: 25). Bourdieu believed that there was much to be gained from both. Both are essential but offer only one side of the story. Bourdieu wanted to create a theory that is both structured (*opus operatum*- efficacy of action) and structuring (*modus operandi*- method of doing something) (Bourdieu, 1990; Grenfell, 2012b)

Essentially, the theory can be considered a socio-cultural framework that "presents the practices and experiences of a social group" (Rhynas, 2005: 181). Arguably, this is an appropriate perspective to understand the position of nurses and take account of the role of education, learning, culture and status and how these impact on nursing practice (Bourdieu, 1971, 1990, 2006)

Bourdieu stressed the importance of understanding and reading his work in the context of the time he was writing (Grenfell, 2012a). For Bourdieu, this was a time when French society was dealing with the fallout of its colonial past and place within the world. Similarly, this study takes place within a context. This context is an increasingly stretched health system, where service is struggling to meet demand. Mental health services, in particular, have received attention for this increased demand and married with long waiting times to access appropriate interventions. This makes the NHS, the key field or structure in which MHNs practice, inherently political. This in turn, will impact the context of the study and its findings.

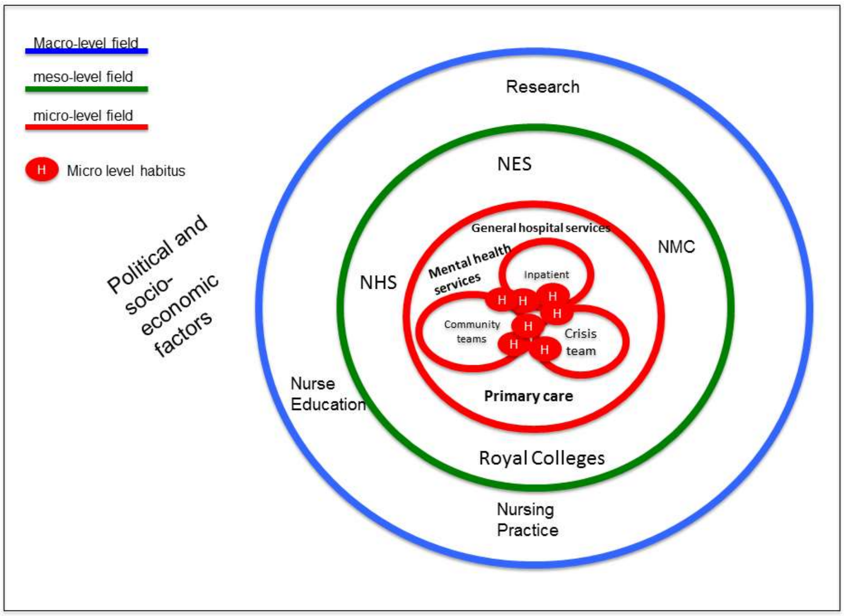
There are three core concepts in Bourdieu's *Theory of Practice*. These are Field, Capital and Habitus (Bourdieu, 1977, 1990). Bourdieu stressed the importance of the interdependent nature of these concepts for his theory and that they should not be considered in isolation. As mentioned earlier, due to the challenging nature of his writing, they are often explored separately so the concepts can be grasped and applied, acknowledging at all times their interdependence. In the proceeding sections, I will discuss the concepts individually before discussing their interdependence.

### 3.4.1 Field

Field refers to relationships in the social space and the structures and forces contained within that social space (Bourdieu, 1977; McKinnon et al., 2011; Thomson, 2012). Fields are multidimensional spaces and contexts and include institutions or workplaces. Bourdieu (1977, p.266) defines a social field as "a system of relations between positions of special agents and institutions who struggle for common cause." Fields have boundaries and therefore, there is a limit to what can be done within a field. Each field contains positions which are occupied by agents or actors. Each field has its own set of rules or *doxa*.

In this study, fields can be considered at a micro level, such as the ward or community team, but also at a macro level, with the organisation (NHS), the government and the regulator (NMC) are also fields in their own right. Bourdieu argued that these various fields are interacting and interdepend at various levels. Writers have argued that this can make the understanding and application of the theory a challenge. Several writers recommend 'mapping' out the field to help understand these complexities and see who is competing for dominance (Grenfell, 2012b; Nairn and Pinnock, 2017). The relevant fields, as applied to this study, are mapped out and illustrated in Figure 3 to help give context to this study.

**Figure 3: Representation of various fields within the study**



Bourdieu argued that the field should be the primary source of study, as it is the relationships within that field that are important as opposed to individual actors (Bourdieu, 1990; Thomson, 2012). For this study the fields in question will be the inpatient wards and community mental health teams. The reason for this is explained further in chapter four. The study will focus on MHNs as the primary actors within the fields. This is not to say that MHNs are the only actors within the field. Pragmatically it would not be within the scope of this study to explore all fields in depth. Furthermore, it is clear from the literature review that MHNs are perhaps unclear of their position within the field. Participants in this study did bring my attention to other actors.

### 3.4.2 Capital

Capital can simply be understood as the forms or the means, resources or power a person possesses (Bourdieu, 1984, 1990, 1993, 2006; Bourdieu and Eagleton, 1992; Moore, 2012). Bourdieu outlined a number of forms of capital. These are; economic, social, cultural and symbolic forms of capital. The field attributes the 'value' of the various capital. Capital is used by actors as currency to be exchanged in order to progress within the field.

#### 3.4.2.1 Economic capital

This can refer to monetary and labour exchanges as well as the possession of fixed assets such as property. It is important to note that because of the often substantial monetary value associated with this form of capital, economic capital does not have superior value to other forms of capital within the field.

Economic capital could be considered implicitly in this thesis when participants refer to workload pressures impacting on their role. In this instance, managers and indeed people much higher up the hierarchy are in a position of power, as they control the economic capital within the field, which impacts on participants' perception of the resources they have available to support patients. Economic capital is seen explicitly in chapter six, when discussing pre-registration education. This education is exchanged within the fields for registration with the regulator (The NMC) in order to practice as a RN. This in turn, allows the RN to earn economic capital in the form of wages.

#### 3.4.2.2 Social and cultural capital

Social and cultural capital are discussed together, as they are similar. Social capital is the number of resources which an individual or group possess. This is achieved through the acquisition of acquaintances, relationships and networks, with people having multiple networks and hierarchies. Social capital is about whom you know and the network of people around you. This can mean being connected to a few people but who possess much capital. These networks and relationships are forms of capital in themselves. Groups share capital to give a collective capital and therefore, a collective increase in power.

Cultural capital is about the tastes, skills and manners that people possess. It is about knowing how to behave in a particular context. They are important forms of capital as they help create a collective identity among people sharing similar forms of capital (Bourdieu, 1984, 2006). In this study, this could be MHNs whom all studied the same degree programme at the same institution or having a similar outlook or disposition to certain care practices. However, it can also refer to material possessions, clothing and tastes. Carter (2014) articulates that social and cultural capital in nursing is not just about education, skills, and experience but also the values that motivate us to be nurses. Bourdieu identified three forms of cultural capital. They are; embodied, objectified and institutionalised capital.

Embodied cultural capital refers to knowledge that resides already within us from childhood, including early schooling as well as the knowledge that we seek out ourselves. This can also include language. These include the skills of our mind and body, including our accent, posture and mannerisms as well as our taste in cultural phenomena such as music and art. More powerful social classes will use these traits in order to distinguish themselves from others and communicate their status and power.

Objectified capital is material objects that can be used to show our status and class. This can be a particular brand of the motor car and is based on owning 'things.' In nursing, uniforms act as a powerful form of objectified capital, showing exactly where one sits within the hierarchy, with the uniform becoming a darker shade of blue as someone moves up within the field.

Institutionalised cultural capital is concerned with symbols of competence, authority and credentials. It is essentially how society measures our social capital. Bourdieu (1984) in particular viewed educational qualifications as an institutionalised form of cultural capital. He saw them as legally sanctioned "cultural competence" (p.20) that are independent of the abilities of the graduate. Institutionalised cultural capital often leads to actors achieving more capital in the field in two ways. A higher degree, in theory, should lead to the actor acquiring higher economic capital in terms of salary in paid employment. University education allows the graduate to develop new skills, or embodied capital which can be exchanged for this economic gain. Graduating from certain institutions also allow for the development of social capital in terms of joining prestigious alumni groups and expanding their social networks. However, being awarded a degree from particular institutions will on its own, transmit prestige and more capital over others.

#### 3.4.2.3 Symbolic capital

This is the automatic process that occurs when people enter the field with their various forms of capital (Bourdieu, 1990; Bourdieu and Wacquant, 2013; Moore, 2012). Their capital gets transformed by taking on a symbolic meaning, depending on the context and nature of the field. Actors, who have certain forms of capital, hold an advantage on entering the field, depending on the nature of the field. Symbolic capital communicates prestige and a person's reputation for competence and respectability. It is about recognition and legitimisation of one's capital. It is an implicit form that shows the many relationships and capital a person possesses leading to status. Actors can use this capital to accumulate more and advance further within the field. Such capital can be considered positive, but it might also have a divisive function. For example, knowledge acquisition could also become a mechanism for social division with some actors exerting dominance over another because of increased capital.

### 3.4.3 Habitus

Habitus is a concept, which critics argue make the theory most challenging to grasp. Lipcombe (2016) articulates that the term is made problematic by researchers who do not explain to the reader what version of habitus they employ, as it developed throughout Bourdieu's career and writings.

Habitus can be considered the attributes that people possess as a result of their upbringing and experiences (Bourdieu, 1977, 1990, 1992a; Bourdieu and Wacquant, 2013; Maton, 2012; Wacquant, 2001). Habitus is our ways of acting, feeling, thinking and being. These dispositions will lead to certain perceptions, appreciations and practices and therefore act as another structure.

Bourdieu employs the concept to help answer questions such as: how can individual agency and social structure be reconciled, and how does the outer and inner-self help shape each other? It is a "structured and structuring structure" (Bourdieu, 1990: 53). It is structured by one's past and current circumstances, for example, family background and educational experiences. It is structuring in that it shapes present and future practices. It is not acting in isolation, and we are not pre-programmed, instead it comes through interaction or unconscious relationships within the field.

Narin (2016) articulates that habitus is how behaviour is reproduced and becomes habitual. This is because how people act within the field is determined by their habitus, which is developed over time. People will act a certain way when they belong to a particular group, with that group having a collective identity.

Not all habituses have equal value, much like how various forms of capital also do not hold similar value. Therefore, through its link with capital, habitus also tells us something about social class. The dominant habitus is the dominant set of values and attitudes held by the dominant class. Bourdieu used the term habitus to incorporate cultural and traditional compounds of individuals into his theory.

Habitus is enacted when people unconsciously incorporate their attitudes and values into their practice. Nursing can be considered habitus. Nurses are exposed to practices which are, in turn shaped by previous practice (Narin and Pinnock, 2017). Nurses may be influenced by the individual habitus or their collective 'nursing' habitus within the healthcare system. While some argue that nursing habitus is ingrained early on, others argue that nurses develop a professional habitus as part of the socialisation and learning (Narin and Pinnock, 2017).

Bourdieu claimed that previous accounts tend to focus on regular practices or habits without examining the underlining principles that generate these practices. This was a key finding from the empirical literature discussed above. Researchers identified that nurses were ambivalent and voiced ambiguity regarding their role, but did not manage to articulate why this the case. Employing complex concepts such as habitus may help in overcome this shortfall.

### 3.4.4 Interaction of concepts

Bourdieu summed up his theory with the following equation, which demonstrates how the key concepts interact with each other to result in the development of practices;

$$[(\text{habitus})(\text{capital})] + \text{field} = \text{practice}$$

Habitus and capital interact together, with actors attempting to use their pre-existing capital to gain additional capital and move up within the field hierarchy. Their habitus internally regulates agency. This dynamic is given its meaning by the field in which the action takes place (Rhynas, 2005). Practices are not the result of habitus but rather the relationship between one's habitus and current circumstances. To understand practice, we must understand evolving fields within which actors are situated and the evolving habituses which actors bring to their social field, including their capital. Therefore capital and field represent the structure, while the practice or agency is influenced by the habitus (Rhynas, 2005). This allows structures to be considered alongside individual responses to these structures.

This approach is helpful in exploring mental health nursing. MHNs are not at homogeneous group. This is illustrated by Tilley (2005), who edited a collection of essays of the state of the field of knowledge in mental health nursing based around UK institutions. Commentaries from international academics supplemented this. Reading the collection, it becomes apparent that the very field itself is disputed. As Ryan (In Tilley, 2005) comments, an apparent dichotomy exists on how to answer the question 'what is MHN knowledge?' This is between those who believe that such knowledge would be developed by multidisciplinary research teams who value scientific knowledge and those who believe that knowledge comes in experiential forms derived from the lived experience of pSMI. Even those in the 'middle ground' it seems the priority is given to non-nursing forms of knowledge, instead drawing on approaches from the fields of counselling and psychotherapy. Simply put, there is a divide between 'objective’ approaches that emphasises the biological basis for care and the ‘subjective’ elements of practice, often considered the ‘craft’ of caring.

## 3.5 Bourdieu, language and meaning

In this section, I discuss Bourdieu’s writings on language and its implication for meaning. This is in relationship to language as another form of capital but also how language is the weapon in which symbolic violence inflicts harm (Bourdieu, 1992b, 1992c; Schubert, 2012; Thompson, 1992).

Bourdieu warned that we should “beware of words,” as they are social constructs and not value-neutral. Language for Bourdieu is “an instrument of power and action” (Bourdieu and Eagleton, 1992: 111). It is an essential facet in demonstrating how people express themselves and interact with each other. Language use is another example of a social construct. Language helps to both express the social structure but also reproduce it (Bourdieu, 1992b, 1992c; Thompson, 1992). As a practicing MHN, I have always been aware of the power of language. Words are the central tool with which MHNs utilise in order to carry out our work. Words can hurt or heal. In a therapeutic encounter, language and our choice of words can reinforce a socially constructed stigmatising stereotype of mental illness, or challenge it.

This argument is supported by Gee (2014) who argues that language is not just about words but also how the use of particular words communicates to others how we are a certain kind of person who is doing a certain kind of role and this language use makes others recognise us as occupying a particular role. People will use different types of language depending on the situation which they find themselves in. Because of this, the language they use helps shape and communicate their identity in a context-specific manner (Gee, 2014). Language derives its meaning from its function; the identity it is used to communicate

The word ‘practice’ and the word ‘game’ can be used interchangeably (Gee, 2014). Gee (2014, p.5) states “In a sense all language gets its meaning from a game, though we don't typically use the word 'game'. We use the word 'practice'" Therefore Bourdieu's theory of practice lays out the foundation for how language gets its meaning from the practices within which it is used, while at the same time, language structures our practice or game and brings it into existence. Gee (2014, p.8) states that these practices are always ways of saying, doing and being; "Meaning as an integration of ways of saying (informing), doing (action) and being (identity) and grammar as a set of tools to bring about this integration." Therefore, language has meaning from the practices in which and through which it is used. The practices give meaning to the language.

Language therefore, is both a structured and structuring force; language shapes our role identity. Our professional identity will be structured by the language we use, such as professional jargon and acronyms, or language which conveys our incorporated knowledge and skills. This will in turn, communicate to a messenger, such as a patient or another colleague, who will interrepret that identity and assign meaning to the person. For example, a nurse explaining a procedure or treatment to a patient will use a different language within the interaction, which would be different if the nurse was speaking about the procedure with colleagues or medical staff. It would be different again if the nurse were explaining such a procedure in a non-medical setting. Therefore, it is also the context in which the words are spoken which give identity, meaning and power.

### 3.5.1 Language as capital

In this regards, language can be considered a significant form of cultural influence and capital. This is because language used in any exchange between people can demonstrate one's position within the field (Bourdieu, 1984, 1992c). This language use can be learned by others within the field to help them to socialise or develop their capital. Language can be exchanged and used to progress within the field. This is because an institution is a set of social situations which give certain people power via their status and resources allocated to them. This allows people to speak with differing levels of authority (Bourdieu, 1992c; Gee, 2014; Schubert, 2012; Thompson, 1992).

An example might be that the nurse in the example above has been given the authority to explain the procedure, reassuring the patient but does not have the authority to seek the informed consent of the patient for the procedure. This is something that the institution has placed in the hands of the medical staff. The field gives the language (the capital) its value because the field recognises and acknowledges it as such and that such capital is vested in certain groups.

Language can also be used to communicate with other members that they belong to a particular group and therefore have a collective identity. For example, the use of medical terminology in the practice setting can demonstrate a level of knowledge as well as communicating membership of a particular group. Nursing has its own set of words and vocabulary, which in turn shape the experience and understanding of nursing (Crowe, 1998). Language can be used by actors in the field to socialise new individuals into practices and structures.

Arguably knowing how to use language to interact with various people and in particular contexts is what gives it its status as capital. As in the example above, the nurse knowing which words to use depending on their audience and context. This capital can be enacted in several ways. For example, the stigma surrounding pSMI and the language which some professionals use creates and perpetuates further stigma. The stigma and hostility can also be directed towards the staff who work in MH services, who are seen as other or different because of their practice context.

### 3.5.2 Symbolic violence

Because of the social capital implicit in language, Bourdieu considered it a form of domination (Bourdieu, 1992c, 1992e; Bourdieu and Eagleton, 1992; Bourdieu and Wacquant, 2013). The power of language is not in words themselves but, instead, in the way in which the social world interprets both the words and their context (Schubert, 2012).

Forms of symbolic domination, such as language produce and maintain social hierarchies and inequality. The result of such social domination is what Bourdieu termed 'symbolic violence' (Bourdieu, 1992c; Bourdieu and Eagleton, 1992). Symbolic violence can be described as an "unperceived form of violence" (Schubert, 2012: 180) exerted by the dominant classes in order to produce and protect their power. Members of the dominant classes need to exert little energy to maintain dominance. Both dominated, and dominant forces go about unquestioning its legitimacy and by acting in their own best interests within the system (Bourdieu, 1992c; Thompson, 1992). This violence is symbolic because it is not an evert physical force, but rather expressed through the language used by the dominant class (Bourdieu and Eagleton, 1992; Schubert, 2012). While this may mean that symbolic violence is perceived as a gentler form of violence, it does not make it any less real as suffering occurs as a result of both (Bourdieu, 1992b, 1992c; Schubert, 2012).

It some ways it is a more effective form of violence because it is often misrecognised but is still internalised by members of society and therefore those who are subject to it become complicit with it (Bourdieu, 1992b; Bourdieu and Eagleton, 1992). In some ways, symbolic violence is the product of the game which Gee (2014) discusses, and in each game there are winners and losers. In the context of this study, this may be the nurses who may hold little capital within the field.

For Bourdieu, sociology as a discipline can provide tools to highlight and illuminate symbolic violence which in turn should reduce suffering (Bourdieu, 1992a; Deer, 2012). This may be a particularly useful concept in my study as nurses, and in particular, MHNs are often perceived as a voiceless and marginalised profession who do not hold much capital in the field of health services. In chapter five, I present data which I have analysed through Bourdieu's lens, which shows that MHN practice regarding physical healthcare is often invisible or not conceptualised as 'nursing care.' This is arguably a form of symbolic violence.

It is often argued that nursing as a profession is so marginalised because of the internal conflicts and debates that exist among the profession itself. This example of symbolic violence may best be illustrated by examining the development of nurse education and in particular the transition from hospital-based training into a graduate-level profession. Bourdieu emphasises that schools teach students particular things in particular ways which socialise them in a particular way. Only certain subjects are taught and only in certain ways and with certain forms of judgement. Nursing's transition into the academy raises questions about whether we socialise students differently and what impact that has.

There is a perception both externally and within the profession that such degree-educated nurses are not fit for purpose with an accompanying discourse that they are 'too posh to wash' (Lauder et al., 2008). The 'how and what' of nurse education has developed over generations as patient need grows in complexity. This is an example of what Schubert (2012, p183) would call the "structuring of structures is a historical process." This raises questions such as who decides what knowledge should be taught and for what purposes. This point is illustrated further in chapter six of this thesis.

### 3.5.3 Translation, researcher and context

Another way to understand language is to examine the use of translation. Bassnett (2002: 4) discusses the contrasting views of the translator; "A force for good, a creative artist in own their own right" versus the translator who engages in a "highly suspect activity" that is rife with inequality and power relations. That is because as a translator, your decision to translate certain words in certain ways is a form of power, which gives meaning to the new translation. As a translator, you give meaning to the culture of the translated language as the process of translation means making another culture comprehensible. Languages are steeped within cultures, and no culture can therefore exist without language. For this reason, Bassnett (2002: 9) argues that "the figure of the subservient translator has been replaced with the visibly manipulative translator, a creative artist mediating between cultures and languages."

The role of a qualitative researcher and translator are not entirely different. Both use the tool of language to communicate and make sense of meaning and stories. Both are required to decode messages and comprehend what people are really communicating and then make that accessible for a target audience. It is the researcher, much like the translator, that gives meaning to participants by the questions they choose to ask, by their use of transcription processes which is a much more subjective endeavour than might seem on the surface, and finally by the researcher's use of interpretation to sculpt and mould a set of findings that tell a story.

## 3.6 Summary

This chapter has focused on the theoretical perspectives which I have drawn on in conceptualising this study. It opens with my rationale for drawing on social theory to study nursing practice. I then outlined how I conceptualised 'role' and 'professional identity.' I then move on to outline my use of Bourdieu's writings and in particular, his Theory of Practice, outlining the key concepts which make up his theory; ‘field’, ‘capital’ and ‘habitus’ and how they relate to the context of this study. This chapter concludes with a discussion on Bourdieu’s view of language and the implications this has for meaning within the study.

# Chapter 4: Methods

## 4.1 Introduction

This is the second of two methodology chapters. While the previous chapter detailed the theoretical concepts, this chapter provides an outline of my approach to conducting the study and the justification for the decisions made during this process. I begin by outlining my ontological and epistemological position. I provide a justification for pursuing a qualitative approach. I discuss and reflect on the various ethical issues which occurred as part of this study, in particular, the ethics of qualitative interviews and having a pre-established professional relationship with participants. The next section gives details on the study setting and my approach to recruiting participants and the criteria I used to reach my sample of 14 RNs. I then provide a detailed account of my data collection methods, namely a short demographic questionnaire and semi-structured interviews. This account includes my rationale for choosing interviews as my method of data collection as well as the role of space and place in conducting them. I then move on to consider how I answered the research questions via analysis. This includes a detailed discussion on the process of transcription as well as how I arrived at two findings chapters that are centred around Bourdieu's concepts of 'field' and 'capital.' The chapter concludes with an outline on how I ensured quality throughout the research process.

## 4.2 Ontology and Epistemology

Ontology makes us question our beliefs about the nature and form of reality (Crotty, 1998; Guba and Lincoln, 1998). Epistemology is the theory of knowledge (Parahoo, 2014). It is concerned with answering the question "how do we know what we know" (Crotty, 1998: 8). A particular epistemological position assumes a particular view of reality; therefore, Crotty (1998) argues that both ontology and epistemology are inextricably linked.

Both ontological and epistemological positions can best be understood as a continuum between realism and relativism. Realists believe in a fixed, objective reality outside the existence of human beings and akin to the natural sciences. In contrast, relativists believe that there is no one true reality, but multiple ones constructed by our interactions and interpretations in the world. Often research textbooks present these positions as a dichotomy (Braun and Clarke, 2006; Lipscomb, 2007; McEvoy and Richards, 2006)

Grenfell (2012b) states that Bourdieu's key concepts should be applied to new research projects, both ones that propose theories and hypotheses, and ones that involve the collection of empirical data and analysis. This is because Bourdieu's goal was the engagement of both in order to understand social processes better (Bourdieu and Wacquant, 2013). As Grenfall (2012b: 214) articulates; "the study of the social object can be described most simply as an ongoing and reflexive interplay between the two positions- empirical investigation and theoretical explanation."

Bourdieu's view of reality was that it was complex; it was multidimensional because structures and the humans that interact with them are complex (Bourdieu, 1977, 1990). For Bourdieu, his *theory of practice* was about overcoming the divide that existed within the social sciences by uniting in one theory, objective realism and subjective relativism. Therefore, his ontological and epistemological position is one of 'structuralism constructionist.' For Bourdieu, reality consisted of objective structures that existed outwith and alongside individuals, which in turn influenced practices, with individuals interacting with these structures. It is these interactions that give rise to the construction of meaning.

In this thesis, my ontological outlook is that reality is socially constructed, context-dependent and subjectively perceived (Crotty, 1998). Both the participants and I in this study are social actors, who have to interpret their activities together, and it is these meanings, embedded in language, that constitutes social reality (Blaikie, 2000). Social reality comes about because of social actors interacting and negotiating meaning for their actions and situations (Blaikie, 2000). However, this meaning is subjective and open to interpretation. In this study, this social reality will be enacted by examining the experiences of MHNs and their physical healthcare practices working within the field, including the nurses' subjective interpretations of their practices. This is within the specific context of one Scottish NHS health board.

My epistemological position is determined by asking the question, how can I, as a researcher, know what I know in terms of MHNs' practice regarding physical healthcare for pSMI? In this regards, I have a constructionist perspective. I do not believe there is one objective truth or viewpoint. Rather, like Crotty (1998: 8–9), I believe that "truth, or meanings, comes into existence in and out of our engagement with the realities in our world. There is no meaning without a mind. Meaning is not discovered, but constructed." Meaning is constructed by my interaction with the MHNs in this study and how they make sense of their practice regarding physical healthcare for their patients. How structures define or 'construct' nursing roles will affect how 'agents' practice these roles. It is likely that the MHNs 'role' will also be constructed by different stakeholders, such as patients, employers and the regulator. Each of these will construct role differently, but some will have more authority than others, but all will nonetheless influence the individual.

This also involves acknowledging my role within the process is also an interpretive one as the findings will be shaped by my interpretive lens. This lens can never be objective because of my personal experiences, my role within the study and my interest in the phenomenon under investigation. I will bring all of these to bear on the construction of meaning and the findings within the study.

## 4.3 Research Design

Ontological and Epistemology positions will guide how phenomena should be best studied, and the designs and methods that would appropriately answer the research aims (Parahoo, 2014). The research question will also determine what kind of data is needed. I deemed a qualitative approach to be the most appropriate to answer the research questions, and it appeared to be most congruent with my ontological and epistemological positions. I found that Braun and Clarke's (Braun and Clarke, 2006, 2014, 2019a; Clarke and Braun, 2013a; Terry et al., 2017; Vossler et al., 2017) position on qualitative research reflected my constructionist orientation, namely that new knowledge is generated through the interactive process between the researcher and participant and the researcher's interruption of the subsequent data. I also felt that the ontological and epistemological position reflected Bourdieu's approach to research, which was a "structuralist constructionist."

A qualitative approach allows for a meaningful and rich exploration of the topic, which will lead to a better understanding of key concepts (Parahoo, 2014; Silverman, 2009). Qualitative research is particularly useful at examining intangible concepts that cannot be measured, such as role, culture and education (Clarke and Braun, 2013a). Qualitative research is about creating and interpreting meaning from the stories that participants share, which are context-bound (Braun and Clarke, 2019a; Gibson and Brown, 2009; Vossler et al., 2017). A qualitative approach will allow hearing from the participants in their own words and in their context. There is no one way to 'do' qualitative research, and numerous approaches exist (Flick, 2018; Gibson and Brown, 2009; Silverman, 2009). This study's methods and analysis will be influenced by the writings of Braun and Clarke (Braun and Clarke, 2006, 2016, 2019a; Clarke and Braun, 2013a, 2013b, 2018) but also the Bourdieu's writings outlined in the previous chapter. While not always considered a method in its own right, Thematic Analysis (TA) is useful in identifying and analysing patterns of meaning across a data set (Clarke and Braun, 2013a). It is not concerned with the accuracy of what participants say, but rather the meaning they attribute to it. While there are other forms of TA, which take a more reductionist approach (Guest et al., 2012; Joffe, 2011) , I felt that Braun and Clarke's approach was most congruent with my own ontological and epistemological position.

TA is a flexible approach to qualitative design (Braun and Clarke, 2006, 2019a; Clarke and Braun, 2013a). This flexibility is something which Bourdieu called for when undertaking research. It is not tied to any one ontological or epistemological position. Additionally, it can be used in combination with several theoretical frameworks.

## 4.4 Ethical issues

Ethical issues will occur at all stages of the research process (McDermid et al., 2014). Often ethical issues in qualitative research are subtle in nature which can make them difficult to identify (Orb et al., 2001). In this section, I will detail the steps I took to ensure my research was conducted to the highest ethical standard, including applying for ethical approval, the role of informed consent and confidentially. I will discuss the steps I took to ensure I upheld principles of good data management before concluding the section on discussing the ethics of qualitative interviews and being an 'insider' in the research setting.

### 4.4.1 Ethical approval and NHS access

In order to ensure that this project constituted good ethical practice, the study was reviewed by the School of Health in Social Science ethics committee. No data was collected until the study received a favourable opinion (See Appendix B ). While the study received only very mirror amendments, this process took longer than expected (approx. 8 weeks) due to the backlog of applications.

As the proposed participants were NHS staff, the project did not require review by an NHS ethics committee. This is due to NHS Health Research Authority and ACCORD definitions of research (See Appendix A).  However, the study still required NHS Research and Development approval. This process of applying via college processes lasted from October to December 2017.

Once finally allowed to submit my R&D form, NHS approval was granted in a matter of hours (See Appendix C). A deciding factor in the very swift approval was my employment status within the organisation and that I had already held discussions with the Chief Nurse for MH services, who had provided constructive feedback on an early draft of the study protocol.

### 4.4.2 Informed consent

To ensure that potential participants were clear about what the study involved and what they were being asked to do, they were provided with a participant information sheet (PIS) (See Appendix D). This was emailed to all staff within the service. I also distributed physical copies. Participants had as much time as they wanted prior to agreeing to participate. Once they agreed and a time arranged for the interview, I reviewed the PIS again with participants at the start of the interview, allowing time for any questions prior to participants giving their informed consent. Participants communicated their consent by signing a consent form (See Appendix E). This was countersigned by the researcher. A copy was provided to each participant, and another was retained in the study file.

### 4.4.3 Volunteerism

All participants agreed to take part in this study on their own volition. It was made expressly clear that this study was separate from the NHS and that participation or non-participation would not affect participants' employment in any way. Participants would be free to withdraw from the study at any time and with 'no questions asked.' Thankfully no participant withdrew at any point. If they had withdrawn, their data would have been removed from the study.

### 4.4.4 Confidentiality

As participation in this study was not tied to employment conditions, confidentiality had to be strictly maintained. Participation and non-participation was not communicated with any level of NHS management. All data (written and electronic) was encrypted and securely held in accordance with University guidelines and national legislation- see 'data management'.

All personal and identifiable information was anonymised to protect people's identities. People were issued with participant information numbers (Allmark et al., 2009). These consisted of three digits- made up of a letter to identify the participant's 'field' (H=hospital or C= community) and a two-digit number based on recruitment sequence. These were also used during the transcription process to identify who was speaking. This made the process of data analysis more straightforward, in terms of finding chunks of text and presenting them. I chose such codes to denote speakers as assigning names or pseudonyms can be problematic (Hammersley, 2010). Firstly, it assumes that the participant wishes to remain anonymous, but the choice of a pseudonym may inadvertently communicate information about the participant. This raises questions about what information should or should not be included (Allmark et al., 2009; Hammersley, 2010). The use of pseudonyms may assume a level of speakership, which cannot be assumed as participants may wish to speak on behalf of themselves or others (Hammersley, 2010).

It was clearly explained to participants as part of the informed consent process that there were certain circumstances where confidentiality may have to be broken. For example, circumstances may arise where the researcher believed from what the participant disclosed that there is a significant risk to either the participant or someone in their care, including disclosure of the serious crime. As RNs, the researcher and participants were well aware of this in order to adhere to their professional code of conduct. It was deemed that the likelihood of this occurring to be low due to the interview content being about routine practice and generally not considered sensitive or intimate. There was no occasion where anything discussed in an interview raised concern for the safety and well-being of either the interviewee or the people in their care.

### 4.4.5 Data management

In accordance with University of Edinburgh protocol (Academic and Clinical Central Office for Research & Development (ACCORD), 2014), a project-specific data management plan was developed (See Appendix F). This helped ensure that all aspects of the research process adhered to strict data management principles in order to safeguard participant confidentiality and protect from other data-breach related harm.

The key points from this data management plan were; all electronic data, including interview auto-recordings, will be stored on a university computer server which is encrypted and password protected and only accessible by the researcher. All audio-recordings will be destroyed at the end of the study. Interview transcriptions were to be anonymised so that no individuals may be identified. 'Hard copy' data (e.g. data on digital voice recorders, printed documents, and handwritten documents) would be stored in a locked cupboard in the School of Health at the University of Edinburgh. The cupboard was only accessible by the researcher and was in a keypad-entry office. Anonymised data will be held for five years after collection in accordance with university guidelines.

While this initially felt like another bureaucratic 'hoop to jump through' it proved to be one of the most useful steps in developing the study. For the first time, I was forced to focus on the practicalities of conducting this study and give clear and specific thought as to how I was going to uphold a key ethical principle. Due to the relatively simple research design, the plan involved only four pages, but within that, I was clear in how and what would happen to the data and indeed what constituted data in my study. It also made me consider how I was going to organise any electronic or written data. As the study progressed, I found myself referring to it time and time again. Far from being another bureaucratic process, it became a very active and living document.

As part of this, I developed a Study folder. Having previously worked on a large clinical trial, I learned first-hand the importance of organised documentation. Borrowing the concept of the 'trial file' from Good Clinical Practice (ICH, 1997), I developed my own 'study file' which was a physical folder containing all the relevant documents from protocol, consent forms and data management plan.

### 4.4.6 Ethics of interviews

Qualitative interviews are not without inherent ethical issues. These include unintended cathartic effect and power dynamics (Allmark et al., 2009; Hewitt, 2007; Pillow, 2010; Rossetto, 2014).

Qualitative interviews can have a therapeutic and cathartic effect on participants (Pillow, 2010). There is also an argument that participation in such qualitative studies is burdensome and therefore best avoided, especially when interviewing people about sensitive issues. Biddle *et al.,* (2013) reported that participants (n=63) who took part in qualitative studies exploring self-harm were asked to measure their well-being before and after participating in the interview. Fifty to 70% of participants reported increased well-being from participating, reporting the experience to be cathartic. Of those that reported a decrease in well-being (18-27%), they reported this was transient and as a result of being reminded of difficult times and their desire to participate and contribute to the research far outweighed the risks. Other research which address topics that are potentially stigmatising, such as sexual risk behaviour in young adults, again participants reported that being able to talk freely about their experience in a non-judgemental forum was cathartic, and unintentionally made them reflect and come to realisations about their experiences (Bourne and Robson, 2015).

While this is an unintended consequence, it can be a source of ethical concern. However, this study was not deemed a sensitive topic, but rather one that focuses on everyday practice. Rossetto (2014) argues that the therapeutic benefit in qualitative interviews must be acknowledged as this possibility is going to affect participant responses, reactions and therefore, how the researcher makes sense of the collected data. I feel that embracing this unintended consequence is the best way to deal with the issue. If participants experienced cathartic moments, it is likely because the interview encouraged participants to engage in a reflexive process, which can be used to learn and improve their practice going forward(Rolfe, 2002, 2014).

All qualitative interviews, regardless of the topic, involve elements of power dynamics, emotional impact on the part of both parties and a sense of identity work which can make the process unpredictable and hazardous (Allmark et al., 2009; Miller, 2017). Being able to listen and make participants feel comfortable is essential to getting participants to ‘open up’ and ‘disclose’ their experiences. However, this disclosure could be framed another way and the urge to ‘confess' may be an effect of 'disciplinary power' where the information shared will be scrutinised by the institution and as a way of critiquing individuals (Watson, 2006). I feel this has been overcome by emphasising the different nature of the research from participant's employing organisation and that no information will be disclosed to the person's line manager.

### 4.4.7 Insider/Outsider relationship

A unique factor in conducting this study was that I worked clinically as a staff nurse within the inpatient area and had good working relationships with the relevant community teams. This had to potential to cause ethical issues. Indeed, Cribb (2003) argues that the majority of ethical issues in qualitative interviews come from the researcher /participant dynamic. This required particular thought, especially if I was to interview a participant who holds a higher position. They may have the potential to impact on the type of data and therefore, the quality of the study (Miller, 2017; Sivell et al., 2015). Similarly, participants may be alienated by the fact that the researcher is known and worked with them (McDermid et al., 2014).

Several steps were utilised to overcome these issues. Firstly, the uncertainty in being interviewed by a colleague was acknowledged and discussed with participants. Secondly, it was made very clear that the interview was for research purposes and that the researcher is there in a clear and separate identity- that of a researcher as opposed to staff nurse. Researchers need to ensure that their position as researcher and not a practitioner is made clear from the start (Sivell *et al.,* 2015).

There is a need to consider how the design and conduct allow for trusting relationships to form, how questions allow participants to adequately describe their experiences and allow them to talk about what is important to them (Miller, 2017). This may be aided when the researcher is perceived as an 'insider' which may result in participants offering up rich data as they may feel that they can speak freer with someone who understands their position. However, this also poses a threat to data collection. Participants may assume that the researcher has a certain level of knowledge and consequently use language and expressions that are vague and colloquial. Very early on during data collection, I learned of the importance of emphasising this, so participants did not make assumptions about my knowledge and therefore impact on the quality of the data. Listening back and reflecting on interview skills was key to ensuring that the data collected was good quality. This meant asking clarifying questions. Conversely, being an 'insider' did significantly aide my recruitment process, and I do feel participants spoke relatively freely.

Rossetto (2014) argues that participants in qualitative interviews are more equal partners than participants in other forms of research as they co-create meaning. However, participants may feel obliged to participate because of their known relationship with the researcher (Allmark *et al.,* 2009). Finally, it was emphasised that all participants would be treated fairly and equally and that participants are under no obligation to participate. On reflection, being acutely aware of the challenges faced in interviewing people known to me, I perhaps overcompensated with a nonchalant attitude, when at times, I could have been more persistent in recruiting people.

Another significant advantage to being an 'insider' was being acutely aware of the context in which the study was taking place. This is not only something which Bourdieu emphasised, but its importance is also stressed in the literature on qualitative interviews (Braun and Clarke, 2019a; Rossetto, 2014; Roulston, 2011; Roulston and Choi, 2018). Often how conversations unfold depend on the knowledge of the interviewer. Without knowing the context, researchers may find it challenging to know what question to ask or even understand the data that the participant provided. I feel my unique knowledge of the services meant I was best placed to ask the right questions and draw out rich data.

### 4.4.8 Researcher safety

While the risk of harm to the researcher in undertaking qualitative research is considered low, there is still apparent risks that required thought (Clarke and Braun, 2013a). Such risks are even present when interviewing participants that traditionally pose a low risk. Some of these arise from lone-working. Both the local NHS health board and the university have well-established lone working policies which were strictly followed. The researcher ensured there was a balance between maintaining safety and protecting the confidentiality of participants. The researcher drew on strategies to maintain safety recommended by  Clarke and Braun (2013a). All interview times and places were recorded on the researcher’s Microsoft Office365 calendar. Only the Participant number and location was recorded. This calendar was shared with a 'research buddy' who was another postgraduate student in the same workspace. The 'buddy' agreed only to access this if there was a problem, and they had not heard that the researcher is safe. When the interview has been completed, the researcher would 'check-in' with their 'buddy' to inform them that they are safe via text message or short phone call. There was never an occasion where the researcher was not safe and well.

## 4.5 Research participants

In taking a constructionist approach, researchers must afford greater attention to the context of the study (Hardin, 2003). As meaning-making is context-bound (Bourdieu, 1990, 1992b; Braun and Clarke, 2019a; Gee, 2014), this context plays a role in how and what people communicate when telling their story (Hardin, 2003). A frequent critique of qualitative research is that reports fail to articulate the study setting in any meaningful manner (Schreier, 2018; Sim et al., 2018a, 2018b; Vossler et al., 2017). It is hoped that providing as much detail as possible about the study setting and the participants, I will allow the reader to make their own assertions about the quality of the study and in particular the transferability of the findings to 'fit' with the reader's context (Nowell et al., 2017; Parahoo, 2014; Rolfe, 2006; Tobin and Begley, 2004). In this section, I provide an outline of the study setting in the confines of confidentiality, my approach to sampling, including demographic information on my participants. I also detail the inclusion and exclusion criteria. The section concludes with details of the recruitment process.

### 4.5.1 Setting

This study took place in one NHS health board in Scotland. The health board serves an area of 1725 km$^2$ and covers four separate local authorities. There is a mix of urban and rural areas and includes multiple areas of deprivation. MH teams are organised by sectors across the health board. There are four covering the urban area and three for the rural areas. Each sector contains primary and secondary MH services.

Additionally, there are a number of intensive home treatment teams (IHTT), which offer an alternative to hospital admission. Inpatient facilities are concentrated across two sites- the largest being a psychiatric hospital located in an urban suburb. It contains approx. 300 inpatient beds. The second site is co-located in a large district general hospital and contains approx. 60 beds for acute general adult psychiatry, along with several specialist regional services.

### 4.5.2 Population

The participants were drawn from a large population of registered mental health nurses (RMNs). According to finance/payroll figures, there were 902 whole-time equivalents employed within the service at the point of data collection.

### 4.5.3 Sample

Nurses working specifically within the large psychiatric hospital, and the corresponding community teams and IHTTs, who cover urban areas were targeted for recruitment. These became the two 'fields' for the study. The rationale behind this is that both contain the majority of RMNs overall within the health board (Hospital site 471.1 WTE, Urban community teams 163.8 WTE). Only if recruitment was unsuccessful, did I intend to funnel out to other sites within the health board. Secondly, the inpatient teams are aligned to specific community-based teams and are therefore clinically linked with a clear shared boundary.

An equal number of participants were recruited from within each 'field.' The reason for particular focus is the very different nature of clinical work between the inpatient and community setting. While nurses in hospitals may have been traditionally viewed as doing physical health activities, as more services move to community-based delivery, we do not know if the 'field' of community mental health impacts on the nurses' role. Additionally, to prioritise one 'field' over the other would not give an accurate reflection on the role of the MHN.

When designing the study, I envisaged recruiting between 12 and 16 registered nurses. However, in keeping with qualitative approaches, the data should dictate the number of participants. Various textbooks talk about ‘saturation’ and the need to recruit participants until no new data can be added to the analysis (Braun and Clarke, 2019b; Crouch and McKenzie, 2006; O’Reilly and Parker, 2013; Sim et al., 2018b). However, Low (2019) argues that saturation is an ill-thoughtout concept and is poorly executed in part to a lack of a unifying definition. Definitions rest on a sense of completeness or absolute endpoint, which Low (2019: 136) points out is “a logical impossibility”.

These points are further substantiated by Braun and Clarke (2019b) in their critique of data saturation, with the authors concluding that for reflexive TA it is not a useful concept and one which is not ontologically sensible or coherent. Instead, they argue that it is a much more pragmatic decision when to stop recruitment.

Additionally, studies with small sample sizes do not produce any less ‘richness of data’ compared to excessively large sample sizes (Low, 2019; Schreier, 2018). Indeed, excessively large sample sizes may result in too much data being collected, which could in turn result in an insufficient and superficial analysis (Schreier, 2018; Low 2019). It also carries the risk of placing an ethical burden on participants (Schreier, 2018).

In my approach to stopping data collection, I focused on the richness of data in order to address the research aims. I felt that a natural repetition occurred when conducting the interviews. For me, this occurred when I had reached 14 participants across the two fields. I had no outstanding interviews arranged at this point and so therefore did not need to cancel any potential participants. This was also a pragmatic decision based on time and progress. In answering the question, "when is enough data enough" I felt Low's (2019, p.135) viewpoint is helpful; "Analysis is never complete; there is always something new to discover, some new insight to be made". There comes the point where one does need to be pragmatic and move on from collection to analysis and to answering the research questions.

Schreier (2018) outlines various approaches to sampling; purposeful, convenience, criterion. On reflection, I took an eclectic approach. It was purposeful in that I required people who could provide rich data to answer the questions. There was an element of convenience as there were multiple people in the setting who could fulfil that role and who were available. Finally, it was also a criterion sample as there were specific criteria which I wished to include in my sample; an equal weight given to the two fields, inclusion of people working in various specialities, level of educational attainment, Agenda for Change (AfC) bands, gender, work pattern as well as ensuring a mix of people at various stages of their career. I also wished to have dual-trained nurses within the sample as a result of the findings within the literature discussed in chapter two.

Table 2 details the demographic background of the sample, taken from the demographic questionnaire, which is discussed further in section 5. Table 3 details the sample based on the criteria discussed above. Overall, I feel I achieved a good mix across the criteria. While it would have been advantageous to have a dual-qualified nurse who worked within the inpatient setting, this proved impossible, as none identified wished to participate.

**Table 2: Demographic information of sample**

| | Inpatient setting | Community setting | Overall |
|---|---|---|---|
| **Population Sample** | N=471.1 WTE<br>n=7 | N=163.8 WTE<br>n=7 | N=634.9<br>n=14 |
| **Average Age** | 37.7 years<br>(29-47 years) | 38.9<br>(31-51 years) | 39.2<br>(29-51 years) |
| **Gender** | Male = 2<br>Female = 5 | Male = 3<br>Female = 4 | Male = 5<br>Female = 9 |
| **Banding** | AfC 5= 5<br>AfC6 = 2 | AfC5= 1<br>AfC6= 6 | AfC5= 6<br>AfC6 = 8 |
| **Average Hrs/wk** | 32.3<br>(12 – 37.5hrs) | 34.6<br>(22.5 - 37.5hrs) | 33<br>(12-37.5) |
| **Years qualified as RMN** | 11.03<br>(1.7-26.3 yrs) | 12.55<br>(7.4-25.3yrs) | 12.56<br>(1.7-26.3) |
| **Years working in current post** | 5.56<br>(0.5-26.3 yrs) | 6.8<br>(0.5-18yrs) | 7.17<br>(0.5-26.3 yrs) |
| **Highest qualification** | Diploma = 1<br>Bachelors (O)= 2<br>Bachelors (H)= 4 | Diploma= 2<br>Bachelors (O)= 2<br>Bachelors (H)= 1<br>PgDip= 2 | Diploma = 3<br>Bachelors (O)= 4<br>Bachelors (H)= 5<br>PgDip= 2 |
| **Setting** | Rehab = 1<br>Acute admissions= 6 | IHTT= 2<br>CMHT= 5 | |

### 4.5.4 Inclusion/exclusion

The inclusion and exclusion criteria are detailed in Figure 4. They were developed in order to access the people most likely to work with adults aged 18-64 with a diagnosis of SMI. Dual-qualified nurses were included as it is likely they will offer unique insights into education, habitus and its impact on role. Previous studies discussed in the literature review have found that dual-qualified nurses may not have better attitudes but may be self-report more confidence in this area of practice (Howard and Gamble, 2011)

**Figure 4: Inclusion & Exclusion criteria**

**Inclusion criteria:**

Registered Nurses (Mental Health division), Band 5 AfC and above

Or

Dual qualified nurses (RN Mental Health plus any other part of the register), Band 5 AfC and above *and*

Working in 'general adult (18-65)' mental health services within the NHS

Can work in any service delivery/model of care (inpatient, community, crisis intervention).

Has worked in the area for 6 months or more.

**Exclusion criteria:**

Student nurses

Non-registered nursing staff

Nurses working in a liaison environment.

Nurses working in specialist services such as;

- Perinatal Mental Health
- Eating Disorders
- Child and Adolescence
- Dementia services
- Forensic mental health

Non-mental health qualified nurses.

Nurses working outside the NHS

Nurses who solely work on a 'bank' or 'agency' capacity

Has worked in the area for less than 6 months

### 4.5.5 Access

As part of gaining access, discussions were held with the Chief Nurse/General Manager of local mental health services. They provided their support to the study, and this made R&D approval significantly easier. While it was planned to present the study to the clinical nurse managers and senior charge nurses, it was felt this was not necessary in the end due to my employment within the organisation making accessing staff easier. It appeared I was very much viewed as an 'insider.'

**Table 3: Breakdown of criteria for sample**

| | Field | | Setting | | | | Gender | | AfC banding | | | Work pattern | | | Highest educational attainment | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Participant | Inpatient | Community | Acute | Rehab | CMHT | IHTT | Male | Female | Band 5 | Band 6 | Band 7 | Full-time | Part-time | Dual training | Diploma | Bachelors (Ord) | Bachelors (Hons) | PgCert | Masters | Year qualified |
| 1 | ■ | | ■ | | | | | ■ | ■ | | | | ■ | | | ■ | | | | 2005 |
| 2 | | ■ | | | | ■ | | ■ | | ■ | | ■ | | | | | | ■ | | 2007 |
| 3 | | ■ | | | ■ | | | ■ | | ■ | | ■ | | ■ | | ■ | | | | 2007 |
| 4 | | ■ | | | | ■ | ■ | | | ■ | | ■ | | | | ■ | | | | 2009 |
| 5 | ■ | | ■ | | | | | | ■ | | | | ■ | | | | ■ | | | 2002 |
| 6 | | ■ | | | ■ | | | ■ | | ■ | | ■ | | | | | | ■ | | 2010 |
| 7 | | ■ | | | ■ | | | ■ | ■ | | | | ■ | ■ | ■ | | | | | 2003 |
| 8 | ■ | | | ■ | | | | ■ | | ■ | | ■ | | | | | ■ | | | 2001 |
| 9 | ■ | | ■ | | | | ■ | | | ■ | | ■ | | | | ■ | | | | 2011 |
| 10 | ■ | | ■ | | | | | ■ | ■ | | | | ■ | | ■ | | | | | 1991 |
| 11 | ■ | | ■ | | | | ■ | | ■ | | | ■ | | | | ■ | | | | 2016 |
| 12 | ■ | | ■ | | | | | ■ | ■ | | | ■ | | | | | ■ | | | 2016 |
| 13 | | ■ | | | ■ | | ■ | | | ■ | | ■ | | | | | ■ | | | 2000 |
| 14 | | ■ | | | ■ | | ■ | | | ■ | | ■ | | | ■ | | | | | 1993 |
| | 7 | 7 | 6 | 1 | 5 | 2 | 5 | 8 | 6 | 8 | 0 | 10 | 4 | 2 | 3 | 5 | 4 | 2 | 0 | |

### 4.5.6 Recruitment

This ‘insider’ status made recruitment relatively straightforward. Firstly, the PIS and poster (see Appendix G) were emailed to all staff members within MH services. Posters advertising the study were also advertised in relevant clinical areas. On the back of this, several senior charge nurses approached me directly to offer their support. I was told I was welcome to enter a ward at any time and approach staff as much as needed in order to get my desired sample. This open atmosphere was very welcome, and one which I feel was afforded to me merely because of my perceived 'insider' status. While I had predicted that having a prior professional relationship within the clinical area would aid recruitment, I was surprised to the extent and the enthusiasm demonstrated by people.

Recruitment got off to a strong start. People very soon emailed offering their time, and I conducted four interviews within the first week. In particular, there was a very enthusiastic response from the home treatment team, to the extent that I had to say no to some people due to the sampling strategy. In this instance, I politely explained that I had enough participants recruited from within their team and required participants from across multiple teams.

Indeed, both participants who worked within that service spoke 'off the record' about how important they felt that their team were invited to participate. They felt as 24-hour service, which offered an alternative to hospital, they had an incredibly unique view and outlook on the topic and would not necessarily always be considered to have a role in this area of practice. Data collected also suggested they had unique challenges in this area of practice.

As recruitment progressed, it became increasingly challenging. This was not for want of participants but rather the practicalities of facilitating interviews. The 'Beast from the East' hit Scotland right in the middle of data collection. This caused a delay long after the snow had melted. It took weeks to rearrange interviews. This was because of shift patterns, night duty etc. I also had to contend with the end of the NHS annual leave cycle and the inpatient wards were experiencing significantly high levels of clinical need married with a bed crisis. This really impacted on the ability of inpatient staff to participate. For example, one participant who due to their banding and post, was considered an ideal participant. It took four attempts to conduct the interview, with it having to be abandoned at the very last minute each time. This was obviously very frustrating.

Community teams were also experiencing their own pressures. While CPNs traditionally manage their own diaries, data collection coincided with unprecedented clinical need. The bed shortages were impacting on their caseloads and risk management. For example, one CPN whom I approached wrote back a lovely email stating while they were really passionate about the topic, their team were 4.0WTE RMNs short, and consequently, they had no available appointments in their diary for the forthcoming four months. This excluded one whole CMHT from participating.

This is not uncommon when recruiting nurses as participants in qualitative research studies. Luck *et al.,* (2017) highlights that the political climate of the organisation can often impact on both the recruitment of nurses to studies but also the data which they may offer up during the interview. This can be particularly evident if services are going through an organisational change, where consequently, participants may feel unsettled and may suspect the purposes of data collection (Luck *et al.,* 2017). While participants did bring these issues to the fore in their interviews, I feel it was less so in their willingness to participate. I feel my 'insider' status allowed me to provide the 'personal touch' called for within the literature to overcome recruitment challenges as well as being very sensitive to the political climate of the services (Luck et al., 2017; Marks et al., 2017).

## 4.6 Data collection

The following section details my approach to collecting the data within the study. This includes a rationale for the use of a short demographic questionnaire, the use of semi-structured interviews as well as a discussion on conducting a pilot interview and the use of space and place in conducting the interviews.

### 4.6.1 Demographic questionnaire

A basic demographic questionnaire was developed (see Appendix H). Participants were asked to complete this at the start of the interview. This data was necessary in order to help transparency regarding sampling (Braun and Clarke, 2019b; O'Reilly and Parker, 2013; Parahoo, 2014; Schreier, 2018; Silverman, 2009) and also assisted the researcher in ensuring they recruited participants who were in a position to provide meaningful data (Clarke and Braun, 2013a; Flick, 2018; Gavin, 2012; Parahoo, 2014; Silverman, 2009) As discussed above, such data provides the reader with greater context to aide in their ability to assess the findings 'generalisability' and 'fit' to their setting.

Bourdieu made clear the importance of educational attainment, workplace culture, socialisation and broader structural factors in the environment. Therefore, it was considered essential as part of the sampling processes that the educational and professional background of the nurses in this study were recorded and considered as part of the analysis.

### 4.6.2 Interviews as a method of data collection

Interviews are an established method of data collection in qualitative research and particularly lend themselves to exploring studies that seek to understand the experience of the participant (Clarke and Braun, 2013a; Roulston, 2011). They are also good at providing the researcher with data on the social conditions in which participants live and work. Researchers use interviews for different research purposes and may not conceptualise them the same way (Roulston and Choi, 2018). Thought should also be given to ensuring that the conceptual framework and analysis methods are congruent (Roulston and Choi, 2018; Silverman, 2009).

Therefore, there is a need to explain what 'interview' meant in the context of this study. As this study aimed to find out the work situation of MHNs and how they understood their role concerning an aspect of practice, it was decided that semi-structured interviews informed by Denzin (2001) were the best fit for meeting these aims. Denzin coined this the 'reflective interview.' This approach assumes that the interviewee has no essential self but various versions which they perform via the relationship with the interviewer. Because of the questioning of if such a method can generate truthful accounts, the data generated is considered "reflective, dialogical or performance" (Denzin, 2001: 24)

I felt that Denzin's position was congruent with my own ontological and epistemological views. Namely, there is no one reality but rather multiple, co-constructed versions. I, therefore, felt one method of data collection was sufficient. Hardin (2003) takes a similar view to Denzin, conceptualising interviews as a "social performance" where both the interviewer and interviewee "are simultaneously the authors, characters and audiences of the stories being constructed" (p540). This performance role for the interviewee is supported by Watson (2006) who argues that the interviewee has just as much work to do as the interviewer. The interviewee must offer up data and do so in a way that captures the attention of the researcher. Because of this, Potter and Hepburn  (2005) argue that one cannot assume that interviews are able to access the internal states of participants' minds authentically, and therefore there are few claims made of their objectivity (Roulston, 2011). In light of this view and that the goal of the research was to discover people's believes, perspectives and sense of meaning, I felt a triangulation of methods would achieve little.

Semi-structured interviews are seen as a compromise between unstructured and structured approaches and allows for a flexible approach to each interview (Doody and Noonan, 2013). Unstructured interviews may yield too much unfocused data, resulting in a time-consuming analysis period. A structured approach would be too rigid. It is felt that neither approach would provide sufficient data to address the research aims.

A loose interview guide was prepared in order to guide the interview and ensure that data likely to address the aims was collected (See Appendix I). While it is acknowledged that the questions which researchers ask directly shape the responses (Hardin, 2003), the interview guide was viewed as just that, a guide. It became an active document that was regularly reviewed during the data collection phase. Such an approach allowed for the appropriate use of open and closed questions to reach the nuance of issues, while also allowing the interviewee space to talk about what they wanted to discuss (Roulston and Choi, 2018). One-to-one interviews have the advantage of allowing the participant to give answers to questions in a safe and confidential environment and not have to fear reprise from managers and colleagues if discussing provocative areas of practice.

In considering methods for this study, focus groups was also considered as a suitable approach. Focus groups have the advantage of being able to witness first-hand the meaning-making process via the interaction between participants in the group (Clarke and Braun, 2013a). Focus groups also allow for a wide range of views from people discussing issues in 'everyday' language (Clarke and Braun, 2013a). However, being sensitised to the practice area, I decided against this as a method for two reasons. Firstly, focus groups can inhibit some people from speaking openly. I felt that the combination of different participants may prohibit discussion, particularly if a manager was to participate in the group. My own experiences made me aware that this could be an issue and threaten data collection. Secondly, the clinical areas were short-staffed and experiencing high-clinical need. Focus groups can be difficult to recruit 'busy' people to such as nurses to participate. I felt knowing the context of the study setting that recruitment would be near impossible with this method.

I also considered the use of direct observations. However, I decided against this approach for a number of reasons. Firstly, considering my ontological position and social constructionist outlook, meaning is co-created and there are multiple realities. I therefore felt observations did not 'fit' with this. Observations can help to sensitise the researcher to the research setting (Parahoo 2014). However, I did not feel this was required considering my 'insider' status. Finally, there was a pragmatic reason. This was the issue of receiving a favourable ethical opinion in order to conduct observations in both an acute psychiatric setting or in the case of CPNs, in people's homes.

### 4.6.3 Pilot study

I elected to conduct a pilot interview in order to trial the schedule, practice interview techniques and use of the recording equipment.

This proved a worthwhile endeavour for refining the interview schedule. The pilot participant also threw up data which I had not considered before. They gave feedback that they found the pace of the interview good and felt comfortable to speak. The participant was an experienced band seven nurse who had worked in the inpatient setting for over 20 years. This proved to be an unseen burden, as listening back an apparent power dynamic came to the fore, which meant I did not ask as many probing questions as I could. My notes from the event showed there was some incongruence between what the participant was saying and their body language, which at one point became quite guarded and closed. I also mumbled and struggled to articulate questions.

As a RMN, I felt I was practised in many essential interviewing skills, including establishing professional rapport, active listening, phrasing questions and creating a safe space. While the conditions for a therapeutic engagement and a research interview share several commonalities (Coyle and Wright, 1996; Watson, 2006), I soon realised that they felt very different. In this regards, my experience mirrors Newman *et al.,* (2017), a novice researcher with a similar professional background who also made assumptions about preparedness to conduct research interviews. This realisation came when conducting the pilot interview.

On reflection, it felt at times that the participant had a negative attitude to younger, newly qualified nurses; a sort of attack on 'degree nurses'. This evoked a strong reaction in me that at one point when the participant was discussing some nurses not being able to take a blood pressure manually, I replied "not on our ward. We take them all manually" Obviously such comments by the researcher could jeopardise the quality of the interview and answers elicited. I feel that the pilot study did show my naivety in my skills and as a consequence, I developed a healthy self-consciousness regarding my interviewing technique which I used to refine and reflect on when conducting the actual data collection.

### 4.6.4 Conducting the interviews

Holstein and Gubrium (1995) argue that detailing how interviews were conducted is one way to overcome criticisms and improve a study's quality. Data was collected over 19 weeks, commencing on 16th January 2018 and ended on by 23rd May 2018. Interviews totalled 10 hours and 53 minutes which resulted in 112,359 words when transcribed. The mean interview length was 00:46:40. There was little difference in length between hospital and community participants.

Soon into conducting data, the advantage of this semi-structured approach became apparent. They allowed for a dialogue between the researcher and the participant, which facilitated a more immediate response to the data participants brought to the interview. For example, follow-up questions could be posed, and questions could be reworded when the participant was unsure. It also allowed the participant to raise issues which they felt were pertinent, which at times lead to rich and meaningful data (Doody and Noonan, 2013; Parahoo, 2014).

I was cognisant of Roulston and Choi's (2018) view that a good qualitative interview should not be dominated by either interviewer's voice or the interviewee's agenda. Instead, it should feel like a communication where tension between the research question and the experience of the interviewee is explored. While acknowledging that my professional background did not automatically prepare me to conduct research interviews, I did draw on the skills I learned as an MHN and some offered in the counselling literature on conducting interviews in order to achieve this aim. Coyle and Wright (1996) argue that therapeutic and research interviews draw on similar techniques when establishing rapport, such as being non-argumentative, supportive and active listening. Establishing rapport is seen as key to promoting open and honest dialogue (Coyle and Wright, 1996).

Feedback and 'off the record' comments from participants that they enjoyed the experience of speaking and reflecting on practice made me think I achieved this goal. In particular, I received much feedback that participants felt I put them at ease and created an atmosphere where they felt they could speak freely. Reviewing this feedback very early on in the process boosted my confidence that I was hitting the right notes with participants and consequently getting the depth of data I desired. However, two interviews felt slightly jilted. Off the record comments in both revealed that they were extremely nervous because of the digital recorder. While somewhat frustrating, both confirmed that it was not due to the nature of questions or how they were asked.

Others provided off the cuff comments when the recorder was stopped that would have also contributed meaningful data. For example, one participant commented afterwards that they "toned down" their criticism of pre-registration training because they did not want to come across as “too negative.” These were noted in my journal for reflection during analysis.

### 4.6.5 The use of space in conducting interviews

Gagnon *et al.,* (2015) states that interview location is often overlooked in qualitative and in particular, nursing research. Engaging with the concepts of 'space' and 'place' is another way to engage in reflexivity and therefore improve the study's rigour. It is argued that researchers need to engage in “explicit analysis” of their interview locations; both the physical space and the social context in which the encounter takes place (Gagnon et al., 2015: 203). This is because places and spaces affect the information shared or communicated during the interview (Elwood and Martin, 2000).

‘Place’ is considered “a bounded phenomenon- ranging from scale of regions to buildings but within which and with which social and psychological relations are formed” (Andrews, 2002: 3). ‘Space’ is not considered absolute “and a void or distance to be measured or crossed, but is understood as relative, coming into existence because of social processes and phenomenon” (Andrews, 2002: 4). In this regards, interview locations become like “micro geographies” (Elwood and Martin, 2000).

On reflection, I am guilty of Gagnon *et al.,* (2015) charge and did not fully appreciate the impact of space and place of interview location on the research process. Choosing the location for a qualitative interview is also a pragmatic decision between places that are accessible and convenient for participants, conducive to discussion, but as spaces that take into account social processes such as power dynamics (Elmir et al., 2011; Elwood and Martin, 2000). In this regards, I leaned more on the practical side of decision-making. I assumed that some staff would prefer to be interviewed in their workplace. Others may feel that this is imposing on their confidentiality and would not be able to speak freely. In which case, the participant would be offered an interview in a suitable room in the School of Health in Social Science. Similarly, there are numerous university rooms within the hospital grounds but very separate from clinical areas. This location would also provide participants with convenience but also be in a quiet and safe place away from the clinical area.

Table 4 outlines the various locations used for the conduct of the interviews. The majority of interviews were conducted at meeting rooms within the inpatient hospital. This was a pragmatic decision as these meeting rooms are in a central administration area away from the clinical area. However, earlier engagement with the literature would have allowed me to think about how this location interacts with the places where nurses practice. For example, despite being above their area of practice, a lot of participants commented that they had never been up there. Therefore, it is an area that is removed from the participants' practice. This may have been a favourable decision as it provided distance and space to think.

**Table 4: Interview locations by participant**

| Participant | Location |
|---|---|
| H 1 | Hospital meeting room |
| C 2 | Hospital meeting room |
| C 3 | CMHT meeting room |
| C 4 | Hospital meeting room |
| H 5 | Hospital meeting room |
| C 6 | University meeting room |
| C 7 | University meeting room |
| H 8 | Hospital meeting room |
| H 9 | Hospital meeting room |
| H 10 | Hospital meeting room |
| H 11 | Hospital meeting room |
| H 12 | Ward meeting room |
| C 13 | University teaching room |
| C 14 | CMHT meeting room |

H= Hospital/Inpatient
C= Community/Outpatients

Nevertheless, it is also incredibly busy with an open plan working area. There are many people who can gaze in on the various meeting rooms. While blinds were closed and no one knew what ‘meeting’ was going on was, it made me reflect on a point that Gagnon *et al.* (2015) raise; space is directly related to confidentiality, dignity and respect. Therefore a conscious focus on space and place is ethics in action. I feel this is an important point as Foucault (1975) discussed the institutional production of space; how space through its surveillance and regulation is an essential ingredient in the institutional exercise of power. However, choosing such a location, it could be argued that there was accidental institutional interference, or participants might have censored themselves because of this particular place.

Notably, two of the interviews took place in a meeting room near my office at the university. There is an assumption that such university places may not be conducive to carrying out qualitative interviews as they may highlight a power imbalance, where the researcher is set up in an 'expert' position (Elwood and Martin, 2000; Gagnon *et al.,* 2015). This space was a bright room with high ceilings and has a large bay window that overlooks the Meadows. This is significant as the two interviews that took place here were substantially longer compared to the others. While it is difficult to know without conducting appropriate follow-up with the two participants, this location was likely conducive to participants feeling able to offer up rich data about the topic. I had to discontinue using this room as it was turned into office space midway through data collection.

## 4.7 Data analysis

Data analysis is about prolonged immersion, thoughtfulness and reflection on the data (Braun and Clarke, 2006, 2019a; Flick, 2014; Gavin, 2012; Gibson and Brown, 2009; Roulston, 2013; Smith, 2009). The analysis process should result in the researcher being able to answer the questions outlined at the start of the research journey. For me, this proved a long, confusing and disconcerting stage of the journey. As a novice researcher, it was the stage that I became most 'stuck' on. Bourdieu's writings do not give much guidance only that the study 'field' should be the principal focus.

In planning and conducting my analysis, I was influenced by the writings of Braun and Clarke (Braun and Clarke, 2006, 2014, 2019a; Clarke and Braun, 2013a). In contrast to some qualitative methodologies which I found bewildering and confusing as a novice, I found their writing to be clear, accessible and went a long way to dispelling the mystery of qualitative analysis. I found their approach to qualitative research sat with my own outlook, namely that the data is a form of raw clay, which I as a researcher, mould to tell a story. Their approach to qualitative analysis, namely their approach to thematic analysis is outlined in a number of books and papers (Braun and Clarke, 2006, 2014, 2016, 2019a, 2019b; Clarke and Braun, 2013a, 2013b, 2018).

TA is a method for identifying, analysing and interpreting patterns of meanings (themes) within qualitative data. TA is useful to interrogate patterns within social and personal meaning around a topic and ask questions regarding the implications for such meaning (Braun and Clarke, 2014; Williamson et al., 2017)

DeSantis and Ugarriza (2000) discuss how researchers have failed to define what they mean by 'theme' particularly in nursing research. The function of a theme is to unite large bodies of data which might otherwise seem unrelated as well as capturing the meaning and essence of the meaning or experience, or as DeSantis and Ugarriza (2000, p362) define a theme "[…] is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature of the basis of the experience into a meaningful whole." Or in other words, a theme is "a pattern of shared meaning underpinned or united by a core, central organising concept" (Terry et al., 2017: 593). Themes act like key characters in a story (Clarke and Braun 2018, p.108)

TA is not bound to any one theoretical framework (Braun and Clarke, 2006). Critics have claimed that makes the method atheoretical. In opposition to this view, Braun and Clarke have published many commentaries, making clear that that is not the case (Braun and Clarke, 2019a; Clarke and Braun, 2018). Indeed, they insist that all qualitative research requires a firm theoretical underpinning which should be made explicit from the outset by the researchers. Rather, TA is theoretically flexible, allowing the researcher to choose the appropriate theory and how this theory will influence the conduct of the study (Braun and Clarke 2013, 2018 & 2019). Indeed, they argue that TA is nothing more than the mere description and lacks interpretive clout if it is not used within an existing theoretical framework in order to provide context for the analytical claims made within the analysis (Braun and Clarke, 2019a; Terry et al., 2017). This allowed me to draw on Bourdieu's key concepts which I outlined in chapter three to inform my analysis.

Braun and Clarke have outlined the various stages of how to conduct a TA. Rather than using the phases as a 'cookbook,' I used them as a starting guide to begin analysis and as a map of where the process may take me. It is important to note that qualitative data analysis is not a linear process, and therefore, these 'phases' will require the researcher to review and revisit, moving back and forth. However, identifying and explicitly stating what the researcher does helps the study's transparency. In contrast to other forms of TA which advocate the use of codebooks and calculating reliably of coding between two researchers (Guest et al., 2012; Joffe, 2011), Braun and Clarke take a flexible and non-prescription approach. Therefore, the phases should be seen as a guide or loose structure in order to spell out the 'how' of analysis. It takes account of the view that there is no one correct way to analyse data in a qualitative paradigm because there is no one 'truth.' While Braun and Clarke outline six stages (2006), including producing the final report, my process involved four broad stages which I have outlined below.

### 4.7.1 Familiarisation with the data & transcribing.

The process of transcribing is how I first familiarised myself with the data in this study; transcribing and analysing are not separate tasks (Clarke and Braun, 2013a; Jenks, 2018; Sandelowski, 1994). Jenks (2018) argues that very few people have explored the complexities and challenges of transcribing with any great detail, in what is a very complex and problematic process. This is because one is not just translating spoken speech into written text, but also transcribing social interactions (Jenks, 2018).

Kowal and O'Connell (2013) state that much of the complexity and incoherence comes from questions of what is the purpose of the transcript. Mishler (1991) may have already answered this when he described transcription as a process of 'entexualizing' in which speech is transformed into text that can be read and subject to analysis in ways that speech in action at the moment of conversation never can be. Yet written language can never entirely accurately represent the spoken word, and therefore, any transcript is always only a partial representation (Sandelowski, 1994; Skukauskaite, 2014). This makes it a very interpretive process but also a political one as the transcriber is constructing meaning by how they choose to represent the participant in what they choose to transcribe and how (Bucholtz, 2000; Jenks, 2018; Sandelowski, 1994; Skukauskaite, 2014).

In order to capture both the language and some of the social processes, I adapted a notation system (See Appendix J). No notation system will allow for complete accuracy, mainly when we accept that the final product will only be a partial representation (Kowal and O'Connell, 2013). I choose to adopt Jefferson's notation system (2004) as my system of choice. As the act of transcription is context-bound by study (Skukauskaite, 2014), I adopted and developed the notation system to work for me. It allowed for linguistic and paralinguistic features to be captured (Skukauskaite, 2014). This allowed me to record other useful contents of the interview such as laughter, sighing, tone and intonation, which would aid in the interpretation of the data. More importantly, it allowed for me to be consistent in the approach to transcribing across the data set so that I could make sense of my own work during further analysis.

I also felt it necessary to amend and adopt a notation system rather than rigid obedience as Kowal and O'Connell (2013) raise the point that there are two roles involved in the act of transcription: the transcriber and the transcript user. In answering the question, who are we thinking about when producing the transcript, the answer is me, the researcher. I am both the creator and end-user of the transcript. This point illuminated to me my subjective role in the process. For one of the first times in the research process, I felt like Bassnett's (2002: 10) "manipulative translator" as I translated my audio into text. I was consciously aware that I had power over how my participants spoke and therefore, how their words would be interrupted. As Hammersley (2010: 1440) articulates, a transcript is a "creative document" in which the researcher, in this instance, me is very much implicated. I was making decisions about not just what to transcribe but how that was best represented. While I felt my transcriptions were accurate and made a decision to transcribe everything I could hear in the sound file, there were times when it was not even possible to identify the speech. My rationale for this approach is that it is unclear how and what noises (paralinguistic) are communicating and therefore such information 'given off' can be as useful as what is intentionally communicated through speech (Bucholtz, 2000; Hammersley, 2010).

I transcribed all interviews. This allowed for complete immersion in the data. Additionally, this process allowed me to reflect on my interview technique, record my thoughts and how this may impact on the data (Clarke and Braun, 2013a). While the plan was to transcribe before moving onto the next interview, the way recruitment ran, this was simply not possible in the early and late stages of data collection. By the end of the process, it took me approx. six hours to transcribe a 40-minute interview, and additional two hours to proofread and remove identifying information.

While I enjoyed immersing myself in the data and thinking of relevant conceptual ideas, it was a rather arduous and tedious task. I found it physically and mentally draining. Mentally as it required concentration to focus on the recording in order to gain an accurate representation of the interview. Physically, I developed a ganglion on my right wrist and a repetitive strain injury in my upper body, isolated to my left side thanks to the shifting foundations of my 1780s office floor!

When transcription was finished, I read through the entire data set multiple times. I used this stage of the process to write down any interesting analytical interests or thoughts. Braun and Clarke (2006) call for ‘active’ reading; reading which searches for meanings and patterns. To help make this process active, I utilised Charmaz (Charmaz, 2014a, 2014b) approach which suggests the researcher asks the following questions when initially getting familiar and coding the data (p.127);

- What processes are going on in the data or being described by participants?
- How are participants acting within this process or events they are talking about it?
- What feelings and thoughts do the participants describe during this process?

To make this process easier, I printed off all the anonymised transcripts with a large margin so I could write my notes on the pages. I found that the process of physically writing pen to paper helped my analytical thinking and in fact, made the process an active one, congruent with both Charmaz and Braun and Clarke.

### 4.7.2 Generating initial codes

After the first, rather long phase, I started coding the transcripts to generate initial codes. This involved working systematically through the entire data set and identifying aspects that may form the basis of repeated patterns. Codes are the smallest unit of analysis. They capture something interesting feature of the data, often in relation to the research question. Codes are the building blocks for themes which are larger patterns of meaning underpinned by a central organising concept or shared core belief or essence.

I chose to use the computer software Nvivo, to manage my data and assist with the coding. I conceptualised it as a filing cabinet which was able to place all the examples of particular codes in one place. While Nvivo has many features, it also comes with the same risks as any other piece of software. In my case, the university updated the operating system across the university, which was incongruent with the version of NVivo installed. As a result, Nvivo would randomly crash, or in one instance, I was locked out of my data for two weeks. I chose not to code each individual line, but rather the unit of analysis was the surrounding paragraph so that the context of the speech was not lost. This is congruent with aspects of language and meaning outlined in chapter three.

Coding should be an organic process, and one that comes from deep engagement with the data. Both coding and theme development are interpretive. This subjectivity is seen as an advantage rather than something that needs to be grappled with uncomfortably. Indeed, Terry *et al.,* (2017: 6) state;

> “The analysis is seen as something created by the researcher, at the intersection of the data, their theoretical and conceptual frameworks, disciplinary knowledge, and research skills and experience; it is not seen as something waiting ‘in’ the data to be found.”

### 4.7.3 Searching for themes

Phase three started with the long list of the codes generated in the previous phase. I began sorting these codes into various categories. Again, I returned to pen and paper, writing all my initial codes on post-it notes and then sorting them into loose groupings on flip board paper. Again, similar to the process of familiarisation, I felt the need to make this an active process to help with my analytical thinking.

The stage also involved comparing and contrasting different codes and seeing which may be combined as they actually had the same core meaning. I used the process of supervision to assist in the verification off themes, including bringing my post-it notes to display and talk through my thinking. The relevant coded data extracts were then collated for each category which became candidate themes. Themes are therefore much like characters in a novel, or a film which are telling the story of the data as opposed to buckets into which everything said about a particular issue is collected and placed into (Terry et al., 2017). Themes are active creations of the researcher rather than passively emerging from the data (Braun and Clarke, 2016).

I then went about scrutinising these extracts further by using some of the prompts outlined in Figure 5. During the process, I did a lot of writing and re-working. Again, using the supervision process to discuss issues and for verification of analysis. In considering the various relationships between codes and themes as well as different level of themes. I began mapping out these relationships. It soon became apparent that Bourdieu's writings had consciously and subconsciously influenced my thinking. At this point I took the codes developed and mapped them out in relation to the field (see Appendix K) This seemed a pragmatic thing to do, as Bourdieu states that field should be the primary focus of study. I used the codes I previously generated to see which ones belonged to 'field' and which ones worked in the field as forms of capital.

**Figure 5: Prompts used to encourage analytical thinking**

How are participants
  Saying
  Doing
  Being
Communicating beyond words
Language as a form of capital
  Who controls language
  Why this type of talk in this situation
  What is the effect of participant language?
How are they saying/doing their role?
  What are the consequences?
What is the relationship between language used and context?
How is context impacting on
  Meaning
  Research participant
  Speaking as an individual or institution
  Is the context structured or structuring?
What activity is this communication building or enacting?
How much freedom do people have to carry out activity?
How are other portrayed?
And what is relationship between participants' ID and others

At this point, I was very aware of the advice which my critical friend offered. That was to ensure that my theoretical framework worked for me and that it did not force me to conform to a particular way of thinking. However, as I got further and further into my data analysis, organising my findings under Bourdieu's key terms felt organic and a natural progression.

### 4.7.4 Producing the report

This phase is laid out in the findings section of this thesis, which consists of two chapters; one for the ‘field’ and a second for the ‘capital’ as the codes generated tell the story of mental health nurses and physical healthcare.

## 4.8 Quality

Quality is a contested term in qualitative research (Parahoo, 2014). In addressing the quality of this study, I discuss three concepts; rigour, reflexivity and Braun and Clarke's (2006) quality checklist.

Some argue that terms used to judge quality in quantitative studies should be imposed on making judgements regarding qualitative studies (Morse et al., 2002; Silverman, 2009; Spiers et al., 2018), while others have suggested the adoption of entirely new concepts such as 'trustworthiness' as suggested by Lincoln and Guba (1985). A study's trustworthiness should be judged by its credibility, transferability, dependability and confirmability. Indeed, it has been argued that the development of various terms and criteria have caused excessive levels of confusion for researchers, which itself has impacted on the ability to demonstrate rigour (Morse et al., 2002).

### 4.8.1 Rigour

Rigour is shown when a researcher "devises a systematic method whose assumptions are congruent with the way one conceptualises the subject matter" (Reicher and Taylor 2005, p.549). Similarly, it is ensuring that the process is carried out in a transparent and trustworthy manner (Parahoo, 2014). Though discussing Grounded Theory, Cooney (2011) considers rigour in two parts; methodological rigour and interpretative rigour. I found these terms helpful in considering rigour in this study.

This study demonstrates methodological rigour by clearly showing how the study was conducted from start to finish. The study will demonstrate interpretative rigour by clearly showing how participants were chosen, how the analysis was performed and developed.

### 4.8.2 Reflexivity

This approach to rigour might be a more appropriate assessment of quality when one considers the arguments put forward by Gary Rolfe. Rolfe (2006) argues that the development of criteria discussed above does not make methodological sense, as there is no unified qualitative paradigm or language. This makes the development of any generic quality criteria difficult.

Instead, Rolfe (2006) argues for the use of reflexivity. This involves the researcher exploring the subjective nature of the study and their own influence on the process. This is important in terms of theoretical frameworks. Bourdieu argued that how people view the world is coloured by their education, employment, status and background. These in turn, could colour the data collection and analysis. He believed one could never be objective in researching a field. Therefore, conscious thought to the role of the researcher is key to overcoming this subjectivity by articulating the assumptions of the researcher and how and to what extent they affected the whole research process (Braun and Clarke, 2019a). This has been discussed throughout this chapter at the various stages of the research process.

Finlay (2003) states that there are numerous kinds of reflexivity. The one most relevant for this study is intersubjective reflexivity. This helps explore the mutual meaning involved in the researcher/participant relationship. It can help identify the nature of the relationship and the unconscious processes that structure it (Finlay 2003). It also takes account of the researcher's "emotional investment" in the process (Finaly 2003, p8). Reflexivity is also helpful in order to navigate any unexpected issues which occur throughout the research process, for example, the conduct of a problematic interview (Hewitt, 2007).

These reflections were recorded in a handwritten diary and in the ‘memo’ function in Nvivo. This allowed me to record my thoughts and opinions regarding the process of collection and analysis, including the decision-making processes. This should also assist the researcher in viewing situations from different perspectives (Aléx and Hammarström, 2008). Reflections also included the researcher's own ambitions in the research agenda as well as identifying any noted power imbalances in relationships (Thompson and Chambers, 2012). I used some of the issues which I noted as the basis of discussion in research supervision, which greatly helped in particular during the data collection phase but also how my ideas were developing during the analysis.

**Table 5: A 15-point checklist of criteria for good Thematic Analysis. Taken from Braun and Clarke 2006**

| Process | No | Criteria |
|---|---|---|
| Transcription | 1 | The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy' |
| Coding | 2 | Each data item has been given equal attention in the coding process. |
| | 3 | Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive. |
| | 4 | All relevant extracts for all each theme have been collated. |
| | 5 | Themes have been checked against each other and back to the original data set. |
| | 6 | Themes are internally coherent, consistent, and distinctive. |
| Analysis | 7 | Data have been analysed, interpreted, made sense of- rather than just paraphrased or described |
| | 8 | Analysis and data match each other-/ the extracts illustrate the analytic claims |
| | 9 | Analysis tells a convincing and well-organised story about the data and topic |
| | 10 | A good balance between analytic narrative and illustrative extracts is provided. |
| Overall | 11 | Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly |
| Written report | 12 | The assumptions about, and specific approach to, thematic analysis are clearly explicated |
| | 13 | There is a good fit between what you claim you do, and what you show you have done-/ i.e. described method and reported analysis are consistent. |
| | 14 | The language and concepts used in the report are consistent with the epistemological position of the analysis. |
| | 15 | The researcher is positioned as active in the research process; themes do not just 'emerge'. |

### 4.8.3 Braun and Clarke's quality criteria

Braun and Clarke (2006) state that a good TA will be explicit about what the researcher did throughout the process. Arguably this point applies to any qualitative study. Braun and Clarke (2006) provide a 15-point checklist (See Table 5) that researchers can use to ensure the approach to analysis is rigorous. Rather than a set of criteria, it contains several pragmatic points which any researcher should consider when conducting their analysis. I found this a straightforward and helpful approach in ensuring that what I did was rigorous and congruent

## 4.9 Summary

This chapter began by outlining my approach and justification for a qualitative approach. I discussed and reflected on the various ethical issues which occurred as part of this study, in particular, the ethics of qualitative interviews and having a pre-established professional relationship with participants. I then discuss the study setting, providing details about the study sample and my approach to recruitment. I then provided a detailed account of my data collection methods, namely a short demographic questionnaire and semi-structured interviews, including my rationale for choosing interviews as my method of data collection as well as the role of space and place in conducting them. I then outlined my approach to data analysis, including a detailed discussion on the process of transcription. The chapter concluded with an outline on how I ensured quality throughout the research process.

# Chapter 5: Findings I- The Field

## 5.1 Introduction

This is the first of two findings chapters in this thesis. This chapter focuses on issues relating to the field of physical healthcare practice for MHNs. The second analyses the capital MHNs utilise in their practice. This chapter is divided into two parts. The first part (Part I) examines the structural issues apparent in the field. The second part (Part II) is an analysis on some of the boundaries and tensions within and between the fields of study. Much of this chapter answers my first research aim of finding out how relationships and structural issues impact on MHN practice. Part I opens with a brief overview of what constitutes the issues within the field across both the inpatient and community setting. I then outline how my participants conceptualised physical healthcare and relate this to pSMIs' understandings. I then go on to discuss several structural issues impacting on MHNs PHC practice. These include the burden of accountability, discourse on risk management in mental health, organisational support, change, socioeconomic factors. In Part II, I discuss the boundaries between different fields, the actors within them and how this tension demonstrates issues of power. To my knowledge, this is the first study to move beyond describing nursing practice for physical healthcare for pSMI, to explain what is influencing and driving this practice in the first place. This examination of wider organisational and structural issues is unique within the existing literature.

## PART I

## 5.2 Introduction to the field

As outlined already in chapter 4, the 'outpatient' and 'inpatient' settings are the two principal fields for this study. However, these fields do not sit in isolation, but rather are interconnected to other fields that impact on the ‘actors’ (the MHNs) in their respective fields. Analysis reveals that MHNs’ PHC practice takes place in a complex field. All the participants voiced that they had a role in meeting the physical healthcare needs of people with SMI. On the whole, they were positive about this area of practice and no one stated ‘this isn’t my role.’ This is in contrast to some of the findings of the literature review in chapter two. However, a recently published systematic review by Dickens *et al* . (2019) show that globally attitudes to this area of practice are improving and this study complements these findings. Participants often did not realise that they were ‘doing’ physical healthcare tasks as such tasks were embedded into their routine, every day work. Therefore, participants’ physical healthcare work is likely invisible and may not be conceptualised as physical healthcare. Inpatient staff had a more ‘task-based’ approach while community staff appeared more focused on long-term pieces of work around health promotion and lifestyle advice.

However, several structural factors impact on participants’ ability to provide appropriate physical healthcare for people with SMI. Firstly, nurses perceived accountability as a burden and they feared the consequences of working in a ‘blame culture.’ A tension exists between meeting expectations of professional accountability and recovery-orientated practice which promotes patient autonomy and choice. This is evident when exploring the impact of risk management on practice. Participants perceived a lack of support from the organisation. Some nurses felt that socio-economic circumstances of patients impacted on their practice while others felt that it played no role.

Tensions between the various fields and structures are at play which is impacting on MH nurses ‘doing’ physical healthcare. This includes tensions between primary and secondary care, between MH services themselves and between MH and physical health services more generally. It may account for nurses questioning their role. It was clear that there was a significant emotional burden to this area of practice which is not always recognised or discussed.

## 5.3 Conceptualising physical healthcare for pSMI

No policy or study has attempted to define or conceptualise physical healthcare from the perspective of staff. A number of the studies reviewed in chapter two sought the views of health professionals on physical healthcare for pSMI. While effort has been spent understanding the barriers and personal experiences of physical healthcare from the perspective of staff and pSMI, there is less understood about what it actually constitutes in the first place. For this reason, this was one of the first issues I explored with participants so the interview was situated within the participants own understanding and context.

Participants gave a wide variety of answers to what physical healthcare for pSMI meant to them. Generally, inpatient participants were more 'task oriented' and concerned with managing acute issues. Community participants were generally more focused on long-term work on lifestyle issues. However, across the whole set similar answers were provided.

> C06: it's more about (.) their health (.) their physical health rather than (.) am them needing treatment

Participants discussed the importance of assessing physical health as part of a holistic assessment process and it was more than just one thing or another.

> C03: I think it's a lot more complex than then just physical health I think (.) the yeah the waters are far muddier than (.) than just one thing or the other (.) I feel like if there was a name we could (.) ya know combine the two then I would (.) between mental health and physical health (.) it's not just am one or the other

> C07: ya kinda best to look at the (.) the whole person

> H10: is about providing global care

> H11: they're interlinked inextricably interlinked

It was considered important to gain a baseline of a person's health and then monitor for any changes but also what constituted pSMI's day-to-day functioning around

ADLs. This included vital signs, drug testing, pregnancy screening and blood glucose monitoring.

> C02: it's its's mainly about getting a baseline and monitoring people's health

> C03: aaaam I suppose it's about (.) how (.) physically well somebody is

> C04: how people function day to day really (.) how they manage their own health and wellbeing

> H05: so it is quite important to (.) keep a baseline for patients (.) ya know I know we do obs when people come in

It was also seen as vital in order to discount any underlying physical cause that may be manifesting as mental illness.

> H01: presenting very differently effecting their behaviour their mental state

> H05: I think getting' baselines (.) taking obs amm (.) ruling out any physical cause for mental illness

> C07: anything going on that could (.) have unbalanced the mental health side of things

Participants felt they had a role in monitoring the impact of psychiatric medications;

> H05: the medication we use is very heavy duty as well and am (.) there can be lots of physical health problems

> C13: being aware of (.) am impact of medication can have on physical health

> C14: our treatment can cause all sorts of difficulties with physical care

Participants felt PHC meant the management of both acute (deteriorating patient) and long-term comorbidities such as diabetes and asthma and how the patient coped living with a LTC such as diabetes;

> C03: assessments […] I think that should be done regularly if people have a (.) specific condition

> H05: if somebody has an existing condition you should do them daily sometimes several times a day

> C06: those specific conditions and how they're managed

> H12: something that would contribute to making a patient physically unwell

Participants also felt they had a role to play in providing education and support around healthy choices including nutrition, sleep hygiene, exercise, smoking and other substances.

> C04: in acute wards maybe need a bit more (.) education about (.) what's (.) healthy choices

> C06: the basics really of (.) good nutrition exercise sleep (.) am (.) it means (.) sort of basic health promotion

> H11: exercise obviously also comes into physical healthcare and (.) just walking and getting out

> C14: you're talking about advice and healthy living (.) monitoring of all that

Physical healthcare was not just about 'doing things' to people but the participants saw their role as advocating for patients to access appropriate PHC services. They report doing this by supporting them to make appointments with other professionals such as the GP and then accompanying them to such appointments. They also saw their role as liaising with other professionals, such as those in tertiary services, and ensuring advice was implemented and followed up.

> C02: it's about liaising with the GP sometimes obviously we deal with acutely unwell people so it's about (.) making the appointment for them sometimes the GP (.) sometimes accompanying them (.) to the GP

> C03: we need to be (.) asking about it and maybe going along to appointments or (.) asking (.) 'do you want someone to go along with ya' (.) speaking to whose involved making sure that there's follow up

> H09: making sure they attend appointments with (.) ah other members of the MDT meeting any outpatient appointments they might have […] any advice is (.) comes from those is followed and passed on correctly

> C14: we should be (.) tryin' to get people to go along there but some people won't (.) am (.) I suppose in that I think as well support (.) supporting people to actually get out of their house (.)

Participants were clear that a person's motivation had to be clearly understood and how a psychiatric condition may impact on motivation levels and ability to engage with supports.

> C13: the impact it has on their motivation and their ability to carry out exercise just to look after themselves generally

Some participants went as far as to state that physical healthcare for this population was a human rights issue and nearly all participants communicated a sense of ensuring their patients were treated the same as those who do not have a mental health diagnosis.

> C13: we all have the same basic health needs

> H08: everybody has a right to healthcare regardless of who they are […] so you have to treat that just as (.) significantly as anybody else so

Some authors argue that professionals understanding of physical healthcare has been very narrowly focused, concentrating on correct diagnosis, management and prevention of physical illness and in very biomedical terms. Happell *et al.,* (2016) gives two examples to illustrate this point, showing that work undertaken by Chu *et al.,* (2020). Lambert (2012) and Mangurian *et al.,* (2010) focused on a very biomedical physical health screen such as vital signs and other measurements but consequently ignore the lifestyle issues contributing to poor physical health for pSMI.

However, it does not appear to be the case in this study. It is evident from above that participants conceptualisations are rather broad, holistic and involve more than simply undertaking tasks or performing clinical skills on the person. It is also clear that participants tried to understand this in relation to the unique issues faced by pSMI. In this regards, the participants in this study's conceptualisations mirror the recent findings of how people with lived experience conceptualise physical healthcare. Happell *et al.,* (2016) conducted focus groups with 31 Australian pSMI to try and understand their views on what physical healthcare meant. They found that what was important to pSMI was that physical and mental health were not separated but that one very much impacted on the other. It was also about the absence of physical illness including LTCs and pain. There was also a clear focus on mobility- both physical exercise but also the contribution of mental health to a sedentary lifestyle. In this regards, physical healthcare was about being functional and being able to engage in everyday activities. The sample were also clear that socioeconomic determinants such as poverty and housing play a major role, particularly around lifestyle behaviours such as healthy eating and diet. This is similar to qualitative findings by Çelik Ince *et al.*, (2019) who interviewed 12 pSMI and their carers in Turkey. Issues such as motivation and knowledge about physical healthcare were key issues for participants as well as support in addressing lifestyle issues and side effects of medication.

What was striking in this study was that nurses often did not realise that they were doing physical healthcare. Often only when asked to give examples and unpicking these did they come to the realisation that they were providing interventions. The point about advocacy and facilitating access may not conform to the traditional views of nursing practice but it is very important to highlight. It shows that MHN role may not be to directly provide all interventions but to simply provide support so pSMI can access the services that will best meet their needs. If nurses themselves are not aware of what they are doing, then it is likely this work is invisible to others. It is therefore not documented by nurses, or discussed by other actors. The reason for this may be that clinical work such as direct patient care is given more capital in nursing and is how the profession wishes to portray itself (Allen, 2014). This is at the expense of what Allen (2018) terms 'organising work.'[8] These findings chime with Allen's (2014) ethnographic work. Allen shadowed nurses (n=40) in various acute care settings in order examine the organisational components of nursing practice in their own right. Similarly, the nurses' work in Allen's (2014) study was unseen and invisible yet had a massive impact on patient care.

Therefore, some of the 'care' the MHNs in this thesis report, may not be traditionally conceptualised as care but are just as important in supporting pSMI in having their physical healthcare needs met.

---

[8] Organising work refers "to those everyday elements of nursing practice concerned with the coordination and organisation of patient care. It is related to but distinct from direct patient care and nursing management. Whereas the former is patient-focused and the latter is primarily unit-focused, organising work is 'care trajectory'-focused. A 'care trajectory' refers to 'the unfolding of patients' health and social care needs, and the total organisation of work associated with meeting those needs, plus the impact on those involved with that work and its organisation (Allen, 2018)

# 5.4 The burden of accountability

This next section details my analysis of the issue of accountability in practice. Generally accountability was perceived by participants as negative and burdensome. I draw on Bourdieu's concept of symbolic violence to support my interpretation of the data. I then move on to discuss how accountability is often shifted onto medical staff within the field. I then discuss accountability regarding task allocation within the field before discussing the impact of accountability on emotions. This section concludes with a discussion in the context of the existing literature on accountability in nursing.

## 5.4.1 Accountability and responsibility

It has been well-documented within the literature that MHNs, particularly those in an inpatient setting report that they perceive a high burden of responsibility for patient safety and consequently find themselves practicing defensively in order to avoid blame (Manuel and Crowe, 2014; Slemon et al., 2017). Indeed, nurses report that they fear professional repercussions for such patient behaviours as absconding and self-harm. Therefore, it may not be a surprise that participants perceived themselves as having high levels of responsibility for physical healthcare.

It was apparent that participants saw it as their responsibility to care for the whole person, and thus included people's physical health. Participants felt that if they did not undertake this then they could be considered neglectful. It is not clear what constituted neglectful. Data presented below shows that this sense of responsibility comes from a number of sources including a strong emphasis on accountability during pre-registration education, pressure from the organisation to 'cover all bases' along with high expectations from others including fellow colleagues, patients and management. The phrase "*encoded in us*" sounds like it's something invisible but programmed into people as part of their education. In this example there is also a sense of frustration that this perception existed when the staff perceived themselves not have the appropriate training.

> H12: they are under our care so we have a responsibility for them and I think if we did not pursue physical health needs then that would fall under a neglectful bracket

> *I: and this sense of duty and accountability. where do you think that comes from?*
>
> H12: I think that that's encoded in us from the NMC throughout my training there's big emphasis on accountability and (.) yeah I think we have this sort of pressure on us to cover all bases and make sure that no stone is left unturned
>
> *I: where do you think this pressure comes from?*
>
> H12: so people's expectations (.) sometimes (.) patients have these kinda 5 star expectations of the NHS am (.) but also (.) from peers from your colleagues and also from (.) am (.) management (.) that things (.) shouldn't be missed that we should be picking up everything despite not having training in it (.)

### 5.4.2 Accountability for learning needs & competency

Participants on the whole reported a strong sense of being accountable for their own learning needs. This is likely been shaped around discourses surrounding continuing professional development, the advent of revalidation as well as the concept of autonomous learners perpetuated by higher education and the NMC.

However, there appears to be an incongruence between participants reporting that they received inadequate preparation for physical healthcare during their education, yet holding a very strong sense of responsibility and accountability, extending to identifying and meeting their own learning needs. In this example, the participant appears to be absolving the organisation from responsibility. However, if gaps in knowledge exist as a consequence of pre-registration education, then it is unclear what moral or professional responsibility the individual possesses to fill that gap.

> C02: ((pauses)) I mean of course you can blame it all on them [the organisation] and us ya know ya can blame it on that and say it's their fault they don't give me any knowledge. I'm quite a believer in you (.) seek your own knowledge (.) if you see a gap in your knowledge [...] I think if I have got any gaps in my knowledge and I have to go and look for courses and ask my manager [...] I'm responsible for my own learning (.) but it's not spoon fed to me ok

Most participants recognised the gap in their knowledge and need for training, however self-reporting that they are responsible and should not have to be "*spoon-fed*." There is a sense of having to seek out learning opportunities and that opportunities are not actively promoted or exist within the institution. This sense of taking responsibility for their own learning extended to looking outside the institution's provision of training needs in order to satisfy their requirements.

> H05: I do loads of these online courses (.) cause I'm really sad (.) I am so I have done things like (.) recognising the cardiac patient (.) am what else have I done (.) I do a lot of them (.) st johns ambulance stuff

Data illustrates that participants felt they should have taken more responsibility for their own learning as a student nurse, and therefore they might have been better prepared for the physical health issues which they faced in practice.

> H01: ((inhales)) I don't want to necessarily attribute that to the kind of training that I had (.) bu::t (.) it was more about me as a student then that I should have really looked more ya know than my independence study on my own in that area (.) ah because university just gave us the skeleton ya know (.) I had to as a student then (.) I didn't know how deep to delve into that

However, the participant admits that they were unsure of how far to delve in terms of knowledge. Similarly, other participants discussed how they should not have expected the university to provide knowledge, but rather, they should have sought that out themselves.

It is likely that the sense of responsibility is being driven by participants' post-registration experience and the realities of practice. It is likely that education in this instance may not have instilled this responsibility for PHC in students, or else the university has assumed that it did through its teaching. Still, despite a reported lack of education and training, the participants were clear in their responsibilities and the possible consequences of neglecting same. Discourses around continuing professional development, lifelong learning and that university graduates should be curious and self-directed learners (Nursing and Midwifery Council, 2015b; Pabico et al., 2019; Willis, 2015) may have resulted in participants having this clear sense that they are in the driving seat. However, it is also apparent that the institutions (both NHS as employer and university as educator) is not providing an abundance of opportunities to further develop that knowledge, or if they do, they appear few and far between.

This would be also congruent with definitions of accountability. For example, Krautscheid (2014) is clear that accountable practice is not just direct patient care, but also nurses' accountability for their own learning and maintaining competence. In contrast, the RCN (2017) argues that for a nurse to be accountable they must;

- have the ability (knowledge and skills) to perform the activity or intervention
- accept the responsibility for doing the activity
- have the authority to perform the activity within their role, through delegation and the policies and protocols of the organisation.

This makes the concept of being accountable for one's own learning needs problematic. While participants appear to accept that they are accountable, it is unclear if participants are when they state that they have not had enough education and training on particular physical healthcare issues. While they appear to accept their responsibility, it is unclear at what cost that has been. It is unclear who has given participants the 'authority' to perform activities. It appears that the two big institutions have not provided people with that authority- the university by not providing adequate educational provision and the NHS by not having a clear policy, outlining roles, responsibilities and educational training opportunities related to physical healthcare for pSMI. This makes accountability another form of symbolic violence as there is a clear burden on the individual with the benefit to the large institution.

The participant, whose data is presented below, voiced their motivation for undertaking further training was because they felt either way they were going to be held accountable if "*something went wrong*" [H10]. In particular if an adverse event occurs, the participant implies that the person's training record is scrutinised. This raises the question of 'what is the purpose of training?' and in this instance it appears to be used as another an form of control against nursing staff. Data suggests that because of the level of accountability, it stops nurses from providing PHC because they are scared that if it goes wrong they may face consequences. The participant goes on to describe a cycle of emotion which contributes to driving attitudes towards this area of practice. Fear appears to be the driving factor and this fear develops due to the perception of accountability. The participant in the example below felt they were being held responsible for more and more. In particular in the absence of other professionals who are also experiencing cut backs, the nurses were absorbing their tasks such as housing and various referrals which means physical health, or indeed even care was not being prioritised. The participant felt the workforce was being diluted and there was no extra staff to absorb the extra work. This also accounts for a level of avoidance as the participant felt there was a sense that people were overwhelmed and avoidance was a form of self-preservation, or placing barriers to avoid having to take on any more work.

> H10: well it is ya have to absolutely because if something happens and it transpires that you have been trained and you should know what to do and yet you didn't or you didn't use the right resources people information or whatever then you're accountable
>
> *I: do you think that people are (.) scared and (.) about doing physical healthcare for that reason (.) cause of that layer of accountability*
>
> H10: absolutely (.) you are still going to be accountable wither ya know or not (.) if you don't do the right thing by somebody then your still going to be accountable so as may as well get on with it and go on the courses

### 5.4.3 Accountability and competence

Data suggests that accountability was related to managing competency. This appears to be a significant issue when providing complex care. It appears that this competency agenda is driven by a risk management perspective. In the example below, the participant states very clearly that this was done "*to protect the indemnity of individual staff.*" It appears that as a charge nurse this participant had to assume a level of accountability that was somewhat burdensome, judging the number of steps they were required to take. Even within the organisation there was conflicting advice about how to manage staffs' competencies regarding Nasogastric (NG) feeds and indeed staff competency. What appeared lacking throughout this discussion was that the patient was at the centre of what they were doing- although this comes out later in the interview and it is clear that the team provided a high level of care, going to great lengths to ensure they were doing the right thing, in this instance it appears that the motivation came from an institutional agenda as opposed to a patient-centred one.

> H09:It was about making sure our staff were competent, seeking as much advice as possible getting shown multiple times how to do to do the feeds and having that recorded accurately for each member of staff so sort of

> playing it as safe as I possibly could to protect our ye ye know the the personal indemnity of each member of staff

In the following passage, the same participant almost appears to be reassuring themselves in stating that their role was to make sure no corners were cut and that the competencies were met. It is unclear if the participant is describing 'competency' or 'confidence' or how they were conceptualising or measuring either. It would appear that the participant is performing their charge nurse role here by taking the lead for managing others 'competencies.' In this regards, they embody the institution and enacting what the institution thinks is important. It is unclear what is meant by "*doing the correct thing*"- correct thing for the institution, for the patient or for the staff who the participant had responsibility for. There is a tension here between the charge nurse manging others while at the same time, having the expectation that staff will do so themselves through seeking education and upskilling when they identify gaps in their knowledge and skills.

> H08: ahhh well I suppose that is my role to do that so if I feel like I'm not cutting any corners if I feel like I'm doing it correctly and that that they were the competencies were covered then I'm managing that then I'm doing the correct thing […] the negative thing is sometimes people saying 'I'm not competent to do that' 'I'm not doing that' but then not looking at how they can become competent […] seeking advice in doing that ah I suppose that's the negative thing about I've encountered about it […] make sure that they that skills deficit or that competency deficit can be kinda managed?

The relationship between competency and accountability are interesting. In particular it is unclear how staff maintain competency and therefore their accountability with the NMC, particularly if they are not being routinely exposed to certain skills. It is unclear what responsibility the organisation have for this and how explicit this responsibility is made. The participant discusses that they were frustrated when staff would sometimes use competency as a reason why they could not perform a task.

It remains unclear if staff are doing so because they don't have the knowledge and therefore working within the limitations and scope of their practice or because they fear that they will face sanctions on their practice if they do something wrong. With the focus on competency, it raises the question of who is competent and why. The person discusses how they managed the competency deficit in their area for that particular patient's needs. There is also a sense that the individual has to maintain competency but what is the role and responsibilities of the institution in doing this. It appears in this phrase that the emphasis lies on the individual to seek support if they feel they are not competent.

It is likely that concept of competency discussed above is linked to clinical governance frameworks. Indeed, it is argued that when discussing accountability, it cannot be examined without the context of clinical governance (Watson, 2008). This is because the Department of Health  (1998) made a link that quality services are also ones that are accountable and set out a requirement that all NHS services creates systems and leadership to enable quality that are underpinned by people being accountable. However, Watson (2008) is critical of this development. He argues that it results in a set of policy and protocols developed to manage organisational risk, of which practitioners must follow. This results in there being less scope for people to act individually in a given set of circumstances. Arguably, this is what is systems approach is trying to achieve; consistent standards of care and patient safety.

This raises the question if it is a problematic system or simply the systems  are not working and they are operationalised in a manner that feels punitive . In this study, it appears punitive. Accountability feels like it is dictated by a clinical governance framework that is imposed on people, feels pervasive and one that exists to protect the institution, as opposed to one where the patient is at the centre of care. For Watson (2008), accountability becomes something hierarchical and structural; something that can be 'managed' through reporting mechanisms and performance management.

In this way, accountability becomes a form of symbolic violence, clinical governance frameworks using imperatives which practitioners must follow, or else they could be seen as not meeting the requirement of being contractually accountable via the organisation's frameworks. This then results in staff feeling like they must follow protocol and does not allow for nurses to use their own clinical reasoning, even if this may be in the best interests of the patient. Accountability becomes a form of control, or a weapon which an institution can use over its employees with the possibility of the nurse being referred for fitness to practice (FtP) and potentially losing their registration and therefore their career. This is not to mention the shame and distress of undergoing such a process. Indeed Abbott (1988: 73) argued that accountability is a reflection of “power relations and control in a subordinated division of labour”

### 5.4.4 Accountability and medical staff

Throughout the data there is an interplay between nursing, accountability and medical staff. This often comes about through the self-reported limitation of knowledge and skills on the part of the participants. Also, because of the “*nature of the beast*” [C02]- i.e. the primary function being to operate a mental health service while acknowledging people’s needs need to be viewed holistically. As a result of this participants report often seeking the advice of medical staff when they are unsure of physical health issues. In these instances, participants would seek the advice of the junior doctor or in the community, try and engage people with their GP.

> C02: am because I guess because we’re a mental health service now that doesn’t mean to say that we don’t look at people’s physical health but we are not the experts in it (.) I totally recognise my limitations of my knowledge and therefore if there is something I don’t know about I ask a medical staff or we will refer to the GP

This accountability is demonstrated in the data when participants discuss the decision-making process in managing patients’ needs. In this example, the participant gave the example of when conducting a psychiatric assessment with someone with a possible alcohol-related psychosis and the need to seek medical advice

> C02: anyway the partner had confirmed that that was with her so on that situation we phoned the SpR[9]. I phoned the SpR to take advice on what to do with her because I know about DTs of course I do. […] I phoned the A&E she was coming over they weren’t overly happy am with receiving that lady however because I phoned the SpR that gave it some credence

The participant successfully identified that the psychosis was secondary to alcohol withdrawal and consequently needed medical attention, as opposed to psychiatric care. Despite reaching this judgement successfully, they still sought the advice of the psychiatric registrar. There is a sense of needing to do so in order to legitimise the decision-making process. It is unclear if this is due to limitations in knowledge and confidence or is it the power structure of the organisation where medical staff are still

---

[9] Specialist Registrar. A senior doctor, below consultant level.

the dominant power despite have being a nurse-led service. There also appears to be a sense of 'checking with' medical staff in case something adverse occurs.

This interaction between accountability and medical staff is played out during medical emergencies. One participant talked about dealing with medical emergencies in the context of being the bleep holder and site coordinator. Again the participant talks about the junior doctor taking over the responsibility as soon as possible. This appears to be because the medical staff's knowledge is seen as having particular capital that is of greater value than that of a nurse- even though in the context of psychiatric inpatient care, there is not much that can be done on site except stabilise the patient. There is a clear emotion in that it is *"it's scary being the person responsible"* [H08]. While they are the bleep holder, in any medical emergency, the medical staff appear to hold the accountability. Therefore, there appears to be some incongruence. There appears to be a perception that if things go wrong that the site-coordinator (a nurse) will be held to account more than the medical staff. There is also a sense that such a role is overwhelming.

There are occasions when the nurse may have more knowledge than medical staff. The same participant later talks about performing wound care. This is an example of where "*the junior doctors are happy to let nursing staff attend to anything they can*". It is unclear if this viewed positively or negatively by the participant. This may be because the junior doctor feels burdened by other pressures that having a colleague who is competent and autonomous may make for a change. In the same phrase the participant discusses that now they have completed a wound management course, people would look to them for advice whenever anything associated with wound care came about.

Participants discussed a sense of needing to be better at physical healthcare. It is unclear why they think they need to be better and where this is coming from. Some data suggests that a perceived lack of knowledge appears to drive a sense of responsibility or lack thereof. In one instance, "putting it back" on medical staff to make decisions regarding the impact of physical health issues on the management of mental health in the community. The participant seems to have no issue with this and therefore medical staff become a form of capital to manage the issue of accountability- nurses are accountable but doctors are more so.

> C04: I suppose it's putting it back on the doctors a little bit as to how it should be managed in the community
>
> *I: And how do you feel about (.) you said that term putting it back on the doctors (.) how do you feel about doing that?*
>
> C04: More comfortable because my knowledge of how we would manage hypertension or being diabetic is not great so yeah so just need to seek the advice and find out what they would do

Some of the reasons for this may be because of the discourse regarding possible fitness to practice(FtP). It is recognised that medical and nursing staff have different regulatory legislative frameworks. In particular it is perceived that the NMC's framework is narrowly defined (Maxwell, 2016). This has resulted in a disproportionate focus on FtP. It is recognised that there has been too low a bar for referrals and that the processes are traumatic for those involved. Indeed in 2014-2015, 0.7% of the register were referred for FtP[10], yet the process used up half of all income generated from registration fees (Nursing and Midwifery Council, 2015a).

Former RCN Chief Executive, Peter Carter has raised the differences between different professional regulators approach to FtP but also that it appears when issues do occur and practice goes wrong, there is a disproportionate level of accountability on the individual nurse and procedures to not consider the accountability of the institution who create the conditions for permit and promote best practice (Maxwell, 2016). This is further proof of the power dynamics at play when it comes to considering accountability.

### 5.4.5 Task allocation & delegation

A number of the inpatient participants discussed the use of task allocation, such as completion of vital signs monitoring. This was seen as a way of mitigating the unpredictable environments which they practiced. Despite an overwhelming sense of

---

[10] Of the 0.7% referred, 77% resulted in some form of sanction.

unpredictability, it was still seen that tasks needed to be completed regardless of clinical demands and adverse incidents. Having a routine and structure mitigated against that. Also, making people responsible for ensuring tasks such as vital signs monitoring are completed was also a way of ensuring *"things got done"* [H05]. When it came to providing complex physical care, where a patient had multiple deficits in maintaining their activities of daily living, care rounding or intentional rounding[11] was used. Again, there is a sense that this is a structure to ensure that *"things get done"* [H01] and someone has their needs met, but that it may be another thing to hold people to account over.

Harris *et al.,* (2019) reports on the findings of a large realist evaluation of intentional care rounding in England. Data was collected from surveys, observation and interview with a variety of stakeholders including nurses, managers, patients and family members. Despite the widespread use of intentional rounding, its purpose is unclear and there is a limited evidence base of how it works in practice. The findings report that intentional rounding places an emphasis on 'box ticking' that privileges a transactional, task-orientated and perspective approach rather than personalised care. In this context, it prioritises accountability and risk management above everything else. Rather than supporting the development of therapeutic relationships, it fed into the discourse around organisational obsession with risk management. Indeed, there appeared to be a focus on completing documentation over the actual care delivered as well as auditing said documentation. However, some participants did report that this documentation provided proof of care delivered and therefore acted against allegations of poor practice. However, this further perpetuates the risk management culture.

There is also a question about who provides the care. One participant discussed the operation of a physical health check clinic being provided within the community team. This clinic is run by a non-registered support worker, with no registered nurse

---

[11] Care rounding or intentional rounding is known by many names including 'hourly rounding', 'proactive patient rounds', 'comfort rounds' or 'rounds with intent to care'. It is a protocol of standard regular checks with individual patients at set intervals that aims to meet the fundamental needs of people and provide appropriate 'bedside' nursing care. There is a standardised protocol used by the nurse for each patient. The term 'intentional rounding' was originally coined by the Owensboro Medical Health System Inc in the United States (Harris et al., 2019; Sims et al., 2018).

input. The participant in this instance had issues with this and why it was delegated to a support worker. The participant felt that PH is seen as not important hence why it can be operated by a lower grade of staff member with less qualifications. There is a choice between in house support-worker led clinic and a patient seeing their GP. There is a clear sense that people prefer their patients to be seen by the GP.

> C03: I have no concerns about the support worker's practice. It's overseen by a CPN who I believe is dual trained. I don't know how much input they have to be honest if any […] I think there should be a nurse at least […] I think it means that there's a lot more we could be doing than blood pressure […] I think the person that was dealing with it at the time […] in my opinion they very much delegated it to whoever ((pauses)) I don't exactly what the reasons were but that would have been part of it […] I am sure it would have been 'it's just a blood pressure' 'it's just this' 'it's just that' but it's not.

This raises a number of issues. Firstly, it could be that there is an engrained hierarchy of knowledge, and with GPs being perceived to be better educated, are a more accountable person whom to manage the anxieties of physical healthcare. On the other hand, it appears that screening is viewed as a simple 'task' that anyone can perform as opposed to a complex intervention which requires interpretation of results and formulation of appropriate nursing care. If we consider the pressure placed on participants to see people and manage risk, this referring such tasks to others becomes a form of self-preservation to manage anxieties, particularly in managing anxieties of something going wrong due to a lack of confidence to appropriately intervene in physical health is mitigated against.

Secondly, this approach of delegating to a lesser grade of staff member is a form of task-shifting. This is a well-documented phenomenon in healthcare (Abbott, 1988; Fealy et al., 2018; Walsh, 2019). This comes with a risk that the care delivered is less safe and effective than if delivered by someone of a higher grade. Similar to the intentional rounding above, it prioritises transactional 'task' orientated care as opposed to holistic assessment with follow-up interventions. By making this phenomenon visible in this study, there is a risk that managers can continue to employ and allocate such tasks to less qualified staff, with the remit that they are 'simple tasks'

### 5.4.6 Accountability & Impact on Emotions

Emotions appear to have a significant impact around some of the issues of accountability and responsibility. Arguably, the fear which the institution possess around things going wrong appear to have resulted in participants absorbing this burden, who in turn push it onto medical staff or GPs. It means people are left confused about what exactly there role is and their scope of practice. It appears that Accountability stops the development of practice as people appear to be scared of professional consequences if they get it wrong, particularly if someone else within the service is responsible for this. It may also be a sense of not wanting to do harm to a patient but there is also a sense of not wanting to do harm to self- in a way a form of self-preservation.

In this instance, the participant below appears to be relying on legislation in order to manage difficult emotions and in some manner, minimise their distress as a result. One participant discussed that certain difficulties or problems raised difficult emotions, where nurses and doctors had to engage in restrictive practices including forced feeding in people with anorexia. The participant felt the mental health act allows for safeguards for some of these practices and assists them in maintaining a sense of accountability. It therefore safeguards the person and allows for treatment while at the same time justifying and legalising the actions of health professionals.

> C07: I've also seen it being used for someone who was anorexic […] she was detained (.) to implement feeding against her will (.) am (.) pretty tough doing that because (.) in mental health it's almost ya know ya can't force people to do things (.) but then when it comes to that (.) […] I think it's (.) when for nurses (.) and doctors probably (.) that (.) it's (.) the mental health act and to have sort of legal things to safeguard yourself because to make that kinda decision and to stick with that as a (.) person is really hard

Participants recounted that they find it difficult to shut off with the worry that they did everything correctly and the possible consequences of not doing so. It should be questioned about what is meant by "something going wrong" as in healthcare, the risk is high and sometimes cannot be mitigated but rather only managed. Arguably, there should be an expectation of adverse incidents including psychiatric and physical deterioration when people are in an acute environment. We see the impact of PHC in the following extract;

> H12: […] stressed. Very stressed am especially when you are in a situation that you are quite clearly out of your depth, dealing with and you're trying to ya know do your best escalating it to ya know the certain people but I think it's one of these things that stays with you it's really quite difficult to when you leave your shift to stop thinking about

This culture is felt to also develop as a consequence of fear and blame. People are hindered from taking the first steps for fear if it goes wrong, they will be held responsible. This is also generated by working in an era of austerity where there is a stretch on resources.

In the example above, the participant talks about 'bad things' happening if things are not picked up. It is unclear if this is for the patient or for the staff members concerned or both. There is an incongruence- while at one part it appears that the nurses are accountable but things have to hand over to the doctor because the nurse does not have the knowledge. This raises questions about how culpable someone is if they do not have the knowledge. If we consider the RCN (2017) discussion on accountability, it is unclear if the participant can be accountable.

Data suggests that the burden of accountability was strong and that was because the organisation used the code of conduct as a stick- therefore providing them with all the responsibility but none of the power over resources to implement good practice in this area. In particular, a dismissive attitude where nurses, because of their code of conduct were expected to provide a service without any resources. This appears to be driven by a sense that the organisation, as much as they are supporting people through crisis, is itself in crisis and therefore because of that, physical health is not on the agenda. There appears to be a passing of the burden from the organisation to the individual nurses. It is left to the nurse to decide what resources are needed but the organisation to grant same.

> C06: I think a lot of (.) responsibilities can be (.) ya know we're nurses (.) we::: (.) register under a code of conduct (.) and (.) that places on us an awful lot of individual (.) professional responsibility […] I don't think (.) our organisation is particularly (.) strong (.) in (.) thinking about the resources that we need to do those things so (.) I have been in situations where (.) yeah I don't know how (.) I could you could go down a really sort of shaky road with that I think but (.) am (.) I think historically there's been a big sort of attitude 'oh well that's your job and you need to just find a way to do it'

Similarly, data below shows how the impact of handing over responsibility of vital signs on a patient admission. The participant could not complete them because of a lack of basic equipment. Despite this, they were blamed when the patient experienced an adverse event. The participant appears quite self-aware and reflective, stating that it was easier for the organisation to place the blame on them rather than examine the structural and organisation factors which account for why the participant was unable to complete the vital signs monitoring due to a lack of basic equipment. The participant also described a sort of 'organisation fatigue' where being so overworked and over stretched that it allows for a non-critical approach to take precedence and allow for the blame culture to be enacted. But also because perhaps no one has influence over the structural issues- such issues are faceless and therefore the default is to blame the individual nurse.

> C06: it's easier to just say ((bangs desk with hand)) 'you should have done that and you didn't do it' (.) [umhum] I think (.) sometimes people it it's too complicated and it's not that people don't care (.) but it's cause people are busy and knackered and (.) and it's easier to sort of (.) place the sort of responsibility and the blame down the way than it is to start thinking about how can I (.) cause somethings you can't influence the structures that have made it that way

### 5.4.7 Discussion

When considering participants' discussion of accountability, it is important to set out what exactly is meant by the term. It is considered a difficult concept to define and Jacobs (2008) argues that it is rather "paradoxical" because no one really knows what it means. A reading of the literature supports this argument, showing that there is no consistent language or definition (Drach-Zahavy et al., 2018; Krautscheid, 2014; Leonenko and Drach-Zahavy, 2016; Royal College of Nursing, 2017). Instead, the literature shows that professional nursing accountability is challenging to both describe and define. The concept means different things to different people and groups. This argument is also supported by Tingle (2008), who argues that there is no universally agreed definition but instead there is an 'essential flavour' that implies people are answerable and should be able to provide a reasoned account for one's actions or omissions. Others argue that the term can be best understood as having three meanings; an expectation that professionals will have responsibility for their decisions (responsibility), will make their action transparent (transparency), and will agree to be judged in accordance with accepted values in society (answerability) (Bovens, 2006; Chassin et al., 2010).

A lack of definition may not actually make much of a difference. Regardless, nurses are registered professionals accountable to an external regulatory body and ultimately it is the regulator's conceptualisation of accountability is what matters. Both the NMC (2015b) and the GMC (General Medical Council, 2013) are clear in what they expect from registered practitioners. For them, it is about being able to explain and justify one's clinical decisions as well as being answerable for one's actions and omissions regardless of advice or direction from another professional. This comes through from what participants say about feeling responsible, even when having not received good preparation in PHC.

However, this may itself make accountability such a violent concept (Bourdieu, 1992c; Weininger, 2003). The violence resides in its 'hard to define' nature, despite being so prevalent within the field, which may mean it can be used by those in power to dominate others. This trickiness and inability to be pinned down may allow for the concept to be exploited, allowing for the definers, in this instance, the regulator and the employer to change the goal posts to suit their need. What is never made clear is how accountability should be delivered or how it makes things better (Jacobs, 2008). The fact that both the dominant and suppressed appear complicit in this inability to define accountability, yet it feels omniscient, shows that the concept has legitimacy and power despite being poorly understood. It serves the best interests of the suppresser, in this instance, the employer and indeed government by ensuring the availability of a subservient and disciplined workforce who can be 'pulled into line' by holding them accountable.

Definitions make an assumption that accountability is inexplicably linked with professionalism. Indeed several authors have argued that this is the case (Krautscheid, 2014; McGann, 2008; Watson, 2008; Watson and Tilley, 2008). This link between accountability and professionalism is shared by the NMC and the CNOs of the 4 UK nations, when they define professionalism as "characterised by the autonomous evidence-based decision making by members of an occupation who share the same values and education. Professionalism in nursing and midwifery is realised through purposeful relationships and underpinned by environments that facilitate professional practice. Professional nurses and midwives demonstrate and embrace accountability for their actions” (Nursing and Midwifery Council, 2017: 3).

This link between accountability and professionalism is also evident in the academic literature. Krautscheid (2014: 46) links accountability and professionalism by defining “professional nursing accountability” as “taking responsibility for one's nursing judgments, actions, and omissions as they relate to lifelong learning, maintaining competency, and upholding both quality patient care outcomes and standards of the profession while being answerable to those who are influenced by one's nursing practice. This may explain why participants felt responsible for their competency and that of others.

## 5.5 The dominance of risk discourse

This section examines the impact of risk in a mental health context on MHNs physical healthcare practices. This is another structural issue that impacts on MHN practice. It is argued that risk management is the most dominant preoccupation in mental health services to the detriment of other areas of practice (Bowers, 2006; Clancy and Happell, 2014; Felton and Wright, 2018; Rio et al., 2019). This is because it is argued that unlike other hospital settings, psychiatric patients risk is understood as not only affecting the individual but staff and possibly the wider public (Franks, 2004). One of the biggest indicators of the dominance of the risk discourse at a macro level is the increasing rates of compulsory treatment highlighted in mental health act monitoring reports (Mental Welfare Commission for Scotland, 2019). This is in stark contrast to the political discussion regarding more care in the community, people being the active agents in decision-making regarding their own care and increased focus on people's rights. It is apparent that risk management is another form of symbolic violence, closely linked to accountability, and prohibits MHNs from practicing in a manner congruent with their values.

There was a clear sense throughout the inpatient and community setting that some features of the field were simply "*the nature of the beast*" [H01]. In particular, the focus on risk management and assessment of mental state was seen as a key responsibility of nursing staff. This had a particular focus in the home treatment team as this service acts as 'gate keeper' for inpatient beds. This gate keeping role is heavily informed by an assessment of risk. The main issues being considered are the risk to the person and the risk the person poses to others. Because of this intense focus on risk, it may not be surprising that physical health does not hold the same focus for this service.

> C02: during the day my day job is (.) intensive home treatment team which is again assessment (.) ongoing support assessing risk assessing mental state (.) sign posting (.) amm (.) that's kinda it in a nutshell

> C04: assessment service so ya kinda have two roles (.) mental health assessment service is all about assessments sign-posting (.) deciding if people need admitted or (.) oor what care they need

The team has to be reactive to crisis and deterioration in mental state which is decided on an assessment of risk. It might be that the focus on this is so great that physical health might rightly not be the focus or indeed would add emphasis on this might result in the service being diluted. But also the service has a particular focus and need to meet, which is an alternative to hospital. If this is the case, and resources such as inpatient beds are scarce, then the focus is probably going to become somewhat reductionist to assessment of risk.

> C02: ok so it depends […] it's about dealing with support calls (.) taking the appropriate action (.) amm (.) obviously we're completing reactive team so we have a board where all the visits are on that changes constantly (.) am depending on people's mental state

Data suggested that because some services was focused on assessment, mental health symptoms and consequent risk factors was the bulk of the assessment. This left little room for considering physical health issues. The service exists to manage a level of risk that allows people to be looked after in their own home as alternative to hospital.

> C04: I think when ya go and do the assessment you are really focused on ((pauses)) symptoms mental health (.) what's going on with their mental

> health (.) their symptoms and risk factors so sometimes the bulk of the assessment is about that and ya come out of an assessment and sometimes think you touched on physical health needs (.) ya probably could have done more […] I think we are so focused on risk (.) with IHTT (.) and it's all about risk factors and weither somebody is well enough to be at home or in hospital […] we're there to manage mental state and risk and physical health gets pushed to the side a bit […] physical health can sometimes be a bit of an afterthought when it comes to to what we are doing

It was felt that the focus on risk management and crisis prevention meant that physical health issues took a back seat. While acknowledging they were important, there was also a sense that people were overwhelmed with the unpredictable nature of their role and therefore physical health is viewed as an 'add on.' What is unclear is why is physical health was not also being considered in making them assessments of risk including related to deteriorating mental state. This is likely because it is based on an assessment of need and in where a person needs to be. Essentially, are people so risky that they need hospital or can they be cared for within their own home. This focus may leave little room to consider physical health issues unless there is some obvious reason why a person may require acute medical care.

It was felt that the organisation was not empowering or supporting nursing staff to develop physical health practice because it was not on their agenda as they were focused on managing the management of risk within the system. In particular, participants felt that leadership was focused on responding to and dealing with the consequences of adverse events such as completed suicides.

> C04: In terms of physical health care (.) I wouldn't say a huge amount I don't think there's there's much support or (.) encouragement to be focusing on physical healthcare

> H09: they [management] their mostly responding to (.) more serious events and am (.) reviews and things like that suicide reviews and bits and pieces and things that haven't worked well

There are a number of external drivers for the management of risk. One such factor being the government HEAT standard[12], of people being seen and treated within four

---

[12] The Scottish Government HEAT target for accident and emergency was that 95% of patients presenting would be seen and treated within four hours. HEAT targets were replaced in December 2019 with Local Delivery Plan (LDP) standards. LDP Standards are priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance. If someone presents to A&E and require a mental health assessment, this comes within the four-hour standard.

hours. This standard exists to improve the patient experience. As a result, services need to be reactive and make quick assessments and decisions. In the data below, the participant talks about how it is a case of deciding if someone needs IHTT or not. Therefore, it is unlikely due to the time constraints that physical health would have much room for discussion, as the decision is an arbitrary one; does the person need intensive home treatment or not.

> C02: we receive referrals from CMHTS (.) am from social work (.) from psychology (.) from quite a wide range so (.) we have a four hour turn around time so so it's about (.) assessing people and seeing whether they require IHTT or not

A number of staff across the range of participants discussed the unpredictable nature of their services and how it often resulted in working with people in crisis. This need to work alongside people to do long term pieces of work while simultaneously working with people in crisis, presented quite a challenge.

> C03: there's quite a lot of crisis management going on at the moment just seems to be the way it is with my caseload (.) other times it can be just more about focused on (.) helping people move forward (.) with their lives wherever that is they want to be

and;

> *I: you said you feel like you are doing a lot of crisis management at the moment (.)does that impact on your practice in this area?*
>
> C13: yeah cause you wouldn't even think about it to be honest (.) it's just not (.) not am there
>
> *I: it's not there (.) it's not the priority at that point?*
>
> C13: yeah yeah (.) and people are not going to listen to anything at that point in time anyway I think really

The focus of having to be reactive may simply mean that physical health is not the priority for people when they are in crisis. Participants spoke about how they were

---

firefighting often and this meant they were often reacting to things rather than being able to do proactive long-term pieces of work. Therefore, the focus on managing crisis meant that often other things got prioritised.

> C03: amm (.) No every day seems to be very different am I am sure if I looked at my diary it would be very different and I can start off in the morning and go 'oh there's all my appointments' but (.) that can change (.) within (.) like the the hour or within like one phone call […] so then your kinda tryin to fight fires and then ya have to (.) ya know cancel other people's appointments (.) or you get a relative phoning up and saying 'this person's in crisis' (.)

It was apparent that emotional crisis took precedent. If people are in acute crisis, it is debatable how concerned they will be about their physical health, and it unlikely opportune to raise difficult issues of weight and health behaviours which some can find difficult to address and may not be particularly supportive when in a state of crisis. Hospital staff work with people in acute states and therefore it raises a question why the inpatient nurses see it as their role and expected to provide such a service but it is not established practice for the community team, who are working with an equally ill patient group. It is likely that because they are working in people's own homes, the environment may not allow for such screening or intervention. Working with people with acute mental states meant that was the principal concern, the one with associated risks and outcomes, including the person causing harm to themselves or others.

> C06: I think for some people they fall down as a result of (.) kinda mental health crisis and (.) that (.) they're driven by something else (.) am (.) and that becomes (.) difficult to pick up again ((pauses)) I think it becomes a very low (.) priority especially if you're looking at (.) sort of people who are (.) not (.) particularly safe in themselves from minute to minute then (.) that's the number one priority

One participant discussed the concept of 'risk to self' and how it meant more than just self-injury or self-harm but also meant someone's ability to care for themselves and address their activities of daily living including eating and drinking. The participant was clear that such risks should be considered when assessing someone's mental state and gave an example of a patient on their caseload whose self-neglect was so poor; it was felt hospital environment was needed in order to address this deficit and support him. The participant felt it was important that legislative powers under the mental health were enacted in order to preserve someone's health and this meant a broad assessment of risk- not just if someone posed a risk of harming themselves or others. This is because this participant felt in particular that physical and mental health were so explicitly linked. The participant felt the use of the mental health act here was proportionate and necessary. The participant makes the link between deteriorating mental state and possible physical health harm as a result of this.

> C03: he wasn't eating and attending to his personal care […] he (.) was (.) detained and admitted to hospital […] it was quite extreme that he was (.) those powers were used but (.) needed […] it allowed us to care for him and (.) if kinda power to kinda help […] he wasn't in a good way […] that kinda thing does does help in terms risk to self (.) is a huge one because we think of risk to self (.) like suicidal thoughts [yeah umhum] but it's not ya know and […] but he's a real (.) risk to himself really like serious suicide attempts but also his like physical well being (.) was a real risk (.) and am (.) he can like I guess his physical wellbeing really kinda dips and he stops eating and drinking am (.) so yeah in terms of risk to self

These findings mirror previous work undertaken to examine the impact of risk on mental healthcare. In particular, qualitative work undertaken by Clancy and Happell (2014) in Australia and Felton *et al.,* (2018) in England. Clancy and Happell (2014) conducted semi-structured qualitative interviews with 21 clinicians and 22 senior managers, across a range of health professionals including nurses. Felton *et al*. undertook a mixed methods case study approach, including observations and semi-structured interviews with 17 mental health professionals, the majority of whom were nurses working across either inpatient or community settings. Clancy and Happell (2014) found that there is a tension to be found between accountability and managing risk and recovery-orientated practice. Participants felt the risk agenda was driven by procedure and bureaucracy, with a negative impact on care. Felton *et al.,* (2018) report similar findings, with risk management being seen as 'core' professional practice yet in conflict with dictum of recovery-focused care. Indeed, their analysis found that patients are reduced to objects to be managed.

In this regards, risk assessment is a form of institutional control over individuals (McKeown et al., 2017). This fear of blame violently inhibits nursing practice. For example the fear of blame is so strong in the literature that some studies report that nurses whose patients abscond or who self-harm or attempt suicide report fear of disciplinary action (Crowe and Deane, 2018; Cutcliffe et al., 2006; De Santis et al., 2015; Gerace and Muir-Cochrane, 2019; Grotto et al., 2015; Morrissey et al., 2018; Muir-Cochrane et al., 2011; Slemon et al., 2017). Consequently, Cole-King and Lepping (2010) suggested that this fear of negative consequences may increase risk, in that clinicians may avoid discussing risk with patients for fear they then need to manage the risk, and the potential negative outcomes should they fail to do so.

Both the findings from previous studies and the work around risk in this study are vivid examples of Bourdieu's concept of symbolic violence discussed in chapter three. This is because it is clear that the organisation are dominant in managing this discourse and use it to maintain a degree of control. The motivation is to avoid blame when things go wrong to the extent this blame is passed onto nurses through the practices of the organisation. Therefore, the organisation possess power. It may be that it is not so much the case that the organisation have power but rather that the perception of power and the consequent perceived threat of blame, is enough to help it maintain power. It is an example of a self-serving organisation as opposed to one embodying person-centred care.

This symbolic violence has consequences for both pSMI and nurses. Firstly, what makes this approach so violent is that it strips people of anything that makes them human and instead they are objectified as 'risk objects' to be managed. Therefore through the use of language of risk, people lose their identity. As Felton *et al.* argue, it is another form of diagnostic overshadowing[13]- everything else is overlooked for the sake of risk. In this study the physical health issues that people bring with them are minimised because participants appear overwhelmed by the issues of risk.

Secondly, this discourse obscures the harmful nature of some practices used to manage risk. Evidence suggest risks are created by the organisation through its implementation of various treatments and 'risk management' policies, that themselves create risks, which are often downplayed or ignored completely (Coffey et al., 2017; Slemon et al., 2017). These include restrictive practices such as constant

---

[13] Diagnostic overshadowing is "a process by which physical symptoms are misattributed to mental illness" (Jones et al., 2008: 169).

observations, seclusion and restraint but also the long-term use of psychotropic medication. The reason why individual practitioners may be overlooking these are simply because they are not in the interest of the organisation, who are setting the agenda. Instead the dominance of narrow views of risk such of suicide, self-harm or violent acts to others consume and dominate so much effort that other risks are simply ignored. Individual practitioners may be following the organisational agenda for fear of disciplinary action. The focus on predictability of risk of suicide is disproportionate when we consider the very real immediate risks pSMI are living with that are likely to result in a shortened life. This appears evident in the data in this study, where physical health is perceived to be not seen as a priority by the organisation.

This is itself is violent as Slemon *et al.,* (2017) argue that framing risk management strategies as 'treatment' legitimises harmful practices but also prohibits the development of genuine treatment through the use of therapeutic relationships. While nurses often report wishing to provide therapeutic, recovery-orientated care, this is overshadowed by the requirement to intervene and 'manage' risk including extensive documentation with clear rationale for each intervention in order to avoid blame (Slemon *et al.,* 2017).

The emotional wellbeing of participants is compromised. It is easy to see how nurses may experience a cognitive dissonance. On one hand, the organisation is using the language of person-centred care in policy and across its work, therefore portraying the organisation as operating in this way. MHNs receive education on the importance and value of therapeutic relationships. However, the reality appears different from the rhetoric. This may account for conflicted feelings and subsequent distress and anxiety.

What makes the focus on risk particularly violent, is that the participants are never going to be able to meet the expectations of their employer. Previous studies have shown that at the very least, assessment of risk is problematic (Coffey et al., 2017; Higgins et al., 2016; Morrissey et al., 2018). Evidence would suggest that as professionals, we are not very good at predicting the future (Rahman, 2013). This is not to point judgement or blame at professionals, but rather our prediction of future events are still at best predicted by looking at probability based on previous behaviour and demographic statistics. This discourse does not allow for the fact that that despite the findings and efforts of staff to 'objectify' people- they remain that- human and therefore will always be inherently unpredictable.

It is clear that risk discourse is part of the habitus of participants. It appears that participants are structured by the organisational pressure to predict and mitigate risks but also this is structuring their current practice to the extent that they appear overcome with a burden of risk management to the determent of other areas of practice such as PHC. It is apparent that the findings in this study mirror the findings of previous work which has shown the impact of risk management. What is unique in this circumstances is that it shows that it may not be appropriate to prioritise physical health issues where assessment and management of risk is a priority during crisis.

## 5.6 Organisational Support

There was a clear sense across the inpatient and community data that the organisation did not provide enough support for staff to provide physical healthcare. This was communicated by participants either expressing that they were unclear what support was provided or that what was provided was not sufficient. The support provided appeared to have little impact on participants. For example, some participants could name only LearnPro e-learning modules or the staff intranet as the only source of support the organisation provided. They also felt there was little support or encouragement to pursue PHC. In the following example, the participant discusses the HR systems used to record learning and training (LearnPro, EmPower, KSF). It is interesting that *"that's for us to recognise our training needs"* which again highlights that the individual is held responsible. The participant discusses the formal process of appraisal but admits that they have rarely had a discussion about physical health topics.

> C02: ((pauses)) ((sighs)) I'm gonna show a huge gap in knowledge there I don't know (.) LearnPro I know (.) because I do it regularly but also I guess we have access to the database (.) am ya know about (.) evidence-based practice I guess (.) am we have access to that as nurses (.) so we can look at that am (.) no there's not much else […] There's there's emPower isn't there and that's for us to recognise our training needs (.) I guess you have your KSF every year (.) mine doesn't tend to gear around chat around physical health to be honest [ok] am (.) yeah not hugely

It was felt that the HR system was difficult and cumbersome to use. It was deemed difficult for participants to be able to identify and meet their learning needs. They felt there was a lack of topics to do with physical health and the system required the user to use very specific words and phrases in order to find what they were looking for. There was also a lack of refresher training available to upskill in knowledge and skills gained as a student. It was felt that one reason for the lack of visibility is that physical health was not seen as a priority for the service. However, this is because it is competing with other demands, such as trauma-informed care, a topic, which the health board provided a lot of CPD.

> H08: not a lot (.) we can look up training on emPower and see if we can find things (.) the training am (.) database is really difficult to find what you are

> looking for (.) it's not that user friendly (.) ya have to be aware of there are very specific words that are used in the titles of the courses […] I don't really know what else if if if they provide other stuff it's not widely advertised

It was also felt that the organisation did not provide adequate equipment to meet the needs of patients. This ranged from appropriate hospital-type beds to basic equipment for monitoring a person's vital signs. It was also felt that electronic equipment mean that nurses were loosing skills as they relied on electronic equipment to take vital signs. Participants also reported that it was often difficult and cumbersome to procure essential equipment, with the process being bureaucratic. Despite the lack of equipment, participants still felt that the organisation put pressure on them to meet needs and consequently this expectation was unrealistic when equipment and structures did not always allow for this.

> *I: and what support does your organisation provide to you in order to carry out this area of practice?*
>
> C07: am (.) hot desking (.) one computer between five people (.) aah (.)
>
> *I: so it sounds like resources are stretched?*
>
> C07: yeah (.)

> H08: yeah so the availability of (.) equipment (.) the length of time it takes to get dressings and things like that (.) ordered from PECOS it can take (.) it can actually take weeks so ya can spend a couple of weeks running around other wards trying to borrow equipment and steal things […]

> C06: I don't think (.) our organisation is particularly (.) strong (.) in (.) thinking about the resources that we need to do those things so (.) I have been in situations where (.) yeah I don't know how (.) I could you could go down a really sort of shaky road with that I think but (.) am (.) I think historically there's been a big sort of attitude 'oh well that's your job and you need to just find a way to do it'
>
> *I: without necessarily giving you the resources?*
>
> C06: without giving you the resources and actually (.) operating in (.) in crisis a lot of the time in terms of being under staffed underfunded (.) under everythinged (.) and again that being just being at the bottom of (.) the list of priorities

The lack of basic equipment was one motivation for getting people engaged with mainstream services such as the person's own GP, as it was felt they were better equipped. While this may be important in terms of reducing stigma and parity of esteem, it must also be considered that some people will simply never engage with primary care services. Therefore, it is a concern that the mental health services lack basic equipment and therefore how much investigation and intervention they could provide is questionable. For example one of the community teams report that they are debating if they should have a defibrillator in the event of a member of the public having a cardiac arrest.

One participant felt that structural processes inhibited practice- for example sending people to A&E for what they considered "basic" physical investigations and treatments because it is the organisational protocol.

> C06: even when I think about being in the wards (.) ya know we're sending people to the (.) to the [general hospital] for (.) really basic ((laughs)) (.) physical health interventions […] that's a structural (.) health board that is a strategic issue (.) that's got nothing to do with (.) nurses or their knowledge […] that's the facilities (.) ((pauses)) […] if ya had a nurse (.) in a ward (.) who was able to ya know (.) put up a drip and like (.) doesn't matter there wouldn't be one anyway you would still be expected to (.) transfer them so I think there's a whole kind of (.) organisational level (.) that (.) has an impact on that too

While this may be the reality, there may be good reasons why such policies exist. It may be that maintaining staff competence and confidence would prove too difficult that it is easier and indeed safer to transfer people if they require such interventions. In this instance, the participant felt it was a strategic level and had little to do with the confidence and knowledge base of the staff but was due to basic facilities. It gives the perception that the inpatient nurses are 'not real nurses' but actually this has been a strategic decision made my management which is impacting on how mental health nurses perceive their abilities and identities.

Participants felt that a number of decisions made by the organisation affected their ability to meet people's needs. These decisions often resulted in added pressure for front line staff and consequently affected the day-to-day work practices of participants. It was felt that a number of these were down to finances yet government and health board pressures to see more people. In the following example, the participant felt more time was spent 'ticking boxes' rather than providing care for people. There is less resources to go around and people appear more concerned about paper work and moving people off the caseloads than providing care.

> C14: the government are tellin' us that were we need to improve mental health care (.) there's less beds in the hospital (.) we've got less amm (.) staff (.) to see people (.) we've got more (.) time spent tickin' boxes like paperwork (.) well now computer […] basically there is less resources there as well with the voluntary sector and am (.) getting' peoples support (.) that we need that we know they need (.) so we can withdraw

Management seem to have a particular view on what staff in the community should be doing. The participant gave the example that as a senior nurse, managers do not approve of them seeing certain people who 'just need a bit of support.' Managers appear to minimise the work that mental health nurses do. The support might seem rather basic such as advice on tenancy or helping someone access a community service- but management seem to think lower grade staff can undertake that work to free CPNs up to do more assessment and work perceived as more bureaucratic. The role has changed from direct care to referring people for care and support. The processes round arranging this extra support was also seen as bureaucratic and rather capitalistic in that if someone only requires two hours support, this is not picked up by support agencies who tender for care contracts. This data chimes again with work by Allen (2014), whose participants resented being taken away from the 'bed side.'

> C14: we're we're told now that 'ok now you're a band 6 (.) you shouldn't be providing somebody with support' (.) now that support might be to (.) just give advice about tenancy to get them out and about in the community (.) improve confidence (.) you (.) refer somebody you you refer somebody to social care direct (.) a social worker comes in (.) does a care needs assessment (.) funding gets agreed (.) it gets put out to tender

## 5.7 Change

The concept of change appears throughout the data. The data referred to change within the organisation, the impact of the change in personnel, change in the type of presentations, attitudes and work practices.

### 5.7.1 Organisational change

There is a sense that things within the organisation were in a constant state of flux, to the extent that participants voiced that they found it difficult to keep up to date with what they were meant to be doing in terms of supporting people with their physical health. Because of the organisational changes, attentions are diverted and what you wish to focus on as a nurse is not always congruent with the organisation. One participant discussed a range of organisational changes, including a business consultancy firm following them around and attempting to make significant changes to working patterns. All these things have contributed feelings of negativity and disconcertedness. The participant describes a picture of people being overwhelmed and a sense of scrutiny about their everyday practice, that they are left questioning what they are doing in a negative manner and one that takes away from their focus on providing good quality care, let alone care that addresses people's physical health.

The following example, the participant felt that the approach was a top down one, they did not feel involved, were disempowered, and not being communicated with left people feeling overwhelmed and stressed.

> C13: am (.) ((sighs)) I suppose it again (.) I mean (.) physical health is (.) bit of a focus in some ways just now so it's better than what it was but I think because things are constantly changing (.) you're kinda keeping up on them and your focus gets (.) diverted to that (.) so (.) am (.) auch I mean there's been so many changes over the last few years that that have (.) I mean organisational stuff not necessarily the job itself like (.) am changes to the way we worked at weekends (.) changing to (.) I don't know if you were around when Meridian were around [hmm yes] and that all had a big (.) big I mean negative impact (.) there's nothing good about it ((both laugh)) Am and that really just detracted from everything (.) that had a huge negative impact on everybody and I think what they were then doing during the day (.) in every aspect of (.) what they were doing (.) so not just physical health but just the (.) the stuff that (.) ya know the stuff sure ya know all the (.) that kinda stuff is happening all the time and it just takes away the focus from other stuff you don't get time to stop and sit back and think 'right what do I need to do' (.) yeah

Some of the practices were particularly damaging as they took a rather reductionist approach to care, stating how long people should be seen and how long it should take CPNs to travel to appointments, completely ignoring the realities of practice and unpredictable nature of people with long term mental health problems. This sense of flux resulted in participants viewing changes often as being fads, flavours of the month and meant that nothing was ever embedded in practice.

> C13: ah ((sighs)) ((pauses really stupid examples of (.) like 'google says ya can get from this place to this place in this amount of time' (.) so that's how much time you've got to do it (.) ah ok but that's (.) not real
>
> *I: so them organisational change fads [yeah] impacting on your ability to do what you want to do?*
>
> C13: yeah exactly (.) just ya mean cause that's just (.) how it (.) how it is I'm sure everywhere were (.) you've got these big changes that are stressful especially when ya don't really know what's going on and it's (.) it does interfere with (.) just everything you're doing really

It was felt that poor leadership allowed this to happen, and essentially encourage an approach of "*drop what you are doing*" [C13] and focus on this new priority. Participants felt this to be frustrating and not a productive or helpful way of working. They felt this hierarchical approach to their work focus as undermining.

Another organisational change was the development of brand new services. One participant was a charge nurse in a new ward that had only been open a year at the time of interview. This presented a set of challenges as priorities of writing and embedding Standard Operating Procedures (SOPs) in practice and trying to get the new team to mix well together prior to developing areas of practice.

> H08: it's a::mM (.) it's very (.) different to any other post I've been in the ward was brand new (.) am only opened last June (.) so:: there it was quite an interesting process settin' that up (.) am the the whole team was brand new as well so trying to (.) get everybody to gel as a team has been a bit of a challenge

Change in service processes were not always seen as a positive thing but often took time and perceived to make life more difficult instead of simplifying things. This was perceived as putting increased pressure on time and the time they had to spend with patients as it was another thing that needed to be completed. Therefore, there is less time to do physical healthcare interventions

> C03: yeah I guess it's just a kind appointments (.) sometimes we have meetings (.) am so the (.) sometimes we're in the clozapine clinic that can take up like a whole morning am (.) now we've just decided that we're having an assessment clinic to see if people (.) do need to be assessed for (.) ah CPN so that's gonna add pressure

### 5.7.2 Changes in presentation

There are numerous examples within the data of changes in the types of presentations that services were seeing. Participants discussed the changes in patient presentations over the years. In particular, the increase in the number of people they were seeing with a diagnosis of borderline personality disorder (BPD) had significantly increased. This was not viewed positively as the participant felt the team was set up to support people experiencing psychosis, they did not have adequate training or skills in working with people with BPD and were expected to provide a service, when the understanding of that label might have been particularly nuanced and sophisticated. They felt their experience and that of their colleagues was working with psychosis and therefore getting to grips with supporting people with BPD presented as challenging, particularly on an emotional level. The participant questions how successfully they work with people with this label and if to this day, they are best placed to support it.

> C13: when I first started there it was more kinda of bipolar and schizophrenia but now (.) lot of people with ah personality disorders (.) which is (.) changed what we do quite a bit (.) […] am ((pauses)) I guess probably because as the (.) as we got more and more people with that diagnosis coming in (.) […] it's not really why the team was set up (.) I suppose (.) am and because we had worked with people with psychosis mainly that was kinda our (.) I say our but mine but generally […] I guess I had a lot of experience in that ((pauses)) and I guess to this day there is still debate about wither we're (.) best place to (.) help people with personality disorders (.) I don't know ah (.) how good a success rate we have

This raises questions such as are more people being diagnosed with this label than before. There are likely a number of reasons. Firstly, there is more awareness of mental health issues and people seeking support for this than ever before. Secondly, the mental health Act in Scotland specifically allows for personality disorder in order to meet criteria for detention and compulsion under the act. This has likely increased the number of people being seen by NHS services.

This has obvious impact on the work people do but it is questionable if it should be affecting how MHNs address patients' physical health needs. While not stating it directly, I suspect that this change in trends in diagnosis comes with a greater burden and risk of burnout as it is well documented that people with a label of personality disorder can be a challenge to staff with high levels of therapeutic pessimism, perceived lack of staff support and often present frequently in crisis and resulting in having to manage high levels of risk which can often be chronic in nature (Westwood and Baker, 2010). This may result in 'firefighting' which would perhaps detract from long-term pieces of work around emotional wellbeing, including physical health promotion.

Another change in presentation of patients was the changes in health behaviours. As services moved towards smoke free environments, in keeping with the wider trend in society around tobacco consumption, participants felt that smoking rates declined but the use of other substances have increased and in particular the consumption of the new psychoactive substances (NPSs) or 'legal highs' which bring their own set of physical health issues.

> H05: I think a few different people don't smoke as much as they used to (.) am so we don't see that but we do have lot of other drugs and things that we need to look out for

> H12: we have had a lot of the legal highs and things that was quite difficult (.) period (.) that seems to be improving (.) well with legislation and things been made more difficult (.) we are not seeing quite as much of that anymore

### 5.7.3 Change in working practices

A substantial change in working practice has been surrounding the initiation of the drug clozapine. This is something that was traditionally commenced when a person was receiving inpatient care. However due to the pressure on beds, it is something which the CMHT and home treatment team have had to take on. The commencement of clozapine requires significant physical health monitoring and therefore was traditionally seen as best placed to occur as an inpatient. It has now meant that this burden falls to CMHTs and home treatment team to coordinate and deliver, something that traditionally they would not have done. This would be in keeping with the move to more care in the community.

> C02: because the wards are very busy we often now (.) commence clozapine in the community (.) so we generally do that hand in hand with the CMHT they identify someone (.) they'll an' they'll they'll now approach us and ask us to fill in the monitoring of the (.) obs (.) outwit hours

A participant also discussed the roll out of psychosocial interventions for people with psychosis. This is something the team were very experienced in delivering and the participant discussed how much they enjoyed it. In particular, the use of workbooks provided a structure for the work they undertook in supporting people to live well with psychosis. However, due to a change in approach and redesign, how this is delivered has changed. The participant reported that they were "*in the dark*" about how that was going to look. They reported as such things were in limbo and consequently this created a sense of uncertainty which in turn lead to negative emotions and a sense of being overwhelmed.

> C13: it's gonna become more of a focus again [psychosocial interventions] over the next sort of while but it feels little bit in limbo just now cause the whole (.) way of delivering it is changing (.) and we don't really know how it's changed yet because (.) we've got to find out […] a little bit [in the dark] it's not (.) it's just that (.) we're waiting for the next bit to start so we can just get back on with it again

Another change in working practice was the adoption of 'paper lite' practices and electronic patient records (EPRs). There were diverging views about this development. One participant felt that as a consequence of the TRAK system, they had access to a large amount of information about patients which they sometimes felt uncomfortable about. For example, information which they argued they do not necessarily need to know and which some patients may not appreciate. They discussed that as a result some nurses feel they have the right to know everything about a patient because they are MHNs and not because it will bring much benefit to the patient. This might contravene privacy and confidentiality and that sometimes she does not need to know that a patient has been for a smear test or attended A&E for something minor. This may raise ethical issues, as if a nurse is aware their patient has a physical health problem, they may feel they are then accountable and responsible for providing intervention.

> C06: […] I (.) have got a big issue with electronic patient records (.) and the fact that I can go into my work at 9 o'clock on a Monday morning and see everything that's happened (.) for and to a person (.) whose on my caseload […] I can look at a person's entire health record not just incidences of mental health but (.) and I can know about (.) things before they do

In contrast, participants talked about the development of TRAK[14] was really useful as it allowed for information to be shared across teams and allowed them to know if a patient presented to A&E and if so, was this related to their mental health or was the contact with acute services going to impact on their mental wellbeing. It was also useful for if a patient was admitted to the general hospital and being kept to up to date on their progress.

> C14: TRAK has been one of the best things (.)TRAK has been a revelation for me ya know if somebody's presented to (.) A&E or something like that I can go in there and find out the stuff that's been done

Technology and its adaption was seen to have negative consequences for the maintenance of core clinical skills. One participant discussed that skills were being lost because of use of electronic machines that were essential to the assessment of a patient, the requirement to touch and feel a patient allowed you much more information about how they are doing.

> H05: pressure manually and not rely on a machine because a lot of people can't now (.) ya know cause they all use machines and they aren't that accurate (.) am also ya don't (.) the machines a machine and ya don't hear the noses (.) and ya don't hear ya know (.) ya can't ya can tell the pulse is 90 but you don't know if it's regular (.) you don't know if it's thready (.) ya don't know if its booming ya don't know if it's weak

> H10: I don't know I mean on our ward we certainly (.) do ((pauses)) see that students aren't automatically going for a spygh (.) they are relying on machines

### 5.7.4 Change in attitudes

Data shows that participants have experienced a change in attitudes towards those with pSMI. In particular, one participant felt that the emphasis on holistic person-centred care along with the discourse on parity of esteem and mentioned specifically, reciprocity[15], meant there was much more focus on attending to physical health needs as part of holistic and person-centred care agenda. They felt this was a change they had experienced gradually over the years.

> C02: I guess it's more about holistic care that's what they are pushing for ahhhh am (.) and reciprocity (.) ya kno:::w ah […] there will be a push in practice (.) towards (.) thinking about physical healthcare and thinking about

---

[14] TRAK is the name of the electronic patient record (EPR) system used within the health board

[15] This is one of 10 principles underpinning the Mental Health (Care and Treatment)(Scotland) Act 2003

> the person as a person rather than just someone with a mental health problem

One experienced nurse commented that there was less stigma around mental illness and therefore people were seen more as a human being first as opposed to an 'other' and therefore the standard of care improved as the stigma reduced and everyone is treated in the same way. This meant there has been a great focus on meeting all the needs of the person and in a sense trying to achieve a sense of equality and parity of esteem.

> H10: I think it's a sign of the times that the (.) sort of amount of stigma is kinda reduced a bit about mental health (.) I think people do recognise that everybody is an individual everybody is a human first and foremost and deserves to be treated the same way

In contrast, another participant felt there was a growing separation and divide in the health service which they were unclear how it or where it has developed. In their many years' experience, they felt there was a more reductionist approach developing where people get treated for different parts in different places. The participant discussed how there used to be a general ward in the psychiatric hospital that was appropriately staffed and which used to address the physical health needs of patients in-house but current practice is to refer to the general hospital instead. The participant felt this was a negative development as on the whole, people were better in the psychiatric services as there were in a familiar environment where their needs were being appropriately met;

> C07: I feel there's been a separation sort of (.) over the last I would say over the last ten or fifteen years there's been a definite separation between (.) mental health and physical health I mean when I was working in [psychiatric hospital] when I very first started there was a general ward within the [psychiatric hospital] for physical (.) people with physical health problems (.) people were treated all in house now (.) if someone is in hospital and has a physical problem (.) they're generally taken a way and put into [the general hospital] (.) therefore (.) yes getting the best physical care but (.) completely isolated from their peers from the environment they're used to maybe more distressing

### 5.7.5 Change in personnel

Change in personnel could also be positive, particularly if a leader brings a new energy to the team. For example, one participant reported they had a new manager and for the first time in years new ideas and suggestions for improving practice, including physical health of patients were being brought to the fore. Previously this had been stopped by a culture of fear of a senior member of the team who people looked towards for approval, a person with leadership but not a manager. There was a sense of questioning practice that was bringing about positive changes.

> C03: We've got new new management [ok] and there is one member of the team they are (.) am (.) no longer here (.) I personally found them very (.) am ya know they weren't a bad person am (.) but if he is (.) a band 6 but if he said (.) 'this is what I think this is what should be happening' there was an element of fear and no one would argue with him (.) and he was very much for (.) ya know that passing the physical health clinic onto a support worker for example (.) so that's what happened [umhum] whereas now there is opportunity in in the team to be like 'should that happen?' or why don't we (.) ya know try this so there is changes like that CPN meeting we just had (.) there's thing happenin now that (.) was (.) never being discussed before so there's yeah changes in team changes in management am ((pauses)) yeah

## 5.8 Socioeconomic factors

A number of participants saw the link between socioeconomic circumstances of their patients and the impact it had on wellbeing and in particular, poor housing. This was not universally held but rather there was varying agreement about the impact that such factors influenced decisions are addressing patients' physical healthcare.

Community staff were more diverse and spoke at greater length about the impact of socioeconomic factors and appear to have a more nuanced understanding in comparison to participants in the inpatient setting.

One participant felt that one of the contributing factors was the educational attainment of pSMI. It was felt that those with a long-term mental illness likely experienced a disruption in their education, which disrupted their development and health literacy including nutrition and exercise. This is further compounded with participants reporting that their patients were generally poor at engaging with primary care services. The use of 'they' in the following example illustrates the divide between staff and patients

> C04: people who don't have severe mental health problems so yeah […] amm:: (.) education [umhum] (.) upbringing (.) sort of social class (.) ammm (.) I suppose they are probably not that good at engaging with (.) sort of primary services like your GPs and things like that an' they probably need more support than other members of the (.) the public

> C14: I would (.) say yes because I think there is less education into (.) food stuffs (.) as ya say a lot of poverty […] I think it does have a (.) big impact […] yeah definitely education but not just not restricted to classes (.) before I got married (.) I was quite partial to an economy burger ((humour)) aye

It is often assumed that this is "*basic*" but as participants stressed, pSMI often do not have this knowledge and therefore should not be assumed that they do. In this example, the participant talks about delivering a simple intervention regarding sugar consumption for a pSMI they were working with. This involved using a website to illustrate to the pSMI how much sugar was in their favourite soft drink and getting them to visually depict that. This allowed the participant to offer advice about strategies for reducing sugar, which may appear basic, but are fundamental and which pSMI clearly lacked at times;

> C06: I said just try buying some ya know low sugar stuff and he did (.) it does work sometimes ((laughs)) he's not consistent but I suppose that's (.) I mean (.) this really basic (.) what seems I mean really obvious but it's not to so many people a lot of people just haven't (.)had the life skills

Participants also discussed disruption in education was also compounded by facing various degrees of childhood adversity including poverty. For example, being born into families where the primary care giver might also have a SMI and live a chaotic social existence. Therefore, participants felt that this resulted in pSMI having poor routines and structures. Their basic skills in self-care and personal hygiene including eating and drinking may be non-existent or impaired. However there is also an acknowledgement that some of this is down to the fact people may have low self-esteem and may not feel like they are worthy of taking care of themselves. If people are in a constant state of mental distress it may be difficult for them to take care of themselves.

> C06: amm ((pauses)) I think for some people (.) they have never been met (.) so they've come through (.) some degree of childhood adversity and actually those things have never been attended to so they've never built up

> those kinda health routines or knowledge even (.) am (.) I think for some people they fall down as a result of (.) kinda mental health crisis and (.)

Most community participants saw the link between poor housing, economic deprivation and poor mental health. They felt their role was to help people to "*manage a bit better*" [C14]. In particular, they note that pSMI do not have a lot of money. The language in this example illustrates that there is a judgement being made about people's lifestyle and that pSMI are making poor choices; and that the poor socio-economic standards are a consequence of poor decision-making

> C04: the (.) majority of mental health patients come from (.) quite difficult social backgrounds (.) economically they don't have much money (.) if they do have money it's it's sort of benefits that are frittered away on (.) smoking drinking drugs […] usually spent (.) quite badly on things that are unhelpful

What is interesting is that despite this rather nuanced discussion and reflection on socioeconomic factors, a number of participants stated that it would not make a difference to the intervention or outcome. It did not appear to change how the participant approached the assessment process, as they felt they would consider physical health issues to the same degree. Arguably if people are in poor socioeconomic circumstances, this will impact on the sort of interventions which a CPN can provide. It seems somewhat incongruent, recognising that people do not have money and then not taking the wider socioeconomic factors into play in any physical health issue.

> C04: I mean yay a (.) I think you are already aware of that (.) before you start working in a community team but when you come to IHTT you can see that (.) sort of disparity (.) over the city it's we spend a lot more time in (.) areas of the city that are run down am (.) then areas like (.) [affluent suburb] or whatever I think it's (.) it's obviously a problem
>
> *I: does that change how you might influence or intervene on someone's physical healthcare?*
>
> C04: ((pauses)) no I don't think so (.) I think I would still go in and (.) still do the same […] I don't think would affect (.) my sort of assessment of (.) physical health [umhum] ya still just treat it the same
>
> *I: and provide the same interventions?*
>
> C04: yeap

> C14: ((pauses)) No I'll still impart the same advice to anybody ya know (.) is that what you mean (.) no matter what class or background (.) same advice

In contrast, some participants felt that working each day across extremes of economic and social environments did not change their approach to patient assessment but it did change what advice and intervention they could offer. Poor socio-economic circumstances meant that even providing nutritional advice was a challenge as people may not have the financial means to implement it- such as 5 pieces of fruit and vegetables a day. They felt income was the biggest factor in determining what interventions were practical. It is clear from the example below that working across the extremes of socioeconomic situations had an emotional impact on the participant, stating that it could be breath-taking considering the level of poverty some people live in.

> C07: I mean some people have got terrible (.) low income and it and it impacts on everything it impacts on well the food that they buy am (.) what they are able to do outwith the home environment (.) can't really afford to go to the gym (.) can't ya know wouldn't spend the extra money to go to the gym (.) am where as at the other end of the scale (.) ya know I I (.) I wouldn't say the treatment is any different but the things that ya can offer certain people it can be slightly different (.) am (.) things that ya can suggest to people […] it does change how ya (.) not that ya want to (.) but ya do kinda (.) have to kinda taylor what you're able to offer to people's situations I think
>
> *I: it sounds very polar opposites*
>
> C07: it is [yeah yeah] the [affluent part of city] to (.) ya know like [socially deprived areas] (.)and it's completely like (.) just such a vast difference between ya know
>
> *I: it sounds like that creates quite a challenge in actually going about your day to day practice?*
>
> C07: ah it can be (.) I don't I mean I I just ya know every body's the same to me (.) but when ya see the different situations that people are living in and it can be quite (.) take your breathe sometimes

A community nurse had a somewhat different perspective on socioeconomic influences. They made a distinction between being in a deprived area and in a deprived situation. They saw it that the nature of someone's illness drove the impact. For example, being unable to return to paid employment and therefore having to become reliant on benefits. To some extent, poor health results in poor macroeconomics. This participant, like the example above, felt that money did play a role in what interventions they could provide as some things, which are beneficial for both physical and mental wellbeing, were unattainable to some of their patients because of their financial circumstances. Others, who felt that provision of activities on wellbeing was poor for this population, supported this point. They felt activities were either aimed at people with very severe and enduring illness or else very high functioning people. But anything in the middle is not supportive or does not exist. Accessing community supports, which were either high-functioning/mainstream or middle-range, have a financial implication for the pSMI which must be considered.

> *I: are you working with a large number of people from (.) maybe more socially economically deprived areas or is it more (.) areas that a bit better off?*
>
> C06:I wouldn't say they were (.) ah ((sighs)) deprived areas but I'm (.) ah most of the people that I work with are definitely in deprived situations (.) and I wouldn't say that that's (.) because of their (.) sort of socio-economic background I would say it's because (.) they've been unwell and that's the circumstances that they've (.) the circumstances have been a result of that I think (.) I couldn't say that I'm working with anybody whose (.) no most people are unemployed (.) am (.) and not kinda never have been employed but have been employed and are no longer able to work (.) am yeah
>
> *I: and then does that then impact on your ability to provide physical healthcare interventions or does it play a role in maybe how you deliver (.) interventions?*
>
> C06: ((pauses)) I think money becomes quite a big issue in terms of promoting good nutrition particularly and (.) exercise

And;

> C07: I mean just sort of (.) like fed up (.) they've had a hard time ya know they're at their lowest ebb or close to it (.) are not gonna go out and jog around a park or (.) ya know (.) finding the internal (.) drive and motivation to do these kinds of thing is not gonna happen it's just ya know (.) it wouldn't happen for the best of us (.) so I think (.) it you have to help direct people towards like very supportive atmospheres (.) and they (.) are either (.) they either don't exist in the sense that (.) you're paying money for those and you're paying probably (.) a tenner for a class or whatever (.) or they are very very am (.) very sort of (. ) at the (.) very severe end of mental health provision which (.) means sort of very low (.) geared to people who are very low functioning (.) am (.) there's really not a lot in the middle ground ya know 'oh well I'm I wanna go to a yoga class' (.) 'alright well here's one that's three quid' (.) like (.) ya know not (.) yeah

In contrast to community staff, inpatient nurses were much clearer regarding the role of socioeconomics. It was universality felt that such factors do not really come into assessment of physical healthcare as everyone is provided with the same standard of baseline measurements. The inpatient participants spoke much less about health promoting and advice giving compared to their community colleagues. A global, holistic approach was seen to be favoured across the board.

> H09:I don't think I don't think so I think it works out the same because (.) we get a whole kinda of (.) wherever you are in the city I've worked in all the all the different sector wards (.) […] ye get a big wide spectrum of of society really
>
> *I: and say you had someone from a more deprived area (.) versus someone from maybe a more affluent area (.) would that in any way influence how you go about addressing their physical health needs?*
>
> H09:No I don't think so

Inpatient staff did note that the socioeconomic background of patients may impact on their presentation. For example, it was felt that those who use substances were from a much more deprived backgrounds but again, this would not impact on approach or intervention

> H12: I don't think it impacts on our practice or (.) our abilities to (.) treat the patients but I think the physical ailments that (.) for example this sector […] (.) I se::: think this is just my personal opinion (.) that am (.) for example the [other sector] they perhaps deal with more (.) am (.) drug induced physical ailments where as we don't get as many of them (.) am so I think divided between each sector (.) perhaps the physical demand is different
>
> *I: ok interesting*
>
> H12: but I don't I think it ya know I don't think our abilities our different as from nursing standpoint I just think we have to deal with is different
>
> *I: your interventions are the same regardless*?
>
> H12: yeah yeah

It is unclear why some staff recognised the role in social inequalities but then felt it has no impact on interventions. There could be several reasons for this. Firstly, Mental Health pre-registration curricula in Scotland take a 'values-based' approach (NHS Education for Scotland, 2012). This has been mandated by the NMC. In Scotland this has been developed further, with NES recommending the integration of the 10

Essential Shared Capabilities (10ESCs)[16] into all pre-registration mental health programmes (NES, 2012). Two of these values are 'challenging inequality' and 'providing service-user centred care.' However, as Elliott and Masters (2009) argue, such mandates as challenging inequality are themselves significantly challenging to achieve. That is because a large majority of the factors that contribute to inequality are wider structural issues such as poverty and poor housing. Therefore they may not be within the capacity of MHNs to tackle, as they require significant work on the part of national governments. Participants may have been acutely aware that such socioeconomic factors do play a role in health, but may struggle to articulate interventions. This is a common critique of values-based curricula. While being able to provide a common set of attitudes and values is important, they do not provide students with concrete interventions to tackle these mantles when in practice.

Secondly, until the most recent update to the NMC code of conduct, it was explicitly stated that nurses were expected to challenge inequality and discrimination. Therefore, participants may have felt simply embarrassed to admit that they treat different people differently for fear that they will be judged as being discriminatory and therefore in breach of their code of conduct.

The inpatient context may be easier to comprehend. Inpatient staff work in a rather more contained and structured environment to working in the community. There are standard admissions and discharge processes including physical health screenings. In this regard, they are very likely to 'treat everyone' the same, as the same set of baseline monitoring is expected for everyone. In this regards, it is perhaps clearer what staff must do. Inpatient staff have an advantageous position as they are in some ways working in a bubble, away from the complexity of differing and varying home environments. As the patient comes to them and all patients are in the one setting, as opposed to the community, it may be very easy for inpatient staff to separate themselves from this complexity and some of the wider structural issues such as poor

---

[16] The 10 ESCs were originally developed jointly by the Department of Health in England, The Sainsbury Centre for Mental Health and the National Institute for Mental Health in England in conjunction with people with lived experience and carers. The 10ESCs set out the shared values that all staff working in mental health should possess (NHS Education for Scotland, 2011).

housing and food poverty. In particular this last issue is less significant in the hospital as everyone is being provided with the same food.

# PART II

## 5.9 Boundaries in the Field

Part II of this chapter focuses on some of the boundaries that exist within the field. These boundaries are often the sources of tension. This section will discuss the need for MHNs to navigate and negotiate these boundaries in order to meet patient needs. I then explore some of the tensions between mental health services and primary care. I then discuss how mental and physical health occupy different physical spaces and places that come to occupy different tensions. I further discuss the boundary between different mental health services before discussing how workload can be used as a way of managing tensions. In contrast to earlier sections, the use of a shared language appears to be a manner of overcoming these tensions in the field. This section concludes with a discussion around the boundary between staff and patients.

### 5.9.1 Navigating, negotiating & setting boundaries.

There is a recognition that boundaries between different parts of the health service are difficult to negotiate. Participants gave clear reasons why MHNs need to provide support to pSMI- as the boundaries between different parts of the healthcare system are difficult for staff to navigate, let alone for pSMI who may have a variety of cognitive and psychological barriers to overcome. In order to overcome this participants reported providing support to patients by accompanying them to appointments for their physical health if that would be helpful.

> C03: (.) as I was saying (.) assessments I think that should be done regularly if people have a (.) specific condition (.) then we need to be clued up on it (.) we need to be (.) asking about it and maybe going along to appointments or (.) asking ya know (.) do you want someone to kinda go along with ya (.) like ya know (.) speaking to whose involved making sure that there's follow up (.) havin' meetings with other professionals and (.) yeah

> C07: […] (.) ya know people are maybe living quite chaotic lives and are a bit disorganised (.) tend to (.) care for their mental health because they'll because if they need extra medication for their mental health that's fine yes I'll go and ask the GP but if it's a physical problem (.) it doesn't seem to happen and I think there is a a (.) kinda (.) there's a role there for maybe (.) a bit more physical intervention like OK 'I'll take you to the GP because you

> are needing bloods done or I'll take ya to the GP' but that doesn't seem to happen

This approach is not just about patients but also about staff having to negotiate and navigate care, especially with non-mental health settings. There is a clear sense from participants that they are a mental health service and therefore mental health needs are their priority, while at the same time, balancing that view that they meet the needs of patients holistically. From the extracts below, there appears to be a clear sense of identity as a mental health service. The participants place themselves as not expert in physical health issues and feel that part of the boundaries of care is also about the boundary one places on the knowledge of one's own limitations which may dictate that someone should be seen by their GP. In the case of the home treatment team, there is a clear boundary set about what they can and cannot do. They feel their main role is to monitor and signpost vital signs such as blood pressure and weight. Anything beyond that requires the GP to be involved. Often to negotiate this boundary between them and primary care, the staff support patients by assisting them to make appointments and accompany them if necessary to the GP practice. However, it is also clear that this is dependent on time and resources.

> C02: it's about liaising with the GP sometimes obviously we deal with acutely unwell people so it's about (.) making the appointment for them sometimes the GP (.) sometimes accompanying them (.) to the GP (.) if we if staff have time and that but it's (.) I See the role as kinda monitoring and then action anything anything that we are concerned about […] because we're a mental health service now that doesn't mean to say that we don't look at people's physical health but we are not the experts in it (.) I totally recognise my limitations of my knowledge and therefore if there is something I don't know about I ask a medical staff or we will refer to the GP

This negotiating services has a dual purpose. It allows MH services to provide holistic care while at the same time protect themselves from role expansion which may result in service dilution. It also allows for gaps in knowledge to be covered up.

Furthermore, the home treatment team are clear that their role is to support someone's mental health and not to provide a package of care in order to meet the physical health needs of patients including fundamental care like attending to personal hygiene. This requires input from social services who are tasked with providing this. This may be understandable as the focus is providing intensive support, it would not be possible to provide this level of care for everyone and therefore the service would be diluted. Instead they have a role in organising such packages of care and attempting to ensure such plans are put in place so people can be discharged home quicker. This is an example of Allen's (2015) 'organising work' concept discussed in part I of this chapter.

> C04: I think with the guy with Huntington's and the incontinence and the issues with skin (.) would be (.) he needed a bigger care package so it's about arranging a care package (.)

Because of the reactive nature and the role of gate keeping admissions, the home treatment service is likely to require firm boundaries in order to successfully execute that role when managing high levels of risk and competing demands. This would link with the concept of risk discussed earlier in the chapter. This 'organising work' allows them to maintain that boundary, and similar to discussed above, serves the function of protecting staff from knowledge gaps but also allow people to receive the best possible care.

### 5.9.2 Primary Care and Mental Health

Negotiating boundaries is not just about MH services approaching non-MH but also visa versa. This is illustrated when participants are discussing when they have to liaise with primary care.

This may mean that there is a power dynamic set up, where the GP because of their medical knowledge and skills has more power and therefore capital. However, MHNs also maintain a boundary in that they are positioned as experts in mental health and therefore GPs and others have to approach them for advice. This sets the MHN up as a gatekeeper for access to appropriate MH services. However, there is a sense that its an unequal relationship as the participant in the example below discusses that some, but not all GPs are supportive of the team approaching them for advice on the management of someone's physical health. Yet GPs will regularly refer people to the home treatment or assessment service for support with mental health issues. The participant acknowledges that everyone has pressures and therefore GP may feel that they have enough duties in addition to advising other teams. The participant in this example states that sometimes it comes down to people's personalities and how open they are to support or being supported.

> C04: Not that much because I think their focus is on (.) they see us as being mental health professionals and I suppose if they're contacting us they're usually looking for (.) for guidance on how to deal with someone (.) like doing the MHAS shifts GPs will phone but they're looking for (.) a bit of support and guidance on how to manage somebody (.) with mental health problems
>
> *I: Is it common for you to seek advice from them regarding patients' physical health?*
>
> C04: yeah I think GPs yeah (.) GPs are someone who we'll contact quite a lot
>
> *I: And they are quite receptive to that contact?*
>
> C04: some are [h]
>
> *I: Some? Ok (.) why are some (.) very and others not?*
>
> C04: I I think maybe they are a bit surprised that an acute mental health team are having to get a bit of physical advice and why can't we manage that within our own team am (.) everyone's got their pressures and (.)

It is important to remember that we are only hearing from one perspective; MHNs and it may be that staff in primary care have a different story to tell regarding their interactions with MH services.

The boundaries of care have clear impact on perception of someone's role. In particular, regarding what is the remit of the GP and that of MH services. This participant clearly struggled with this and found that a culture existed for a long time of what different teams did or did not do. The participant identified that fear was a significant perpetuating factor in driving this culture and why people behaved the way they do.

> C06: ah ye just within mental health nurses in general (.) am 'don't do that' 'we don;'t know that' 'that's what GPs are for' 'that's what' (.) ya know 'we do mental health' I think there is a really (.) and I think this same is true of other (.) specialties in terms of mental health [umhum] 'oh mental health's for them (.) we don't do that we only do this' kinda thing […] I think it probably comes from fear (.) cause ya don't know and ya don't wanna get it wrong and so it's better if it's just someone else's responsibility
>
> I: so you think the culture comes from fear?
>
> C06: am ((pauses)) yeah I think it probably comes a little bit from laziness too but I think (.) the strongest thing is probably fear (.) people feel (.) uncertain (.)

A further power dynamic is evident in the field regarding perceptions of MH services. A further issue of power is highlighted when participants discussed how psychiatry is blamed for all of people's physical health problems, and in particular treatments used in psychiatry. The participant is clear that non-mental health services use this assertion without engaging in much investigation. Therefore the staff working within mental health services have little capital. There is a sense that people have their boundaries marked, and any attempt to address these results in conflict. This example shows a contrast between the holistic and in some ways systematic assessment of a person's needs versus a reductionist approach, taken in other areas of healthcare to approaching patient's needs. It appears that the participant's view is disregarded;

> C14: I've got somebody just now (.) or well one of my bug bears (.) when somebody from mental health goes and it's psychiatry that's blamed for everything (.) I've got somebody that's been having problems with (.) passing urine (.) and actually 'it's his lithium' straight away (.) ya know well (.) and he's going in for tests and everyone's havin' to communicate (.) cause Lithium is known for it (.) [yeah yeah] but ya know there's (.) it might be prostate (.) ya know ya got to check everything

There is a clear boundary that has to be negotiated if the p SMI has comorbid issues, which require close liaison with primary care. One participant who worked with a patient with complex care needs described a very bureaucratic process in order for their patient to access GP appointments. This resulted in having to arrange a set appointment each weeks which in itself was not straightforward and required negotiation with practice managers. The participant states that the particular practice was overwhelmed and therefore it may explain why practices and access was quite beurocratic. However, this has an obvious impact of being able to meet the needs of patients. When the boundary is overcome it can have positive impact on patient care. Such work can allow for the nurse to advocate and get the best possible care for the pSMI.

> C06: I went and met the district nurses who were (.) doing the insulin (.) I went (.) I think the the (.) the most vital part of that so (.) this person was like all of us (.) am registered with a totally overwhelmed GP practice (.) was (.) which had some weird and (.) individual policy about how you make appointments (.) which this person was nex- (.) I can't get an appointment with my GP (.) living a reasonably stable and (.) like healthcare aware life

### 5.9.3 Boundary between mental / physical health: Fields & Places

Some tensions within the fields are illustrated when exploring the aetiology of people's presentations. It is not just about the physical space a service occupies but what these spaces come to represent and the boundary between what is and is not possible.

When the issue of aetiology of presentation comes about, there is a sense that something has to take priority. In the example below, the participant is clear that as the person is in an inpatient mental health setting, the priority in some ways is the person's mental health and therefore it becomes a case of managing expectations and realities of what can be delivered. Participants, as part of their assessment and observations have to negotiate the boundary of what is causing a person's presentation and perhaps is the physical health issue a way of eliciting care or a way of taking the focus away from the mental health issue which might be difficult or painful for the person to address. The participant in this example is clear not to dismiss physical health but more there is a sense that there is a time and a place- in this way, placing a boundary on the patient but also on their own scope of practice within the physical space of inpatient care. This appears to have the effect that physical healthcare occupies a separate place out with the psychiatric hospital.

> H12: ah I mean (.) I think they feel ok about it because it's something that they they (.) want addressed (.) am (.) and sometimes (.) sometimes (.) the physical health (.) is (.) more predominant that the mental health which is quite difficult because (.) sometimes we have to say ya know (.) 'that's ok I understand but you have that issue but that's maybe something you could sort out when you are discharged from here and you could go to your GP about it (.) we're trying to primarily (.) help you with X' but sometimes obviously (.) if there is something going on then (.) the mental health an physical health need to be deal with (.) in co-cocordance

This idea of separate spaces is developed further by a community-based participant. They remark how they have observed a growing separation which has developed and boundaries that have been created between physical and mental health services over the previous number of years. This is demonstrated by the separation of spaces for the treatment of different discrete systems of the body. It appears that people must access separate spaces in order to be treated for different issues.

> C07: I think there is a bit of a separation and I don't know (.) why or where it comes from it's almost (.) 'right we'll treat this part here and we'll treat this part here' but there's no (.) overall (.) I think that's a miss at the [psychiatric hospital] I do I feel that that's a big kinda (.) down fall that the general ward isn't there anymore (.) the medical ward

There is also an issue of in what space and place should particular care needs be met. This is demonstrated by a participant discussing meeting a patient with very complex needs. In this example a participant recounted providing complex care to someone with severe depression and multiple co-morbid issues which were further complicated by the depression. In particular the person required PEG and RIG feeding[17]. The participant felt that the patient should have been managed on a medical ward. It was felt that that would have been a safer option. However, the participant described a lot of resistance from the medical ward. Again it appears that acute services have greater capital than mental health services and as a result the person was nursed in a mental health ward. This then led to a complex process of upskilling staff to ensure competency. The participant described liaising and negotiating this boundary of who should do what as stressful and time consuming.

> *I: should that patient be managed elsewhere do you think?*
>
> H09: ((pauses)) my thought through the whole thing (.) is that it should have been managed on a on a medical ward (.) where everybody has their competency up to date (.) if these interventions they've got lots of experience in it (.) am and (.) it's it would be safer to do so because it was somebody who was sort of really physically frail am that had lots of co-morbidities am that am that if if they had had a major cardiac event ah or any number of things (.) am they would have been better suited in a in a general medical ward (.) am but we've got a lot of resistance from the general medical ward (.) ah they felt that we had a route of (.) getting fluids into into this patient ah so would why so why did they need to come to the [general hospital] […] it did cause some stress at times

In contrast, other participants felt the opposite was true and therefore it was not a universally held belief. Some participants were of the strong belief that pSMI did not get the same level of care when they were treated in a non-MH setting. Part of negotiating the boundaries is trying as much as possible to keep pSMI in the MH hospital. This was seen to be a manner of overcoming some of the perceived stigma that pSMI faced in acute and general hospital settings. Some participants felt that

---

[17] PEG stands for Percutaneous Endoscopic Gastrostomy - inserted via an endoscope down the oesophagus. RIG stands for Radiologically Inserted Gastrostomy - inserted using X-ray guidance after having barium placed inside the stomach.

such patients' needs were dismissed by staff in general settings due to stigma and poor attitudes. In this sense mental health nurse becomes protective of this and try to avoid conflict and potential harm for the patient.

> H05: ah I think WE do (.) am I (.) don't know that [general hospital] does an awful lot (.) but I think we do (.) I think we am (.) like to keep our patients as much as possible because we do feel they will be neglected and I have to say (.) the lady we nursed through terminal cancer (.) am was very much been forgotten and she left us on (.) quite a dose of MST on a regular basis and they had her on paracetamol she had liver cancer (.) how her liver was supposed to process the paracetamol and not too sure (.) but they kept saying 'oh she's not in pain' and have you asked her 'well she doesn't complain' of anything she was just getting an (.) part of that was her presentation […] she was being overlooked and ignored and as long as she was quiet so I think we try very hard […] we feel very much for them that (.) they might not get or they might feel the judgement the stigma [umhum] so I think we do go the extra mile to hold onto them and provide what care we can unless necessary to transfer out

> H08: am I think (.) I think what I'm getting to is that people don't feel there's if somebody is not expressing any pain or if the medical staff haven't said to take their observations then they don't see a need to do it

For example, in one setting, a pSMI with palliative care needs was not transferred to a hospice setting but instead nursed to their death in an acute mental health ward. A number of the participants in this study were involved in this person's care. This was because the ward staff had an established relationship with the pSMI and felt that they could best meet their needs. This may have resulted in the boundaries being shifted in order to meet the patient's needs. This puts a certain pressure on the staff which they did not seem to mind, in terms of having to learn on their feet. This is rather uplifting to see nursing striving to provide a high level of individualised care. Arguably, this shifting of boundaries could be a dangerous thing as a precedence has been set. It may not be in the remit of psychiatric services to provide this level of care when there are so many other competing demands and it may create an unrealistic expectation on staff in the future. Interestingly, this participant discussed at length at a different part of the interview the various time pressures they faced but also seems accepting of the need to provide this level of care.

> H05: I would say in the last couple of months we provided (.) terminal palliative cancer care to a lady who was with us for about three months and she died on the ward ah and we were using a lot of equipment drugs liaison with (.) service providers that we wouldn't normally work with and providing a service we wouldn't normally provide we were learning (.) on the job and on our feet literarily (.) and (.) very much wanted to do the best we could for this lady am (.) so that was very interesting

Some of the tension on the boundary between mental and physical health services is driven by fear. This fear and the resulting behaviour of trying to shift the responsibility onto the other team is felt to be dangerous as it appears to result in gaps in care. However, it was also felt that this fear is driven by the level of accountability which everyone holds, and therefore this creates conflict at boundaries between the various fields. Often with a sense that people are not competent and confident and therefore refer to other services. But also the pressure to see and treat people for mental health issues means that anything beyond this cannot be addressed due to time pressures.

> C03: I think it's fear as well (.) [umhum] ya know 'we're mental health nurses this is what we know' (.) straight off to the [general hospital] and it's the same on the flip side as well (.) if there's someone over in the [general hospital] that's got mental health problems (.) ((gasps)) 'They need to be on a constant!' (.) 'mental health problems send them back to the [psych hospital]' (.) and it's dangerous because things get missed (.) and ya know and people aren't given the correct treatment (.) where they should be […] I think maybe it comes back to fear [umhum] like physical health again is our (.) equivalent ya know of the [local psych hospital] (.) ya know like they have the [local general hospital] (.) we have the GP (.) Physical health boom! throw them at the GP (.) 'speak to your GP about that' that's the war cry in here

This tension is further demonstrated when it is unclear who should meet certain patient needs. In this example, the participant talks about their experience of looking after people who were misplaced, likely because there was no other service which would best meet their needs, or a lack of resources. There is a clear power dynamic between general/physical health services which appears to be unfairly placed against mental health services. The participant discusses that there is a focus to get mental health patients back towards the mental health setting quickly, often at a pace where it is felt that their physical health needs are not been fully met or could be met in a psychiatric setting. It is felt that this is driven by the stigma shown towards mental health patients and as a result fear drives clinical decision making

> H10: ahh (.) I would say (.) currently on the ward I'm on now (.) I don't feel we've let anyone down vastly (.) however I would say working ah (.) the last time in (.) in intensive care there were a couple of incidences of (.) complex care (.) people misplaced ah (.) within the system […] from the [general hospital] to push people back to mental health services quicker than we would like because they don't have the expertise and they lack the confidence in dealing with however they are very quick to expect us to run an IV line to have McKinley driver (.) in place am (.) and all the rest of it so I think there is a bit of difficulty there

Some fields occupy particular physical spaces. The spaces are also self-limiting. They are structured physically by issues such as stigma, lack of resources and assumptions about what MH services need and require, but in turn are then structured by these limitations in terms of what they can do to support physical health, therefore structuring future practice. This is demonstrated by a participant discussing the lack of physical infrastructure in the mental health assessment service and their inability to perform certain clinical investigations such as urinalysis. Such investigations may be a key indicator of the aetiology of someone's presentation and therefore what they need. This boundary has a tension in it- having to arrange for people to attend A&E indicates that is something that requires work and to be negotiated. This is something that can be quite smooth- often because the MH nurses appear to have some capital in the A&E setting as "the trust we know what we are doing" [C02}. However this is not always the case and in this instance must be escalated to medical staff to negotiate who sees and treats the patient. This feels like it is enacting the traditional doctor/nurse power role.

> *I: do you think we should have the facilities here maybe to to be able to do things like test people's urine or do you think that might lead to more issues?*
>
> C02: That's a difficult one in't it because I guess (.) am (.) eh eh mental health assessment service we eh ya know on nightshift it's a busy shift (.) am (.) yeah the eh and although we pull in the duty doc and ya know ask them questions about stuff also I've phoned the SpR before as well to get some advice about wither someone should go to A&E or not (.) am (.) there is a blood pressure monitor down there so we can do the basics [yeah] I don't see there being a huge problem with us being able to test someone's urine but practically how that would happen (.) with public toilets (.) collecting the urine and ya know the dipstick and everything how that the facilities are not really down there clinically to allow that so [yeah]

Indeed, medical staff seem key to helping nursing staff negotiate these boundaries and ensure that concerns about patients are attended to, including the need to be seen in specialist services such as cardiology. In this example, when I mentioned leadership, the participant talks about medical staff;

> C03: ((pauses)) I think with (.) with our doctors if there (.) if there was any problems in terms of physical health (.) they would be I would have good confidence in all three of them to be quite quick and highlight that (.) ya know and give us the support to kinda (.) move forward to kinda (.) to deal with it […] or if someone needed ya know like hospital like refer to [the general hospital] or anything like there's (.) yeah (.) or or even like (.) speaking to this the the doctors in [the general hospital] had a patient that was admitted there and and they were quite good there and they were good at speaking to the doctor there and getting back to me

### 5.9.4 Workload & Time pressures

Throughout the data, participants spoke about various workload and time pressures. As a result of this, there appears to be a focus on shifting tasks and responsibilities onto other fields.

> *I: why do you think that is?*
>
> C07: I don't know (.) I really don't know (.) I mean it probably comes down to time and money at some point at somewhere along the line (.) am (.) we've all got big busy caseloads […] just because I'm a mental health nurse I'm not gonna (.) I'm still gonna say that that needs addressed (.) 'come on we need to get you get this dressing fixed' (.) where as not really supposed to do that you're kinda you are supposed to stick to your lane and say 'right we'll I'll refer ya to a district nurse'

Physical health screening reveals a particular tension. There is a sense here that there is a tension between generalists and specialists. There is a perception that a GP's role is a certain scope of practice and therefore they should take responsibility for screening. I sense that this is some way driven by excessive workloads. While on the one hand the participant talks about the need to be holistic, there is also a need to battle high workloads and discharging this to the GP is one way around managing that. Therefore the boundary becomes a case of battle for who has the biggest workload to overcome.

> C14: cause I think what's the point on having a specialities (.) if you're not gonna use them (.) you're asking somebody to do bits and pieces of everything (.) I mean your GPs have got bits and pieces of everything (.) but you've got practice nurses in there (.) who more they're more physically (.) I'm contradicting myself a bit I'm aware of that (.) but that's their field (.) and I'm saying it's more holistic and we should be aware of everything (.) but in the same time the pressure on us (.) for our (.) for our paperwork (.) is more (.) I activities an' (.) health checks should be the GP in my opinion I don't know maybe it's just I dunno

This sense of pressure is not just physical healthcare services but also being driven by pressures on MH services. In this example the participant discusses a patient they were looking after with significant anxiety and poorly controlled diabetes. As a result of significant weight loss, the person was admitted to the physical health hospital. The participant was ordered by management to withdraw while the person was in hospital. This appeared to have a significant emotional response from the participant who became visibly upset when discussing this. They felt bad for the person alone in hospital and makes the point that after the 3 weeks they still had to address the self harm and anxiety. This decision was made by management and is another example of challenging the boundaries of care and how tensions on whose responsible for interventions impact on patient care.

> C07: her care ya know (.) the care management (.) the care changed because she (.) she was in intensive care for a lot of periods so she ya know she's under the consultants there (.) and yeah that was (.) that was life threatening her illness (.) but also her mental illness was life threatening (.) I felt but ya go from the care of one consultant to another consultant and then (.) the work is the same and it emanated down so we were basically ya know we were kinda out of it we were she was off our caseload so to speak (.) am and that that's even just saying that out loud that sounds awful (.) but that's that's how it was treated 'well she's not on our caseload anymore (.) so (.) and there's hundreds of other people that you've gotta see it's really difficult [umhum] so yeah (.) I didn't like that

Some participants voiced that the significant administration burden of the roles impacts on their practice and what they have time to do. This is a further example of 'organising work' discussed above. However, in this example it appears to be a negative development. This links to the discussion on accountability above. Paperwork was viewed as important from the perspective of the organisational demands for accountability. This seems to take precedence and is cited as reason for why nurses do not have time to provide care;

> H09: yeah yeah and I ah finding time to do that is often difficult so we ah (.) so (.) part of our role is making sure that (.) ah (.) paperwork is clear and accurately filled out (.) we am (.) and we also audit that so that's that's part of the kinda PCAT audit

As a result of reported cuts to social care and availability of other members of the MTD, there appears to be a tension regarding perceived task shifting. This tension is regarding the boundary over who is responsible for meeting the social needs. This leaves less time for other activities and impacts on other aspects of nursing care such as physical health needs of pSMI. There is also a sense that the nursing staff are being held accountable and for social issues effecting patients such as housing and post discharge support. There is a sense that boundaries are being blurred and this does not appear to have a good effect on nursing staff and their role perception but is leading to negative emotion which in turn leads to a vicious cycle impacting on practice.

> *I: you described very interestingly as well almost like a kinda vicious cycle of (.) not being able to do it [the ignorance and fear] and therefore not being*

*confident and therefore becoming quite avoidant (.) do you think it's the same for qualified staff as well too?*

H10: absolutely

*I: it's a fear that drives it?*

H10: umhum absolutely

*I: and where do you think that fear comes from?*

H10: I think it is the responsibility accountability thing it's so overwhelming I think there is such a huge amount of responsibility and accountability put on trained nurses these days (.) ah increasingly so as services are not resourced and funded (.) OTs are like hen's teeth social workers hen's teeth (.) and we are taking on our role is being more and more and more clouded and extended am but aren't more of us coming in to do the extra work because as I said we're not getting the OTs and social work staff in to augment what we are doing and the boundaries are clouded so I think there's a (.) a bit of there's sort of waterlogged 'I can't take much more' I can only do what I can do (.) am so I think there is a avoidance that goes on at times (.) partly for that reason

It often results in nursing staff reporting that they do not have the time to look after themselves but also find it difficult to complete all tasks, including physical healthcare. This is interesting as it appears again that the organisation may not be valuing physical healthcare as it's the tasks or activities which excels a patient to discharge which appear to carry greater capital, yet there have been examples were the organisation has still expected nurses to address physical healthcare for fear of risk or blame. There is a sense here that the nurse does not wish to cut corners as they value physical healthcare and see it as core nursing role, therefore sacrifice other things such as lunch breaks and home time in order to get everything done. This may also be because the participant fears that they will be held accountable and blamed by the organisation if they miss anything.

*I: so you described this kinda clouding of boundaries (.) and having to absorb perhaps other professionals work (.) how does that impact on your ability to provide physical healthcare for patients?*

H10: it means you have to work at the speed of light and squash things in and you have to have time management down to an absolute (.) that's wimble of a gauge between each activity and you don't get lunch and you don't get breakfast and you can't relieve yourself when you need to pee ah (.) that occurs very frequently I often leave late and I've had no lunch (.) and I don't really think the NHS appreciate how much the services run on good will (.)

### 5.9.5 Shared Language to overcome difficulties

One way of overcoming some of the boundaries is when professionals share a common language. Numerous participants discussed the development of the National Early Warning Score (NEWS)[18]. This has resulted in both MH and non-MH services within the NHS using the same processes for managing a deteriorating patient. This has helped negotiate the boundaries between mental health and acute medical setting. It appears from the extract below that as a consequence, MHNs are being listened to when they express a concern regarding a patient's physical presentation.

> H05: I think NEWS and stuff has (.) definitely so that's a new sort of implementation (.) definitely has and I think that's a good thing (.) am (.) to have a sort of generic thing across all the hospitals In Scotland (.) or ah (.) nationally

This concept of a shared language or vocabulary is also important for the management of long term conditions. If a MHN has the same language as say, medical staff, it allows for them to liaise effectively with others but also translate that for the patient. It allows them to interpret advice which they in turn can provide to the patient/develop their practice in caring for someone's LTC.

> H09: I guess I guess more awareness of how you are managing someone's chronic condition so actually what you're doing the treatment you are giving them (.) how that works (.) and then it means you can better communicate with the medical team or the diabetes specialist nurse am (.) so I think your knowledge base helps you effectively communicate the patients' needs
>
> I: Ok so being able to communicate that need and in the shared language
>
> H09: and also yeah yeah (.) a shared language and also communicate that to the patient as well that's very helpful (.)

---

[18] National Early Warning Score (NEWS), first produced in 2012 and updated in 2017 is a 'track and trigger' system in order to detect, prevent and better manage patient deterioration (Royal College of Physicians, 2017). The system has standardised the assessment and response to acute illness. The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six physiological parameters form the basis of the scoring system are respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness or new confusion and temperature.

### 5.9.6 Boundaries between patient and staff

The boundaries also need to be negotiated within the relationship with a patient. For some, patients may expect the nurse to know everything but for others they do not wish to discuss their physical health as they perceive MH nurses to be there to discuss and help with mental health. It is acknowledged that some patients have an established relationship with their GP and may not want that being impacted. Participants felt that explaining the boundary to patients- in particular that physical and mental are interlinked and therefore monitoring things like sleep and appetite are important.

> *I: How do you think patients feel (.) about (.) yourself intervening with their physical health or providing care around their physical health?*
>
> C03: Yeah I think am (.) that's a good question actually because I think ya know (.) a lot of people see us as […] your role is to (.) think about our mental health (.) and (.) it's ya know it's a lot of time its explaining to people that it's the whole bigger picture that they impact things have on (.) ya know your mental health has on your sleep and sleep and appetite ya know how how they all connect […] but some people are a bit (.) ehm (.) reluctant when it comes to (.) especially weight it's quite a sensitive (.) am subject other people are really grateful that you're kinda (.) acknowledging that yeah ya know 'help me out here' there's a problem

Therefore nurses need to be boundaried in how they go about addressing physical health and respecting the boundaries which patients have put in place. Some of this is also around the person's mental state and how far that can go with physical health before the relationship is jeopardised. There is a sense that the therapeutic relationship and respect for the patients' views are paramount.

> C02: I think sometimes they're like a bit there's two schools or camps right one is 'you're a nurse ya know everything' [umhum] therefore 'what ya mean ya don't know about physical health' […] so they're like a nurse is a nurse to them they don't understand that it's very different training […] the other school of thought is (.) am they have a relationship with their GP they don't want ya nosing […] we deal with (.) acutely unwell and then they start to get better (.) when someone is acutely unwell (.) do they really wanna sit and talk about their physical health problems guess ya give them the opportunity […] obviously there are some people in the middle but am (.) generally that's the I think the (.) they fit into two things

Here the nurse is clear that they need to respect the wishes of the patient and not pry too much, but respect that they may not wish for the MHN to be involved or know about all aspects of their care, including the management of complex care. The boundary of what is appropriate confidentiality has to be negotiated in order to maintain the relationship.

> C06: and also just (.) ya know I really feel uncomfortable about (.) prying too much I think (.) there's a lot of (.) I think there's a lot of mental health nurses who (.) we're we're kinda conditioned into thinking everything about a person is our business (.) and I really don't (.) feel that (.) I feel like there are things that (.) if people bring it to me then fine but I'm really careful about asking too much about (.) people's finances or asking too much about (.) what they eat ya know (.) like ah yeah (.) I'm a wee bit I'm a wee bit careful (.) about that and (.) I guess (.) because I don't want (.) I never go in to a (.) an interaction with somebody in like and like to fix them

## 5.10 Summary

This is the first of two findings chapters in this thesis. It addresses my first research question of how structural issues within the work environment impact on MHN practice. This chapter has been structured into two separate parts. Part I opens with a discussion on how participants conceptualised physical healthcare. Some of the things they spoke about may not be traditionally conceptused as 'nursing work' as it is not direct patient care. However, on top of providing a range of interventions, MHNs are key to advocating, liaising and arranging appropriate access to physical healthcare for pSMI. In this way, a lot of their work is invisible and is similar to Allen's (2015) ethnographic work regarding nursing practice, invisibility and organising work. Part I goes on to discuss a number of structural issues within the field. These are all impacting on MHN practice to varying degrees. The first two of these, accountability and risk are discussed in light of Bourdieu's concept of symbolic violence. The chapter moves on to explore organisational support for physical healthcare before discussing various aspects of change. Part I ends with a discussion on the impact of socioeconomic factors on MHN practice.

Part II examined some of the boundaries that exist within the field and how many of these are sources of conflict. MHNs have a role in navigating, negotiating and setting boundaries. They are key to pSMI accessing primary care. The chapter moves on to discuss the boundary between physical and mental health services and how place and space can occupy different meanings. This leads to a discussion of workload and time pressures which have resulted in physical healthcare being shifted to different fields. Part II concludes by discussing the role of shared language in overcoming difficulties within the fields. It ends by discussing the boundaries between staff and patients, and how mindful staff need to be of this when addressing pSMI physical healthcare needs.

# Chapter 6: Findings II- Capital

## 6.1 Introduction

This is the second of two findings chapters in this thesis. This chapter explores the capital (or lack of in some instances) that MHNs possess and use to navigate the field. Much of this understanding of capital assists in answering my second research question on educational experiences and competencies. Similar to the previous chapter, it is presented in two parts for ease of reading. Part I examines the role of therapeutic relationships (TR) and specialist nursing roles within the field. In the section on TR, I discuss how MHNs utilise TRs as the basis for all interventions, how it is the basis for building trust with people so difficult and sensitive topics, such as physical healthcare can be raised. It is therefore a valuable form of capital that participants use to function within the field. I discuss the challenges of MH legislation and how physical health issues could pose a threat to the TR, which was primarily focused on assessing and supporting people's MH. The section ends with situating these findings within my own university department's cannon of research on TRs in MHN practice. In the next section I discuss how specialist roles carry capital with both other nurses and more importantly, pSMI. I present data showing how participants feel such a role should exist for meeting the physical healthcare needs of pSMI. I then go onto explore the specifics of how this may occur. This section concludes with situating these findings in relation to recently published evaluations of similar roles.

Part II presents findings related to different forms of knowledge, which represent different forms of capital; (1) knowledge gained during pre-registration as a form of capital, (2) knowledge gained post-registration and (3) confidence as a form of capital. The first part discusses knowledge gained when people are student nurses. It starts off by presenting data regarding the current pre-registration nursing programme content. This moves onto discussing the tension and power dynamics between HEIs and their NHS practice partners, with placements being the site where these tensions play out. I then move onto explore the issue of achieving competence and how this may be difficult if MHN practice is currently invisible, as discussed in the previous chapter. I then explore how both general placements during pre-registration, as well as the concept of dual training, are forms of capital. The section concludes with a discussion of these issues and analysis of who has the capital within the field. This discussion is situated with the historical context of nurse education in the UK in the past thirty years as well as drawing on the seminal work of Patricia Benner's (1984) *Novice to Expert* study.

The next section in part II explores capital gained post-registration. This capital, or knowledge takes different forms, the most important being knowledge gained from experience. This appears to be the most significant form of capital and is once again discussed in the context of Benner's work. This section moves on to look at the role of both formal and informal learning and the value both have within the field. Lastly, this section concludes by examining role modelling and its role in knowledge development.

The final section in this chapter explores the important role of confidence in MHN executing their role in physical healthcare. This section starts by exploring how confidence first starts to develop in student nurses. I then explore the role of experience in increasing confidence and as an important form of capital in progressing within the field. I then explore the impact of a lack of confidence and how it is contributing to an emotional burden for MHN in this area of practice. I then move onto discuss the role of confidence and identity as a MHN before briefly looking how a lack of confidence can also act as a motivating factor. This section concludes with a discussion, where I endeavour to unpick the interplay between 'competence' and 'confidence.' Whilst these terms are not mutually exclusive, the literature points to a complex dynamic. This has led me to conclude that not enough attention is paid to developing confidence at both pre- and post-registration. I provide a critique of competency-based education and how its focus in nurse education may explain some of the tensions discussed regarding pre-registration education.

# PART I

## 6.2 Therapeutic Relationships

The building, maintaining and ending of therapeutic relationships (TRs) and therapeutic use of self to aid recovery is seen as the cornerstone of mental health nursing (Browne et al., 2015; Peplau, 1991). Participants throughout the data referenced the importance of TRs when working with pSMI. This did not just apply when providing mental health support but was seen as key to the delivery of any intervention, including providing physical healthcare. In this section, I present data that shows how MHNs go about using TR as the basis for physical health interventions. It is therefore a valuable form of capital that participants use to function within the field. This section also deals with the challenges such as the impact of MH legislation and boundaries. It was also felt that physical health issues could pose a threat to the TR, which was primarily focused on assessing and supporting people's MH. The section ends with situating these findings within my own university department's cannon of research on TRs in MHN practice. This appears to be similar to some of the issues discussed in chapter five. However, in this context, TRs is a form of capital that nurses use to provide physical healthcare.

Participants voiced that having a TR with a pSMI was seen as key to any intervention, whether it be promotion of self-care or supporting someone with their ADLs when the person is unwell. The development of a TR was seen as the basis for all other interventions. It allowed for discrete things to be noticed which could be used to encourage engagement and help the person to maintain a level of self-care. It was viewed by participants as the foundation stone before moving on to anything else more complex. Without it, any other work would be seen as difficult to achieve.

> H01: they will tell you to go so it's about timing and having established a therapeutic relationship with your patient (.) if there's still so acutely unwell (.) you can still (.) depending on how they will receive that information so it's about getting to know your patient and when to intervene and when to discuss those things

> H11: well in this particular scenario (.) am (.) I would encourage (.) the patient but I mean for first it starts with your relationship with the person (.)

> I was able to give her a particular smile that sounds really daft but (.) ya know ya look at someone in a particular way and they know you (.) ya ken they give a little smile (.) Just anything to go on and then sharing that reaction (.) getting that first contact (.) and then building upon that

The building and maintenance of TRs take physical effort as well as emotional. The physical effort can have a deeper meaning as it communicates to pSMI that physical health matters, that the nurse cares about their own wellbeing but also by the nurse making physical efforts to maintain the TR, such as visiting the person in their home, communicates that the nurse also cares about the pSMI's wellbeing.

> C06: I dunno there's a gratitude there that feels like I've made more of an effort (.) to come and see them especially if the weather is crap or (.) am I I Think it's yeah (.) it changes the dynamic I think (.) yeah
>
> *I: in a good way?*
>
> C06: in a good way!

The TR functions as a basis for MHNs to be able to probe and examine things that may be sensitive in nature. Without a TR, it would not be possible to do so. MHN skills allow for skilled communication to take place that means MHNs are able to broach difficult topics of conversation, such as weight management with pSMI. Physical health issues were seen as just another 'difficult' conversation that nurses have to have with pSMI, alongside other psychosocial issues. Data suggests this is done in a very nonchalant and informal manner. TRs were seen as important in discussing physical health issues with both those who are acutely unwell and therefore may find it difficult to trust staff, and those in the community doing long-term pieces of work.

> H10: we're skilled (.) ah communicators and there are ways and means of going about broaching difficult topics […] I'd kinda done something quite informal with her in her room (.) and then had to go through to the treatment room ask if I could check her obs I was concerned about her levels of nausea and (.) said to her ya know concerned that she had disclosed that she had under (.) undertaken some activities with somebody but wouldn't remember recall if she had full (.) intercourse and I said would it be possible or a chance that she would be pregnant and if so could we just do a sample and I could have done in two minutes and she was (.) floods of tears but very grateful at the same time

and

> H01: I'm so conscious about not saying the wrong thing to her and not offend her (.) cause she is from the same part of where we are from (.) so I

> know exactly how she might react to (.) me even thought I would say it sensitively to her (.) doesn't mean that that will effect the kind of level of care that would be or addressing the weight issue (.) and I think
>
> *I: it sounds from what you're saying if you do it in a sensitive way they they're (.) generally kinda ok with it*
>
> C14: hmmm they're more likely to work together on it aye
>
> *I: so maybe not what's said but how you say it?*
>
> C14: of course aye

In this following example, the nurse knowing this man and what keeps him well was essential to motivating him to engage with physical health services as well as knowing the impact of physical health issues on his mental health. It is apparent that the nurse used their TR as the instrument to intervene.

> C07: well (.) it's not really that exciting but it's just that a wee man who lives on his own again totally isolated (.) chronic mental health but (.) gets on with his life quite the thing but I had been to see him (.) and ah I noticed he was hobbling a little bit and I had asked him ya know 'what's happened' he didn't want to tell me and then (.) took his (.) just by chance (.) had taken his slippers off while I was there and I noticed (.) ya know through the the (.) the holes in his socks there was like claw-like toe nails (.) so I kinda said 'can I see you feet' even though probably that's not really my remit but […] so I was glad that ya know that had happened (.) glad I was able to get them cut because they were really bad and for his sake because it was like (.) 'I can go back out again (.) nothing wrong with my mental health I'm fine I'll go ya know to the choir' (.) simple but (.) ya know and I think if you are not looking (.) at the whole person (.) ya know I could quite easily gone to his house and said 'awh well your mood is still low ok that's fine we'll see maybe increase your medication and I'll come back and see ya next week' (.) could easily have done that but I thought nah it's more to this ya know and it's so (.) yeah that was that was a good one

One participant had a slightly different take on TRs. They discussed the use of psychological formulation and how it increased the development of TRs with pSMI. In this example below, the participant describes pSMI's surprise albeit apprehension, that they were been viewed as a 'whole person.' It was valued by the participant who felt that it might not have changed the intervention, it did change the relationship and that in turn may help with intervening on difficult subject matters; A sense of getting to know the whole person in their unique context. It was an opportunity to find out what was important for the person in their life and not solely the professional agenda.

> C13: yeah I mean I guess when that started it totally changed the way we (.) worked with folk […] when we first started to ya know you do a history of somebody (.) and it was fairly relatively ya know you'd get a bit of a history but it was relatively superficial (.) and it was when we started doing the formulations we'd start getting a history of somebody from (.) birth to now (.) am and (.) it (.) certainly when we started doing it I found a lot of people (.) we kinda saying (.) I guess they appreciated that you were taking an interest in their whole life and you were looking at the bigger picture […] I'd remember stuff that they'd told me and they were kinda surprised by that cause maybe (.) not used to somebody showing a (.) an interest in things (.) am (.) so in some ways I'm not sure if the formulation made any difference to what we did to people in the end but it certainly (.) impacted with the relationships we had with folk (.) so it was a good thing

Participants working within the inpatient setting felt that the use of a key worker system was a vehicle for intervention. It allowed MHNs to build TRs but also then allowed for 1:1 sessions with pSMI where physical health issues could be raised.

> H12: ammm so it would be one to one time (.) so obviously we have a key working system on this ward and (.) the patients that you key work (.) you at least try and […] have a spare moment I think it's quite good to go and have that sort of extra intensive time with them (.)

Community participants discussed the importance of longitudinal TRs. Participants stressed that such TRs are not easily formed and take time. Therefore, caring for people is a process and having a stable base is the key to any piece of work. It means spending time with people and seeing what they need. TR has various phases. There is a sense of it being a journey. In the following example the participant discusses their journey around the city, cycling to people's homes. In some ways this could be seen to be representative of the journey which a TRs take. The use of "whole way through" is interesting, as there is a sense of it not being one discreet thing but to be viewed on a bigger picture.

> C06: I tend to see people at home (.) we have got the option of seeing people in (.) the sort of (.) office but I prefer actually to get out and (.) see people at home if that if they are ok with that […] because I'm not long into this role (.) and I've actually been trying to build a caseload I'm in the quite (.) quite sort of (.) initial to medium stages with everybody that I'm working with so (.) that's still involving quite a lot of assessment really quite a lot of relationship building […] I've only kinda seen one person (.) the whole way through the journey (.) am to discharge

TRs were seen as important as participants in the community voiced that pSMI are often socially isolated with little other support. Due to the nature of SMI, it was felt that trust is sometimes a difficult thing to maintain. MHNs might be the only professional that pSMI trust to provide any sort of intervention. Therefore there is a need to be to be "*quietly persistent*" [C07, C13] in order to intervene with physical health issues. The data shows that participants accepted that pSMI may require multiple prompts. The need to down play things so as to not scare people and be rather nonchalant was viewed as important so as to not come across as imposing on people. TRs are therefore an essential form of capital that allows for the needs of pSMI to be met within their own timeframe.

In this example below, it appears that the nurse has already identified that there is a physical health issue and it's on their agenda, but also knows that a 'softly softly' approach is what is going to be most effective. Working as a CPN in secondary care with long-term relationships often may mean that relatively simple things will require long-term work just to get the person to consider taking action or accepting support. But without that relationship it may be that patients would not have their physical health needs addressed, especially if they find it difficult to engage with primary care services.

> I: how do you think patients feel about you intervening or discussing their physical health with them?
>
> C07: depends I mean some people just don't have anybody else to speak to […] I don't know I'm not really I'm not very good at (.) pussyfooting around something if I think something needs to be said I'll say it but I'll say it in such a way that (.) 'come on I'll give ya a wee hand (.) come on just let's all (.) put the bath on' or something (.) but (.) I do address things am (.) and generally it's fine (.) some people will just tell ya to F off but that's fair enough I've heard that a million times (.) am (.) but I think sometimes being consistent and (.) not even (.) forcing any issues just saying 'we can talk about it next time' and not forgetting about it and always bringing it back up (.) am (.) which is probably really annoying for folk but (.) I do tend to just sort of try and be sort of quietly persistent (.) and encourage them to realise that ya know but ignoring it it's not going to get better by itself and we need to kinda look at this and (.) take the focus off something else ya know (.) so (.)
>
> *I: so it sounds like it's kinda quietly softly softly approach and*
>
> C07: yeah

This same level of building trust was also seen as important in the context of acute care. When people are acutely unwell, a TR is essential to be able to intervene. It may also require the nurse to provide multiple prompts and supports with meeting their physical health needs. In particular, the acuteness of illness may impact on the patient's perception of the nurses' support.

> H01: umm and having established a therapeutic relationship with your patient (.) if there's still so acutely unwell (.) you can still ya know (.) depending on how they will receive that information so it's about getting to know your patient and when to intervene and when to discuss those things

> H10: a quick few minute chat can give you a contact point (.) 'oh you're doing this or doing that' ya know 'have ya had enough to eat' 'did you enjoy the food' ya know using it for those (.) ah so it's amazing what ya can get round and as long as in the back of your head you have this (.) litany of things ya want to ask certain people you can fit it in ya know doing all sorts of activities helping people change their bed put their washing in the washing machine 'oh by the way mrs joe blogs have ya (.) done this are you feeling ok with that what are your thoughts?'

> *I: so it sounds quite informal?*

> H10:absolutely yeah

> H12: to be honest chatted to her tried to keep her calm […] yeah use all sorts of different ways to approach her verbally (.) being initially am (.) quite serious with her quite firm and then going from like quite blaze it's not a big deal kinda thing just trying to figure out a way to get through

While TRs was generally seen as a form of capital, it was also viewed that discussing physical health issues with patients may prove as a threat to the relationship. It was viewed as a threat because the TR was the central tool which allowed assessment and intervention in people's mental health. This could be undermined by intervening on a health promotion issue that may not be appreciated by pSMI. It was seen that there was a particular way to deliver health promotion interventions or discuss difficult topics such as weight management with pSMI. These topics can be sensitive in nature and often people do not like discussing them, nor being told or dictated to what they should do. Therefore, knowing the person is key to being able to have difficult conversations. Therefore, within TRs, there appears to be a hierarchy of competing agendas between physical and mental health. In the following example, the participant notes that they can still provide the person with information and let them make up their own mind. In this way there is a sense of trying to be respectful. TRs are connected to personal values. There is a sense that more will be achieved by not inflicting something the person really does not wish, especially when the nurse is there to help them manage their mental health

> I: Ok (.) and it does sound like just back to that thing about personal values that ya your are kinda aware of your own personal values things like smoking [yeah yeah] does it play a role in how you work?

> C02: yeah yeah it does because ah ah ((pauses)) ya can't kinda sit in someone's house ya tryin' to build a therapeutic relationship with (.) being holier than thou about ya know 'don't do this' 'don't do that' 'don't eat that' (.) of course you can advice but you can offer advice (.) I I think the person themselves needs to (.) ya know embrace it or not embrace it

> C14: no body likes to be told that they're not healthy do they? [no] and some people like to (.) look at what ya can do about it instead of getting' the bus from your doorstep walk to the next bus stop and I'll meet ya out somewhere in the community (.) and then get off the bus early and walk the next bit (.) I mean you're talking about feelin' out of breathe (.) ya need to build up your stamina (.) [umhum] that's (.) ya know ya can work round it (.) aye I I in this job you're often tellin' people stuff that they don't want to really hear (.) you've got to be sensitive haven't ya (.) [yeah] like ya know I'm not a (.) I can sometimes skirt about the issue a wee bit too much ((laughs)) I I don't like tellin' somebody something they don't wanna hear but (.) ya need to (.) it's part of the job

The role of mental health legislation is also discussed alongside this tension between balancing choice and care. It was felt that this could also pose a threat to TRs and undermine its capital. It was felt if someone was subject to compulsory treatment measures, of which the treatment was causing significant adverse physical side-effects. This can be extremely distressing for both pSMI and participants yet legislation does not necessarily take account of that and creates a difficulty in building a TR. So while there is a moral obligation to attend to people's physical health, the legal requirement under mental health law is less obvious. To an extent, MHNs are complicit with creating harm from treatment but are also being expected to manage the consequences.

> C06: as soon as the mental health act comes into play there becomes a moral question of (.) am (.) looking after people in a way that's different from (.) them not being under an Act I think (.) am
>
> I: in what way is it different?
>
> C06: because I think people are are deprived of something (.) because that (.) system is depriving them of (.) sometimes in really (.) powerful ways ya know and (.) hopefully ya know I wouldn't (.) certain that that's for their benefit and ya know in their best interest but still (.) am from their perspective I think (.) that that's a whole other ball game from people who are (.) voluntary who are not (.) compelled to accept treatment (.) [interesting] but also (.) we're giving in that circumstance we're giving people medicines ((laughs)) that are inherently harmful to their physical health (.)

### 6.1.1 Discussion

Much of the above would chime with other studies on the role of TRs in mental health nursing. Peplau's work (1991) is considered seminal in this regards. She formally identified the importance of the nurse-patient relationship. Humanistic in approach, it emphasised the interpersonal relationship as central to MHN and the role of the nurse themselves as a tool to aid people's recovery. Therefore it should not be seen as surprising that participants in this study discussed the concept.

While TRs clearly have capital within the field, it would be naïve to assume that TRs should be an accepted and uncontested concept. Despite the widespread acknowledgement of the importance of TRs in MHN, research findings show that nursing practice is not always congruent with the concept. Tilley (2005) outlines how even within my own institution, TRs have been a key topic of research, with findings often taking a critical perspective. John (1960) explored the working situation for nurses working across four inpatient settings. Despite the prevailing zeitgeist of moving away from stigmatising attitudes and custodial practice, care was very much in this light and there was little evidence of a 'whole person' or a professional approach to nursing care.

Annie Altschul's work has proved some of the most seminal. While she reviewed her position over the years (Tilley, 2002), her early work and in particular, her observational study of nurse-patient interactions in an inpatient setting was particularly critical of how TRs were uncritically implemented (Altschul, 1972). She felt that TRs in practice lacked reflexivity, accountability or a theoretical grounding. She conducted interviews with nurses after observing their practice and asked for them to account for their patient interactions. Similar to John (1960), she found that nurses placed little value on their work and having little therapeutic effect, despite patients finding it so. My study chimes with Altschul in that both illuminate an area of nursing practice that was largely invisible, including to nurses themselves. Similarly, findings in this study show that nurses do not always recognise their own work.

In contrast to John and Altschul, Sladden (1977) undertook a study of community psychiatric nurses (CPNs). She noted that TRs had much capital, particularly when working with long-term patients who struggled to trust professionals. Sladden critiqued John and Altschul's work as she felt they had not provided an adequate definition of nursing role. She found that nurses within her own study were unclear themselves regarding their role in the changing social context and closing down of institutions. This resulted in a lack of model of care and subsequent ambiguity. Building on this, Pollock's (1987) study of CPNs found that participants struggled to maintain TRs due to a lack of resources which they had to obscure in order to fit with the concept of individualised care. This would chime very much with the organisational contexts which I discussed in chapter 5 and the tensions that this created for participants.

Tilley (1990) undertook an interpretive study of interaction between patients diagnosed with neurotic conditions and nurses in two inpatient wards. He found that nurses and patients constructed knowledge, negotiated power dynamics through the use of common sense as a resource for analysing and appraising patients accounts. This concept of 'common sense' is a critique of Altschul, who viewed this approach as a negative, as it failed to show a difference between professional interactions and anyone 'off the street.' For her, common sense was meaningless. Instead Tilley draw's on Benner's (1984) work to show that this construction of common sense or intuition is born out of a complex processing of both theoretical and practical knowledge that comes from experience. The findings in this study would be congruent with Tilley's (1990) outlook. This is something which I will explore in a later section in this chapter when discussing experience as a form of capital.

Stenhouse (2009) took a different approach. While the previous studies have focused on nurses' position, Stenhouse studied the perspectives of patients. Participants talked about unfulfilled expectations, expecting to develop a TR with nursing staff who would spend time with them. Participants linked this to the concept of safety and reported that they perceived nursing staff often did not notice when patients felt threatened. This resulted in a sense of frustration and of distance between patient and nurse. While my study had a very different focus to Stenhouse's work, the most obvious being that participants were patients and mine were nurses, participants still brought TRs to the fore and was apparent that it was something that they valued. While nurses may identify TRs as valuable, it does not mean patients experience them.

This study adds to the institutional cannon on therapeutic relationships in MHN practice. While those before me have very much focused on TRs in the context of recovery from mental distress, the findings from this study are unique in that it shows that MHNs are using TRs and their engagement skills as the basis for physical healthcare interventions. This may also explain why physical healthcare is invisible- because it is bound up with TRs and this is usually conceptualised as a 'sole' mental health nursing approach. While it appears that TRs have capital, at least from the perspective of nurses within the field, we cannot be certain. Relationship implies there is at least one other party involved, in this instance, pSMI. It was out with the scope of this study to include them as participants. However, it would be worth considering this in light of Stenhouse's (2009) findings. The fact that some of this physical health 'stuff' is invisible and bound up with TRs may imply that others view therapeutic engagement as having low capital. This low value in turn contributes to the invisibility. If practice is not seen, it cannot be valued, recorded or measured. This lack of recording perpetuates the cycle. Therefore Altschul's desire for people to 'account' for their interactions may have credence. Indeed, this was a feature in both English and Australian studies presented in chapter two; nurses claim to value physical healthcare but do not seem to be documenting it.

In contrast, the approaches which participants outlined above are in keeping with recent studies that have detailed the ingredients of TRs. These include active engagement and taking a very adaptative approach to pSMI that involves using a triad of listening, understanding, and responding (McAllister et al., 2019). These were evident in participants' accounts. While it is traditionally viewed that MHNs use these skills to respond to distress, it is clear from participants that they are using these same skills to provide various physical healthcare interventions including health promotion. This makes MHNs perfectly placed to provide such interventions, as they are likely to be able to sustain a TR that is going to have to be longitudinal in nature, accepting that such health promotion interventions require time to bring about change. Secondly, much of the role around developing health promoting interventions requires the core ingredients of TR in order to successfully deliver them. These engagement skills are ones that MHNs are highly-versed in and utilise in their daily practice.

This section has discussed the role of TR as a form of capital used by MHN in the field. I outline why they are important and how they can be used as a basis for having difficult or sensitive conversations with pSMI, particularly around lifestyle behaviours that can prove difficult to raise. Participants discussed how they use their skills to intervene and this is congruent with what engagement skills outlined in previous MHN research. This section also outlines some of the challenges to this form of capital such as MH legislation and appropriate boundaries. The section concludes with framing how my findings sit within my own institution's cannon on MHN research and what they have contributed to our understanding of therapeutic relationships.

## 6.3 Specialist Nursing Roles for physical healthcare

In chapter two, I presented a number of studies that showed specialist nursing roles for physical healthcare have been utilised and shown to make improvements in pSMI's wellbeing. Therefore, they may be a form of capital or potential form of capital within the field. Such specialist nursing roles in other areas of healthcare have been considered to add significant value to patient care, in areas such as diabetes care, cancer, multiple sclerosis and irritable bowel disease (Lawler et al., 2019; Leary et al., 2018; Punshon et al., 2020; Stewart et al., 2020). Such roles have been shown to improve a variety of patient outcomes as well as having economic savings for healthcare systems. No such roles existed in the services in which my participants worked. Participants did articulate that such a role should exist for meeting the physical healthcare needs of pSMI. They articulated that if such a role would help to remove barriers that arise from trying to treat mental health difficulties, allow for increased access to services for pSMI, allows for a team member who will have knowledge and understanding of people's mental health including trauma history and would bridge the gap between nursing and medical as well as primary and secondary care. This section concludes with situating these findings in relation to recently published evaluations of similar roles.

Participants specifically discussed nurses undertaking such a role. Some participants discussed that other specialist nurses exist within their service and were able to articulate the value that they bring for both patients and staff. One participant discussed that they had a specialist nurse for other things such as self-harm. This clinician was viewed very positively by both staff and patients. They act not only as a resource and support for staff when needing advice, but also provided direct patient intervention. The person was described as flexible and approachable. It was felt that such a role of physical healthcare was needed and it was envisaged that such a role would espouse similar characteristics.

> H10: I think that would be great (.) we've got one who is a clinical nurse specialist in self-harm (.) we used to have one for acute services rehab services and they were a fountain of knowledge they provided a lot of interesting groups (.) for (.) educational purposes (.) for am (.) relative support (.) am (.) yeah and a lot of 1:1 supervision and also somebody would could phone on a ward base and say 'we're really struggling what would you advocate we would do' or 'how could do this differently'

It was felt that nurses undertaking this specialist role would allow pSMI to have more time than a traditional GP appointment which are limited to approx. ten minutes (Royal College of General Practitioners, 2013). It was also felt that nurses were best placed to undertake this role as they would potentially have deeper knowledge of the person's mental health. It was felt that this would have the advantage of seeing people in their social context but also being able to provide integrated care. It was felt that such a role would be particularly helpful if someone had experienced trauma and were being able to trust a healthcare professional may be quite difficult.

> I: how would you feel (.) you said about a GP but how would you feel about a specialist nurse undertaking that role?
>
> C07: fine [yeah] yeah I think there is room for it [umhum] am (.) not I mean I don't (.) financially it's never gonna happen but I do think it would be (.)
>
> I: do you think there is appetite for it among your colleagues?
>
> C07: […] so people who are maybe (.) work within the team know a bit about their mental health know a bit about their background but are there for the physical side (.) I think that would be good

It was also felt that such a role would improve communication between nursing and medical staff. It is interesting that the participant below saw it as an alternative to having to “chase the medical team” who are viewed as stretched and overworked. Such a specialist nursing role may run the risk as being used as a substitute for medical staff or a way of making their role easier, as opposed to increasing the scope of nursing practice in a manner that puts the patient at the centre. This would run the risk that such tasks could be simply discharged to a nurse specialist or advanced nurse practitioner because physical health appears to have less weight within the organisation. Previous studies have shown the difficulties in the development of advanced practitioner roles and in particular how they are being used to substitute medical roles (Walsh, 2019).

> H12: (.) I think that would be really good I think sometimes because the medical team are so stretched ya know if there is somebody really unwell they do on this ward certainly they are quite good at reviewing them on a daily basis but for example at the weekend if the plan isn’t in place there’s no medical team it’s the duty doctor who doesn’t know the patient […] at rapid rundowns but if we had a nurse part of the some one from the nursing team that might bridge that gap

One participant discussed a previous project that was implemented to improve patients physical health in the community. It appears it led to some temporary improvements. However, due to funding it stopped. The participants discussed that the organisers tried to integrate into the care team. There is a sense of apprehension regarding what such roles can achieve. This participant perceives the person as having a challenging role and one where concerted efforts may not yield much dividends. However, this could show the need for a dedicated role as it is well documented that pSMI find it difficult to be motivated and engaged in sustained lifestyle changes (Firth et al., 2019; Verhaeghe et al., 2013). Therefore there is need for a co-ordinated and dedicated approach.

> C13: there was the keep well project that stopped now hasn’t it (.) I mean they weren’t mental health nurses but they were (.) that was quite a few years ago now wasn’t it (.) but (.) I guess so they did try and get directly involved in the team cause we’ve had (.) we’ve had lots of I guess failed attempts (.) to set up this physical health checks clinic over the last few years actually and they were involved in it for a while (.) ah but they (.) they lost their funding didn’t they I think and (.) stopped (.) am (.) I don’t know I mean I get it would probably be an interesting job it would be quite a challenging task cause I guess a lot of the same issues come up which is (.) am ya can take a horse to water but ya can’t make it drink kinda thing ((laughs)) which is (.) yeah

One participant presented an alternative view on specialist roles for physical healthcare. While admitting their own contradiction from what they had said previously, they were able to give quite a direct answer. Perhaps the person felt conflicted because the process of engaging in interview made them think about some of these issues for the first time. The participant gives a sense that MHNs cannot be all things to all people, and therefore specialists in various physical health issues should be involved as opposed to mental health nurses. This view may arise as the participant throughout talked about the strains on their role and the pressure to see people, therefore may be feeling rather frustrated and overworked and therefore unlikely to want to see further change. This view should be considered as while such a specialist role may provide nurses with more capital, it may result in an increased silo effect and where basic needs go further unattended to as there is a sole focus on mental health issues.

> C14: auch I'm gonna contradict myself again here I think it's cause it's holistic person but I (.) ((sighs)) ya should be ya should be (.) doing everything [yeah] but then again ya got to look ya know I'm working with mental health I'm no- (.) primarily dealin' with schizophrenia (.) bipolar disorder I'm not here to do (.) Huntington's (.) or things like that (.) ya do offer your specialist fields for a reason

### 6.3.1 Discussion

A number of points raised by participants have been explored elsewhere within the literature. As I discussed in chapter two, specialist nursing roles for physical healthcare for pSMI have been discussed for some time within the Australian literature. Over time, it is clear to see that such roles have the potential to improve patient outcomes but also act as a source of support for members of the MDT.

What is most interesting is the conclusion of researchers in the state of Victoria in Australia. They were clear that implementing guidelines for screening on their own is not enough. It is the tacit knowledge that the specialist nurse brings to the role that is needed to implement any guidelines. It is their ability to co-ordinate and educate staff and pSMI that makes the difference. Therefore, this is similar to 'organising work' that Allen (2014, 2018) refers to that nurses do, except in this instance, at a specialist level.

Therefore such roles occupy multiple forms of capital. Such specialist nurses would likely have high social and cultural capital. Social capital, in their ability to liaise with others and negotiate boundaries between primary and secondary care, or between the pSMI and the wider MDT. This is something that participants in this study feel would be of value to them in their practice. Much of the capital appears to be embodied as it is the knowledge, skills and language of the specialist nurse that gives the role value within the field. This capital can also become institutionised as to have such a role is the organisation endorsing and valuing this capital. What is interesting in this thesis, is that participants only spoke of one other specialist nursing role for self-harm. None of the participants identified that there was a person who took forward a specialist physical health role in their teams beyond support from medical staff. This may indicate that the organisation has low value on such roles and not recognising their full scope of practice.

This organisational position is not separate from practicing nurses as seen by my participant who had a different view on these matters. The alternative view of my participant was also evident in earlier work done in Australia in implementing a specialist cardiometabolic nurse (Happell et al., 2013). Prior to implementation there was some hesitation for the reasons my participant gave. However, follow-up studies have shown there was less hostility and indeed the merits were appreciated by nursing staff (Happell, Platania-Phung, Stanton, et al., 2015). Nurses themselves may not hold such roles in particularly high esteem and it is not just the organisation. Though arguably if there are few specialist roles in existence, nurses will not be exposed to their potential and therefore may not see their value.

What is also interesting in this study, is that participants discussed the role in relation to benefiting patient care and increasing their own knowledge. They did not discuss how such a role may give nursing increased status within the field. Studies examining ANP and expanded roles have found that nurses in such roles experience increased self-esteem and confidence, which can lead to changes in their perceived sense of professional identity (Piil et al., 2012). These enhanced roles are often salaried at higher rates to reflect the increased knowledge, skills and responsibilities of the occupier. They therefore have the potential to be an economic form of capital for nurses within the study fields and beyond.

# PART II

## 6.4 Knowledge gained during pre-registration education as capital

This section discusses knowledge gained when people are student nurses, both from the perspective of participants reflecting on their own time as students as well as when they act as mentors to current students. Overall, pre-registration mental health nurse education was generally viewed in negative terms and appears to have little capital within the field. This section starts off by presenting data regarding perceptions of the current programme. This moves onto discussing the divide and power dynamics between HEIs and their NHS practice partners. Placements appear to be the site where these tensions play out. I then move onto explore the issue of achieving competency and how this may be difficult if MHN practice is currently invisible. It is also complicated by an ad-hoc placement allocation system that participants feel is not supporting student learning. I then explore both general placements during pre-registration, as well as the concept of dual training. It appears that both have mixed cultural capital within the field but play a role in influencing physical healthcare for pSMI but also MHN identity. The section concludes with a discussion of these issues and explore who has the capital within the field. This discussion is situated with the historical context of nurse education in the UK in the past thirty years as well as drawing on the seminal work for Patricia Benner's (1984) *Novice to Expert* study.

### 6.4.1 Perceptions of the current programme

Current pre-registration nurse education provision was perceived in negative terms by all participants- both those who were recent graduates and more experienced nurses who provide mentorship to student nurses undertaking clinical placements. It was felt that the current local provider of mental health nurse education was not adequately preparing students for the future role in terms of meeting patients fundamental physical health needs. It was felt that the curriculum and approach to practice learning lacked a systematic approach and consequently, this has resulted in participants attributing little capital to pre-registration learning.

Participants who were more recent graduates, felt that their experiences did not prepare them for the level of physical need. They felt that their education in this topic was poorly delivered, contained basic knowledge, limited to vital signs monitoring and was difficult to grasp as there was no attempt to apply it within a mental health specific context.

> H11: ha! ((pauses)) I'll have to think about that ((laughs)) nothings jumping immediately to mind
>
> H12: honestly the bits of my training that dealt with physical healthcare (.) was (.) the (.) back then SEWS and now NEWS charts and that was kind of (.) it (.) […] I think it's quite basic […] there should have been more I think (.) the expectation (.) that is on us to (.) be able to deal with medical emergencies physical ailments illnesses all the ward the training that we received is not sufficient and well below par (.) to uphold that expectation

One participant remarked that during their training, none of this content was delivered by mental health nurses, but rather by the 'adult' nursing team, making the content seem separate and creating a perceived schism within their learning. Overall, it was felt that generally did not prepare them for their role as mental health nurses and that physical health was a separate entity;

> C06: the most important thing for (.) sort of your purpose is is that my training involved NO::: (.) NO:: sort of 'adult' nursing component whatsoever (.) aside from ya know a few theory modules in first year that I can't even remember (.) so a module (.) anatomy and physiology module (.) I think that was probably it (.) actually am (.) there was another on that talked about basic nursing care (.) […] very little attention I would say in (.) in the curriculum to (.) assessing physical health or thinking about physical health […] the module the anatomy and physiology module was delivered by adult nursing team wasn't delivered so there was no kinda cross over between 'this is how it (.) amm (.) thinking about with from that knowledge base or from that discipline it was very separate (.) it was separate it was in a different place (.) delivered by a different team (.) am (.) it was seen as something 'other' from then what we did (.)
>
> I: *do you think your education made a difference (.) your overall training made a difference to (.) how you address patient's physical healthcare now that you're qualified?*
>
> H11: ((pauses)) probably no
>
> *I: no (.) why not?*

> H11: because I've (.) I would have I would have done the things I'm doing now had I not gone through my training am (.) I don't know if I learned anything

> H01: physical health also plays a very crucial role and (.) none of our modules really (.) touched on that I don't recall actually having a module that was specifically on physical health ya know addressing issues like that

There appears to be a contradiction in this regard. While admitting that the physical health provision in their training was poor, one person stated that they got the value of holism from their training and the values that underpinned it. They described it *"becoming part of them"* [C02] and that meant striving to meet people's physical health needs. So despite a clear separation of learning, participants still appear to gain a sense of needing to be holistic. This could be because they are a product of a values-based curriculum which espouses concepts of recovery-focused practice in a mental health context, which would also acknowledge the need to see the whole person. This is rather problematic, as it raises ethical questions about enforcing certain dictums such as recovery-focused care and the need to challenge inequalities without providing students with the knowledge and skills to be able to do so in practice.

### 6.4.2 Tensions

The data reveals on several occasions the tensions between the universities and practice placements. Often when discussing this, participants referred to 'the university' but did not mention any individual. Indeed, there was no mention of nurse lecturers. Their lack of mention may be interesting as it possibly highlights the disconnect that participants felt between mentors in practice and the university as an institution. Throughout the data, the university comes across as faceless and rather unaccountable institution, yet one which yields a lot of power. Despite pre-registration education being a 50:50 partnership between the practice placements and Higher Education Institutions, this partnership appears rather strained across the data. For example;

> H11: I I think the first thing that strikes me when ya ask that question ((laughs)) is (.) in most people if I'm being honest we've all have a conversation as we're (.) I think [the university] are at times (.) ah frustrating (.) I think a lot of us feel frustrated

Participants expressed the view that during their training, it was felt that physical health learning was 'left to placement' to learn, without any theoretical input from the part of the HEI. Instead it was felt that the theoretical component was taken up with subject matter which was deemed irrelevant;

> H08:(.) I think the training that students get (.) is really lacking (.) the modules are nonsense am (.) my partner is doing his training (.) he did two modules on how health and social care services were integrating […] I don't understand (.) where the focus is […] their modules are pointless (.) absolutely pointless

> C02: I would say we got about ten weeks on the body…nothing else… placements… depends where ya where [on placement]

Clinical placements appear to be the main site for tensions and issues of power. In particular, how the partnership between HEIs and clinical practice played out. All participants felt current pre-registration education provision put students and patients at risk as it was felt that placement allocation left too much to chance and therefore students were not afforded the opportunity to gain a full array of experiences. Participants felt that being a student provided an essential opportunity to be exposed to various physical health skills. For example, it was acknowledged that in certain settings, such as care of elderly mental health where more likely to be able to provide students with opportunity to gain knowledge and skills, than compared to a community mental health team, where the provision of physical healthcare is limited. Therefore, having a random allocation impacts on students possible exposure to such care;

> H05: it's a very different type of nursing definitely but we did learn a lot… it depends really where their placement was.

> H08: [the university] don't seem to give any consideration to a range of experience […] they're not giving any thought to (.) trying to give the students as wide a range of experience as they can (.) it's like they're just chucking them in any old (.) place that they'll fit (.) without any consideration to (.) their career and their development

> H10: it's the way the placements it's the way [the university] are doing it there doesn't seem to be a lot of thought or rhyme or reason I think

Participants felt that the current model of placement allocation left too much to chance, which meant that the opportunities to acquire and gain competency in key physical health skills were heavily dependent on the individual students previous placement experiences. It was felt that this is exacerbated by the poor physical health content covered in the theory element of the course and therefore participants felt that the burden fell on them to provide students with this learning.

> H10: I think also the problem being when for instance the student I've got just now she's had one ward placement and she is in her management

> H12: […] I might be a bit more equipped now is due to (.) going away and trying to do things myself (.) through experience and courses

### 6.4.3 Achieving competencies

It was felt that as a consequence of the ad-hoc placement allocation, students and mentors struggled with opportunities to achieve the competencies required of the HEI, which in turn is required for NMC registration. In particular, mentors commented that the placement learning objectives aren't geared towards physical health enough or if they are in the assessment booklet, they are not congruent and at times unrealistic with the setting. Mentors also felt students were not getting enough theoretical knowledge when they were in university, and as a result, it was creating a disconnect between theory and practice

> H05: I really think it makes a huge difference to (.) ah I don't think people do quite enough on physical healthcare at university nowadays

There were also several comments made about not knowing the current curriculum and being unsure what to expect of a student's knowledge and skills at each stage of the programme. This could reflect a lack of partnership working, not so much on a strategic level but rather how it is operationalised by people on the ground.

> H09: I have a bit of an idea of what they do and what they get trained in and often times ya get told 'we haven't done that' and ya don't know if that's about their attendance or bit about the course cause I never did the course here in [this city] (.) I have no idea ah (.) what what they actually cover (.) so it's just about making sure that any knowledge deficits are covered (.) on that placement or else whenever necessary

> C13: I don't know how much they have been taught (.) I don't know if I have (.) it makes me think I probably not really (.) asked people enough about that

Generally, the assessment tool used was not popular and seen as lacking. It therefore a low form of institutionalised capital as it was felt that it did not appear to contribute to people's development within the field. This is interesting in terms of viewing students on a journey of development

> C13: m I think certainly the last student that I had which was just ah (.) a month or so ago (.) am there was some of the (.) ya know the (.) competencies ya gotta meet (.) related to physical health that (.) that there wasn't going to be an opportunity to do those (.) am (.) in that placement (.) ya know I don't think there's a huge focus on the (.) in the competencies on (.) physical health really (.) there's little bits about am (.) got I can't memorise the book

> H05: I haven't seen any great deal of evidence of physical health in (.) the new booklets (.) I think there is one (.) cause I had a third year student recently and there is one am (.) case study that they have to do about physical health but there's not a great deal

As a result, participants who are also mentors discussed challenges of students meeting competencies in their practice area and the lengths they have to go to in order to do so, particularly if the participant identifies that it is something which is not very visible in their routine practice. This appears to be more of an issue for community staff as opposed to inpatients. Participants described having to resort to students practising key skills like vital signs monitoring on staff members because their placement experiences have not allowed for this exposure. There is a clear sense of frustration as a result of having to resort to this;

> I: so it sounds like maybe if they were doing a placement here (.) it might not have the full range of opportunities just because of the nature of the service?

> C02: yeah yeah on a ward they'd probably see a lot more

> C03: I think in this placement (.) students would struggle to put (.) training into (.) practice (.) the last (.) student that we did that I did any kinda work with in terms of physical health (.) was sitting in the office (.) with a (.) blood pressure machine (.) because we spoke about it am physical health and (.) she had been learning to do (.) she had been taught am (.) how to take a blood pressure but she wasn't sure (.) and I was saying to her so many people opt for the (.) electric machine (.) and don't be one of those nurses (.) if there's a chance to use (.) am the manual machine (.) and like go for it because there's gonna be much more accurate and […] so we sat and we (.) practiced on people passing through the office (.) but that shouldn't be the case (.) we shouldn't need to practice (.) on each other [umhum] we should be (.) ya know it's that shouldn't be we should have been out (.) seeing patients and practicing

> C04: ((pauses)) it's difficult because I suppose in the community we're not on the wards so we are not doing (.) and it's an answer in itself (.) and we're probably not managing people's physical health as as much as on the wards

> so (.) it’s not something that I speak to students about that much that come on placement

This also meant that students have to seek out alternative opportunities out with their placement area to meet competencies. One CPN, gave the example of a student who had to try and arrange time with the district nurse in order to get exposure to things like wound care.

> C07: she was almost finished and she was trying desperately to (.) ah get some time with one of the district nurses so she could get a bit of kinda (.) physical input (.) ya know she had to tick off in her book that she’d done obs and she had done this and that (.) and at that point and at that late stage (.) to me late stage (.) she’s she hadn’t had an opportunity to do these things […] we made them happen am (.) but it’s a bit of a false set up (.) am (.) but yeah she was able to do it (.) I could sense she was kinda frustrated by it as well

### 6.4.4 General placements as a form of capital

There were mixed views about having general placements as part of pre-registration education. Their capital depended very much on the circumstances of the person. People fell largely into one of three categories; Those who had general experience and valued it, those that had but felt it was irrelevant and those who did not and wished that they had.

The advantages to having general placements as a novice were considered to be a sense of routine and an awareness and grounding in basic physical health interventions. It exposed participants to things which they could then take back into mental health settings, including basic wound care and vital signs monitoring;

> C03: it was regardless of which fields of nursing you were going into you were all in first year (.) in together (.) regardless (.) and you learned to do all the basics (.) and you all had a placement in a general ward you all had a placement in surgical mental health and learning disability (.) so that you could do all the basics (.) and you learned about (.) ya know wound care ya know all the all the kinds of things every nurse needs to know about

> H05: when I did my training I think people were (.) more clued up on physical health in terms of (.) making sure all these things are done and more meticulous about keeping charts and things (.) it’s getting better again now (.) but I think ya know we did do the general placements

One participant commented that that while their physical health knowledge was limited, they learned everything they knew during their training and as a result had a clear sense of what it meant to nurse and how to look after patients. It should be noted that in this example, this participant did not train within Scotland.

> H08: yeah (.) so ah (.) in the school of nursing that's where we would have ben thought about about obs (.) am (.) and what they all meant (.) we did wound management (.) […] that's where we learned all that we know and I think our (.) physical health knowledge is quite limited (.) as mental health nurses but (.) anything I learned was there am ((pauses)) we would have done a bit about the side effects of medication and stuff when we were in the school of nursing and how that can impact on people's physical health as well (.) am (.) but yeah that that's where all our knowledge came from really (.)

In this regards, general placements act as a incorporated forms of knowledge and cultural capital as participants gained knowledge that then resides within them and they pass on.

It was also felt that having general placements allowed for participants to develop their acute assessment skills. These physical assessment skills were seen to have capital as they helped in the overall patient assessment. In particular, those with a general experience appreciated having that as it made them aware of physical health issues and their possible complications and this experience has also helped them to rule out physical health causes if someone has a deteriorating mental state. When describing uncertainty about what was going on for a person in their care, often regarding the aetiology of problems being 'functional' or 'organic', it appears that having 'general' experience is a form of capital in determining how likely you are to be able to observe and come to conclusions.

> H05: […] a huge impact like I said if I hadn't had a general placement (.) and I hadn't had a dual trained mentor (.) […] it wasn't just me there (.) there's other nurses on the ward that had the same kinda experiences and that's been like 'oh god no we definitely have to count resps' and we have to do it for a minute and we have to this ya know (.) so yeah it's good
>
> H10: and we had half the year spent in a surgical ward and half a year spent on a medical ward and I think that provided a fabulous grounding in basic nursing care and awareness of physiology anatomy and care (.)
>
> I: ok so you feel like some of these ideas and you go about day to day come from your training and your education
>
> H10: absolutely! Absolutely [ok] I think it's been a fundamental part

In the examples above, participants appear to value this and see it as a form of capital to help provide care to patients. There appears to be a separation made between nurses who have this experience and its view as capital and those that do not; almost an 'us' and 'them' In particular, nurses who underwent 'modular' training (Pre-Project 2000) felt that it was good experience and contributed to them valuing physical healthcare. This was recognised by themselves and participants who were newly qualified, who wished they had had the same level of general experience. It appears that such nurses possess an objectified form of cultural capital, as their experience is some ways communicates a status that others do not have. In doing so, it allows such nurses to progress within the field.

Participants felt it was important that students were exposed to doing things manually and properly assessing patients by touching and feeling for them. This developed skills in managing deteriorating patients. The outlook also appears to be valued by other colleagues as the participant makes reference that her and her colleague, who had similar training experiences, are laughed at because they always have a watch to do things manually. It appears that this is valued by the other team members. Staff felt that if students and newly qualified staff are exposed to this, they are more likely to know its value and incorporate it into their own practice. They appeared to see this as their role when mentoring students and ensuring that students were exposed to manual vital signs monitoring. In this example, there is more objectified capital in the form of the watch "with the second hand," an object that communicates status and the cultural capital to others.

> H05: I think it does yeah (.) I mean they always laugh cause me and my colleague because we're been qualified for quite a long time well her longer than me (.) we've always got a watch (.) am cause 'who's got a second hand' and we've always got one (.) am in doin' resps and (.) people are starting to because of the NEWS starting to do that again more am but it's something we were always taught ya had to do […] ((pauses)) (.) some of them […] I don't know I mean on our ward we certainly (.) do ((pauses)) see that students aren't automatically going for a spygh (.) they are relying on machines (.) they haven't been taught to take pulses and stuff am we (.) do guide them (.) towards the manual spygh and ah speak about the importance of that and talk about the NEWS charts

It was not universally accepted that general placements brought capital, or the knowledge derived brought about capital for the participant.

> C13: so that first year and a half did get general placement (.) child placement which (.) was five weeks in a nursery which was quite fun but no use ((laughs)) am (.) as (.) likewise learning disabilities again was really interesting and adult again […] it was really interesting but it was such a long time ago (.) I didn't really learn anything there that I would (.) be able to use

Interestingly several nurses commented that having a general placement confirmed that they didn't want to do general nursing but instead, found they were suited to mental health. This is often due to the perceived rigid routine of general wards but also that mental health sparked curiosity and interest. Therefore, the placement experiences in general settings, for some at least, helped them form an identity as a mental health nurse.

> C07: but yeah I mean I think the training then (.) am even though I started off doing general I had already decided kinda about six weeks in that I was gonna move to mental health because I just enjoyed (.) it sparked my interest

Some reported that as mental health students, they were viewed as the 'other' and therefore not affording the same educational opportunities as other students. Often this came about that participants almost instinctively took up the 'mental health nursing role' and used their time to talk to patients. This was often seen as 'wasting time' showing that the 'mental health nurse' identity was not always perceived positively by others. This difference, or likely habitus prohibits people from developing capital. If learning opportunities are withheld, then participants are restricted from gaining incorporated knowledge that can be used to progress within their own field.

> H08: I got to do 6 weeks general (.) I did two weeks surgical and two weeks medical and two weeks A&E […] they didn't no because we were mental health (.) students on a general ward we had to check obs and make beds (.) and dip stick urines (.) things like that really basic stuff that we had been doing anyway [umhum] anything more complicated they gave to the general nursing students or they just did it themselves cause it was easier

The third group were mainly newly qualified staff who did not undertake any general placements. These participants discussed that that they felt that by entering into the mental health 'field of practice' from year 1, they were disadvantaged in terms of knowledge and practical exposure. Some participants felt that such approach meant that not all graduates were adequately exposed to opportunities to provide people with fundamental care. Participants who were of an older vintage questioned how student nurses were meant to realistically gain competency in these core skills without adequate exposure.

> *I: Ok you didn't have a general [no] placement in your training? [There was none of that] is that something you would have found helpful?*
>
> C02: Really helpful I always felt that I was really lacking especially on the ward I was really lacking on ahhh (.) ya know what to do with this and what to do with that I think it would be really helpful for people

This appeared not to be a debate over degree-level education but rather the content of the degree. Such NQPs themselves felt that because of the lack of general placements, they perceived themselves to be lacking in skills and confidence;

> H12:absolutely there should have been more I think (.) the expectation (.) that is on us to (.) be able to deal with medical emergencies physical ailments illnesses all the ward the training that we received is not sufficient and well below par (.) to uphold that expectation

### 6.4.5 Dual training as a form of capital

Dual training was another form of capital and a source of knowledge. Participants felt that the biggest value of being dual trained was having increased confidence. It is not so much a form of knowledge, but the perceived knowledge and abilities of being dual trained brings about capital which nurses can utilise to progress within the field. Participants were all directly asked if they were dual trained or had experiencing working with dual trained nurses. This was as a result of the literature review presented in chapter two. Only one dual trained nurse was recruited to this study. However, all participants voiced that being dual trained would likely increase their confidence in addressing patients' physical health issues.

The one nurse who was dual trained felt that the experience had gifted them more confidence alongside an alternative, more holistic view to practice because of the various things they encountered by having that alternative experience. They felt it was confidence as opposed to knowledge. While they acknowledged that they did not know the ins and outs of conditions but instead had an awareness of how they interplay with mental health problems. This confidence comes about during training and being exposed to various conditions and presentations. This confidence in turn appears to be a form of capital. It is perceived that dual trained nurses can deal with issues which non-dual trained nurses have to refer to medical staff.

> C03: ((sighs)) I think it's just given me a bit more (.) maybe confidence [umhum] and awareness (.) am (.) to (.) to know (.) how the two definitely (.) clash and overlap (.) it might be a fairer way to kinda (.) answer that because I'm not gonna sit here and say I know the ins and outs about oh (.) all the problems (.) but I can I definitely know that there are issues but I'm kinda like (.) don't know all the ins and outs of all the physical health problems out there I don't (.) am

It appears that this capital was not always recognised by other team members who still insisted in going to the medical staff for help. This is accounted by the dual trained nurse in the study who expressed a sense of frustration that their skills were not fully utilised. It is unclear why this is and perhaps because people are not aware of the scope of practice of dual trained nurses. It could also be that others do not value such skills and did not see them as important.

> C03: I suspect it's (.) ((sighs)) I think it goes back to this em (.) this general (.) am am mental health divide (.) [umhum] and it's just going back to when I was working on the wards (.) and I don't wanna kinda go back to that [no that's fine talk your experiences please] I think ya know ya know I hated that on the ward (.) it was like ya know when someone (.) had a patient who became unwell (.) it was instantly 'oh well ya know take them off to the [general hospital]' ya know (.) we couldn't possibly deal with them there ya know 'oh they need ya know they need their stitches removed' OH MY GOD get the doctor!' ya know it's like (.) ya know (.) like I can do that (.) I can remove their stitches (.) I can take them out ya know it's just like (.) these are the things as nurses we should be all trained in doing I think (.) I love doing that kinda stuff ya know and I would always say to student nurses 'come here and I'll show you how to remove it eh these stitches'

While dual training might be a useful form of capital, its use and value depends very much on how nurses use that within the field. Participants felt it did not alone make for a better nurse in and of itself but the experience afforded a broader attitude and mindset. Participants felt that dual-trained nurses must be up to date with physical health issues but to have value it also depends on the individuals' characteristics of the nurse and what else and how they execute that capital in the practice setting. A number of people had worked with a number of dual trained nurses in their time and felt that the impact it had made on their practice depended on the individual nurse, their personality, values knowledge and skills and when they did their general training and how much experience they had in that domain. It was felt that one could never make assumptions about someone's knowledge and it depends on their experiences;

> C04: it's all depending on the nurse and wither how knowledgeable they are and when when they were (.) when they did their general training (.) am it

> could have been years ago so sometimes they're helpful to have sometimes they're not just depending on the individual
>
> C06: yeah I'm impressed by it and I think (.) I (.) I don't necessarily think it makes for a better (.) nurse in and of itself cause I think you have to be (.) a good (.) dual trained nurse (.) so just the fact that you're dual trained doesn't necessarily mean but I think if you're (.) a good mental health nurse (.) who (.) is also dual trained you are gonna be (.) more useful am (.) and you're coming at it from (.) a better perspective I think (.)
>
> H09: yeah massively I think (.) and I don't think if somebody tells me they're dual trained (.) it necessarily makes me think they have a different (.) ya know level of expertise than I do

Participants recounted that working alongside dual trained nurses did have some impact on their practice. Being able to spend time with dual trained nurses means that knowledge is exchanged through sharing visits. They help provide confidence to other team members. Participants recounted how dual trained nurses impacted on their knowledge of physical health issues such as infection, keeping a clean environment, task-based care and cleanliness but also importance of why you take someone's blood pressure and importance of not missing things- they are not just vital signs but vital aspects of care. Possessing such capital within a team could mean the dual-trained nurse had an advantageous position to influence the field and their colleagues, depending on how the utilised it. One participant also aspired to be one as they wanted to be more skilled and in a sense was in awe of their clinical skills and knowledge

> C02: yeah there's one on the team she's great [umhum] aye I mean yeah (.) I mean I think (.) it's invaluable to have a dual trained nurse on your team it really is cause they are a good source of knowledge am (.) yeah (.) I'm almost totally in awe
>
> *I: How have they impacted on your practice?*
>
> C02: hugely knowledge wise am (.) just ya know obviously sometimes if people are risky we do joint visits [umhum] so if I'm out with that particular nurse […] just the way ya know if somebody comes up with some physical health she's got the knowledge there I guess I'd be like 'right ok let's contact the GP' or whatever or 'I'll ask the doctors' she's really up to date (.) she's good
>
> C06: In theory it seems a good thing
>
> H01: Oh absolutely! Absolutely! (.) em we do have (.) em nurses who are dual trained (.) and em (.) those nurses are the ones who weeee (.) look to to really address the physical needs of of the patient

> H12: absolutely yeah and I don't know if it's just my personal view but whenever I'm the only trained on I get sent a bank nurse or somebody else to come onto the ward (.) or if there is somebody else on the ward and they are dual trained immediacy you feel more relaxed because you have somebody who is a bit more knowledgeable and that's especially when there's an unwell patient on the ward (.) it makes a difference in that regards

It also had capital in certain circumstances. For example, in an interview situation it was seen as having value, but also acknowledging that in practice it was not something to boast about as really depending on experience, knowledge and skills were limited. It could mean that colleagues would allocate all the physical health tasks to them. This was also acknowledged by another participant, who stated if they were working with a dual-qualified nurse, the dual-qualified nurse would probably not admit to it as they would be given all the physical health tasks because others are too scared to do. It could be used to gain a more favourable position within the field and in this regards, dual training represents a unique form of economic capital, as it could be used to progress and gain further status through promotion and renumeration.

> H01: We give them all the physical health things to do

> C06: if you are an inpatient in a psychiatric inpatient environment you're not going to admit that you are dual trained cause you'll suddenly be doing like all the jobs that everyone else is too frightened to do probably

### 6.4.6 Discussion

This section of the data concerning pre-registration education can be summarised as one where numerous tensions play out. It is clear that the participants perceived themselves as having low influence, and therefore low capital when it comes to influencing pre-registration education. This is despite the fact that practice learning accounts for 50% of student nurses' educational experience. From the perspective of participants, there appears to be a disconnect between the two 'big institutions' in this story; the NHS and the University. It appears to take the form of a disconnect between the lack of physical health theory versus the apparent high physical health needs of pSMI in practice. This may be a case that when new curricula are being developed, it is done with a strategic focus and therefore, there is a discontent between people in strategic roles and the reality of practice.

This raises questions over who decides the content of curriculum. It would appear that some nurse educators hold more capital than others. This is something that is rather invisible in this study but something that is alluded to throughout the data. While the NMC set out standards of education, it is up to individual HEIs to develop their curriculum in partnership with health services. This debate over the content of a curriculum is another source of power tensions. There is evidence to suggest that while there is a 50/50 spilt, these two parts do not hold equal value within the field.

Lauder *et al.,* (2008) found that a significant number of theory hours are self-directed learning and away from HEIs. They are therefore not a drain of the HEIs economic capital. However, they argue that significantly more than 50% of directly-supported learning in pre-registration programmes is delivered by the NHS. Therefore, the assertions within the data that students are not prepared for the reality or practice may have credence and they may be unprepared to provide adequate physical healthcare.

It is difficult to look at these tensions without considering the historical context of pre-registration education. It is unclear if this issue of capital is down to the changes brought about as a result of Project 2000, which moved nurse education away from the hospital-based apprentice style training to one of a rounder, broader educational experience for student nurses. This marked a radical change in philosophy; one where student nurses were no longer paid employees subject to the demands of their hospital. Instead, they enjoyed supernumerary status and entered the clinical area as learners as opposed to part of the workforce. They were no longer 'trainees' but enjoyed student status.

One of the criticisms levelled at Project 2000 was that students were not 'fit to practice' at the point of registration as a result of their programme being 'too academic' and was not adequately preparing students to work in the NHS (Department of Health England, 1999; Lauder et al., 2008). It was felt that due to the lack of time spent in clinical areas, which were instead spent in theory, resulted in clinical skills deficits (Farrand et al., 2006). While some evaluations supported this view (Fulbrook et al., 2000), it is also felt that some evaluations showed a strong bias towards bringing nurse education back to a closer relationship with the NHS workforce (Lauder *et al.,* 2008). In this instance, the NHS lost a significant form of economic capital- a cheap and readily available workforce which they could no longer exercise control over.

It is not clear from the data presented if this is the case within the field in this study. But this argument and tension regarding economic capital is a long-standing one. While none of the participants made reference to this, the economic and the 'too academic' discourse may be influencing the debate around how we best prepare nurses to meet the physical health needs of pSMI.

Watson and Thompson (2000) argue that pre-registration education is a paradox in terms of being viewed as both the source of all 'ills' in nursing, yet is also proposed as the solution to these same ills. It cannot be realistically expected to solve every ill, when some of these ills may be down to poor organisational culture where physical healthcare for pSMI is not valued. HEIs work with NHS partners in developing curricula and must demonstrate to the NMC this collaboration in the development of programmes. Arguably, certain key content is missing because senior nurses from the NHS do not see it and therefore do not highlight it as a concern. This links with the issues of invisibility discussed in the previous chapter.

In a similar vein, this does not negate the concerns of practice staff regarding physical health content within the mental health programme. Competency is more than just skill acquisition and performance. As Benner (1984, xix) stated "Experience-based skill acquisition is safe and quicker when it sits upon a sound educational base." While none of the participants in this study argued or mentioned anything about nurses not needing degrees, there was a sense that the content of what is taught within the degree is an issue. This may show a maturing of the discourse from one of "too posh to wash" to a more nuanced critique of nurse education, where the value of curriculum content is subject to scrutiny. As a result of this scrutiny, pre-registration education appears to have low capital within the field.

Community participants questioned why they were not doing vital signs monitoring with their patients. Similarly, district nurses are needed to help meet some competencies when some of these should arguably be routinely undertaken by mental health nurses in their practice. Students' inability to develop physical health competence in a MH setting because  such opportunities are not available might be symptomatic of the lack of engagement of MH settings with physical healthcare. For example, if some MH settings where physical health care is not mandated as part of the MHN role then naturally there will be no opportunities, and it is unlikely that MHNs in these contexts will feel motivated to identify opportunities because it is not a visible and valued part of their work. This becomes a vicious circle.

Pragmatically, not all competencies can be met in every setting and therefore it would be unrealistic to expect mentors to be able to assess competency when their own competency in a particular skill may be out of date simply because they may not have had to perform it for a long period. If this is the case, it becomes a self-perpetuating issue in that students are not exposed to things during their placements and therefore they do not incorporate into their own practice. Indeed, a number of nurses initially started off in a position of 'I don't really do enough of that' to being able to provide detailed accounts of physical health interventions which they were routinely delivering. Therefore it might not be that students are not being exposed, but rather it may be that staff do not recognise the interventions they are delivering, as discussed in the previous chapter. It may be no surprise that physical healthcare is not part of the habitus in some setting. This remains unchanged as the same leaders who help shape the curriculum are not highlighting this as it may be invisible to them. Therefore, not all the blame can be placed at the door of the HEI.

While these tensions play out, there is a student in the middle of the chasm. It appears that some competencies are difficult to achieve in practice settings and, similar to their placement allocation, it appears that the alternative opportunities required to meet competency are adhoc. It appears that the burden falls with the student to gain adequate exposure, as opposed to the institution taking the lead. It appears that this competency is a form of capital but again has low value as it appears rather meaningless and it was not always clear what participants meant when they discussed competency. It is not completely valueless, as achieving of competency does allow students to progress and ultimately enter the field as RNs. In this regards, nursing degrees are a form of institutionalised capital. This institutionalised capital also allows the holder to acquire economic capital in terms of salary in exchange for their labour.

It is apparent that general experiences during pre-registration, including dual training, appear to shape identity one way or another. It would appear that both are a form of embodied capital as it is knowledge and experience gained but it is also objectified as it becomes a source of capital that can give status in the field. As a form of capital, it contributes to a sense of identity, which in turn acts as capital to confidently navigate the field. It is apparent that those with and without have experienced a structured and structuring impact. Those who have had, it appears to have structured their approach to patient care and consequently structures their current and future practice, including teaching current pre-registration students. Interestingly, that those who did not enjoy the experience of working in general settings voiced that it confirmed they had a separate identity as a MHN.

## 6.5 Knowledge gained post-registration

This section explores the knowledge that nurses formally and informally acquire once they have completed their pre-registration studies and have entered the field as RNs. This is because learning does not stop at the point of registration and indeed Benner (1984) talks about the development of clinicians over time. This knowledge takes different forms. The most important being knowledge gained from experience. This appears to be the most significant form of capital and is once again discussed in the context of Benner's work. This section moves on to look at the role of both formal and informal learning and the value both have within the field. Lastly, this section concludes by examining role modelling and its role in knowledge development. This was seen as important for both novice and experienced participants.

### 6.5.1 Experience

Much of the data would suggest this is in keeping with Benner's *Novice to Expert* study. Experienced nurses talked about growing into the nursing role and only with that came more appreciation for addressing patients physical health needs.

> H01: I have grown in the role […] as I've grown in in my role my understanding of physical health and how it impacts on mental (.) mental health (.) has grown as well.

> C03: I think that seen (.) over the years seen' (.) how patients are kinda (.) treated in terms of (.) like being in the wards and seeing people with like physical health problems and seeing (.) ((sighs)) seeing [h] seeing how they were treated it was just never never great […] that's had a bit of a (.) an impact

Experience in practice resulted in nurses being able to recognise patterns in people's presentations which may be key to understanding patients' problems. Experienced nurses felt that as a result they could pick up on subtle signs such as that something was physically wrong with a patient, ranging from dehydration to side effects of medications and refeeding syndrome. Consequently, they can act by putting interventions in place and by spotting subtle signs can report to medical staff who can undertake further investigations.

> H01: the patient that comes in dehydrated (.) an experienced nurse will know that the patient is dehydrated and then you put in place all the necessary interventions before then you pass it onto the doctor […] am but (.) as I said earlier it depends also on on the level of experience of the nurses whom might necessarily be able to pick up on things like that if somebody

> is complaining of a headache and you've done the physical obs (.) whaat what sort of things are you identifying what is it that you're going to do

Experience also helps in terms of building confidence of being able to raise difficult physical health topic with patients. Participants spoke about the possible outcomes of not intervening but also experience of knowing what impact as a nurse you may have. Experience has shown the consequences of not taking patients physical health concerns seriously and how this may impact on outcomes. It was felt that some of this was gained from 'doing the job'. In this way, learning from previous errors was seen as important.

> H05: it kinda brewed up really quickly (.) am and I think maybe if (.) we had have (.) taken his temperature or something which we do nowadays (.) but if we had taken his temperature at the time maybe people would have noticed it bit better (.) and I always felt really bad about that (.) because he was quite poorly after it it came really quickly and he was quite poorly for a while

> I: and what do you think it is that has made you to get to the point where you do feel comfortable (.) talking about these topics with them?

> C04: a bit of experience (.) seeing the way that it effects people (.) feeling a bit more confident in my ability to discuss it with them

Participants also appeared to value having a breadth of experience over the course of their careers. This did not just mean working with patients, but also having personal experience of illness meant a whole new experience which could in turn be used to inform practice. A participant commented that their own poor health made them more aware of patients' needs.

> C03: hey got diabetes is that gonna like stress them out is it gonna have some kinda (.) like psychological impact (.) ya know and that just well (.) thinking about my own (.) kinda personal experiences if ya've got like if I've hada (.) ya know I was unwell like last year (.) for a while (.) trying to get medications right and stuff and the impact it can have

In order to gain a broad experience, one had to move around the field and not stay in the one place. Participants who had worked outside the local area reported that they felt it put them in a better position as they had been exposed to different settings including practices in different health boards within Scotland but also different countries.

> H01: I didn't have that understanding at all but (.) the mo:::re I work in different clinical settings like as I said ya know earlier that I do […] I now

> start (.) to gain more knowledge as to how physical health can impact on someone's mental state

> H09:yeah (.) I trained in [A different Scottish City] (.) so studied at […] am (.) I (.) yeah and then my first post was in a rural area so in worked in a few different wards rehab (.) ah the acute ward and the IPCU in [a rural hospital] (.) It was good experience and helps

Nurses who had acute care experience were also viewed positively. Experienced nurses felt that working in such a setting allowed students and newly qualified staff to be exposed to a broad range of physical health conditions which the nurses have to get to grips with and manage. It was felt that this was essential before taking up a community post.

> C07: but to go out into the community and have absolutely no (.) grounding at all in anything (.) very first placement (.) just yeah I just find that really quite (.) it must be quite scary as a student I mean just haven't kinda done (.) I think the basics first and then maybe community

> H10: it's a combination I do think they need more time on the wards (.) I really do […] as I've said even just now we've got a whole lot of physical things going on (.) am so she will get the experience but that's been quite scary for her

Charge nurses in the hospital talked about the experience of managing medical emergencies because they undertook clinical site co-ordinator on a rota basis, who make up part of the emergency response team in the hospital. While they found this daunting, they also appear to value it and felt that continued exposure resulted in increased confidence.

> H08: I carry a bleep and when the wards put out a double 2 double 2 for medical emergencies that comes through my bleep and I have to respond to those wards really quickly (.) with all the emergency equipment […] it is an expected part of that role […] cause it's quite stressful (.) scary being the person responsible for that

> H01: ahhhmmmm it doesn't worry me necessarily because (.) ((inaudiable)) in the diabetes ya know its things ya know that I have come across for a very long time and I'm confident enough

> H09: I think it's just about experience and about how we manage personal care am (.) yeah it's it's just about kinda of practice and confidence and (.) ah supporting your staff in managing that

### 6.5.2 Formal Learning

The need to continue to gain experience was not confined to just student nurses. The participants recognised their need to be continuously exposed to things in practice and have further education. Generally, post-registration learning was received in a much more favourable light than pre-registration. While it was recognised that there was a shortage of formal learning provided by the health board, those that had attended courses generally felt they were constructive and impacted on their practice. In this example, the participant is able to articulate why these day-long courses were valuable;

> H01: they were in-depth (.) they were through (.) it wasn't rushed it wasn't rushed one day (.) ahm it it was in-depth it was participatory (.) opposed to my training at university as I said […] I enjoyed them for that reason that they were in-depth I I participated (.) ahm (.) and (.) they were eye opening there were things I did not know as well it was new information which was exciting as well (.) […] it think its because the course was delivered in a very simple (.) simple way (.) which made my understanding of the course content a lot easier and so therefore it made it easy for me to remember to put that into practice

However, this was not a universally-held view. In the following example, the participant recognised they had unmet learning needs in the area of wound care and went on a course. However, the course was pitched at too high a level for what they were dealing with in their setting and therefore the participant was unable to apply it as they were not exposed to the same level of wounds in their clinical practice. This raised the issue of being exposed to clinical situations.

> C02: wound care (.) haven't necessary put it into practice since ya know and it was a long time ago [ok] I went on a wound care training course (.) I recognised but it was too technical (.) ya know I guess I'm dealing with people who self-harm amm (.) and it's the basics I'm needin'

Participants talked about the challenges of putting new knowledge into practice if they were not being exposed to appropriate clinical opportunities to get competencies signed off and then use the skills unsupervised.

> H11: so I did the catheterisation course (.) but then had (.) I think sorta maybe seven or eight of them or observe and then do a few yourself before you could actually carry out the procedure and that never happened it just never (.) I was suppose to go because we didn't have any body that (.) was catatherised (.) so I was gonna have to go to a different

> ward and then it could never be released because of staff nurses etcetera so just never happened

In contrast, another participant talked about having a lot of exposure to wound care working in an all-female ward where there was high rates of self-injury such as cutting and burning. Being able to implement learning in practice is key to it being incorporated into everyday practice. This ability to implement new learning can assist the nurse greatly in navigating the field.

> H08: loads of opportunity so with wound management I was working on a female ward where patients were cutting and (.) not allowing those wounds to heal and it would lead to all sorts of other complications (.) and just after I did that course as well actually we'd got a lady in who had a skin graft done and (.) we had to manage (.) her leg […] then within my role as CCN (.) having to respond to medical emergencies so there is the opportunity to (.) use the skills

Once learning had occurred, it needed to be maintained. It was recognised that maintaining skills was complicated. It was felt that certain environments such as inpatient acute care, people's presentations are so varied and you may not always have the exposure to certain conditions such as diabetes. This meant that staff voiced they find it difficult to realistically maintain competency, often going months or years before they would use certain knowledge and skills.

> H09: because it's not an intervention we do (.) it caused lots of anxieties so part of me (.) seeking as much advice and information as possible and then (.) passing that onto my staff was a way of managing that anxiety
>
> *I: and do you think this anxiety comes from (.) that people aren't doing it every day of the week?*
>
> H09:ye- ye- absolutely! (.) yeah yeah yeah and even people who had done it previously in different areas (.) ah still had anxiety around it because of (.) because they felt they had lost those skills (.)
>
> C06: I did a course (.) […] I think the other thing is that it just falls off because you're not (.) using it with everybody (.) am (.) because it doesn't (.) it's not as though as that would be […] it's like (.) anything that I do in that respect […] the chances of it falling off if I'm not using it every day are pretty high

### 6.5.3 Informal learning from peers

Participants placed high value on knowledge gained from fellow nursing colleagues. It was seen as essential to addressing the physical health needs of patients. This was seen in both inpatient and outpatient fields. The knowledge gained from colleagues had capital when teams were encountering something new.

Participants commented that they would discuss any physical health concerns with nursing colleagues in the first instance. There is evidence that this was more in the inpatient field, where it was viewed there was a structured approach and opportunity i.e. staff hand over, ward rounds etc. However, it was acknowledged that working in a supportive community team meant any issues could be discussed among colleagues in the office. Often this was around health promoting behaviours, while the inpatient setting appeared to be more along an illness paradigm. Often the need for such conversations were driven by the impact psychiatric treatment was having on patients and how best to support pSMI with this.

> H01: I mentioned refeeding syndrome at the time (.) am to one of my colleagues am (.) who had not heard of that before and am so then I had to explain to her what that is and am ((pauses)) ah because of the experience I I had gained

> C13: It can still can get really difficult but we've got a good kinda (.) support in the team and we just (.) ya know something's difficult you just speak to somebody (.) so it's (.) yeah it's ok really I guess

> C14: oh I mean mostly most of the time the conversation comes about because it impacts on our treatment as I think I said before [yeah] it's our treatment that's causin'

This form of telling stories can aid the development of competence. Khomeiran *et al.,* (2006) found that gaining experience did not always have to be 'direct experience' in providing patient care, but listening to others and how they provided care could assist in clinical development. They emphasised the benefit of 'vicarious' experiences where nurses would share their knowledge and experiences, which were found to provide others with useful cues on how to behaviour in particular scenarios.

One way of transmitting knowledge between nursing colleagues was through the use of a 'link nurse' system, where each colleague took a focus on a particular clinical issue, undertook relevant training and then fed that back to the rest of the team, therefore becoming a resource. It was felt that due to the challenges of working in an acute environment, where time was scare, it was a good way of keeping up to date with current research.

> H08: we've got like link nurses and stuff (.) that will work with smoking cessation (.) diabetic nurses (.) the medication am (.) dietitians (.) so we're trying to set up (.) a strong link nurse system on the ward

One participant in the community commented that the motivation of increased knowledge and being in possession of that knowledge put some in a valued position. That is because the link nurse gains embodied knowledge, which in turn can become objectified capital as it gives people status. Therefore such roles could communicate increased status within the field.

> C06: having link nurses as soon as you you have things like link nurses who are skilled up (.) you find that more people want to do it cause actually it's (.) pretty fulfilling (.) and it's a nice position to be in to know things that maybe other people don't know

One participant reported that they undertook learning via Massive Open Online Courses (MOOCS). They then shared that learning with peers and reported starting a trend, where others were now undertaking them. This appeared to be driven by gaps in knowledge and a genuine desire to know more for the sake of the patient. Colleagues would then make up various resource packs which could be accessed by all staff on the ward.

> H05: ya just google massive online courses and they are called MOOCS (.) really cool site and ya type in what you're interested in (.) healthcare (.) they're usually free […] because it's kinda self-directed (.) and but I've got quite a few of the other nurses into it as well but (.) it' it's quite good just to be like 'oh what if that happened again' (.) 'what happens if we have a patient who has that again' so it is quite nice and we do share it with each other

When there was uncertainty regarding a clinical task, participants sought the expertise from other areas within the hospital. For example, if a patient needs catheterisation, they would draw on the knowledge and skills of nurses working within care of the elderly psychiatry as they are more likely to provide such an intervention on a more routine basis than people working in general adult. Alongside that, it was also important to be able to work and learn from outside agencies if nurses were providing care which they ordinarily would not do such as palliative care

> H09: that that was about how the competencies were managed or ah (.) for using the NG feed am (.) I sought advice from (.) lots of different people (.) […] there's areas within the hospital that do NG feeding and PEG feeding am (.) so they they generally gave me the best quality advice

> H10: I would say in the last couple of months we provided (.) terminal palliative cancer care to a lady who was with us for about three months and she died on the ward ah and we were using a lot of equipment drugs liaison with (.) service providers that we wouldn't normally work with and providing

> a service we wouldn't normally provide we were learning (.) on the job and on our feet literarily (.) and (.) very much wanted to do the best we could for this lady am (.) so that was very interesting

### 6.5.4 Role modelling

Another method of transferring knowledge to colleagues was by role modelling. Experienced nurses considered this to be their role, and the need to help more junior members of staff and students. This was in turn valued by less experienced nurses who recognise this role modelling and support. Likewise, less experienced nurses recognised that they have a role in shaping practice and the approach people take by role modelling good behaviour in terms of particular approaches to patient care.

> H05: we (.) do guide them (.) towards the manual spygh and ah speak about the importance of that and talk about the NEWS charts and stuff

> H12: But I don't think its exercised enough am (.) to be honest peer support (.) talking about the next day or (.) whatever with your colleagues that you were on with (.) I think (.) helps (.) […] am I think it would be sort of behaviours learned from other people and that can be (.) good in a way because you learn good behaviours and good (.) practice but also (.) in turn you can learn probably bad practice and avoid that

> H11: I think just hopefully ya know other people noticing how you are I think (.) the way you are with people kinda influences with other people start to react to that person as well so (.) maybe tryin' to just (.) influence (.) the approach (.) at times and everybody does that better for different people

Some of this came about because of the perceived lack of preparedness as a consequence of pre-registration education as discussed above. This perceived lack of preparedness is in a way another form of capital. More experienced nurses expressed sympathy for their current newly-qualified nurses that they were not provided with the same exposure as they had during their nurse training yet have the same level of responsibility.

> H09: I think being aware of it yourself passing on the knowledge and information ya can role model for other people 'well look you can do it this way or this is now best practice' am (.) just raising the profile really and then passing on to your students that that ya have (.) am so yeah

> H10: however we (.) were (.) allowed to experience (.) and have practice in doing things I think (.) ah students don't get access to doing today am they maybe don't fully get the feel of the job and the responsibility am that we hold for people's care

They could see that not having this within their pre-registration education, made their transition to practice challenging and put additional pressure on novices, as there was no denying that patients still had physical health issues. This acted as a driver for the more experienced nurses to role model good practice, so that they could pass on knowledge and skills to the newly qualified nurses, who in turn could then function within the field.

Experienced nurses also discussed the downside to being viewed as 'expert' by others. Having this status brought additional pressures, as less experienced nurses looked to them for guidance and advice. This could be stressful for the experienced nurses, who sometimes voiced feeling an additional responsibility.

> H01: and also the pressure of being now (.) seen as (.) the the more experienced nurse in the team I feel as though I need to brush up on my skills on those things so that when I am to support my eeh colleagues ya know I am at the top of my game with new information that is available out there

### 6.5.5 Discussion

It is no surprise that experience was valued by MHNs within the field. Benner (1984) articulates that it was only through experience and time could people progress from competent to being viewed as an expert. The experience acquired along the way is a form of capital that is required in order to draw on in order to provide physical healthcare and consider the multiple factors influencing patient outcomes. It is similarly structured by previous experiences which in turn structure future ones. It was seen as essential as theory alone cannot adequately encounter the complexities of clinical practice. Experience is an important form of capital as it can be viewed as both an incorporated and objectified form. It is incorporated as it results in the acquisition of knowledge. It is Objectified because this knowledge and experience can contribute to someone's status within the field and being viewed as the 'expert' nurse.

Therefore it is not surprising that the capital held in most value was the knowledge learned in the field from working with others and not the more institutionalised forms of knowledge such as postgraduate qualifications. Indeed, none of the participants discussed undertaking postgraduate level study for this area of practice. However, short courses provided by the organisation, albeit few and far between appear to have more capital because of how participants can return to the field and commence using the knowledge.

## 6.6 Confidence as a form of capital

This is the final section in this chapter and explores the important role of confidence in MHN executing their role in physical healthcare. I explore the important role of experience in increasing confidence as an important form of capital in progressing within the field. I then explore the impact of a lack of confidence and how it contributes to an emotional burden for MHN in this area of practice. I then move onto explore the role of confidence and identity as a MHN before briefly looking how a lack of confidence can also act as a motivating factor. This section ends with a discussion where I endeavour to unpick the interplay between 'competence' and 'confidence.' These terms are not mutually exclusive and the literature points to a complex interplay. This has led me to conclude that not enough focus is paid to developing confidence in novice and expert nurses. I provide a critique of competency and competency-based education and how its focus in nurse education may explain some of the tensions discussed in this chapter.

### 6.6.1 Experience resulting in increased confidence

Confidence came about by gaining experience. Having to have difficult chats and raise issues with patients, such as the need for pregnancy testing or HIV screening means that confidence grows as experience grows. Seeing the effect of providing good physical healthcare also plays a role in building confidence and therefore seeing such interventions as part of the nurse's role. Participants perceive themselves to be good in the role as their knowledge has improved and with that increased knowledge comes the confidence to intervene and provide care- which may not be direct care but may be liaising with others and keeping an overview of how it may be impacting on someone's mental health.

> H01: I think in a way it has influenced my practice with (.) my view on smoking in general am (.) it has given me confidence now when I'm talking to my patients who are on clozapine (.) ya know the benefits cutting down or stopping smoking altogether (.) so it has influenced by practice

> C06: but it would be good if I could think about how all the (.) and I think I'm getting better at that as my knowledge get's better and as I work with more people and I get more confident (.) cause I think a lot of it is about my confidence cause now I'm not really that frightened of (.) just getting in there

Participants also commented that being exposed to difficult situations as they gained more experience helped them to learn and develop and this resulted in participants feeling confident, both in practice and in simulated learning situations. Confidence comes from being submerged into practice and therefore maybe not something the nurse has prior to entering the field- for example being in a busy long-stay care of the elderly ward where there was lot of physical health needs helped gain confidence- an extent of 'just getting on with it.' Confidence comes about as a result of clinical experience;

> H12: so I think it was realistic and really worthwhile quite a lot of (.) by the time I had done the MEAMPI[19] course quite a lot of the situations that were brought up (.) am I had already sort of experienced on the ward but still (.) fully appreciated having the breakdown (.) of the situation (.) what to do what not to do (.) ya know (.) when things aren't available that's ok to do that (.) am and it was just quite reassuring still

> H07: experience up to that point in general apart from one placement a twelve week placement at the [psychiatric hospital] (.) I was given a job (.) as an EN am (.) care of the elderly (.) first day on the job handed the keys in charge of the ward cause (.) it's just how it was in those days (.) am (.) and yeah in at the deep end but (.) learned so much in that two months that it was just (.) I had a bit of everything

Participants reported gaining confidence by working with patients who are confident in managing their own condition. While not doing a particular skill every day of the week impacts confidence, this can be mitigated if the patient has a good knowledge of their own condition, such as diabetes. Data shows that participants working with such patients afforded them the opportunity to gain confidence by seeing how they self-managed.

> H01: but (.) what helps is that patients that we have most of them would have been living with diabetes for years (.) and so they are also so confident in how to manage their own diabetes (.() that really helps and it also helps nurses who've just newly qualified because they are kept right in a way

Confidence has also been increased by the use of clear policy and guidelines. One nurse spoke about how years ago, there was little standard practice regarding diabetes management which resulted in staff having a lot of anxiety that they were doing the correct thing. This has improved as standard guidelines and policy have

---

[19] MEAMPI is a half-day simulation course on managing emergencies in a psychiatric setting

impacted on practice and allow nurses to practice in a manner where they know what they are doing

> H10: am if there any anomalies in those checks you feel less (.) frightened because you are less ignorant about it (.) am certainly with diabetes I think I used to shake in my shoes if somebody was insulin diabetic certainly in the old days cause they wouldn't have (.) they would just have a sliding scale with no (.) sort of definite parameters (.) am (.) so you you used to think 'well shit don't know what I'm going to do' ya know

### 6.6.2 Emotional burden

There were numerous examples where participants voiced that their educational experience as undergraduates is causing nurses to have a confidence crisis but also leading to nurses questioning their self-efficacy. This in turn is leading to an emotional burden. One recent graduate described this below. This appears to function as contributing to a sense a lack of confidence and self-efficacy.

> H12: stressed (.) very stressed am especially when you are in a situation that (.) you are quite clearly out of your depth (.) dealing with and you're trying to ya know do your best escalating it to ya know the certain people (.) but I think it's one of these things that stays with you it's really quite difficult to when you leave your shift to stop thinking about it ya always I do anyway always ruminate and always think (.) did I do everything that I could (.) have I missed anything (.)

In the following example, the participant perceived themselves to have low capital in their field and questioning their professional identity. This would appear to be objectified capital as it indicates a level in a hierarchy. This hierarchy is not within the team or workplace but rather the wider field and that MHN are seen as less than and 'not real nurses' compared to adult/general nurses. In this case, it appears participants perceive themselves to be low in that hierarchy because of their perceived lack of confidence around physical health. This appears rather intense with one participant commenting it is "all consuming." Therefore it would appear that confidence and identity are linked.

> C06: because my what people would call basic nursing knowledge does not exist (.) well no that's not true now it does but I mean I've qualified for eight years and I've that's from what I've done myself (.) am (.) I say it to people all the time (.) ya know I'm not a real nurse (.) that's (.) it's like a cavet (.) I'm a nurse but I'm not a real nurse (.) […] I think about it all the time (.) I think about it all the time and (.) I've sort of toyed with the idea I think I would be (.) a much more (.) rounded and capable (.) CPN if (.) had done like a year of adult nursing (.) […] I think it's more unusual if people do have a good (.) knowledge (.) am (.) yeah (.)

In the following example, a charge nurse is discussing meeting the complex physical health needs of a patient. The participant discusses the massive effort that went into maintaining the patient in a psychiatric setting. They discuss the interplay between experience and confidence. It is clear that staff were competent as the participant comments that they went onto provide a great standard of care. What this shows is that the lack of confidence cause raise professional and personal anxieties for all concerned;

> H09: that was that was a bit about our anxiety around the patient and I suppose it all worked out very very well and he got a really great standard of care while he was here am (.) or he is still here but he continues to get a great standard of care but yeah (.) our anxieties lead to many people being involved whereas with a bit more experience and maybe a bit more confidence we could have managed that am (.) yeah with maybe a bit less input I think

Participants voiced there was a culture of 'buck passing' and avoiding addressing patients physical health needs. In particular, some CPNs participants felt that it was the role of the GP to address physical health needs. It has been known for decades that nurses often use rules and policies as a coping mechanism to to manage difficult emotions such as uncertainty and anxiety (Menzies, 1960). While acknowledging that some of it is driven by significant caseloads and other stressors within the field, a number of participants describe a 'viscous cycle' of emotion which is predominantly driven by an unclear fear. Linked to a lack of systematic approach during pre-registration education, participants felt that students were often gaining experience when it was too late and they were about to qualify. They felt that this was resulting in students having a lack of confidence as they were under pressure to learn a large amount of knowledge and skills, often in the last twelve weeks of their programme.

> C03: I think it's fear as well (.) [umhum] ya know 'we're mental health nurses this is what we know' (.) straight off to the [general hospital] […] there is an awful lot (.) am (.) of people in here that would pass the book quite freely am (.) and I think ya know pressures of (.) having am (.) bigger caseloads and all the rest and the things I mentioned earlier […] I think maybe it comes back to fear [umhum] like physical health again is our (.) equivalent ya know of the [local psych hospital] (.) ya know like they have the [local general hospital] (.) we have the GP (.) Physical health boom! throw them at the GP (.) […] but because they are a nurse and patients probably think we should know that because you are a nurse (.) and without anyone (.) admitting to that (.) to well 'I probably should know it then' that's where the fear can kinda stem from [umhum]

> because nobody is gonna say 'I should know it' (.) [umhum] am but it's this ya know

> H10: if there isn't a lot of that to be done or if they have a lot of community placements and that's not being done (.) they loose that ability they lose that confidence and then the fear hits in and then they want to avoid doing it (.) (.) I tend to be very firm and make them do it day in day out

The lack of capital can result in issues further down the line. It was felt that this fear develops because of students not having adequate exposure to physical health practices during their training and consequently feel under confident. This in turn creates a sense of fear of not knowing what to do and consequently results in people avoiding this area of practice when they qualify. Therefore a 'viscous' cycle is created.

> H12:so I think it (.) the stress is related to uncertainty to (.) lack of (.0 knowledge and understanding (.) and then it just goes in a cycle like that I think we are not (.) a physical hospital

> H11: I honestly think it's just because (.) am (.) partly because I am still new fairly newly qualified certainly only six months in this particular arena (.) ward am (.) so I'm still and I've been in charge of quite a few shifts so I'm still getting to gripes with running the shift eh building confidence in like (.) I've never really been a particularly assertive person so just getting to that point where we're at ya know at the moment (.) I feel like I'm kinda dealing with challenges just on the floor with nursing assistants with basic running of the (.) ward which

### 6.6.3 Identity

The lack of confidence appears to also be linked to how participants are perceived; for example, being a nurse therefore thinking they should know things because they perceive that people are expecting them to know things which they may not have been formally taught. This links to questions of identity discussed previously. It is unclear where this expectation is coming from but is likely influenced by the wider discourses around public expectations of nurses (Hoeve et al., 2014). Although in the second example, it would appear that the expectation comes from patients and public expectations of what nurses can or cannot do. Similar to what is discussed above, there is an emotional component to this, one of fear of not knowing or in some ways imposter syndrome of being 'found out'

> *I: right (.) ok (.) and do you think education has made a difference?*

> H12: I think it's quite basic (.) [ok] yeah

> *I: when you say it's quite basic do you mean without I don't wanna put words in your mouth do you mean that you feel there should have been more*
>
> H12: absolutely there should have been more I think (.) the expectation (.) that is on us to (.) be able to deal with medical emergencies physical ailments illnesses all the ward the training that we received is not sufficient and well below par (.) to uphold that expectation and it's (.) ya know the the reason that (.) I might be a bit more equipped now is due to (.) going away and trying to do things myself (.) through experience and courses (.)

In this example, participant comes to the realisation that they were now indeed a 'nurse' but again the association of 'nurse' with physical health care skills. This recognition of being a nurse comes with a degree of gravity. However, this seriousness contrasts with the description of pre-registration experience, which appears to be a negative one, and an experience that such PHC skills were not taken seriously and therefore a sense of irrelevance. It appears this lack of preparation leads to a lack of confidence and therefore a questioning of one's role.

> C13: I think it's something that (.) I definitely noticed when I qualified was […] in a ward (.) am (.) I'm called a nurse but (.) the people that are cutting themselves (.) I'm not really confident in what to do with these (.) wounds ya know we were never (.) it's not something you are ever taught (.) ya kinda picked up as ya go along in (.) ya know (.) bandage something up or find someone to do it if I couldn't ((laughs)) but yeah know there was not (.) that that that's what I remember (.) really a couple of classes a couple of hours long […] we all felt that cause we are called nurses people have this expectation that ya know all this stuff (.) and we (.) ya don't unless somebody (.) has taught ya (.) ((laughs))
>
> *I: ya suddenly find yourself 'crap I need to deal with this'*
>
> C13: yeah yeah totally

### 6.6.4 Discussion

Confidence does appear to have a role in forming MHN habitus regarding physical healthcare practice. We are structured by our previous experiences which results in an increased sense of confidence. This confidence is also structuring in that it appears to determine the approach to future care activities and confidence in undertaking these. However, a tension exists between confidence and competence. While participants all reported delivering physical healthcare, there was a pervading feeling that people avoided this area of practice because of a lack of confidence, raising the issue of confidence versus competence. Participants reported routinely delivering interventions which they were never formally taught in their education but have picked up as they go along. Nothing within the data suggested that participants were incompetent. It is unclear if people were formally taught would they be more confident and therefore possess more capital within the field.

Competency is derived from the Middle French and Latin word *competens*. To be competent is to be proper or rightly pertinent, to have requisite or adequate ability or qualities, to be legally qualified or adequate, or to have the capacity to function or develop in a particular way (Insert dictionary reference). McMullan *et al.,* (2003) makes a distinction between 'competence' and 'competency', the former being a description of the action or behaviour, while the latter is the individual's behaviour that underpins the competent performance. Khan and Ramachandran (2013: 922) articulate that, "the term 'competency' should strictly be used for the 'skill' itself while competence is the ability to perform that skill and the attribute of the performer".

Benner (1984, p.292) defined competency, as "an interpretively defined area of skilled performance identified and described by its intent, function and meaning (as in competency statement)." She notes that the use of competency is unrelated to the competent stage in the Dreyfus Model of Skill Acquisition. She described the competent nurse as "[having] feelings of mastery and the ability to cope with and manage the many contingencies of clinical nursing" (Benner 1984, p27).

Tilley (2008) points out that there is no universal definition of competency. A literature review by Watson *et al.,* (2002) on the topic of assessment of clinical competence in nursing also could not find any clear consensus on what this entails or how it should be measured. This is because competency assessment is problematic because of the difficultly in determining an appropriate level. This view is also espoused by Pijl-Zieber *et al.,* (2014) who argue that assessment ranges from achieving a minimum set of standards to working in a fully autonomous and independent manner. This issue is not confined to nursing. Similarly, the medical education literature has shown that the US system of accreditation for medical staff lacks a robust evidence base with Lurie *et al.,* (2009) reporting that a systematic review of the evidence found that the competencies could not be validly assessed.

Bargagliotti *et al.,* (1999) argue that a lack of clarity and the complexity of this raises issues such as who is responsible for the maintenance and assessment of continued competency. While an agreed understanding is lacking, it does appear that competency is a continual process and not an end gaol in itself. Therefore, ensuring increasing levels of competency across the workforce is essential to consider and would be congruent with Benner's conceptualisation. However, the literature does show is that much of the focus regarding competency in nurse education centres around pre-registration preparation, with little focus on competence post-registration. Tilley (2008) argues that as a result, there is little evidence of how employers ensure registrants remain up to-to-date with the latest developments in best practice. This may explain where there was an absence of focus on how people maintain skills and competency within this study, where competency appears to be conceptualised as a fixed state or final destination. While there is much focus on maintaining competencies and the responsibility of individuals, the literature shows a paucity of how this occurs. Indeed, there appears to be a lack of mechanisms. This is illustrated in terms of lack of educational support; a lack of CPD opportunities and a sense that the organisation does not do enough. So rather than viewing competency as an issue, it is how that is operationalised in education and clinical practice within this study. Arguably, it means that RNs will, in some ways, loose their competency of certain skills over time, and therefore have less capital to operate within the field. However, this is not unrealistic if a RN practices in a particular context where they will not be routinely using some skills.

However, thought needs to be given to how to maintain these skills. Takase (2013) argues that competency is context and time-bound as knowledge is always evolving and changing. This has particular context as HEIs and NHS partners move towards implementing the new NMC (2018) Pre-registration education standards. These include a comprehensive skills annexe which all nurses must be competent at the point of registration. It has been left to individual institutions to determine what stage of competency students should reach across the fields of practice. This appears problematic as the point of standards is to have a benchmark to which everyone should reach. It is also questionable how many of these skills will be, or indeed should be used routinely in MHN practice. This further raises the issues of how MHN maintain their competency regarding physical health skills and what role the organisation has in supporting this process.

This also appears rather problematic and contradictory in the context of previous historical reforms to the nursing curricula. It is accepted from a number of evaluations of Project2000 that progress was made in shifting thinking away from thinking pre-registration education produced the final product, but rather was the start of a journey of lifelong learning (Fulbrook et al., 2000; MacLeod–Clark et al., 1996). It may appear that we are taking a step back and where once again, pre-registration is being used as the solution to all ills (Watson and Thompson, 2000). This could be an issue of economic capital. If the NHS, as the main employer post-registration is employing people who have been deemed to have achieved more 'competencies' at the point of registration, this means that the NHS is not required to spend as much on training courses and instead it is expected that that skills which were traditionally acquired as a RN now fall to the HEI to teach taking the economic costs away from the NHS.

There is much to critique about a competency-based approach to nursing. One is that it is reductionist, focusing solely on technical skill. While Benner does emphasise the need for mastering technical competency, it is also clear that achieving this is a complex process that involves the interlude of different ways of knowing derived from personal, propositional, and practice experience. This is particularly important in MHN, some of which was discussed in the section on TRs. This is because MHN can be conceptualised more as a craft than a science (Buchanan-Barker and Barker, 2005; Silverstein, 2006).

Indeed, Hewitt and Coffey (2005) found that while pSMI did not deem the technical acumen of nurses worthless, their effectiveness was judged on the extent of a pre-existing collaborative alliance. This links to the issues of invisibility discussed previously. As nursing as a whole appears to prioritise technical competency, perhaps this is at the expense of taking into account the other elements that produce Benner's 'expert' nurse. Therefore, competency in building TR has on the whole, capital in the field of MHN, it does not appear valuable in the wider field of nursing. MHN in particular must make the case for a broad view of competency and one that does not just prioritise technical expertise or performance of a skill, but one that articulates the complex processes such as TR in which these skills are performed. Silverstein (2006) has argued that this focus on technicality is in keeping with the broader discourse around biomedical dominance, and consequently has resulted in dehumanising MHN, where interpersonal skills are deemed 'soft' and are the sacrificial lamb in an era of increased technology and financial constraints.

It is because of this relationship-focused nature of MHN, that Hewitt (2009) considers competence as problematic. As discussed above, this relationship-orientated approach makes quantifying outcomes difficult and may not fit with the dominant positivistic research paradigm, which reinforces technical aspects of interventions as opposed to the mechanism of how these outcomes are achieved i.e. therapeutic relationship. This further results in a bias where there is an acceptance of treatment methods only where the dominant paradigm proves their effectiveness. This is important if we consider that it is health promotion work that is likely needed to improve PH outcomes for pSMI and this requires more than technical competency.

Another issue with competency-based education is its technical primacy as a framework does not fit with other conceptualisations of nurses work and further perpetuates that the work can be carried out by anybody who has been deemed 'competent'. This communicates that the work is of low value. In contrast, McAllister (2015) applies the term "knowledge workers" to nursing. She argues that nurses must interact with different types of knowledge regularly and think about how that knowledge is applied. This process, much like what Benner outlines is complex and requires nurses to engage in multiple cognitive processes, some of which McAllister (2015) identifies as; noticing, drilling down, interpreting, clinically reasoning, brainstorming, creating, linking, translating, reiterating, motivating and inspiring. McAllister's approach is useful in helping to name and unpick the complexity surrounding nurses work and how nurses work may be difficult to qualify and measure. It shows that competency is much more than technical skill, but requires a variety of cognitive processes to successfully execute.

If we consider that evidence suggests pSMI require support in maintaining a healthier lifestyle (Firth et al., 2019; Liu et al., 2017), then MHNs are poised to be able to deliver such interventions in light of their ability to develop and maintain TRs with pSMI.

Evidence also suggests that improvements in health require a longitudinal view. Again, something that MHNs can do. Therefore the NMC skills annexes may have missed the mark and still not giving MHNs the skills they will require to bring about improvement in pSMI physical health as they appear to prioritise technical competencies.

It is argued that the move to competency-based education has been politically-driven. It has been considered that this move, not just in nursing but across practice disciplines, has resulted in the control shifting away from higher education institutions and more towards employers (Sawchuk, 2008). This is in the context of a wider competition agenda and not one that has been a theoretically-informed (Windsor et al., 2012). It is argued that the competency-movement is about creating a flexible and mobile workforce in order to increase productivity. It does this by conceptualising work as a set of generic skills possessed by the individual that are transferable. The issue becomes that such competencies become too generic that they fail to discriminate what is nursing from other professions and cannot be considered to reflect the complexity of nursing work. We have seen this issue being raised within the data where participants were critical of the competency booklets used for student assessment in practice. Indeed, Watson *et al.,* (2002, p.476) capture the point most succinctly when they state;

> "The drive for competence, while not wrong in itself, may be misguided because it comes from and encapsulates an anti-educational mentality. If this is allowed to take root and thrive it will turn back the clock of nursing education by several decades. This drive towards a greater emphasis on competence comes from a mis- guided public and political perception that nurses educated in universities are too clever to care—something for which there is absolutely no evidence."

It is clear from reading Benner's (1984) work around different forms of nursing knowledge, that practical skills were not just a case of practical acumen. Practical knowledge is not merely practicing skills but also learning cultural practices. As Benner (1984, p297) states "It is 'knowing how' as opposed to 'knowing that'." This indicates that higher-level thinking is very much involved in the development of practical skills and the synthesis of multiple ways of knowing including a sound theoretical base. This is important when one considers that one of the key aims of the Project2000 reforms to nurse education in the UK was to change the philosophy from one where students were paid employees under an apprentice-style on the job training, to an approach that was educationally driven and where students were university learners with supernumerary status (Lauder *et al.,* 2008). While competency-based education is the norm across the majority of healthcare disciplines, it is questionable what this is doing to the status of nursing work. While it is an approach that participants voiced criticisms about, the concept of competency appears to accepted by senior nurses leaders without much scrutiny. It goes some way to perpetuating the view that nursing is not compatible with higher-level thinking and therefore its unique contribution to knowledge has low status or is just invisible.

It appears from the data presented that the dominant discourse around 'competency' is in relation to external standards and frameworks. In particular, the discussion regarding organisational risk and how staff competency was something to be managed and risk assessed. However, evidence presented in this chapter and the wider literature may indicate that one cannot look at competency in isolation without also considering confidence. Benner (1984) argues that a competent nurse only comes about when there is a corresponding increased sense of self-worth. Throughout the data there has been a tension between the two. This is because the focus on measuring competency and the need to 'get things right' may actually be hindering skills development instead of encouraging it (Carlisle, 2000). Work from the medical literature has shown that studies broadly identify that students are divided into two categories based on their motivation; students who 'hope for success' and 'fear of failure.' When students appear more motivated by a fear of failure, they tend to avoid achievement situations (Entwistle, 1981). This is then exacerbated by attempts to overcome fear of failure resulting in increased anxiety. Work undertaken by Stewart *et al.,* (2000) exploring similar motivations with junior doctors found that those who had a tendency towards 'hope for success' took greater risks in learning situations. It was found that this confidence allowed junior doctors to continue to perform a task even if they were initially unsuccessful (Stewart et al., 2000). Confidence can therefore help in achieving competence. This is significant in light of the discussion regarding the burden of accountability and the perceived blame culture that participants spoke of in the data presented in chapter five.

On the other hand, Judd *et al.,* (2019) argues that confidence is often inferred as a measure of competence and this can be dangerous. Morgan and Cleave-Hogg (2002) used simulation-based performance assessments to explore whether a breath of clinical experience along with self-reported confidence levels were indicators of competency. 144 medical students attended sessions on anaesthetics situations and were asked to complete a 25-point questionnaire on specific clinical experiences and confidence in their ability to manage clinical situations prior to competing an Objective Structured Clinical Examination (OSCE). The study found that there was a statistically significant correlation between clinical experience and confidence. However, there was none between clinical experience, level of confidence and performance in the OSCE. Therefore, we need to be careful in assuming that confidence and competence are mutually exclusive. While confidence is needed to achieve competency, they are not the same thing. It is also evident that confidence is a consequence of competence, as Marshburn *et al.,* (2009) reported that nurses who self-reported as performing better on competencies were also self-reported more confidence in their skills.

There are similar examples in the nursing literature where competence and confidence have been competing. In particular, work by Holloway *et al.,* (2014) and nurses confidence and competence regarding alcohol. Their study drew on Bandura's (1997, 2004) self-efficacy theory. Bandura (1997, 2004) suggests that if an individual does not believe themselves to be capable of completing a task, they unlikely have the incentive to attempt the task. Consequently, perceived confidence influences whether or not an individual will be able to engage in a particular behaviour or learn tasks. It was found that nurses in the study self-reported a lack of confidence as opposed to competence in intervening in alcohol-related issues and explained why despite being able to, they did not always intervene.

Similar to Holloway *et al.,* (2014), Lauder *et al.,* (2008) found that newly-qualified nurses in Scotland reported a lack of confidence. This study was part of a large government-commissioned, multi-methods review and evaluation of nurse education, including evaluation of the preceptorship programme *Flying Start* used in Scotland. The research team did comment that this perceived lack of confidence by new registrants may be misunderstood as a lack of competence but it would be false. On the contrary, they concluded that it is likely that NQPs have an increased self-awareness of their accountability and that this awareness shows that NQPs recognise the importance of safe practice and an incentive for them to engage in further learning (Lauder *et al.,* 2008). In this manner, the lack of confidence around PHC may mean once again that practice remains invisible.

This would mirror earlier similar evaluations such as Macleod-Clark *et al.,* (1996) descriptive account of Project2000 in England. While practice partners report some initial skill deficits in NQPs, these quickly disappeared with greater exposure in the clinical setting. This comes across strongly in the data in this study, and in particular the need for clinical exposure and an increased sense of confidence and competence as experiences increase. This would be in keeping with Benner's (1984) work who found that experience was a prerequisite for developing into an expert nurse. Benner was clear that experience was gained when theoretical knowledge "[…]is refined, challenged or disconfirmed by actual clinical evidence that enhances or runs counter to the theoretical understanding" (Benner, 1984, p294). She further explains that clinical expertise is only gained "through a process of comparing whole similar and dissimilar clinical situations with one another" (p.294). This makes expertise a hybrid of both practical and theoretical knowledge and one that values a synthesis of multiple ways of knowing. In the context of some of the data presented in this study this is problematic. While it was clear from some participants that without realising it, they were describing their expertise gained over years of valuable clinician experience. However, it is also clear that some participants report not having a sound theoretical basis on which to base their clinical experience. It therefore raises the question if such MHN can ever achieve a level of expertise in this area of practice when conceptualised in the manner Benner has.

## 6.7 Summary

This chapter explored the capital that MHNs possess and use to navigate the field. It starts by exploring the role of therapeutic relationships (TR) and specialist nursing roles within the field. I presented data that shows how MHNs utilise TRs as the basis for all interventions, how it is the basis for building trust with people so difficult and sensitive topics, such as physical healthcare can be raised. It is therefore a valuable form of capital that participants use to function within the field. The section ends with situating these findings within my own university department's cannon of research on TRs in MHN practice. In the next section I discuss how specialist roles carry capital with both other nurses and more importantly, pSMI. I present data showing how participants feel such a role should exist for meeting the physical healthcare needs of pSMI. This section concludes with situating these findings in relation to recently published evaluations of similar roles.

Part II presents findings related to different forms of knowledge and contains three sections; (1) knowledge gained during pre-registration as a form of capital, (2) knowledge gained post-registration and (3) confidence as a form of capital. The first part starts off by presenting data regarding people's experience of pre-registration programmes. This moves onto discussing the tension and power dynamics between HEIs and their NHS practice partners, with placements being the site where these tensions play out. I then explored the issue of achieving competence and how this may be difficult if MHN practice is currently invisible, as discussed in the previous chapter. I then explore how both general placements during pre-registration, as well as the concept of dual training, are forms of capital. The section concluded with a discussion, which is situated with the historical context of nurse education of the past thirty years as well as drawing on the seminal work of Patricia Benner's (1984) *Novice to Expert* study.

The next section in part II explored capital gained post-registration. This capital, or knowledge in different forms, the most important being knowledge gained from experience. This appeared to be the most significant form of capital and is once again was discussed in the context of Benner's work. I discussed the role of both formal and informal learning and the value both have within the field. Lastly, I present data examining role-modelling and its role in knowledge development.

The final section in this chapter explored the important role of confidence in MHN executing their role in physical healthcare. I explored the role of experience in increasing confidence; it is an important form of capital in progressing within the field. I then explored the impact of a lack of confidence and how it is contributing to an emotional burden for MHN in this area of practice. I presented data that illustrates the link between confidence and identity as a MHN. This section concludes with a discussion section, where I unpicked the interplay between 'competence' and 'confidence.' Whilst these terms are not mutually exclusive, the literature points to a complex dynamic. This has led me to conclude that not enough attention is paid to developing confidence both pre- and post-registration.

# Chapter 7: Conclusion

## 7.1 Introduction

This is the final chapter of this thesis. It starts with a summary of the main findings. I then move onto present a discussion section on the contribution Bourdieu's writings made to the process and in particular the interaction of his key concepts. I then present how this thesis has made a contribution to knowledge before discussing the limitations of my approach. I present the implications of the findings for MHN practice, policy, education and research. I conclude with some reflections on my doctoral journey and the construction of this thesis.

## 7.2 Summary of findings

I have presented two findings chapters. The first deals with issues relating to the field. The second details the capital that MHNs possess within the field. A number of the structural and organisational issues presented chapter five answer my first research question. The forms of capital presented in chapter six address answer my second research question regarding educational experiences and competencies assisting MHNs in performing their role in addressing PHC.

Chapter five is presented in two parts. Part I examines the structural issues within the field. Part II is an analysis of some of the boundaries and tensions within the field. MHN practice takes place within a complex field. Part I opens with a discussion on how participants conceptualised PHC. Participants were positive on the whole regarding this area of practice and voiced they had a role in addressing the PH needs of pSMI. MHNs often did not realise they were 'doing' PHC as they were embedded in everyday interaction. Therefore, this area of their practice is invisible.

Participants discussed the burden of accountability. Accountability presents as a form of symbolic violence against MHN. Participants voiced there were high levels of responsibility for PHC and the need to care for the whole person; to do otherwise would be neglectful. This sense of accountability develops during pre-registration but continues when qualified as the organisation also asserts dominance via accountability. Participants voiced that they were accountable for their own learning needs, despite also voicing that they had not received enough education and training. There was some suggestion that participants' motivation to undertake further training was linked to accountability and maintaining competency. There was an evident interplay between nursing and medical accountability, with participants using medical staff to legitimate decision-making. A lack of knowledge of PHC may drive the need to push accountability onto others.

Task allocation was a way of operationalising accountability and try and mitigate the unpredictability of MH services. One way of doing this was through intentional rounding. There was also evidence that PHC tasks were being delegated to non-RNs. It was evident that accountability raised difficult emotions, in particular, fear among participants about what would happen if something went wrong and if they would be blamed.

The dominant discourse around risk in mental health (Risk to self and risk to others) results in participants feeling under pressure to manage risk and deteriorating mental states was overwhelming and stressful. This left little time for PHC.

Generally, participants voiced there was not enough support from the organisation to facilitate MHN PHC practice. It was challenging to access CPD opportunities, and there was a lack of equipment required for PH monitoring.

Participants discussed change in broad terms. Organisational change, changes in working practice and changes in presentation all impacted on MHN practice, leaving participants feeling fatigued and unable to provide PHC. They noted there was also a positive change in terms of better attitudes to pSMI meant improved standards of care, though participants voiced that non-MH services still displayed negative attitudes that impacted on PHC access.

Participants held diverse views on the role socioeconomic factors played on their ability to provide PHC to pSMI.  Some felt it significantly impacted on the type of support they could offer, while others stated it played no role and they treated everyone the same.

Part two of chapter five explored some of the boundaries that exist within the field. This required MHNs to negotiate with other MH services but also primary and tertiary care for PHC. Some of this is achieved through the use of a shared language. It was evident that fear played a role in creating the tensions that exist between different boundaries.

Chapter six was the second of the two findings chapters. It helps to answer my second research question regarding educational experiences and competencies assisting in MHNs executing their role in PHC. Again, it was presented in two parts. These findings present various forms of capital that are evident within the field. Most of these forms were embodied or institutionalised, and some had indirect economic consequences.  Part I explored the role of Therapeutic relationships and specialist nursing roles. TR was one form of capital that participants used to provide PHC interventions. It allows MHNs to support people with self-care as well as allowing more sensitive topics to be probed. Such topics risked jeopardising the TR. It was recognised that because of the long-term nature of SMI, a quietly persistent approach was required.

Participants generally voiced favour for there being a specialist nursing role to support the PHC needs of pSMI within their services. It was felt such person would have capital in terms of their ability to provide support to staff but also having knowledge of the person's MH difficulties and how that may impact on PH interventions. There was a risk that such a role may result in a siloing of care.

Part II starts by exploring the knowledge gained during pre-registration education as capital. This was perceived as a low value in the field for several reasons. It was felt that the content of programmes was not adequately preparing nurses to meet the PHC needs of pSMI. There was a noted separation of teaching from MH and PH, contributing to identity. There was a tension evident between university and NHS from the perspective of participants. It was felt that placement allocation resulted in an adhoc experience.  Participants felt that students would struggle to achieve competencies within their practice setting, resulting in them having to seek alternative learning opportunities.

There were mixed views regarding 'general' placement experiences. Some had it and valued it, those who had it and felt it irrelevant and those that did not have this experience but wished they had. Experience of working with ‘dual-trained’ colleagues resulted in similar views. It was felt that such people had increased confidence to undertake PHC.

Participants voiced gaining knowledge through four ways once qualified; via experience, formal learning, informal learning from peers and role modelling. Participants’ gaining experience chimed with Benner’s work, with participants talking about growing into their role, recognising patterns and this leading to developing confidence.

Formal learning was viewed to have more favourable capital than pre-registration learning. It was felt that short courses were designed so the knowledge could be applied to practice. However, this was not a universally held belief. There were also issues of not being able to maintain skills if there was not adequate exposure.

Informal learning from peers held high-value. It involved learning via a 'link' nurse system for critical topics as well as accessing materials out with the organisation, such as MOOCs. Additionally, experienced nurses felt it was their duty to role model and guide good practice for novices and peers valued this.

The final form of capital discussed is confidence. Gaining experience leads to confidence; this confidence then allows for further experience to be gained. It was found that a lack of confidence leads to an emotional burden; fear develops, which creates avoidance. This lack of confidence may also be contributing to a professional identity that MHNs are ‘less than’ within the nursing family. This chapter explores the link between competency and confidence and concludes that ‘competency-based’ approach may be incongruent with MHN and the development of therapeutic relationships, further perpetuating the invisibility of PHC practice.

## 7.3 Bourdieu’s contribution

Bourdieu’s writings have influenced the direction of this study. One of the advantages of this approach is that his work allowed me to consider the relationship between people and wider structural and organisational factor and how they impacted each other. I think it was instrumental in recognising the individual MHNs experiences against that of structures and intangible concepts. In this regards, it allowed me to consider what Rhynas (2005) termed macro, meso and micro elements of the field all at the same time while also considering the individual experiences of the participants.

I also believe that Bourdieu gave me useful concepts to help set a boundary around my data and uncover some of the issues that at first were not apparent. The findings have been presented in two separate chapters; field and capital. However, they interact with each other in many ways, and this interaction often reveals the participants’ habitus.

This sense of being accountable for one’s learning is linked to the numerous forms of capital that exist and that participants utilise. This is despite some forms of learning, such as pre-registration not holding much value. Nevertheless, educational and clinical competencies, which can be considered a form of capital, are viewed as something to be managed; another facet of accountability and professional regulation.

How accountability is operationalised results in symbolic violence, which further impacts on the capital which nurses can acquire; despite lacking such opportunities, they are expected to perform a role and assume full accountability. Additionally, their perceived lack of PH knowledge (lack of capital) may also explain why participants discuss ‘passing it back’ to medical staff.

Similarly, the issue of risk management is another form of symbolic violence related to accountability and the sense of being blamed if something goes wrong. This eclipses MHNs’ ability to develop other areas of practice, such as PHC. Participants seemed to focus on risk in terms of self-harm, suicide and violence yet we know in pSMI, self-neglect is the most significant risk factor and would be related to PHC.

Some participants stated that risk was much broader and needed to consider this in routine risk assessment and management.

Much of the capital in the form of knowledge gained during pre- and post registration, especially the material related to professional standards and education frameworks, is impacted by structural and organisational factors within the field. The lack of organisational support means that PHC is not always visible. This invisibility becomes a structured and structuring force, resulting in a perpetuating cycle where nurses do not experience PHC as a student in some settings, therefore potentially not valuing it or incorporating it into their habitus because they have never acquired the knowledge or capital. They are unable to progress as the organisation restricts them gaining any capital in this area by the lack of educational and development opportunities. Experience is defined by what is valued by the organisation and by what can be seen. For example, the capital that specialist nursing roles bring is that such a role did not exist. Such a role would be at the bequest of the organisation to develop, support and fund. It is questionable in the face of growing evidence why this role does not exist.

This lack of capital or knowledge helps create a boundary for MHN, limiting their practice and impacting their interaction with other actors within their field- either medical staff or other parts of the health service. This appears to be again driven by accountability and the fear of if things go wrong, which in turn raises emotions such as fear which drive interactions within the field. However, the nature of MHN practice means that it may be appropriate for there to be clear boundaries of what they do so as to not work beyond their scope of practice.

It is also evident that some of the boundaries are set within the field and are dependent on the actors' capital. For instance, nursing people with complex needs and keeping them within the MH setting either because other sections of the health service have more capital and therefore determine this should be the case, or else because participants viewed these other parts as not possessing the necessary therapeutic skills (capital) to meet the holistic needs of the pSMI.

The idea of boundaries between staff and patients is related to the capital of therapeutic relationships. What is interesting about this form of capital is that evidently participants learned these therapeutic skills during their education, saw their application in practice and therefore became part of their habitus. However, it is never stated that they did start to learn such skills during their student days. However, it is an educational experience that gives participants capital and is clearly used within the field, including when addressing PHC for pSMI.

## 7.4 Limitations

Every study will have limitations. The three main limitations for this study include the uni-dimensional nature of my sample, a lack of generalisability and the limitations of my use of the theoretical framework.

A key limitation is that I had the perspective of one professional group- MHNs. The rationale for this is outlined in chapter four. Physical healthcare for pSMI takes place in a multidisciplinary context. It is evident from the work of Liu *et al*., Firth *et al.,* and WHO (2018) that it is not down to one professional grouping to address these unmet physical healthcare needs. In this regards, this study may be unidimensional, and if looking at this topic more broadly, then participants from other professional backgrounds would have been recruited. However, for reasons explained earlier, this study was focusing on mental health nursing practice. Across the globe, nurses make up approx. 60% of the workforce and not studying their practice and shine a light on their expertise would be imprudent and short-sighted. They are the largest group of actors within the field; so while it may be unidimensional, that dimension is rich.

It should be acknowledged that my sample size may be a limitation and that all participants were recruited from a single health board in Scotland. This may impact on the study’s generalisability; a common critique of qualitative research. However, this is something that qualitative research does not aim to achieve. Instead, Parahoo (2014) argues that researchers should focus on providing sufficient detail about the study context, setting and sample. Publishing such details will allow the reader to draw conclusions on how the findings may ‘fit’ with their own situation (Rolfe, 2006).

I hope that providing adequate details regarding the setting and in particular, the makeup of my sample, readers can deduce for themselves how the findings fit with their own experiences and practices.

It must also be acknowledged that my chosen theoretical lens guided my analysis in a particular way. No theoretical framework can answer or provide insight into every facet. The adaption of a different lens would likely have resulted in a somewhat different analysis and therefore produced different findings.

## 7.5 Contribution to Knowledge

This thesis has helped progress the discourse around physical healthcare and MHNs. I arrived at the start of this endeavour to discover ambiguity and indeed much blame towards MHNs with multiple voices shouting if 'they just did this' or 'if they had this type of training' (including my own!). Indeed, the literature presented in chapter two shows that in previous studies nurses have voiced a sense of ambivalence regarding PHC practice. This thesis contributes by highlighting  many reasons why this is the case: holding a burden of accountability, the risk discourse that dominates mental health care allowing little room for anything else and a lack of organisational support. In previous studies, nurses voiced other professionals had more of a role in PHC, and the data in this thesis regarding medical staff related to accountability may help explain why this is felt to be the case. Additionally, nursing practice takes place in a social and political context. This thesis has helped to get to grips with some of the underlying structural and cultural factors that impact MHN practice and gives a 'why' to the 'how.' In this regard, this thesis has helped to contribute towards the first research aim of understanding how relationships and structural issues within the work environment impact on mental health nursing practice.

Indeed, the nature of modern healthcare and working in an under-resourced and stretched health service means that staff do have to prioritise. It, therefore, may not be appropriate to prioritise physical health issues where assessment and management of risk when a pSMI is in crisis is the priority. To my knowledge, this is the first study that has explored physical healthcare for pSMI through this lens. It is, therefore, a unique contribution and understanding of MHN practice.

Several studies presented in chapter two showed that nurses valued holistic care and that their role in physical healthcare may be about overall co-ordination and advocating for access to care. This thesis supports this view and some participants voiced that they saw this as their role. This may be a more realistic expectation and indeed, good utilisation of the MHN skill set. This has been an underexplored viewpoint of the role of the MHN and therefore, highlighting this is a valid contribution to understanding MHN practice.

This thesis also contributes to the debate around specialist nursing roles within this area of practice. While there was clear evidence presented in chapter two of their potential benefit, such a role did not exist within this study's service. However, there was a clear appetite for it.

Education was a significant issue within the studies presented in the literature review of this thesis. It is for this reason that the second research aim was formed; to find out in what way do educational experiences and competencies assist mental health nurses in performing their role. One of the issues identified has been that educational studies have mainly relied on a pre-/post- same-day evaluation, without examining how that knowledge is applied in practice. This thesis shows that it is not just education, but organisational and structural factors impact nurses' ability to apply their new knowledge in practice when they return.

Studies in chapter two also showed that nurses felt their education did not prepare them for their PHC role. This thesis contributes further to this debate as participants shared these same concerns. Much like studies in the literature review, participants in this study expressed that their PHC knowledge was lacking. However, this education may not be so much around performing specific procedures. Instead, this thesis supports the view that nurses require more education around behavioural change and health promotion.

This thesis also shows that nurses value acquiring knowledge from multiple sources and not just formal learning. This outcome may have been influenced by the broad second research aim, which was about more than formal education. Participants in this study appear to value more informal styles, including sharing knowledge with peers and role modelling. This is an important consideration when thinking about how we upskill or maintain the workforce.

From my reading of the literature and relevant policy, it was evident that it was not always clear what people were talking about when discussing PHC for pSMI. It did not seem to be defined anywhere. This thesis provides a conceptualisation of physical healthcare for pSMI from the perspective of MHNs. By asking nurses to conceptualise, it makes their work visible and provides an insight into how MHNs understand physical healthcare for pSMI. This is the first study to address to do so. This is important as, without a clear understanding and even definition of what physical healthcare constitutes for this population, it may result in nurses questioning what exactly they should be focusing on. Consequently, nurses may end up being unable to identify any gaps in their current practice and know what areas require further development. It is likely that without clear policy, nurses will remain unclear about their role. I am unclear how we can critique an area of practice if we do not understand how the people, whose practice is under investigation, understand it in the first place.

Many of the studies in chapter two attempt to measure the attitudes of MHNs to PHC. Over time, it shows that these attitudes are improving and a recent systematic review confirms this (Dickens *et al.*, 2019). This thesis supports this changing view. Indeed, it is evident that MHNs are engaged in physical healthcare and wish to develop this area of their practice but are prohibited from doing so by structural and cultural factors detailed in the findings chapters. MHN practice may be invisible because their PHC practices are bound up with their routine, everyday practice of engaging people via the development and maintenance of therapeutic relationships. This routine nature camouflages the view that MHNs are 'doing' PHC. They appear to be using these skills in order to provide PHC interventions. Making practice visible is essential. As Benner (1984, p.36) argues, when 'expert' clinicians can describe situations in their practice and where their interventions make a difference, then some of the knowledge embedded in the situation becomes visible. It is with this visibility “enhancement and recognition of expertise becomes possible”. This thesis has progressed this aim.

This thesis has also made a methodological contribution. To my knowledge, this is the first study to use sociological theory to explore MHNs’ physical healthcare practices. This thesis therefore presents something new. Additionally, the study has contributed to debates around methods, and in particular the use of space/place in qualitative interviews and the crucial role of transcription.

# 7.6 Implications and recommendations resulting from this study

## 7.6.1 Implications and recommendations for practice

Practice recommendations include the development of ANP roles, increasing MHNs health promotion skills and a more realistic framing of the MHN when it comes to PHC.

There is an emerging evidence base for specialist nursing roles specifically for the physical healthcare needs of pSMI. Some of the evidence for these roles are presented in the literature review chapter of this thesis. Participants in this study saw this as one way of improving patient outcomes as well as being a potential source of support for them. Colleagues in Australia have been ahead in the development of such roles as well as attempting robust evaluation. My Florence Nightingale Foundation scholarship allowed me to visit these services in Australia. These roles are what would be considered Advanced Nurse Practitioner (ANP) scope of practice. There is evidence that such roles can be met with hostility from both within the nursing profession and outside it (Anderson et al., 2020; Fealy et al., 2018). One of the criticisms levelled at advanced practice roles within the profession has been that tasks have been 'shifted' down to nursing staff in order to advantage our medical colleagues (Fealy et al., 2018; Walsh, 2019). Nurses undertaking these roles in Australia were clear they were not meant as a replacement for medical staff to undertake their duties.

Instead, having an ANP for PHC in a MH setting allowed the same person to undertake the required screening, the authority to order and refer to appropriate services but also allow the same person to design and delivery nurse-led interventions, ensuring care did not stop at screening. Such nurses saw themselves as providing holistic patient care as well as having a co-ordinating role and providing support to other professionals. There are many examples of this, including the Bondi Project in Sydney, which is a CMHT-equivalent MDT whose sole focus is on improving the PH of pSMI within their geographical area. In a Scotland context, health boards should consider this approach, including the development of an ANP role-specific to PHC for pSMI within existing teams.

This recommendation is in keeping with those from recent position papers on the global scale of the challenge, with both Firth *et al.,* (2019) and Liu *et al.,* (2017) recognising the role of nurse-led interventions and care coordination approaches in order to deliver on the WHO MRM. Therefore, the findings in this thesis go some way to supporting this by showing there is appetite among MHN for this in practice.

While a lot of existing guidelines have focused on standardised screening, evidence has also shown that screening alone is futile if there is not appropriate interventions. A number of the interventions required are based around lifestyle behaviours. It would be prudent for the Scottish Government to adopt the Public Health England approach and implement *Actions for MHN* (Thomas, 2016). The actions within this document centre around health promotion. While MHN will require some upskilling in terms of knowledge and how to best deliver such interventions, it is clear from this study that MHNs are inclined to this way of thinking. They are perfectly placed with their therapeutic skills to be able to tailor such interventions for this patient group. However, it is also evident that MHNs need to be better at documenting their practice.

There was an inherent lack of mention of sexual health by participants in this study. Only one participant mentioned it, and that was to say they do not deal with it. This is interesting when we consider the increased rates of STIs and HIV infection among pSMI. Sexual health should be viewed similar to any other lifestyle-related behaviour such as weight management, substance use etc. and therefore consideration needs to be given to what role MHN have in this area of practice. Essentially, this may be about empowering MHN to assess sexual health risk and support their patients to access specialist sexual health screening and interventions.

MHNs in this study saw it as their role to support pSMI to access relevant PHC services. This seems realistic and should be encouraged and seen as core to MHN practice. Services need to be realistic about what MHN can and cannot do. It is not realistic for them to deliver a world-class PHC service without any education, CPD or supervision. In short, MHNs cannot be all things to all people all of the time and therefore, this supportive, and advocacy role may be more congruent with their current skill set. This should not be perceived as a lack of skill or incompetence on the part of MHN but instead them being aware of their limitations and scope of practice while ensuring people within their care are still having their health needs addressed. Practice must therefore recognise the vital role MHNs play in supporting people to access services rather than expecting them to deliver interventions which they cannot be reasonably be expected to be competent in.

### 7.6.2 Implications and recommendations for policy

The majority of practice recommendations will not be achieved without strong, robust and transparent policy from both government and individual MH services. It was evident from the participants that they experienced a policy gap. None felt that policy had any significant impact on their practice, and this may be because there is a distinct lack of policy guiding their practice in this area.

The WHO has documented in their MRM that it is not down to one professional group or statutory agency to improve PH outcomes for pSMI. Rather, it requires a 'whole government' approach. While the Scottish Government may appear from the policy review presented in chapter two to be achieving this, the reality is not clear. While it is clear that poor housing and educational attainment have a significant role to play in tackling health inequalities, MH specific strategies need to acknowledge this burden and how they are going to address it. In the Scottish Government’s current MH strategy, they state;

> “Ensure equitable provision of screening programmes, so that the take up of physical health screening amongst people with a mental illness diagnosis is as good as the take-up by people without a mental illness diagnosis” (Scottish Government, 2017: 31).

However, this does not state who is responsible, how it will be achieved and what achievement will look like. The good news is that the wheel does not need to be reinvited and examples of acceptable policy in this area already exist. It is, for this reason, I recommended the adoption of Public Health England's policy above. Indeed, Scotland has already shown international leadership in other public health issues, including suicide and dementia. Arguably, this sort of strategic, long-term approach is needed to improve the situation for pSMI, and a casual mention in a MH policy is not enough.

Similar to the Scottish dementia strategy, good practice already exists. The state of Victoria in Australia has taken this strategic approach, developing a framework for mental health services to follow to improve PHC for pSMI (Department of Health & Human Services, 2019). The framework takes a strategic 'all government' as well as a multidisciplinary approach. It has clearly defined priority areas, and action services need to take. It is designated so each MH 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 one or even five years but rather over a decade to twenty 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.

### 7.6.3 Implications and recommendations for education

As discussed in chapter six, pre-registration education is viewed as the cause and solution to too many problems within nursing practice (Lauder et al., 2008; Watson and Thompson, 2000). Often some of these issues are out with the direct control of nurses in clinical practice as influencing educational policy is more congruent with those occupying strategic roles.

While it is evident that pre-registration education needs to prepare future MHNs to tackle physical health issues, attention needs to be paid to how this is done. Increasing the number of PH skills RMNs are required to be competent in is not in itself going to solve the problem. As discussed previously, competency is ill-defined and misunderstood. One of the main issues is that little thought is given to how nurses maintain their competency post-registration. The NMC’s (2018) latest pre-registration standards list a large number of PH skills that they expect all nurses to be competent in at the point of registration. I believe that unless these skills are taught in an MH-specific context, then they will not be valued. Like any skill, it must be practiced regularly to remain skilled. Therefore, employers need to imagine ways in which RNs in all fields of practice have the opportunity to maintain competency.

It is clear from the findings of this thesis and the wider literature, that nurse education and employers seem very focused on competency. This may be at the expense of developing clinical confidence. While it is clear from the discussion in chapter six that these are not mutually exclusive concepts, it is clear that they share an important relationship. Those in nurse education need to ensure that as well as producing competent learners, we produce confident learners.

There appears to be some discrepancy across undergraduate programmes regarding what content is taught and when relating to relevant PHC topics for MHNs. In this regards, drawing on work by Holloway and Webster (2013) into alcohol education, a similar approach would be beneficial for MH nursing programmes to ascertain what exactly is being taught as well as to account for variance across programmes. This would help identify learning gaps within the current workforce.

It is apparent that the current placement allocation system is not serving all students equally, with too many of the learning opportunities to gain experience around PHC topics being left to chance, depending on the allocation of placements. This is a thorny issue as we need to acknowledge the pressures on placement capacity across programmes and yet the need to educate and produce enough nurses in a short period of time. This pressure has likely contributed very generic learning outcomes and competencies that 'fit' regardless of where a student is allocated. While this may be the reality of the situation, this is not an excuse to do nothing. HEIs and NHS partners should work to have a longer-term view of placement allocation, that ensures a varied placement experience for all students. It is unrealistic always to expect students to reach a level of competency without appropriate exposure and opportunities. Hub and spoke approach might help in providing approach and universities should again work with NHS partners to develop and plan appropriate hub and spoke opportunities for students.

Another issue with the never-ending changing requirements on pre-registration education is that it mostly forgets about the nurses who were subject to the prior standards, with little thought given as to how large sections of the workforce are going to be upskilled so they at a fundamental level, can support students in acquiring the required NMC competencies. Arguably, this is not an issue for pre-registration but an issue of post-registration.

Participants were universal in their critique that there was a lack of CPD opportunities for maintaining knowledge and skills around PHC. It would be prudent for health boards to undertake a training needs analysis of their RN workforce in order to ascertain what training they feel they need with regards to this domain of practice. Such training could then be developed with a specific MH context. Participants who had undertaken some CPD on topics generally found it useful, especially if they could go back into practice and apply it to patients.

The reality of MHN care is that you will not always have patients with specific LTCs present. Therefore it is understandable that staff may not feel confident or competent with specific skills and procedures. This lack of exposure is not necessarily their fault. Arguably, it is immoral to place the full burden of responsibility onto the registrant to maintain competency in knowledge and skills when there is no reasonable avenue to access appropriate learning opportunities. While the regulator has standards for designated post-registration pathways, these are limited to Health Visiting and District Nursing. However, such an approach does little for MHNs who wish to stay working within MH practice.

Obviously getting staff to engage in CPD comes with another set of structural issues such as off duties, work-life balance and staffing levels, which makes it difficult for the employer to release staff for such educational opportunities. However, much like the discourse around degree-level education has moved on from one of expense to one of investment in population health (World Health Organization, 2020), the same must be made for investing in post-registration education. Rather than seeing it as an expense, it must be viewed as a necessary and critical investment in patient safety.

Currently, in Scotland, there is no post-registration provision among the HEIs on PHC specific for pSMI. However, there are numerous examples of such courses existing in programmes within England and the ROI. It would be prudent of the health boards, HEIs and NES to work collaboratively to develop such learning resources. This would serve to upskill those who felt this was a neglected area during their undergraduate education as well as providing CPD for those who wish to refresh key skills.

One approach to overcome these difficulties is to take the opposite approach and develop small-scale teaching programmes known as 'bite-sized' teaching, where staff can refresh knowledge on critical topics. This approach has been applied to PHC topics in MH settings. A recent paper by Bartram *et al.,* (2017) recounts the development of such a programme, which has gained support and funding for learning materials by NHS HEE. Bartram *et al.,* (2017) show that this approach has resulted in a significant increase in practitioner's perceived knowledge of PH issues and that staff found it an effective approach.

As well as its easy implementation, by delivering short, concise sessions at staff handovers, it makes training more accessible and less likely to fall foul of staff shortages. It also has the advantage of providing a ‘little and often’ approach which may be what staff need, so the idea of CPD is built into everyday routines. While this approach does require further evaluation, including long-term outcomes and how staff apply knowledge in practice, it may prove a realistic and cost-effective approach to maintaining and upskilling staff regarding PHC topics.

Not all participants were fully aware of how socioeconomic factors may or may not be influencing their practice. In particular, how they can tailor their interventions based on the circumstances of their patient. While values-based curricula are useful in ensuring we have RMNs practicing in a recovery-orientated and person-centred way, unless we provide future RNs with clear interventions about how they can tackle inequalities and challenge discrimination, then nurses may continue to feel disempowered. I would argue that the teaching of values without concrete interventions is problematic. Therefore, the role of sociological concepts within undergraduate curricula need to be given further consideration and in particular, making the links between health and socioeconomic factors more explicit. This is pertinent in light of the recent Marmot review, which found that inequalities are increasing (Marmot et al., 2020).

### 7.6.4 Implications and recommendations for research

It is clear from the data presented in this thesis PHC comes with emotional labour for MHNs. Therefore, further research drawing on the work of Hochschild (1983) and Smith (2011) may be helpful again in highlighting the realities of MHN practice.

There is a growing debate and acknowledgement within the current global literature and policy that the poor PH of pSMI is a human rights issue. While some participants discussed the challenges of working with people subject to compulsory statutory measures, there was a sense that providing PH interventions created a conflict, when the same participants discussed the need to be recovery-orientated and accepting people's autonomy. Therefore further research in this area would be helpful to understand how nurses make sense of the specific ethical strife associated with this area of practice.

Despite the NMC reviewing their educational standards every half a decade, there is very little evaluation of the impact this has on patient outcomes. This is important as the latest edition, with a detailed skills annexe appears to be a notable increase and shift in how they regulate education programmes. Research should be conducted to see the long-term impact of MHNs having these skills at the point of registration and on patient outcomes. Additionally, any further educational interventions should consider methods beyond pre-/post- tests and instead should consider how knowledge transfers into practice. In both these regards, a realist evaluation approach would be appropriate in finding how what is working, for whom and when.

It is clear that competence and confidence have a complex relationship. While several studies have measured attitudes and training needs, few have applied measures of confidence to this topic. Further research could draw on Holloway *et al.* work, cited in earlier chapters to explore links between confidence, competence and attitudes, particularly across different settings and countries. The year 2020 has seen the publication of the first *Global State of Nursing Report* by WHO (2020). This provides us with an extensive data set about the global nursing workforce. We also have a large data set available via the WHO mental health atlas. It would be worth exploring links across these datasets and if there are any links between patient outcomes and the nursing workforce related to PH for pSMI.

As we have seen during COVID-19 crisis, that often research reported to be multidisciplinary, does not contain any nurses (Brennan, 2020), despite being approx. 60% of the global workforce. This does not serve patients well and may be a waste of precious research funding to not have members from the largest professional grouping, with the most direct care for pSMI on the research team. Nurses have a role to play in delivering the interventions likely to improve outcomes. It would be prudent that researchers involve MHN and research-active MHN get involved in shaping the research agenda. This will mean collaborating and building networks across interdisciplinary boundaries. Indeed, it is acknowledged that for a real improvement in patient outcomes, it will take a multi-intervention approach (Firth et al., 2019) and that will require a multi-method and interdisciplinary approach.

In this regards, it would be helpful to develop research that further explores the boundaries between different professional groups but also different settings such as primary and secondary care. They may involve further qualitative research with other practitioners such as GPs, occupational therapists and psychiatrists to see if some of the same organisational and structural barriers impact on their roles.

While I assumed that participants were not doing physical healthcare or that they would not see the point of my study. As a result, I did not expect them to be as enthusiastic as I found them. I never considered the possibility that MHN might be experts in providing physical healthcare in a manner that is person-centred and sensitive and relative to the person's mental state and circumstance. Therefore, future research may focus on exploring how MHN develop expertise in this area. Replicating Benner's methodology may be helpful in this regards, but it may be difficult to get nurses of various stages to discuss the same clinical examples. However, drawing on and building upon the research approach that Allen (Allen, 2018; Allen and May, 2017) developed for her study exploring nursing work in an acute setting may overcome this. In particular, work that sets to test her translational mobilisation theory may be particularly pertinent as it would help to describe, identify and explain complex organisational contexts and how they are applied to nursing roles.

## 7.7 Reflection on the process

This topic has been with me a very long time. The ideas and questions for this study developed from work I undertook as a masters student. During this time, I was fortunate to undertake a clinical research attachment within a NRS-funded research network, where I was exposed to a variety of large-scale cohort and intervention studies. I was hooked, and with that, I enthusiastically ran back to my supervisor with my excitement of developing an intervention study. My supervisor rightly pointed out that there were too many unknowns within the existing literature. There were still too many how's and why's unanswered that now I cannot even recall what intervention I had in mind. I soon learned that unless I knew the how and why, in other words, the social context, my intervention would be pointless. It was for this reason that I ultimately became attracted to qualitative research.

Key advice offered to me when undertaking this study was to make the theoretical lenses offered by Bourdieu to 'work' for me but without letting it dictate too much. Some may argue that presenting the previous two chapters based around his key concepts of 'field' and 'capital' means I did not heed the advice. I would disagree and state that when it came to analysing the data, the development of themes, it felt natural that this is the story the data was telling. Bourdieu has always been there since this study was conceptualised. My desire to understand the inner workings and mechanisms, the social context and processes made his writings very insightful, albeit unwieldy.

While, *au fait* with Benner's work, she only really took prominence towards the later stages. On reflection, I should have familiarised myself with her work much sooner. One of the greatest pleasures this PhD afforded was having the excuse to read and consume her *Novice to Expert* book. Benner and Bourdieu have some similarities. Both have the aim of uncovering social processes at play which may appear invisible. It is clear from the data presented across both these findings chapter that MHN practice regarding physical healthcare is often invisible. Indeed, Benner (1984, p2) has stated that the failure of nursing to document "practices and clinical observations has deprived nursing theory of the uniqueness and richness of knowledge embedded in expert clinical practice". She goes onto argue that when 'expert' clinicians can describe situations in their practice and where their interventions make a difference, then some of the knowledge embedded in the situation becomes visible. It is with this visibility “enhancement and recognition of expertise becomes possible” (p.36). I feel this study makes a contribution in this regards as it has made an element of MHN practice that is often poorly misunderstood, visible. It has provided a space for nurses to talk about and reflect on their practice and by doing so contributes to clinical knowledge development.

One of my key reflections and observations from the whole process is the importance of asking people to share their experiences. I feel it is a potent tool in making invisible processes come to light. Several participants reflected to me that they enjoyed the process of being interviewed, and it encouraged them to reflect more on their nursing practice with regards to physical healthcare for pSMI. It was delightful interviewing people who, at first struggled to think of examples, to moving to a position of giving me many instances of good practice that they were doing every day in a short space of time within the interview. This is not to mention the critical insights and deep reflections provided in some cases.

What I was most surprised about was the emotional element to the data. My first reading of the interview transcripts, I was taken aback about how much emotion was on the page. This may not be so surprising when we consider the large body of work around nurses' managing their emotions and the emotional labour of caring. I did not expect it to be so prominent regarding this topic. If I had suspected that this was going to be the case, I would have drawn on Hochshild (1983) and Smith's (2011) work for the analysis. However, this would not have told the whole story and may not have achieved the study's aims in their entirety.

One of the reasons why there appears to be an emotional edge to the data is because the nurses interviewed for this study all held positive attitudes to this area of practice. I expected to be met with retorts of 'This is not my job', but nothing could have been further from the truth. Having read the existing literature, I was perhaps coloured by this view and made presumptions on what I might find out. Instead, all the nurses in this study felt that physical healthcare was their role and important consideration in their practice. Indeed, many of the participants came across as passionate about it, and this may explain why their words were tinged with such emotion. In this regards, this finding is congruent with Dickens *et al.,* (2019) systematic review which found that quantitative measures of attitudes are showing improvement in this domain of practice.

## 7.8 Concluding remarks

This thesis has been with me for a long time and was born out of my own educational and practice experiences as a mental health nurse. I have outlined my personal motivations for undertaking this research in chapter 1 as well as some of the policy context for why pSMI and PH is important. I then outlined a policy review as well as empirical research which highlighted some of the key issues. This led to me identifying a gap and subsequently developing questions that tried to find out how structural and organisational factors as well as educational experiences and competencies impact on MHN practice when it comes to PHC. I outlined my approach to this study; namely a qualitative design informed by Bourdieu's theory of practice and thematic analysis. The two findings chapters that follow are my attempt to answer the research questions, with a chapter outlining the field and the second detailing the capital within the field. It is the complex interplay between these two concepts which help reveal MHN PHC habitus, but also show that indeed, structural and organisational factors impact on MHN practice. This is usually not in a positive manner. It is evident that MHNs use therapeutic relationships in order to provide PHC. I then discuss how knowledge gained pre- and post-registration as well as confidence are forms of capital that MHNs use to operate within the field.

This is the final chapter of this thesis. I have presented a summary of the findings before reflecting on the limitations. I have presented recommendations for practice, education, policy and research. The chapter concludes with me reflecting on the research journey.

# References

Abbott AD (1988) *The System of Professions : An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.

Academic and Clinical Central Office for Research & Development (ACCORD) (2014) Research & Development Approvals. Edinburgh: University of Edinburgh & NHS Lothian. Available at: http://www.accord.ed.ac.uk/routemaps/approvals.html.

Academy of Medical Royal Colleges (2016) *Improving the physical health of adults with severe mental illness: essential actions*. London. Available at: http://www.rcpsych.ac.uk/publications/.

Alderson HL and Lawrie SM (2015) Does cigarette smoking cause psychosis? *The Lancet Psychiatry*. Elsevier Ltd. DOI: 10.1016/S2215-0366(15)00239-4.

Aléx L and Hammarström A (2008) Shift in power during an interview situation: methodological reflections inspired by Foucault and Bourdieu. *Nursing Inquiry* 15(2): 169–176. DOI: 10.1111/j.1440-1800.2008.00398.x.

Allen D (2014) *The Invisible Work of Nurses: Hospitals, Organisation and Healthcare*. Taylor and Francis Inc. DOI: 10.4324/9781315857794.

Allen D (2018) Translational Mobilisation Theory: A new paradigm for understanding the organisational elements of nursing work. *International Journal of Nursing Studies* 79: 36–42. DOI: https://doi.org/10.1016/j.ijnurstu.2017.10.010.

Allen D and May C (2017) Organizing Practice and Practicing Organization: An Outline of Translational Mobilization Theory. *SAGE Open* 7(2): 215824401770799. DOI: 10.1177/2158244017707993.

Allmark P, Boote J, Chambers E, et al. (2009) Ethical issues in the use of in-depth interviews: literature review and discussion. *Research Ethics Review* 5(2). article. The Association of Research Ethics Committees: 48–54.

Altschul AT (1972) *Patient-Nurse Interaction : A Study of Interaction Patterns in Acute Psychiatric Wards*. University of Edinburgh. Department of Nursing Studies Monograph ; no. 3, book. Edinburgh: Churchill Livingstone.

Anderson H, Birks Y and Adamson J (2020) Exploring the relationship between nursing identity and advanced nursing practice: An ethnographic study. *Journal of Clinical Nursing* 29(7–8). Blackwell Publishing Ltd: 1195–1208. DOI: 10.1111/jocn.15155.

Andrews GJ (2002) Towards a more place-sensitive nursing research: an invitation to medical and health geography. *Nursing Inquiry* 9(4). John Wiley & Sons, Ltd: 221–238. DOI: 10.1046/j.1440-1800.2002.00157.x.

Bandura A (1997) *Self-Efficacy : The Exercise of Control*. book. New York: W.H. Freeman.

Bandura A (2004) Health Promotion by Social Cognitive Means. *Health Education & Behavior* 31(2): 143–164. DOI: 10.1177/1090198104263660.

Bargagliotti T, Luttrell M and Lenburg CB (1999) Reducing threats to the implementation of a competency-based performance assessment system. *Online journal of issues in nursing* 4(2). article.

Bartels SJ and DiMilia P (2017) Why serious mental illness should be designated a health disparity and the paradox of ethnicity. *The lancet. Psychiatry* 4(5). Elsevier: 351–352. DOI: 10.1016/S2215-0366(17)30111-6.

Bartram R, Dias R, Thompson S, et al. (2017) Bitesized teaching: Delivering knowledge of physical health issues in mental health settings. *British Journal of Mental Health Nursing* 6(6): 265–271. DOI: 10.12968/bjmh.2017.6.6.265.

Bassnett S (2002) *Translation Studies*. London: Routledge.

Benner P (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing*. Menlo Park, CA: Addison-Wesley Publishing.

Biddle L, Cooper J, Owen-Smith A, et al. (2013) Qualitative interviewing with vulnerable populations: Individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders* 145(3): 356–362. DOI: 10.1016/j.jad.2012.08.024.

Björk Brämberg E, Torgerson J, Norman Kjellström A, et al. (2018) Access to primary and specialized somatic health care for persons with severe mental illness: A qualitative study of perceived barriers and facilitators in Swedish health care. *BMC Family Practice* 19(1). BioMed Central Ltd. DOI: 10.1186/s12875-017-0687-0.

Blaikie N (2000) *Designing Social Research : The Logic of Anticipation*. book. Malden, Mass.: Polity Press.

Blakeman P and Ford L (2012) Working in the real world: a review of sociological concepts of health and well-being and their relation to modern mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 19(6). John Wiley & Sons, Ltd: 482–491. DOI: 10.1111/j.1365-2850.2011.01818.x.

Blank MB, Himelhoch S, Walkup J, et al. (2013) Treatment considerations for HIV-infected individuals with severe mental illness. *Current HIV/AIDS reports* 10(4). NIH Public Access: 371–9. DOI: 10.1007/s11904-013-0179-3.

Blythe J and White J (2012) Role of the mental health nurse towards physical health care in serious mental illness: An integrative review of 10 years of UK Literature. *International Journal of Mental Health Nursing* 21(3): 193–201. DOI: 10.1111/j.1447-0349.2011.00792.x.

Bourdieu P (1971) Systems of education and systems of thought. *International social science journal* 19(3). article. Paris: Unesco: 338–358.

Bourdieu P (1977) *Outline of a Theory of Practice*. Cambridge University Press.

Bourdieu P (1984) *Distinction : A Social Critique of the Judgement of Taste*. book. London: Routledge & Kegan Paul.

Bourdieu P (1990) *The Logic of Practice*. Cambridge: Polity.

Bourdieu P (1992a) *An Invitation to Reflexive Sociology* (LJD Wacquanted. ). book. Oxford: Polity Press.

Bourdieu P (1992b) Authorized Language: The Social Conditions for the Effectiveness of Ritual Discourse. In: Thompson J (ed.) *Language & Symbolic Power*. Cambridge: Polity Press, pp. 107–116.

Bourdieu P (1992c) On Symbolic Power. In: Thompson J (ed.) *Language & Symbolic Power*. Cambridge: Polity Press, pp. 163–170.

Bourdieu P (1992d) Rites of Institutions. In: Thompson J (ed.) *Language & Symbolic Power*. Cambridge: Polity Press, pp. 117–126.

Bourdieu P (1992e) The Production and Reproduction of Legitimate Language. In: Thompson J (ed.) *Language & Symbolic Power*. Cambridge: Polity Press, pp. 37–42.

Bourdieu P (1993) *The Field of Cultural Production : Essays on Art and Literature* (R Johnsoned. ). book. Cambridge: Polity Press.

Bourdieu P (2006) The Forms of Capital. In: Lauder H (ed.) *Education, Globalization, and Social Change*. book. Oxford, [England] ; New York, N.Y.: Oxford University Press.

Bourdieu P and Eagleton T (1992) Doxa and common life. *New Left review* (191). article. London: New Left Review Ltd: 111-undefined.

Bourdieu P and Wacquant L (2013) Symbolic capital and social classes. *Journal of classical sociology : JCS* 13(2). article. London, England: SAGE Publications: 292–302. DOI: 10.1177/1468795X12468736.

Bourne AH and Robson MA (2015) Participants' reflections on being interviewed about risk and sexual behaviour: implications for collection of qualitative data on sensitive topics. *International Journal of Social Research Methodology* 18(1). Routledge: 105–116. DOI: 10.1080/13645579.2013.860747.

Bovens M (2006) *Analysing and assessing public accountability. European governance papers (EUROGOV)*. Available at: http://www.connex-network.org/eurogov/pdf/egp-connex-C-06-01.pdf.

Bowers L (2006) On conflict, containment and the relationship between them. *Nursing Inquiry* 13(3). Australia: Blackwell Science: 172–180. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=16918784&site=ehost-live.

Bradstreet S (2013) Aren't we all patients – just not all the time? Scottish Recovery Network. Available at: https://www.scottishrecovery.net/resource/arent-we-all-patients-just-some-of-the-time/ (accessed 18 October 2020).

Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101. DOI: 10.1191/1478088706qp063oa.

Braun V and Clarke V (2014) What can 'thematic analysis' offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*. Co-Action Publishing. DOI: 10.3402/qhw.v9.26152.

Braun V and Clarke V (2016) (Mis)conceptualising themes, thematic analysis, and other problems with Fugard and Potts' (2015) sample-size tool for thematic analysis. *International Journal of Social Research Methodology*. Routledge. DOI: 10.1080/13645579.2016.1195588.

Braun V and Clarke V (2019a) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*. Routledge. DOI: 10.1080/2159676X.2019.1628806.

Braun V and Clarke V (2019b) To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*. Routledge. DOI: 10.1080/2159676X.2019.1704846.

Brennan GK (2020) Multidisciplinary research priorities for the COVID-19 pandemic. *The Lancet Psychiatry* 7(7). Elsevier Ltd: e41. DOI: 10.1016/S2215-0366(20)30226-1.

Bressington D, Mui J, Wells H, et al. (2016) Refocusing on physical health: Community psychiatric nurses' perceptions of using enhanced health checks for people with severe mental illness. *International Journal of Mental Health Nursing* 25(3). Blackwell Publishing: 214–224. DOI: 10.1111/inm.12195.

Bressington D, Badnapurkar A, Inoue S, et al. (2018) Physical health care for people with severe mental illness: The attitudes, practices, and training needs of nurses in three asian countries. *International Journal of Environmental Research and Public Health* 15(2). MDPI AG. DOI: 10.3390/ijerph15020343.

Brown S, Kim M, Mitchell C, et al. (2010) Twenty-five year mortality of a community cohort with schizophrenia. *British Journal of Psychiatry* 196(2). Cambridge

University Press: 116–121. DOI: 10.1192/bjp.bp.109.067512.

Brown T, McKenna B and Furness T (2018) Impact of a nurse practitioner role on metabolic monitoring completion and referrals for consumers admitted to the intensive care area of an acute inpatient psychiatric unit. *International Journal of Mental Health Nursing* 27(1). Blackwell Publishing: 341–348. DOI: 10.1111/inm.12327.

Browne G, Hurley J and Lakeman R (2015) Mental health nursing: what difference does it make? *Journal of psychiatric and mental health nursing* 21(6). article. England: Wiley Subscription Services, Inc: 558–563. DOI: 10.1111/jpm.12162.

Buchanan-Barker P and Barker P (2005) Observation: the original sin of mental health nursing? *Journal Of Psychiatric And Mental Health Nursing* 12(5). Blackwell Science Ltd: 541–549. DOI: 10.1111/j.1365-2850.2005.00876.x.

Bucholtz M (2000) The politics of transcription. *Journal of Pragmatics* 32: 1439–1465. Available at: www.elsevier.nl/locate/pragma.

Butler J (1990) *Gender Trouble : Feminism and the Subversion of Identity*. New York: Routledge.

Campbell J and Leathard H (2000) Nurses' Knowledge of Biological and Related Science. *Nursing Times Research* 5(5): 372–380.

Campos LN, Guimarães MDC and Remien RH (2010) Anxiety and depression symptoms as risk factors for non-adherence to antiretroviral therapy in Brazil. *AIDS and Behavior* 14(2). NIH Public Access: 289–299. DOI: 10.1007/s10461-008-9435-8.

Carlisle C (2000) Reflecting on levels of confidence and competence in skills acquisition. *Medical Education* 34(11). John Wiley & Sons, Ltd: 886–887. DOI: 10.1046/j.1365-2923.2000.00826.x.

Carr-Saunders AM and Wilson PA (1933) *The Professions* . Oxford: Clarendon Press. Available at: https://books.google.co.uk/books/about/The_Professions.html?id=OaorAQAAMAAJ&redir_esc=y (accessed 19 November 2020).

Carter M (2014) Vocation and altruism in nursing. *Nursing Ethics* 21(6): 695–706. DOI: 10.1177/0969733013516159.

Casey D and Hansen T (2003) Chapter 2: Excessive Mortality and Morbidity Associated with Schizophrenia. In: Meyer J and Nasrallah H (eds) *Medical Illness and Schizophrenia*. American Psychiatric Pub. Available at: https://books.google.co.uk/books?hl=en&lr=&id=rRlP3gQ_oWcC&oi=fnd&pg=PA17&dq=Casey+and+Hanson+2003+lung+cancer+mental+illness&ots=JcjyjDqAQx&sig=7m1DcEdNvEt-19IenbfDao6ax6c#v=onepage&q&f=false (accessed 18 October 2020).

Castells M (2010) *The Power of Identity*. 2nd edition / wit... Castells, Manuel, 1942- Information age ; v. 2, book. Malden, Mass.: Wiley-Blackwell.

Çelik Ince S, Partlak Günüşen N and Serçe Ö (2019) Perception of physical health by patients with severe mental illness and their family caregivers: A qualitative study. *Perspectives in Psychiatric Care* 55(4): 718–727. DOI: 10.1111/ppc.12416.

Chadwick A, Street C, McAndrew S, et al. (2012) Minding our own bodies: Reviewing the literature regarding the perceptions of service users diagnosed with serious mental illness on barriers to accessing physical health care. *International Journal of Mental Health Nursing* 21(3): 211–219. DOI: 10.1111/j.1447-0349.2011.00807.x.

Charmaz K (2014a) Focused Coding and Beyond. In: *Constructing Grounded Theory*. London: SAGE Publications.

Charmaz K (2014b) The Logic of Grounded Theory Coding Practices and Initial Coding. In: *Constructing Grounded Theory*. London: SAGE Publications, pp. 109–137.

Chassin MR, Loeb JM, Schmaltz SP, et al. (2010) Accountability Measures — Using Measurement to Promote Quality Improvement. *New England Journal of Medicine* 363(7). Massachusetts Medical Society: 683–688. DOI: 10.1056/nejmsb1002320.

Christmas D (2013) Should patients be patients? Scottish Recovery Network. Available at: https://www.scottishrecovery.net/resource/should-patients-be-patients/ (accessed 18 October 2020).

Chu S, Lambert K and Baker A (2020) What to look for during constant observations: Expert consensus and a tool for observations recording. *Journal of Psychiatric and Mental Health Nursing* 27(1). Blackwell Publishing Ltd: 77–86. DOI: 10.1111/jpm.12555.

Clancy L and Happell B (2014) Tensions of difference: Reconciling organisational imperatives for risk management with consumer-focused care from the perspectives of clinicians and managers. *Journal of Clinical Nursing* 23(21–22). Blackwell Publishing Ltd: 3177–3187. DOI: 10.1111/jocn.12564.

Clarke V and Braun V (2013a) *Successful Qualitative Research : A Practical Guide for Beginners*. London: SAGE.

Clarke V and Braun V (2013b) Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *Sexuality Studies* 26(2): 120–123.

Clarke V and Braun V (2018) Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research* 18(2). Wiley Blackwell: 107–110. DOI: 10.1002/capr.12165.

Clifton A, Repper J, Banks D, et al. (2013) Co-producing social inclusion: The structure/agency conundrum. *Journal of Psychiatric and Mental Health Nursing* 20(6): 514–524. DOI: 10.1111/j.1365-2850.2012.01953.x.

Coffey M, Cohen R, Faulkner A, et al. (2017) Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations* 20(3). Blackwell Publishing Ltd: 471–483. DOI: 10.1111/hex.12474.

Cole-King A and Lepping P (2010) Suicide mitigation: Time for a more realistic approach. *British Journal of General Practice* 60(570). British Journal of General Practice: 3–4. DOI: 10.3399/bjgp10X482022.

Collins E, Tranter S and Irvine F (2012) The physical health of the seriously mentally ill: an overview of the literature. *Journal of Psychiatric & Mental Health Nursing* 19(7): 638–646. DOI: 10.1111/j.1365-2850.2011.01831.x.

Conlon MMM, Bush CJ, Ariyaratnam MI, et al. (2015) Exploring the compatibility of mental health nursing, recovery-focused practice and the welfare state. *Journal Of Psychiatric And Mental Health Nursing* 22(5): 337–343. DOI: 10.1111/jpm.12222.

Cooney A (2011) Rigour and grounded theory. *Nurse Researcher* 18(4): 17–22. DOI: 10.7748/nr2011.07.18.4.17.c8631.

Coyle A and Wright C (1996) Using the counselling interview to collect research data on sensitive topics. *Journal of Health Psychology* 1(4). SAGE Publications Ltd: 431–440. DOI: 10.1177/135910539600100402.

Craig T (2006) Severe mental illness: symptoms, signs and diagnosis. In: Gamble C and Brennan G (eds) *Working with Serious Mental Illness: A Manual for Clinical Practice*. 2nd ed. Edinburgh: Elsevier, pp. 85–110.

Cribb A (2003) Approaching qualitative research. In: Eckstein S (ed.) *Manual for Research Ethics Committees*. Cambridge: Cambridge University Press, pp. 40–48. DOI: 10.1017/CBO9780511550089.009.

Crotty M (1998) *The Foundations of Social Research : Meaning and Perspective in the Research Process*. book. London: SAGE.

Crouch M and McKenzie H (2006) The logic of small samples in interview-based qualitative research. *Social Science Information* 45(4): 483–499. DOI: 10.1177/0539018406069584.

Crowe M (1998) The power of the word: some post-structural considerations of qualitative approaches in nursing research. *Journal of advanced nursing* 28(2). article. Oxford, UK: Blackwell Science Ltd: 339–344. DOI: 10.1046/j.1365-2648.1998.00780.x.

Crowe S and Deane F (2018) Characteristics of mental health recovery model implementation and managers' and clinicians' risk aversion. *Journal of Mental Health Training, Education and Practice* 13(1). Emerald Group Publishing Ltd.: 22–33. DOI: 10.1108/JMHTEP-05-2017-0039.

Cunningham C, Peters K and Mannix J (2013) Physical Health Inequities in People with Severe Mental Illness: Identifying Initiatives for Practice Change. *Issues in Mental Health Nursing* 34(12): 855–862. DOI: 10.3109/01612840.2013.832826.

Cutcliffe JR, Stevenson C, Jackson S, et al. (2006) A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies* 43(7): 791–802. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2009278938&site=ehost-live.

De Hert M, Correll CU, Bobes J, et al. (2011) Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. Blackwell Publishing Ltd. DOI: 10.1002/j.2051-5545.2011.tb00014.x.

de Mey L, Çömlekçi C, de Reuver F, et al. (2016) Oral Hygiene in Patients With Severe Mental Illness: A Pilot Study on the Collaboration Between Oral Hygienists and Mental Health Nurses. *Perspectives in psychiatric care* 52(3). Blackwell Publishing Inc.: 194–200. DOI: 10.1111/ppc.12117.

De Santis M., Myrick H, Lamis D., et al. (2015) Erratum: Suicide-specific Safety in the Inpatient Psychiatric Unit (Issues in Mental Health Nursing Volume 36, Issue 3, (pages 190-199)) DOI: 10.3109/01612840.2014.961625. *Issues in mental health nursing* 36(4). article: 315. DOI: 10.3109/01612840.2015.1050336.

Deer C (2012) Reflexivity. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge.

Denzin NK (2001) The reflexive interview and a performative social science. *Qualitative research : QR* 1(1). article. Thousand Oaks, CA: SAGE Publications: 23–46. DOI: 10.1177/146879410100100102.

Department of Health & Human Services (2019) *Equally Well in Victoria: Physical health framework for specialist mental health services*. Melbourne, Australia.

Department of Health England (1998) *A first class service: quality in the new NHS*. London. Available at: https://webarchive.nationalarchives.gov.uk/20110322225724/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902 (accessed 19 November 2020).

Department of Health England (1999) *Making a Difference: Strengthening the Nursing and Midwifery Contribution to Health and Health Care*. London.

Department of Health England (2006) *Chief Nursing Officer's Review of Mental Health Nursing*. London.

Department of Health ROI (2006) *A Vision for change: Report of the expert group on mental health policy*. Dublin: Stationery Office.

Department of Health South Africia (2013) *Draft Mental Health Policy Framework for*

*South Africa and Strategic Plan 2013-2020.*

Department of Work and Pensions (2007) Disability Rights Commission Annual Report and Accounts April-Sep 2007.

DeSantis L and Ugarriza DN (2000) The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research* 22(3): 351–372. DOI: 10.1177/019394590002200308.

Dickens GL, Ion R, Waters C, et al. (2019) Mental health nurses' attitudes, experience, and knowledge regarding routine physical healthcare: Systematic, integrative review of studies involving 7,549 nurses working in mental health settings. *BMC Nursing* 18(1). BioMed Central Ltd.: 16. DOI: 10.1186/s12912-019-0339-x.

Doherty AM and Gaughran F (2014) The interface of physical and mental health. *Social Psychiatry & Psychiatric Epidemiology* 49(5): 673–682. DOI: 10.1007/s00127-014-0847-7.

Doody O and Noonan M (2013) Preparing and conducting interviews to collect data. *Nurse researcher* 20(5): 28–32. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23687846 (accessed 31 March 2017).

Drach-Zahavy A, Leonenko M and Srulovici E (2018) Towards a measure of accountability in nursing: A three-stage validation study. *Journal of Advanced Nursing* 74(10). Blackwell Publishing Ltd: 2450–2464. DOI: 10.1111/jan.13735.

Durkheim E (1893) *The Division of Labour in Society*. Contemporary social theory, book. Basingstoke: Macmillan.

Dyer JG and McGuinness TM (2008) Reducing HIV risk among people with serious mental illness. *Journal of Psychosocial Nursing and Mental Health Services*. Slack Incorporated. DOI: 10.3928/02793695-20080401-06.

Elliott L and Masters H (2009) Mental health inequalities and mental health nursing. *Journal of Psychiatric & Mental Health Nursing* 16(8): 762–771. DOI: 10.1111/j.1365-2850.2009.01453.x.

Elmir R, Schmied V, Jackson D, et al. (2011) Interviewing people about potentially sensitive topics. *Nurse Researcher* 19(1). RCN Publishing Company Ltd.: 12–16. DOI: 10.7748/nr2011.10.19.1.12.c8766.

Elwood SA and Martin DG (2000) 'Placing' Interviews: Location and Scales of Power in Qualitative Research. *Professional Geographer* 52(4): 649–657.

Entwistle N (1981) *Styles of Learning and Teaching: An Integrated Outline of Educational Psychology for Students, Teachers, and Lecturers.* Chichester: John Wiley & Sons Ltd.

Ezell JM, Cabassa LJ and Siantz E (2013) Contours of Usual Care: Meeting the Medical Needs of Diverse People with Serious Mental Illness. *Journal of Health Care for the*

*Poor & Underserved* 24(4): 1552–1573. DOI: 10.1353/hpu.2013.0158.

Farrand P, McMullan M, Jowett R, et al. (2006) Implementing competency recommendations into pre-registration nursing curricula: Effects upon levels of confidence in clinical skills. *Nurse Education Today* 26(2). Churchill Livingstone: 97–103. DOI: 10.1016/j.nedt.2005.06.002.

Fealy GM, Casey M, O'Leary DF, et al. (2018) Developing and sustaining specialist and advanced practice roles in nursing and midwifery: A discourse on enablers and barriers. *Journal of Clinical Nursing* 27(19–20). Blackwell Publishing Ltd: 3797–3809. DOI: 10.1111/jocn.14550.

Federal Ministry for Health Nigeria (2013) *National Policy for Mental Health Services Delivery in Nigeria*. Lagos.

Felton A and Wright N (2018) Mental health practice: a risky business? *Journal of Mental Health Training, Education and Practice* 13(1). Emerald Group Publishing Ltd.: 1–2. DOI: 10.1108/JMHTEP-11-2017-0061.

Felton A, Repper J and Avis M (2018) The construction of people with mental health problems as risk objects: Findings of a case study inquiry. *Journal of psychiatric and mental health nursing* 25(9–10). article: 558. DOI: 10.1111/jpm.12501.

Finlay L (2003) The Reflexive Journey: Mapping Multiple Routes. In: *Reflexivity*. Oxford, UK: Blackwell Science Ltd, pp. 3–20. DOI: 10.1002/9780470776094.ch1.

Firth J, Siddiqi N, Koyanagi A, et al. (2019) The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *The Lancet Psychiatry* 6(8). Elsevier BV: 675–712. DOI: 10.1016/s2215-0366(19)30132-4.

Flick U (2014) *The SAGE Handbook of Qualitative Data Analysis*. 1 Oliver's Yard, 55 City Road, London EC1Y 1SP United Kingdom : SAGE Publications Ltd. DOI: 10.4135/9781446282243.

Flick U (2018) *The SAGE Handbook of Qualitative Data Collection*. 1 Oliver's Yard, 55 City Road London EC1Y 1SP : SAGE Publications Ltd. DOI: 10.4135/9781526416070.

Foucault M (1975) *Surveiller et punir : naissance de la prison*. Bibliothèque des histoires, book. Paris]: Gallimard.

Franks V (2004) Evidence-based uncertainty in mental health nursing. *Journal of Psychiatric & Mental Health Nursing* 11(1). Wiley-Blackwell: 99–105. DOI: 10.1111/j.1365-2850.2004.00694.x.

Freidson E (1970) *Profession of Medicine : A Study of the Sociology of Applied Knowledge*. book. New York: Harper & Row : Dodd Mead.

Friedli L (2009) *Mental Health, Resilience and Inequalities*. Copenhagen: World Health Organization. Available at:

http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf (accessed 31 March 2017).

Fulbrook P, Rolfe G, Albarran J, et al. (2000) Fit for practice: Project 2000 student nurses' views on how well the curriculum prepares them for clinical practice. *Nurse Education Today* 20(5): 350–357. DOI: 10.1054/nedt.2000.0479.

Furness T, Giandinoto J, Wordie-Thompson E, et al. (2019) Improving physical health outcomes for people with severe mental illness: A proof-of-concept study of nurse practitioner candidate practice. *International Journal of Mental Health Nursing*. Blackwell Publishing: inm.12680. DOI: 10.1111/inm.12680.

Gagnon M, Jacob JD and McCabe J (2015) Locating the qualitative interview: reflecting on space and place in nursing research. *Journal of Research in Nursing* 20(3). SAGE Publications Ltd: 203–215. DOI: 10.1177/1744987114536571.

Gallagher J (2015) Smoking 'may play schizophrenia role' - BBC News. Available at: https://www.bbc.co.uk/news/health-33464480 (accessed 18 October 2020).

Gavin H (2012) Thematic Analysis. In: *Understanding Research Methods and Statistics in Psychology*. London: SAGE Publications Ltd. DOI: 10.4135/9781446214565.

Gee JP (2014) *An Introduction to Discourse Analysis: Theory and Method*. Fourth edition.. book. Abingdon, Oxon ; New York: Routledge.

General Medical Council (2013) *Good medical practice* . London. Available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice (accessed 28 October 2020).

Gerace A and Muir-Cochrane E (2019) Perceptions of nurses working with psychiatric consumers regarding the elimination of seclusion and restraint in psychiatric inpatient settings and emergency departments: An Australian survey. *International Journal of Mental Health Nursing* 28(1). Blackwell Publishing: 209–225. DOI: 10.1111/inm.12522.

Gibson W and Brown A (2009) *Working with Qualitative Data*. 1 Oliver's Yard, 55 City Road, London England EC1Y 1SP United Kingdom : SAGE Publications, Ltd. DOI: 10.4135/9780857029041.

Goffman E (1959) *The Presentation of Self in Everyday Life*. London: Penguin.

Government of British Columbia (2017) *British Columbia's Mental Health and Substance Use Strategy 2017-2020*. Victortia BC.

Government of South Australia (2010) *South Australia's Mental Health and Wellbeing Policy 2010-2015*. Adelaide.

Gray R (2012) Physical health and mental illness: A silent scandal. *International Journal of Mental Health Nursing* 21(3): 191–192. DOI: 10.1111/j.1447-0349.2012.00832.x.

Gray R and Brown E (2017) What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis. *International Journal of Mental Health Nursing* 26(1). Blackwell Publishing: 32–40. DOI: 10.1111/inm.12296.

Grenfell M (2012a) Introduction. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge.

Grenfell M (2012b) Methodology. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge.

Gronholm PC, Onagbesan O and Gardner-Sood P (2017) Care coordinator views and experiences of physical health monitoring in clients with severe mental illness: A qualitative study. *International Journal of Social Psychiatry* 63(7). SAGE Publications Ltd: 580–588. DOI: 10.1177/0020764017723939.

Grotto J, Gerace A, O'Kane D, et al. (2015) Risk assessment and absconding: perceptions, understandings and responses of mental health nurses. *Journal of Clinical Nursing* 24(5–6). Blackwell Publishing Ltd: 855–865. DOI: 10.1111/jocn.12671.

Guba EG and Lincoln YS (1998) Competing paradigms in qualitative research. In: Denzin N and Lincoln Y (eds) *The Landscape of Qualitative Research: Theories and Issues*. Thousand Oaks, CA: Sage Publications, pp. 195–220.

Guest G, MacQueen K and Namey E (2012) *Applied Thematic Analysis*. 2455 Teller Road, Thousand Oaks California 91320 United States : SAGE Publications, Inc. DOI: 10.4135/9781483384436.

Gurillo P, Jauhar S, Murray RM, et al. (2015) Does tobacco use cause psychosis? Systematic review and meta-analysis. *The Lancet Psychiatry* 2(8). Elsevier Ltd: 718–725. DOI: 10.1016/S2215-0366(15)00152-2.

Haddad M, Llewellyn-Jones S, Yarnold S, et al. (2016) Improving the physical health of people with severe mental illness in a low secure forensic unit: An uncontrolled evaluation study of staff training and physical health care plans. *International Journal of Mental Health Nursing* 25(6): 554–565. DOI: 10.1111/inm.12246.

Hammersley M (2010) Reproducing or constructing? Some questions about transcription in social research. *Qualitative Research* 10(5): 553–569. DOI: 10.1177/1468794110375230.

Hannes K and Macaitis K (2012) A move to more systematic and transparent approaches in qualitative evidence synthesis: Update on a review of published papers. *Qualitative Research* 12(4). SAGE PublicationsSage UK: London, England: 402–442. DOI: 10.1177/1468794111432992.

Happell B and Cutcliffe JR (2011) A broken promise? Exploring the lack of evidence for the benefits of comprehensive nursing education. *International Journal of*

*Mental Health Nursing* 20(5): 328–336. DOI: 10.1111/j.1447-0349.2011.00745.x.

Happell B, Platania-Phung C, Gray R, et al. (2011) A role for mental health nursing in the physical health care of consumers with severe mental illness. *Journal of psychiatric and mental health nursing* 18(8): 706–11. DOI: 10.1111/j.1365-2850.2010.01666.x.

Happell Brenda, Platania-Phung C and Scott D (2011) Placing physical activity in mental health care: A leadership role for mental health nurses. *International Journal of Mental Health Nursing* 20(5): 310–318. DOI: 10.1111/j.1447-0349.2010.00732.x.

Happell B, Scott D and Platania-Phung C (2012) Provision of Preventive Services for Cancer and Infectious Diseases Among Individuals with Serious Mental Illness. *Archives of Psychiatric Nursing* 26(3): 192–201. DOI: 10.1016/j.apnu.2011.09.002.

Happell B, Scott D, Platania-Phung C, et al. (2012a) Rural physical health care services for people with serious mental illness: A nursing perspective. *Australian Journal of Rural Health* 20(5): 248–253. DOI: 10.1111/j.1440-1584.2012.01303.x.

Happell B, Scott D, Platania-Phung C, et al. (2012b) Should we or shouldn't we? Mental health nurses' views on physical health care of mental health consumers. *International Journal of Mental Health Nursing* 21(3): 202–210. DOI: 10.1111/j.1447-0349.2011.00799.x.

Happell B, Platania-Phung C and Scott D (2013a) Are Nurses in Mental Health Services Providing Physical Health Care for People with Serious Mental Illness? An Australian Perspective. *Issues in Mental Health Nursing* 34(3): 198–207. DOI: 10.3109/01612840.2012.733907.

Happell B, Platania-Phung C and Scott D (2013b) Mental Health Nurse Incentive Program: Facilitating physical health care for people with mental illness? *International Journal of Mental Health Nursing* 22(5): 399–408. DOI: 10.1111/inm.12006.

Happell B, Scott D and Platania-Phung C (2013) Nurse views on the cardiometabolic health nurse as an approach to improving the physical health of people with serious mental illness in Australia. *International Journal of Mental Health Nursing* 22(5): 418–429. DOI: 10.1111/j.1447-0349.2012.00892.x.

Happell B, Scott D, Nankivell J, et al. (2013) Nurses' Views on Training Needs to Increase Provision of Primary Care for Consumers With Serious Mental Illness. *Perspectives in Psychiatric Care* 49(3): 210–217. DOI: 10.1111/j.1744-6163.2012.00351.x.

Happell B, Platania-Phung C and Scott D (2013c) Physical health care for people with mental illness: Training needs for nurses. *Nurse Education Today* 33(4): 396–401. DOI: 10.1016/j.nedt.2013.01.015.

Happell B, Scott D, Nankivell J, et al. (2013) Screening physical health? Yes! But...:

nurses' views on physical health screening in mental health care. *Journal of Clinical Nursing* 22(15/16): 2286–2297. DOI: 10.1111/j.1365-2702.2012.04325.x.

Happell B, Stanton R, Hoey W, et al. (2014) Cardiometabolic health nursing to improve health and primary care access in community mental health consumers: Baseline physical health outcomes from a randomised controlled trial. In: *Issues in Mental Health Nursing*, 2014. DOI: 10.3109/01612840.2013.842619.

Happell B, Platania-Phung C, Scott D, et al. (2014) Communication With Colleagues: Frequency of Collaboration Regarding Physical Health of Consumers With Mental Illness. *Perspectives in Psychiatric Care* 50(1): 33–43. DOI: 10.1111/ppc.12021.

Happell B, Platania-Phung C, Webster S, et al. (2015) Applying the World Health Organization Mental Health Action Plan to evaluate policy on addressing co-occurrence of physical and mental illnesses in Australia. *Australian Health Review*. DOI: 10.1071/AH14098.

Happell B, Platania-Phung C, Stanton R, et al. (2015) Exploring the Views of Nurses on the Cardiometabolic Health Nurse in Mental Health Services in Australia. *Issues in Mental Health Nursing* 36(2): 135–144. DOI: 10.3109/01612840.2014.901449.

Happell B, Ewart SB, Platania-Phung C, et al. (2016) What Physical Health Means to Me: Perspectives of People with Mental Illness. *Issues in Mental Health Nursing* 37(12). Taylor and Francis Ltd: 934–941. DOI: 10.1080/01612840.2016.1226999.

Hardin PK (2003) Constructing experience in individual interviews, autobiographies and on-line accounts: a poststructuralist approach. *Journal of advanced nursing* 41(6). article. Oxford, UK: Blackwell Science Ltd: 536–544. DOI: 10.1046/j.1365-2648.2003.02565.x.

Hardy S (2012) Training practice nurses to improve the physical health of patients with severe mental illness: Effects on beliefs and attitudes. *International Journal of Mental Health Nursing* 21(3). Wiley-Blackwell: 259–265. DOI: 10.1111/j.1447-0349.2011.00800.x.

Hardy S (2013) Physical health checks for people with severe mental illness. *Primary Health Care* 23(10): 24–26. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2012390336&site=ehost-live.

Hardy S and Huber J (2014) Training Practice nurses to care for people with severe mental illness. *Primary Health Care* 24(3): 18–23. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2012520801&site=ehost-live.

Harris R, Sims S, Leamy M, et al. (2019) Intentional rounding in hospital wards to improve regular interaction and engagement between nurses and patients: a realist evaluation. *Health Services and Delivery Research* 7(35): 1–168. DOI:

10.3310/hsdr07350.

Hemingway S, Trotter F, Stephenson J, et al. (2013) Diabetes: increasing the knowledge base of mental health nurses. *British Journal of Nursing* 22(17): 991–995. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2012310945&site=ehost-live.

Hemingway S, Clifton A, Stephenson J, et al. (2014) Facilitating knowledge of mental health nurses to undertake physical health interventions: a pre-test/post-test evaluation. *Journal of Nursing Management* 22(3): 383–393. DOI: 10.1111/jonm.12220.

Hemingway S, Stephenson J, Trotter F, et al. (2015) Increasing the health literacy of learning disability and mental health nurses in physical care skills: A pre and post-test evaluation of a workshop on diabetes care. *Nurse Education in Practice* 15(1): 30–37. DOI: 10.1016/j.nepr.2014.08.003.

Hennessy S and Cocoman AM (2018) What Is the Impact of Targeted Health Education for Mental Health Nurses in the Provision of Physical Health Care? An Integrated Literature Review. *Issues in Mental Health Nursing*. Taylor and Francis Ltd. DOI: 10.1080/01612840.2018.1429509.

Hewitt J (2007) Ethical components of researcher-researched relationships in qualitative interviewing. *Qualitative Health Research* 17(8): 1149–1159. DOI: 10.1177/1049732307308305.

Hewitt J (2009) Redressing the balance in mental health nursing education: Arguments for a values-based approach. *International Journal of Mental Health Nursing* 18(5): 368–379. DOI: 10.1111/j.1447-0349.2009.00633.x.

Hewitt J and Coffey M (2005) Therapeutic working relationships with people with schizophrenia: literature review. *Journal of Advanced Nursing* 52(5). John Wiley & Sons, Ltd: 561–570. DOI: 10.1111/j.1365-2648.2005.03623.x.

Higgins A, Doyle L, Downes C, et al. (2016) There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice. *International Journal of Mental Health Nursing* 25(2). Blackwell Publishing: 159–170. DOI: 10.1111/inm.12180.

Hoeve Y ten, Jansen G and Roodbol P (2014) The nursing profession: Public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing* 70(2): 295–309. DOI: 10.1111/jan.12177.

Holloway A, Blackman I and Flynn F (2014) A study examining the appropriateness of a self-rated alcohol-related clinical confidence tool as a method of measurement among registered hospital nurses using Rasch analysis. *Journal of Advanced Nursing* 70(4): 937–945. DOI: 10.1111/jan.12264.

Holloway AS and Webster BJ (2013) Alcohol education and training in pre-registration nursing: A national survey to determine curriculum content in the United Kingdom (UK). *Nurse Education Today*. DOI: 10.1016/j.nedt.2012.10.011.

Holstein JA and Gubrium JF (1995) *Active Interview*. book. Los Angeles: SAGE Publications Inc.

Howard L and Gamble C (2011) Supporting mental health nurses to address the physical health needs of people with serious mental illness in acute inpatient care settings. *Journal of Psychiatric & Mental Health Nursing* 18(2): 105–112. DOI: 10.1111/j.1365-2850.2010.01642.x.

ICH (1997) *General Considerations for Clinical Trials (E8)*. Geneva.

Jackson R and Hogg M (2012) Role Identity. In: *Encyclopedia of Identity*. SAGE Publications, Inc. DOI: 10.4135/9781412979306.n206.

Jacobs K (2008) Accountability and Clinical Governance in Nursing: a Critical Overview of the Topic. In: Tilley S and Watson R (eds) *Accountability in Nursing and Midwifery*. Oxford, UK: Blackwell Science Ltd, pp. 21–37. DOI: 10.1002/9780470774564.ch3.

Jefferson G (2004) Glossary of transcript symbols with an introduction. In: Lerner GH (ed.) *Conversation Analysis: Studies from the First Generation*. Amsterdam: John Benjamins, pp. 13–31.

Jenkins R (2008) *Social Identity*. 3rd ed. book. DOI: 10.4324/9780203927410.

Jenks CJ (2018) Recording and Transcribing Social Interaction. In: Flick U (ed.) *The SAGE Handbook of Qualitative Data Collection*. Thousand Oaks: SAGE Publications Ltd, pp. 118–130. DOI: 10.4135/9781526416070.n8.

Joffe H (2011) Thematic Analysis. In: *Qualitative Research Methods in Mental Health and Psychotherapy*. Chichester, UK: John Wiley & Sons, Ltd, pp. 209–223. DOI: 10.1002/9781119973249.ch15.

John A (1960) *Study of the psychiatric nurse and his/her role in the care of the mentally sick*. University of Edinburgh.

Johnson M, Cowin L., Wilson I, et al. (2012) Professional identity and nursing: contemporary theoretical developments and future research challenges. *International nursing review* 59(4). article: 562–569. DOI: 10.1111/j.1466-7657.2012.01013.x.

Jones M, Kruger M and Walsh SM (2016) Preparing non-government organization workers to conduct health checks for people with serious mental illness in regional Australia. *Journal of Psychiatric and Mental Health Nursing* 23(5). Blackwell Publishing Ltd: 247–254. DOI: 10.1111/jpm.12308.

Jones S, Howard L and Thornicroft G (2008) 'Diagnostic overshadowing': worse physical health care for people with mental illness. *Acta Psychiatrica Scandinavica*

118(3): 169–171. DOI: 10.1111/j.1600-0447.2008.01211.x.

Judd BK, Currie J, Dodds KL, et al. (2019) Registered nurses psychophysiological stress and confidence during high-fidelity emergency simulation: Effects on performance. *Nurse Education Today* 78. Churchill Livingstone: 44–49. DOI: 10.1016/j.nedt.2019.04.005.

Karanwal, Mackinnon, Barkat, et al. (2015) *Health and Wellbeing Profile: Scotland overview*. Edinburgh.

Khan FA, Rice D and Tadros G (2013) The use of supportive observations within an inpatient mental health unit for older people and dilemma of using the Mental Health Act (2007) or the Mental Capacity Act (2005) in England and Wales. *Journal of Psychiatric & Mental Health Nursing* 20(1): 91–96. DOI: 10.1111/j.1365-2850.2012.01963.x.

Khomeiran RT, Yekta ZP, Kiger AM, et al. (2006) Professional competence: factors described by nurses as influencing their development. *International Nursing Review* 53(1). John Wiley & Sons, Ltd: 66–72. DOI: 10.1111/j.1466-7657.2006.00432.x.

King M, Semlyen J, Tai SS, et al. (2008) A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. BioMed Central. DOI: 10.1186/1471-244X-8-70.

Knight M, Bolton P and Kopeski L (2017) Providing Physical Care to Persons With Serious Mental Illness: Attitudes, Confidence, Barriers and Psychological Empowerment. *Archives of Psychiatric Nursing* 31(5). W.B. Saunders: 447–453. DOI: 10.1016/j.apnu.2017.07.001.

Kowal S and O'Connell D (2013) Transcription as a crucial step of data analysis. In: Flick U (ed.) *The SAGE Handbook of Qualitative Data Analysis*. Thousand Oaks CA: SAGE Publications, pp. 64–78.

Krautscheid LC (2014) Defining Professional Nursing Accountability: A Literature Review. *Journal of Professional Nursing*. DOI: 10.1016/j.profnurs.2013.06.008.

Kulick OA (2006) Professionalism and OD: The past, the present, and future scenarios. *Organization development journal* 24(3). article. Chesterland: International Society for Organization Development, Inc: 20–32.

Lambert N (2012) Understanding and supporting the physical health needs of clients. *Mental Health Practice* 15(10): 14–19. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2011608496&site=ehost-live.

Lauder W, Roxburgh M, Holland K, et al. (2008) *Nursing and Midwifery in Scotland: Being Fit for Practice The Report of the Evaluation of Fitness For Practice Pre-Registration Nursing and Midwifery Curricula Project*. Edinburgh.

Lawler J, Trevatt P, Elliot C, et al. (2019) Does the Diabetes Specialist Nursing workforce impact the experiences and outcomes of people with diabetes? A hermeneutic review of the evidence. *Human Resources for Health* 17(1). Human Resources for Health: 1–9. DOI: 10.1186/s12960-019-0401-5.

Lawler S (2014) *Identity : Sociological Perspectives*. Second edition.. book. Cambridge: Polity Press.

Lawn S, Zabeen S, Rowlands N, et al. (2018) Hidden care: Revelations of a case-note audit of physical health care in a community mental health service. *International Journal of Mental Health Nursing* 27(6). Blackwell Publishing: 1742–1755. DOI: 10.1111/inm.12479.

Leary A, Mason I and Punshon G (2018) Modelling the Inflammatory Bowel Disease Specialist Nurse Workforce Standards by Determination of Optimum Caseloads in the UK. *Journal of Crohn's & colitis* 12(11): 1295–1301. DOI: 10.1093/ecco-jcc/jjy106.

Leonenko M and Drach-Zahavy A (2016) "You are either out on the court, or sitting on the bench": understanding accountability from the perspectives of nurses and nursing managers. *Journal of Advanced Nursing* 72(11). Blackwell Publishing Ltd: 2718–2727. DOI: 10.1111/jan.13047.

Liaschenko J and Peter E (2004) Nursing ethics and conceptualizations of nursing: profession, practice and work. *Journal of advanced nursing* 46(5). article. Oxford, UK: Blackwell Science Ltd: 488–495. DOI: 10.1111/j.1365-2648.2004.03011.x.

Lincoln Y and Guba E (1985) *Naturalistic Inquiry*. Thousand Oaks: Sage Publications.

Lipscomb M (2007) Mixed method nursing studies: a critical realist critique. *Nursing Philosophy* 9(1). Wiley: 32–45. DOI: 10.1111/j.1466-769x.2007.00325.x.

Lipscomb M (2016) Introduction. In: Lipscomb M (ed.) *Social Theory and Nursing*. New York: Routledge.

Liu N, Daumit GL, Dua T, et al. (2017) Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry* 16(1). Blackwell Publishing Ltd: 30–40. DOI: 10.1002/wps.20384.

Long HA, French DP and Brooks JM (2020) Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences* 1(1). SAGE Publications: 31–42. DOI: 10.1177/2632084320947559.

Low J (2019) A Pragmatic Definition of the Concept of Theoretical Saturation. *Sociological Focus* 52(2). Taylor and Francis Inc.: 131–139. DOI: 10.1080/00380237.2018.1544514.

Luck L, Chok HN and Wilkes L (2017) Nurses as participants in research: An evaluation of recruitment techniques. *Nurse researcher* 25(2). article. England: Royal College of Nursing Publishing Company (RCN): 44–48. DOI: 10.7748/nr.2017.e1546.

Lurie SJ, Mooney CJ and Lyness JM (2009) Measurement of the general competencies of the accreditation council for graduate medical education: A systematic review. *Academic medicine* 84(3). article. United States: 301–309. DOI: 10.1097/ACM.0b013e3181971f08.

MacLeod–Clark J, Maben J and Jones K (1996) *Project 2000: Perceptions of the Philosophy and Practice of Nursing.* London.

MacNeela P, Morris R, Scott A, et al. (2010) Seen as core: a Delphi consensus study of essential elements of mental health nursing care in Ireland. *Archives of Psychiatric Nursing* 24(5): 339–348. DOI: 10.1016/j.apnu.2010.02.001.

Mangurian C, Miller GA, Jackson CT, et al. (2010) State Mental Health Policy: Physical Health Screening in State Mental Health Clinics: The New York Health Indicators Initiative. *Psychiatric Services* 61(4). American Psychiatric Association: 346–348. DOI: 10.1176/ps.2010.61.4.346.

Manuel J and Crowe M (2014) Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing* 23(4). Blackwell Publishing: 336–343. DOI: 10.1111/inm.12063.

Marks A, Wilkes L, Blythe S, et al. (2017) A novice researcher's reflection on recruiting participants for qualitative research. *Nurse researcher* 25(2). article. England: Royal College of Nursing Publishing Company (RCN): 34–38. DOI: 10.7748/nr.2017.e1510.

Marmot M (2010) *Fair society, healthy lives. The Marmot Review- Strategic Review of Health Inequalities in England post-2010. Public Health.* London. Available at: http://dx.doi.org/10.1016/j.puhe.2012.05.014.

Marmot M, Allen J, Boyce T, et al. (2020) *Health Equity in England: The Marmot Review 10 Years On* . London. Available at: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on (accessed 29 October 2020).

Marsh HW and Scalas LF (2010) Self-concept in learning: Reciprocal effects model between academic self-concept and academic achievement. In: Peterson P, Baker E, and McGaw B (eds) *International Encyclopedia of Education.* 3rd ed. Elsevier Ltd, pp. 660–667. DOI: 10.1016/B978-0-08-044894-7.00619-9.

Marshburn DM, Engelke MK and Swanson MS (2009) Relationships of new nurses' perceptions and measured performance-based clinical competence. *The Journal of continuing education in nursing* 40(9). article. United States: SLACK INCORPORATED: 426–432. DOI: 10.3928/00220124-20090824-02.

Maton K (2012) Habitus. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge.

Maxwell E (2016) Perspectives: Professional regulation: public protection or professional burden? *Journal of Research in Nursing* 21(8). SAGE Publications Ltd: 651–655. DOI: 10.1177/1744987116678961.

McAllister M (2015) Exploring transformative learning and the courage to teach a values based curriculum. *Nurse Education in Practice* 15(6). Churchill Livingstone: 480–484. DOI: 10.1016/j.nepr.2015.01.007.

McAllister S, Robert G, Tsianakas V, et al. (2019) Conceptualising nurse-patient therapeutic engagement on acute mental health wards: An integrative review. *International Journal of Nursing Studies*. Elsevier Ltd. DOI: 10.1016/j.ijnurstu.2019.02.013.

McCall G and Simmons JL (1978) *Identities and Interactions: An Examination of Human Associations in Everyday Life*. New York: Macmillan.

McCrae N and Nolan P (2016) *The Story of Nursing in British Mental Hospitals : Echoes from the Corridors* (P Nolaned. ). Routledge key themes in health and society, book. London: Routledge.

McDaid TM and Smyth S (2015) Metabolic abnormalities among people diagnosed with schizophrenia: a literature review and implications for mental health nurses. *Journal of Psychiatric & Mental Health Nursing* 22(3): 157–170. DOI: 10.1111/jpm.12185.

McDermid F, Peters K, Jackson D, et al. (2014) Conducting qualitative research in the context of pre-existing peer and collegial relationships. *Nurse Researcher* 21(5): 28–33. DOI: 10.7748/nr.21.5.28.e1232.

McEvoy P and Richards D (2006) A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing* 11(1): 66–78. DOI: 10.1177/1744987106060192.

McGann S (2008) The Development of Nursing as an Accountable Profession. In: Tilley S and Watson R (eds) *Accountability in Nursing and Midwifery*. Oxford, UK: Blackwell Science Ltd, pp. 9–20. DOI: 10.1002/9780470774564.ch2.

McKenna B, Furness T, Wallace E, et al. (2014) The effectiveness of specialist roles in mental health metabolic monitoring: a retrospective cross-sectional comparison study. *BMC Psychiatry* 14(1). BioMed Central Ltd.: 234. DOI: 10.1186/s12888-014-0234-7.

McKeown M, Wright K and Mercer D (2017) Care planning: a neoliberal three card trick. *Journal of Psychiatric and Mental Health Nursing*. DOI: 10.1111/jpm.12356.

McKinnon AM, Trzebiatowska M and Brittain CC (2011) Bourdieu, capital, and conflict in a religious Field: The case of the 'homosexuality' conflict in the anglican communion. *Journal of Contemporary Religion* 26(3): 355–370. DOI: 10.1080/13537903.2011.616033.

McMullan M, Endacott R, Gray MA, et al. (2003) Portfolios and assessment of competence: A review of the literature. *Journal of Advanced Nursing*. DOI: 10.1046/j.1365-2648.2003.02528.x.

Meepring S, Chien WT, Gray R, et al. (2018) Effects of the Thai Health Improvement Profile intervention on the physical health and health behaviours of people with schizophrenia: A quasi-experimental study. *International Journal of Mental Health Nursing* 27(1). Blackwell Publishing: 126–137. DOI: 10.1111/inm.12301.

Mental Welfare Commission for Scotland (2019) *Mental Health Act Monitoring Report 2018-19*. Edinburgh.

Menzies IEP (1960) Nurses under Stress. *International Nursing Review* 7: 9–16.

Miller T (2017) Telling the difficult things: Creating spaces for disclosure, rapport and 'collusion' in qualitative interviews. *Women's Studies International Forum* 61. Elsevier Ltd: 81–86. DOI: 10.1016/j.wsif.2016.07.005.

Ministry of Health Singapore (2007) *Healthy Minds, Healthy Communities: National Mental Health Blueprint 2007-2012*. Singapore.

Mishler EG (1991) Representing discourse: The rhetoric of transcripion. *Journal of Narrative and Life History* 1: 255–280.

Mitchell AJ, Vancampfort D, Sweers K, et al. (2013) Prevalence of Metabolic Syndrome and Metabolic Abnormalities in Schizophrenia and Related Disorders—A Systematic Review and Meta-Analysis. *Schizophrenia Bulletin* 39(2): 306–318. DOI: 10.1093/schbul/sbr148.

Moore R (2012) Capital. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge.

Morgan PJ and Cleave-Hogg D (2002) Comparison between medical students' experience, confidence and competence. *Medical Education* 36(6). John Wiley & Sons, Ltd: 534–539. DOI: 10.1046/j.1365-2923.2002.01228.x.

Morrissey J, Doyle L and Higgins A (2018) Self-harm: from risk management to relational and recovery-oriented care. *Journal of Mental Health Training, Education and Practice* 13(1). Emerald Group Publishing Ltd.: 34–43. DOI: 10.1108/JMHTEP-03-2017-0017.

Morse JM, Barrett M, Mayan M, et al. (2002) Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods* 1(2). SAGE Publications: 13–22. DOI: 10.1177/160940690200100202.

Mugisha J, De Hert M, Stubbs B, et al. (2017) Physical health policies and metabolic screening in mental health care systems of sub-Saharan African countries: A systematic review. *International Journal of Mental Health Systems*. BioMed Central Ltd. DOI: 10.1186/s13033-017-0141-7.

Muir-Cochrane E, Gerace A, Mosel K, et al. (2011) Managing Risk: Clinical Decision-Making in Mental Health Services. *Issues in Mental Health Nursing* 32(12). Taylor & Francis: 726–734. DOI: 10.3109/01612840.2011.603880.

Mwebe H (2017) Physical health monitoring in mental health settings: a study exploring mental health nurses' views of their role. *Journal of Clinical Nursing* 26(19–20). DOI: 10.1111/jocn.13653.

Nairn S (2016) The purpose and scope of sociological theory: implications for nursing. In: Lipscomb M (ed.) *Social Theory and Nursing*. New York: Routledge.

Nairn S and Pinnock D (2017) Pierre Bourdieu: Expanding the scope of nursing research and practice. *Nursing Philosophy* 18(4). Blackwell Publishing Ltd. DOI: 10.1111/nup.12167.

Nankivell J, Platania-Phung C, Happell B, et al. (2013) Access to Physical Health Care for People with Serious Mental Illness: A Nursing Perspective and a Human Rights Perspective-Common Ground? *Issues in Mental Health Nursing* 34(6): 442–450. DOI: 10.3109/01612840.2012.754974.

Nash M (2010) Assessing nurses' propositional knowledge of physical health. *Mental Health Practice* 14(2): 20–23. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2010824949&site=ehost-live.

Nash M (2011) Improving mental health service users' physical health through medication monitoring: a literature review. *Journal of Nursing Management* 19(3): 360–365. DOI: 10.1111/j.1365-2834.2011.01244.x.

Nash M (2013) Diagnostic overshadowing: a potential barrier to physical health care for mental health service users. *Mental Health Practice* 17(4): 22–26. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=jlh&AN=2012395247&site=ehost-live.

Nash M (2014a) Mental health service users' experiences of diabetes care by Mental Health Nurses: an exploratory study. *Journal of Psychiatric & Mental Health Nursing* 21(8): 715–723. DOI: 10.1111/jpm.12140.

Nash M (2014b) *Physical Health and Well-Being in Mental Health Nursing: Clinical Skills for Practice*. 2nd ed. Berkshire: Open University Press.

National Records of Scotland (2019) *Drug-death rates - comparisons with other countries - 2016 2017 and 2018*.

Neuberger J (1999) Education and debate. *BMJ* 318(7200). British Medical Journal Publishing Group: 1756–1758. DOI: 10.1136/bmj.318.7200.1756.

Newman D, O'Reilly P, Lee SH, et al. (2017) Challenges in accessing and interviewing participants with severe mental illness. *Nurse Researcher* 25(1). RCN Publishing Company Ltd.: 37–42. DOI: 10.7748/nr.2017.e1443.

NHS Education for Scotland (2011) *The 10 Essential Shared Capabilities for Mental Health Practice: Learning Materials*. Edinburgh: NES.

NHS Education for Scotland (2012) *The National Framework for Pre-registration Mental Health Nursing*. Edinburgh.

NHS Scotland (2009) What health workers need to know about gender-based violence : an overview What health workers need to know about gender-based violence Inside :: 1–17.

Nowell LS, Norris JM, White DE, et al. (2017) Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods* 16(1). SAGE Publications Inc. DOI: 10.1177/1609406917733847.

Noyes J, Booth A, Flemming K, et al. (2018) Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology* 97. Elsevier USA: 49–58. DOI: 10.1016/j.jclinepi.2017.06.020.

Nursing and Midwifery Council (2010) *Standards for Pre-Registration Nursing Education*. London: NMC.

Nursing and Midwifery Council (2015a) *Annual Fitness to Practise Report 2014-2015*. London.

Nursing and Midwifery Council (2015b) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.

Nursing and Midwifery Council (2017) *Enabling professionalism in Nursing and Midwifery Practice*. London. Available at: https://www.nmc.org.uk/standards/guidance/professionalism/read-report/ (accessed 28 October 2020).

Nursing and Midwifery Council (2018) *Future nurse: Standards of proficiency for registered nurses*. *Standards of proficiency for registered nurses*. London. Available at: www.nmc.org.uk.

O'Reilly M and Parker N (2013) 'Unsatisfactory Saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research* 13(2): 190–197. DOI: 10.1177/1468794112446106.

Öhlén J and Segesten K (1998) The professional identity of the nurse: concept analysis and development. *Journal of advanced nursing* 28(4). article. Oxford UK: Wiley: 720–727. DOI: 10.1046/j.1365-2648.1998.00704.x.

Orb A, Eisenhauer L and Wynaden D (2001) Ethics in qualitative research. *Journal of Nursing Scholarship* 33(1). Sigma Theta Tau International: 93–96. DOI: 10.1111/j.1547-5069.2001.00093.x.

Organ B, Nicholson E and Castle D (2010) Implementing a physical health strategy in a mental health service. *Australasian Psychiatry* 18(5): 456–459. DOI: 10.3109/10398562.2010.506217.

Pabico C, Perkins CK, Graebe J, et al. (2019) Creating a culture of lifelong learning. *Nursing Management (Springhouse)* 50(2). Lippincott Williams and Wilkins: 9–11. DOI: 10.1097/01.NUMA.0000552736.33707.7b.

Parahoo K (2014) *Nursing Research: Principles, Process and Issues*. 3rd ed. London: Palgrave Macmillan.

Peplau HE (1991) *Interpersonal Relations in Nursing a Conceptual Frame of Reference for Psychodynamic Nursing*. book. New York: Springer.

Piil K, Kolbæk R, Ottmann G, et al. (2012) The impact of the expanded nursing practice on professional identify in Denmark. *Clinical Nurse Specialist* 26(6). Clin Nurse Spec: 329–335. DOI: 10.1097/NUR.0b013e31826e3f43.

Pijl-Zieber EM, Barton S, Konkin J, et al. (2014) Competence and competency-based nursing education: Finding our way through the issues. *Nurse Education Today*. Churchill Livingstone. DOI: 10.1016/j.nedt.2013.09.007.

Pillow W (2010) Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International journal of qualitative studies in education* 16(2). article. Informa UK Limited: 175–196. DOI: 10.1080/0951839032000060635.

Pollock L (1987) *Community psychiatric nursing explained : An analysis of the views of parents, carers and nurses.* University of Edinburgh.

Potter J and Hepburn A (2005) Qualitative interviews in psychology: problems and possibilities. *Qualitative research in psychology* 2(4). article. London: Informa UK Limited: 281–307. DOI: 10.1191/1478088705qp045oa.

Punshon G, Sopala J, Hannan G, et al. (2020) Modelling the Multiple Sclerosis Specialist Nurse Workforce by Determination of Optimum Caseloads in the United Kingdom. *International Journal of MS Care*: 0000–0000. DOI: 10.7224/1537-2073.2019-058.

Purkiss ME and Ceci C (2017) Accounting for knowledgeable practice. In: Lipscomb M (ed.) *Social Theory and Nursing*. London: Routledge.

Rahman (2013) *Quality of Risk Assessment Prior to Suicide and Homicide: A pilot study. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)*. Manchester.

Ramluggun P, Anjoyeb M and D'Cruz G (2017) Mental health nursing students' views on their readiness to address the physical health needs of service users on registration. *International Journal of Mental Health Nursing* 26(6). Blackwell Publishing: 570–579. DOI: 10.1111/inm.12279.

Rhynas SJ (2005) Bourdieu's theory of practice and its potential in nursing research. *Journal Of Advanced Nursing* 50(2). Oxford, UK: 179–186. DOI: 10.1111/j.1365-2648.2005.03377.x.

Rio JHM, Fuller J, Taylor K, et al. (2019) A lack of therapeutic engagement and consumer input in acute inpatient care planning limits fully accountable mental health nursing practice. *International Journal of Mental Health Nursing*. Blackwell Publishing: inm.12684. DOI: 10.1111/inm.12684.

Robson D and Gray R (2007) Serious mental illness and physical health problems: A discussion paper. *International Journal of Nursing Studies* 44(3): 457–466. DOI: 10.1016/j.ijnurstu.2006.07.013.

Robson D and Haddad M (2012) Mental health nurses' attitudes towards the physical health care of people with severe and enduring mental illness: The development of a measurement tool. *International Journal of Nursing Studies* 49(1): 72–83. DOI: 10.1016/j.ijnurstu.2011.07.011.

Robson D, Haddad M, Gray R, et al. (2013) Mental health nursing and physical health care: A cross-sectional study of nurses' attitudes, practice, and perceived training needs for the physical health care of people with severe mental illness. *International Journal of Mental Health Nursing* 22(5). Wiley-Blackwell: 409–417. DOI: 10.1111/j.1447-0349.2012.00883.x.

Rolfe G (2002) Reflective practice: where now? *Nurse Education in Practice* 2(1). Churchill Livingstone: 21–29. DOI: 10.1054/NEPR.2002.0047.

Rolfe G (2006) Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal Of Advanced Nursing* 53(3). Wiley-Blackwell: 304–310. DOI: 10.1111/j.1365-2648.2006.03727.x.

Rolfe G (2014) Rethinking reflective education: What would Dewey have done? *Nurse Education Today* 34(8): 1179–1183. DOI: 10.1016/j.nedt.2014.03.006.

Rossetto KR (2014) Qualitative research interviews: Assessing the therapeutic value and challenges. *Journal of Social and Personal Relationships* 31(4). SAGE Publications Ltd: 482–489. DOI: 10.1177/0265407514522892.

Roulston K (2011) Interview 'problems' as topics for analysis. *Applied Linguistics*. DOI: 10.1093/applin/amq036.

Roulston K (2013) Analysing Interviews. In: Flick U (ed.) *The SAGE Handbook of Qualitative Data Analysis*. Thousand Oaks CA: SAGE Publications, pp. 297–312.

Roulston K and Choi M (2018) Qualitative Interviews. In: Flick U (ed.) *The SAGE*

*Handbook of Qualitative Data Collection*. 1 Oliver's Yard, 55 City Road, London EC1Y 1SP : SAGE Publications Ltd, pp. 233–249. DOI: 10.4135/9781526416070.n15.

Royal College of General Practitioners (2013) *General practice: A vision for the future*. London. DOI: 10.12968/bjcn.2013.18.Sup10.S5.

Royal College of Nursing (2017) *Accountability and delegation A guide for the nursing team*. London.

Royal College of Nursing (2019) *Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs*. London. Available at: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/may/007-618.pdf.

Royal College Of Nursing (2019) *Literature review: Scoping Selected Literature on the Role of the Mental Health Nurse in Improving the Physical Health Care of Clients Diagnosed with Severe Mental Illness*. London.

Royal College of Physicians (2017) *National Early Warning Score (NEWS) 2 Standardising the Assessment of Acute-Illness Severity in the NHS*. Available at: www.rcplondon.ac.uk.

Royal College of Psychiatrists (2015) Schizophrenia | Royal College of Psychiatrists. Available at: https://www.rcpsych.ac.uk/mental-health/problems-disorders/schizophrenia (accessed 18 October 2020).

Ruggeri M, Leese M, Thornicroft G, et al. (2000) Definition and prevalence of severe and persistent mental illness. *The British Journal of Psychiatry* 177(2). Available at: http://bjp.rcpsych.org/content/177/2/149.short (accessed 22 May 2017).

Ryan M and Thakore J (2002) Physical consequences of schizophrenia and its treatment: The metabolic syndrome. *Life Sciences* 71(3): 239–257. DOI: 10.1016/S0024-3205(02)01646-6.

Sandelowski M (1994) *Focus on Qualitative Methods Notes on Transcription*. *Research in Nursing & Health*.

Sawchuk P (2008) Labour perspectives on the new politics of skill and competency formation: International reflections. *Asia Pacific Education Review* 9(1). Springer: 50–62. DOI: 10.1007/BF03025825.

Schreier M (2018) Sampling and Generalization. In: Flick U (ed.) *The SAGE Handbook of Qualitative Data Collection*. SAGE Publications Ltd, pp. 84–97. DOI: 10.4135/9781526416070.n6.

Schubert D (2012) Suffering/Symbolic Violence. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge, pp. 179–194.

Scottish Executive (2006) *Rights, Relationships and Recovery. The Review of Mental Health*

*Nursing in Scotland*. Edinburgh: Scottish Executive.

Scottish Government (2012) *Mental Health Strategy for Scotland 2012-2015*. Edinburgh. Available at: http://www.gov.scot/Topics/Health/Services/Mental-Health/Strategy (accessed 31 March 2017).

Scottish Government (2017) *Mental Health Strategy 2017-2027*. Edinburgh: Scottish Government. Available at: http://www.gov.scot/Publications/2017/03/1750 (accessed 22 May 2017).

Scottish Intercollegiate Guidelines Network (2013) SIGN131: Management of Schizophrenia. Edinburgh: SIGN.

Seaman R, Mitchell R, Dundas R, et al. (2015) How much of the difference in life expectancy between Scottish cities does deprivation explain? *BMC Public Health* 15(1). BioMed Central Ltd.: 1057. DOI: 10.1186/s12889-015-2358-1.

Shuel F, White J, Jones M, et al. (2010) Using the serious mental illness health improvement profile [HIP] to identify physical problems in a cohort of community patients: a pragmatic case series evaluation. *International Journal of Nursing Studies* 47(2): 136–145. DOI: 10.1016/j.ijnurstu.2009.06.003.

Silverman D (2009) *Doing Qualitative Research: A Practical Handbook*. 3rd ed. London: SAGE Publications.

Silverstein CM (2006) Therapeutic Interpersonal Interactions: The Sacrificial Lamb? *Perspectives In Psychiatric Care* 42(1). John Wiley & Sons, Ltd: 33–41. DOI: 10.1111/j.1744-6163.2006.00055.x.

Sim J, Saunders B, Waterfield J, et al. (2018a) Can sample size in qualitative research be determined a priori? *International Journal of Social Research Methodology*. Routledge. DOI: 10.1080/13645579.2018.1454643.

Sim J, Saunders B, Waterfield J, et al. (2018b) The sample size debate: response to Norman Blaikie. *International Journal of Social Research Methodology*. Routledge. DOI: 10.1080/13645579.2018.1454642.

Sims S, Leamy M, Davies N, et al. (2018) Realist synthesis of intentional rounding in hospital wards: Exploring the evidence of what works, for whom, in what circumstances and why. *BMJ Quality and Safety*. BMJ Publishing Group. DOI: 10.1136/bmjqs-2017-006757.

Sivell S, Prout H, Hopewell-Kelly N, et al. (2015) Considerations and recommendations for conducting qualitative research interviews with palliative and end-of-life care patients in the home setting: a consensus paper. DOI: 10.1136/bmjspcare-2015.

Skukauskaite A (2014) Transcribing as Analysis: Logic-in-Use in Entextualizing Interview Conversations. In: *Transcribing as Analysis: Logic-in-Use in Entextualizing Interview Conversations*. SAGE Publications, Ltd. DOI:

10.4135/9781446273050145 32202.

Sladden S (1977) *Psychiatric community nursing: a study of a working situation*. University of Edinburgh.

Slemon A, Jenkins E and Bungay V (2017) Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry* 24(4). Blackwell Publishing Ltd. DOI: 10.1111/nin.12199.

Smith JA (2009) *Qualitative Psychology: A Practical Guide to Research Methods*. 2nd ed. London: SAGE Publications.

Spiers J, Morse JM, Olson K, et al. (2018) Reflection/Commentary on a Past Article: "Verification Strategies for Establishing Reliability and Validity in Qualitative Research". *International Journal of Qualitative Methods* 17(1). SAGE Publications: 160940691878823. DOI: 10.1177/1609406918788237.

Stenhouse RC (2009) *Unfulfilled expectations: a narrative study of individuals' experiences of being a patient on an acute psychiatric inpatient ward in Scotland*. University of Edinburgh.

Stewart I, Leary A, Khakwani A, et al. (2020) Do working practices of cancer nurse specialists improve clinical outcomes? Retrospective cohort analysis from the English National Lung Cancer Audit. *International Journal of Nursing Studies*: 103718. DOI: https://doi.org/10.1016/j.ijnurstu.2020.103718.

Stewart J, O'Halloran C, Barton JR, et al. (2000) Clarifying the concepts of confidence and competence to produce appropriate self-evaluation measurement scales. *Medical Education* 34(11). John Wiley & Sons, Ltd: 903–909. DOI: 10.1046/j.1365-2923.2000.00728.x.

Tajfel H and Turner JC (2019) The Social Identity Theory of Intergroup Behavior. In: Jost J and Sidanius J (eds) *Political Psychology*. Psychology Press, pp. 276–293. DOI: 10.4324/9780203505984-16.

Takase M (2013) The relationship between the levels of nurses' competence and the length of their clinical experience: A tentative model for nursing competence development. *Journal of Clinical Nursing* 22(9–10): 1400–1410. DOI: 10.1111/j.1365-2702.2012.04239.x.

Terry G, Hayfield N, Clarke V, et al. (2017) Thematic Analysis. In: *The SAGE Handbook of Qualitative Research in Psychology*. London: SAGE Publications, pp. 17–36.

Terry J and Cutter J (2013) Does Education Improve Mental Health Practitioners' Confidence in Meeting the Physical Health Needs of Mental Health Service Users? A Mixed Methods Pilot Study. *Issues in Mental Health Nursing* 34(4): 249–255. DOI: 10.3109/01612840.2012.740768.

Thoits P and Virshup L (1997) Me's and we's: Forms and functions of social identities. - PsycNET. In: Ashmore R and Jussim L (eds) *Self and Identity: Fundamental Issues*.

Oxford: Oxford University Press, pp. 106–133. Available at: https://psycnet.apa.org/record/1997-08997-004 (accessed 19 November 2020).

Thomas B (2016) *Improving the physical health of people with mental health problems: Actions for mental health nurses-a new resource*. 19 February. London: OMICS Publishing Group. DOI: 10.4172/1522-4821-c5-022.

Thompson AR and Chambers E (2012) Chapter 3: Ethical issues in qualitative mental health Research. In: Harper D and Thompson A (eds) *Qualitative Research Methods in Mental Health & Psychotherapy*. Chichester: John Wiley & Sons Ltd.

Thompson J (1992) Editor's Introduction. In: Thompson J (ed.) *Language & Symbolic Power* . Cambridge: Polity Press, pp. 1–32.

Thomson P (2012) Field. In: Grenfell M (ed.) *Pierre Bourdieu: Key Concepts*. 2nd ed. New York: Routledge.

Thongsai S, Gray R and Bressington D (2016) The physical health of people with schizophrenia in Asia: Baseline findings from a physical health check programme. *Journal of psychiatric and mental health nursing* 23(5). Blackwell Publishing Ltd: 255–266. DOI: 10.1111/jpm.12300.

Tilley S (1990) *Negotiating realities : making sense of interaction between patients diagnosed as neurotic and nurses in two psychiatric admission wards*. University of Edinburgh.

Tilley S (2002) A note on Annie Altschul, Emeritus Professor of Nursing Studies, The University of Edinburgh. *Journal of psychiatric and mental health nursing* 9(2). article. Oxford, UK: Blackwell Science, Ltd: 128–130. DOI: 10.1046/j.1365-2850.2002.05022.x.

Tilley S (2005) *Psychiatric and Mental Health Nursing the Field of Knowledge* (S Tilleyed. ). book. Oxford: Blackwell Science.

Tilley S (2008) Clinical Governance, Accountability and Mental Health Nursing: an Emergent Story. In: *Accountability in Nursing and Midwifery*. Oxford, UK: Blackwell Science Ltd, pp. 157–169. DOI: 10.1002/9780470774564.ch13.

Tingle J (2008) The Legal Accountability of the Nurse. In: Tilley S and Watson R (eds) *Accountability in Nursing and Midwifery*. Oxford, UK: Blackwell Science Ltd, pp. 47–63. DOI: 10.1002/9780470774564.ch5.

Tobin GA and Begley CM (2004) Methodological rigour within a qualitative framework. *Journal Of Advanced Nursing* 48(4). Wiley-Blackwell: 388–396. DOI: 10.1111/j.1365-2648.2004.03207.x.

Tosh G, Clifton A V, Xia J, et al. (2014) Physical health care monitoring for people with serious mental illness. *Cochrane Database of Systematic Reviews*. John Wiley & Sons, Ltd. DOI: 10.1002/14651858.CD008298.pub3.

Tranter S, Irvine F and Collins E (2012) Innovations aimed at improving the physical health of the seriously mentally ill: an integrative review. *Journal of Clinical Nursing* 21(9/10): 1199–1214. DOI: 10.1111/j.1365-2702.2011.04020.x.

Veitch P and Oates J (2017) Strange bedfellows? Nurses as Responsible Clinicians under the Mental Health Act (England &amp; Wales). *Journal of Psychiatric and Mental Health Nursing*. DOI: 10.1111/jpm.12366.

Verhaeghe N, Maeseneer J, Maes L, et al. (2013) Health promotion in mental health care: perceptions from patients and mental health nurses. *Journal of Clinical Nursing* 22(11/12): 1569–1578. DOI: 10.1111/jocn.12076.

Vossler A, Moller N, Braun V, et al. (2017) How to use thematic analysis with interview data. In: *The Counselling and Psychotherapy Research Handbook*. SAGE Publications Ltd, pp. 183–197. DOI: 10.4135/9781473909847.n13.

Wacquant LJD (2001) *Toward a Social Praxeology : The Structure and Logic of Bourdieu's Sociology*. book.

Walker ER, McGee RE and Druss BG (2015) Mortality in Mental Disorders and Global Disease Burden Implications. *JAMA Psychiatry* 72(4): 334. DOI: 10.1001/jamapsychiatry.2014.2502.

Walker S and McAndrew S (2015) The same but different: discussing the literature regarding mental health nurses' difficulty in meeting the physical health needs of service users, regardless of differing education programmes. *Journal of psychiatric and mental health nursing* 22(8): 640–6. DOI: 10.1111/jpm.12220.

Walsh K (2019) Health systems strengthening: is task shifting the answer to better global health? Available at: https://blogs.bmj.com/bmj/2019/11/08/kieran-walsh-health-systems-strengthening-in-low-income-and-middle-income-countries-is-task-shifting-the-answer-to-better-global-health/ (accessed 10 November 2019).

Wand T (2011) Real mental health promotion requires a reorientation of nursing education, practice and research. *Journal of Psychiatric & Mental Health Nursing* 18(2): 131–138. DOI: 10.1111/j.1365-2850.2010.01634.x.

Wand T (2013) Positioning mental health nursing practice within a positive health paradigm. *International Journal of Mental Health Nursing* 22(2): 116–124. DOI: 10.1111/j.1447-0349.2012.00848.x.

Warne T and McAndrew S (2005) The shackles of abuse: unprepared to work at the edges of reason. *Journal of Psychiatric and Mental Health Nursing* 12(6). John Wiley & Sons, Ltd: 679–686. DOI: 10.1111/j.1365-2850.2005.00893.x.

Watson CJ (2006) Unreliable narrators? 'Inconsistency' (and some inconstancy) in interviews. *Qualitative Research* 6(3): 367–384. DOI: 10.1177/1468794106065008.

Watson R (2008) Accountability and Clinical Governance. In: Tilley S and Watson R (eds) *Accountability in Nursing and Midwifery*. Oxford, UK: Blackwell Science Ltd, pp. 38–46. DOI: 10.1002/9780470774564.ch4.

Watson R and Thompson DR (2000) Recent developments in the UK nurse education: Horses for courses or courses for horses? *Journal of Advanced Nursing* 32(5): 1041–1042.

Watson R and Tilley S (2008) Introduction. In: *Accountability in Nursing and Midwifery*. Oxford, UK: Blackwell Science Ltd, pp. 1–8. DOI: 10.1002/9780470774564.ch1.

Watson R, Stimpson A, Topping A, et al. (2002) Clinical competence assessment in nursing: A systematic review of the literature. *Journal of Advanced Nursing* 39(5): 421–431. DOI: 10.1046/j.1365-2648.2002.02307.x.

Weininger EB (2003) Pierre Bourdieu on Social Class and Symbolic Violence. *Alternative foundations of class analysis*: 119–170.

Welsh ER and McEnany GP (2015) Approaches to Reduce Physical Comorbidity in Individuals Diagnosed With Mental Illness. *Journal of Psychosocial Nursing & Mental Health Services* 53(2): 32–37. DOI: 10.3928/02793695-20150120-01.

Wenger E (1998) *Communities of Practice : Learning, Meaning, and Identity*. Learning in doing, book. Cambridge, [England] ; New York, N.Y.: Cambridge University Press.

Westwood L and Baker J (2010) Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: A review of the literature. *Journal of Psychiatric and Mental Health Nursing* 17(7): 657–662. DOI: 10.1111/j.1365-2850.2010.01579.x.

White J, Gray R and Jones M (2009) The development of the serious mental illness physical Health Improvement Profile. *Journal of Psychiatric & Mental Health Nursing* 16(5). Wiley-Blackwell: 493–498. DOI: 10.1111/j.1365-2850.2009.01375.x.

White J, Hemingway S and Stephenson J (2014) Training Mental Health Nurses to Assess the Physical Health Needs of Mental Health Service Users: A Pre- and Post-test Analysis. *Perspectives in Psychiatric Care* 50(4): 243–250. DOI: 10.1111/ppc.12048.

White MJ and White GB (2006) Implicit and Explicit Occupational Gender Stereotypes. *Sex roles* 55(3). article. New York: Kluwer Academic Publishers-Plenum Publishers: 259–266. DOI: 10.1007/s11199-006-9078-z.

Wilensky HL (1964) The Professionalization of Everyone? *The American journal of sociology* 70(2). article. Chicago: University of Chicago Press: 137–158. DOI: 10.1086/223790.

Williamson K, Given LM and Scifleet P (2017) Qualitative data analysis. In: *Research Methods: Information, Systems, and Contexts: Second Edition*. DOI: 10.1016/B978-0-08-102220-7.00019-4.

Willis, Lord (2015) *Raising the Bar Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants*. London: Health Education England.

Windsor C, Douglas C and Harvey T (2012) Nursing and competencies - a natural fit: The politics of skill/competency formation in nursing. *Nursing Inquiry* 19(3): 213–222. DOI: 10.1111/j.1440-1800.2011.00549.x.

World Health Organization (1948) Constitution of the World Health Organisation. *1948*. Geneva: WHO. Available at: https://www.who.int/about/who-we-are/constitution (accessed 18 October 2020).

World Health Organization (2012) *Mental health action plan 2013 - 2020. WHO*. Geneva: World Health Organization. Available at: http://www.who.int/entity/mental_health/publications/action_plan/en/index.html (accessed 19 October 2020).

World Health Organization (2015) Excess Mortality in Severe Mental Disorders. Meeting report. *Geneva, World Health Organization* (November): 1–82.

World Health Organization (2017a) Mental Health ATLAS 2017. World Health Organization. Available at: http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/ (accessed 19 October 2020).

World Health Organization (2017b) *WHO | Helping people with severe mental disorders live longer and healthier lives. WHO*. Geneva: World Health Organization.

World Health Organization (2018) *Management of Physical Health Conditions in Aduts with Severe Mental Disorders. WHO Guidelines*. Available at: http://apps.who.int.iris (accessed 18 February 2020).

World Health Organization (2020) *State of the World's Nursing 2020: investing in education, jobs and leadership*.

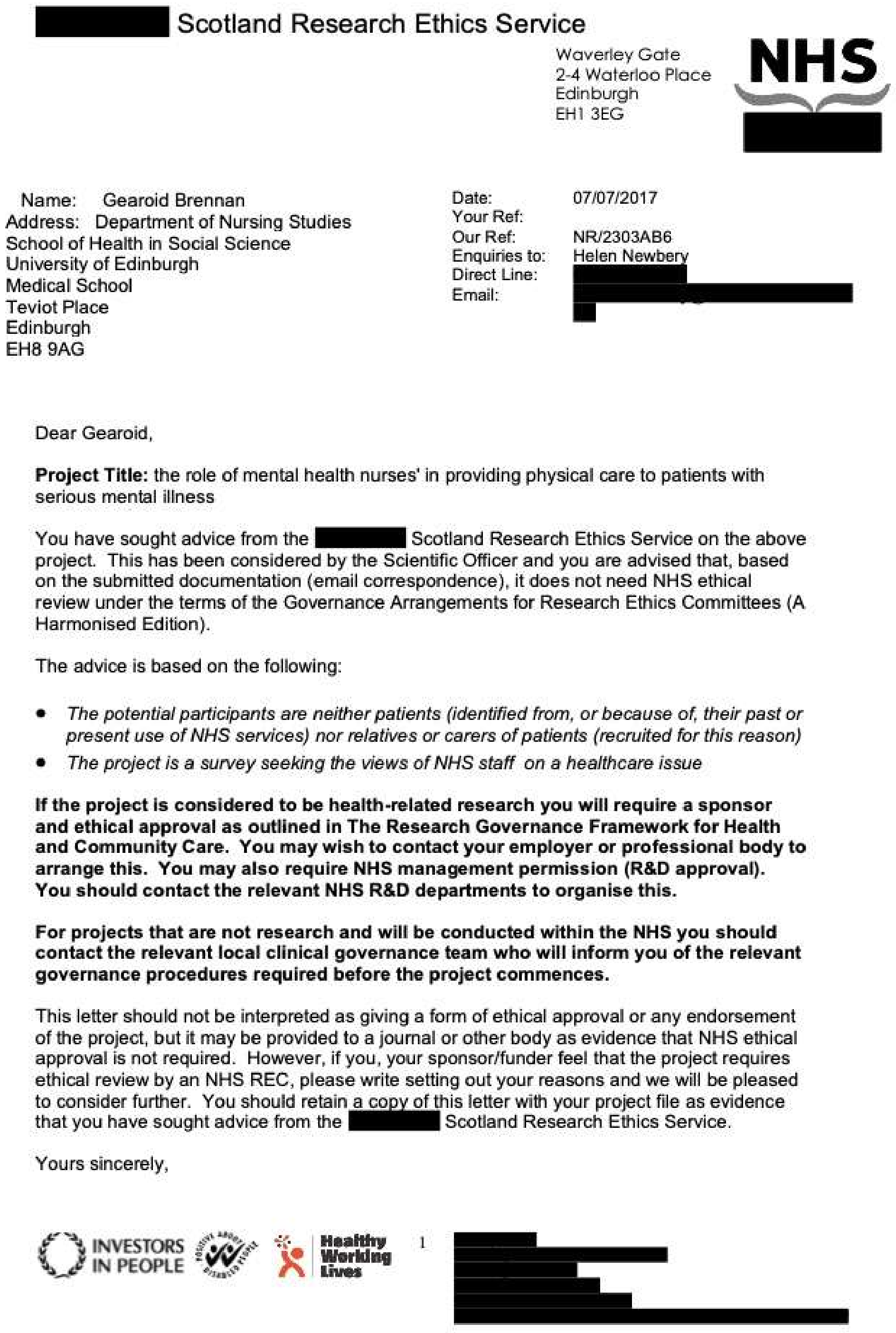
Wynaden D and Heslop K (2016) Providing leadership on a hidden issue: Where are the mental health nurses? *International Journal of Mental Health Nursing*, 1 March. Blackwell Publishing. DOI: 10.1111/inm.12207.

Wynaden D, Heslop B, Heslop K, et al. (2016) The chasm of care: Where does the mental health nursing responsibility lie for the physical health care of people with severe mental illness? *International Journal of Mental Health Nursing* 25(6): 516–525. DOI: 10.1111/inm.12242.

# Appendices

Appendix A: Letter from ACCORD ........ 307
Appendix B: Letter confirming favourable ethical opinion ........ 309
Appendix C: Letter confirming R&D approval ........ 311
Appendix D: Participant Information Sheet ........ 313
Appendix E: Consent form ........ 317
Appendix F: Data Management Plan ........ 319
Appendix G: Recruitment Poster ........ 323
Appendix H: Demographic Questionnaire ........ 325
Appendix I: Interview Guide ........ 329
Appendix J: Transcription Notation System ........ 331
Appendix K: Diagram mapping of the field ........ 333

# Appendix A: Letter from ACCORD



[redacted] Scotland Research Ethics Service

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

NHS
[redacted]

Name: Gearoid Brennan
Address: Department of Nursing Studies
School of Health in Social Science
University of Edinburgh
Medical School
Teviot Place
Edinburgh
EH8 9AG

Date: 07/07/2017
Your Ref:
Our Ref: NR/2303AB6
Enquiries to: Helen Newbery
Direct Line: [redacted]
Email: [redacted]

Dear Gearoid,

**Project Title:** the role of mental health nurses' in providing physical care to patients with serious mental illness

You have sought advice from the [redacted] Scotland Research Ethics Service on the above project. This has been considered by the Scientific Officer and you are advised that, based on the submitted documentation (email correspondence), it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees (A Harmonised Edition).

The advice is based on the following:

- *The potential participants are neither patients (identified from, or because of, their past or present use of NHS services) nor relatives or carers of patients (recruited for this reason)*
- *The project is a survey seeking the views of NHS staff on a healthcare issue*

**If the project is considered to be health-related research you will require a sponsor and ethical approval as outlined in The Research Governance Framework for Health and Community Care. You may wish to contact your employer or professional body to arrange this. You may also require NHS management permission (R&D approval). You should contact the relevant NHS R&D departments to organise this.**

**For projects that are not research and will be conducted within the NHS you should contact the relevant local clinical governance team who will inform you of the relevant governance procedures required before the project commences.**

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that NHS ethical approval is not required. However, if you, your sponsor/funder feel that the project requires ethical review by an NHS REC, please write setting out your reasons and we will be pleased to consider further. You should retain a copy of this letter with your project file as evidence that you have sought advice from the [redacted] Scotland Research Ethics Service.

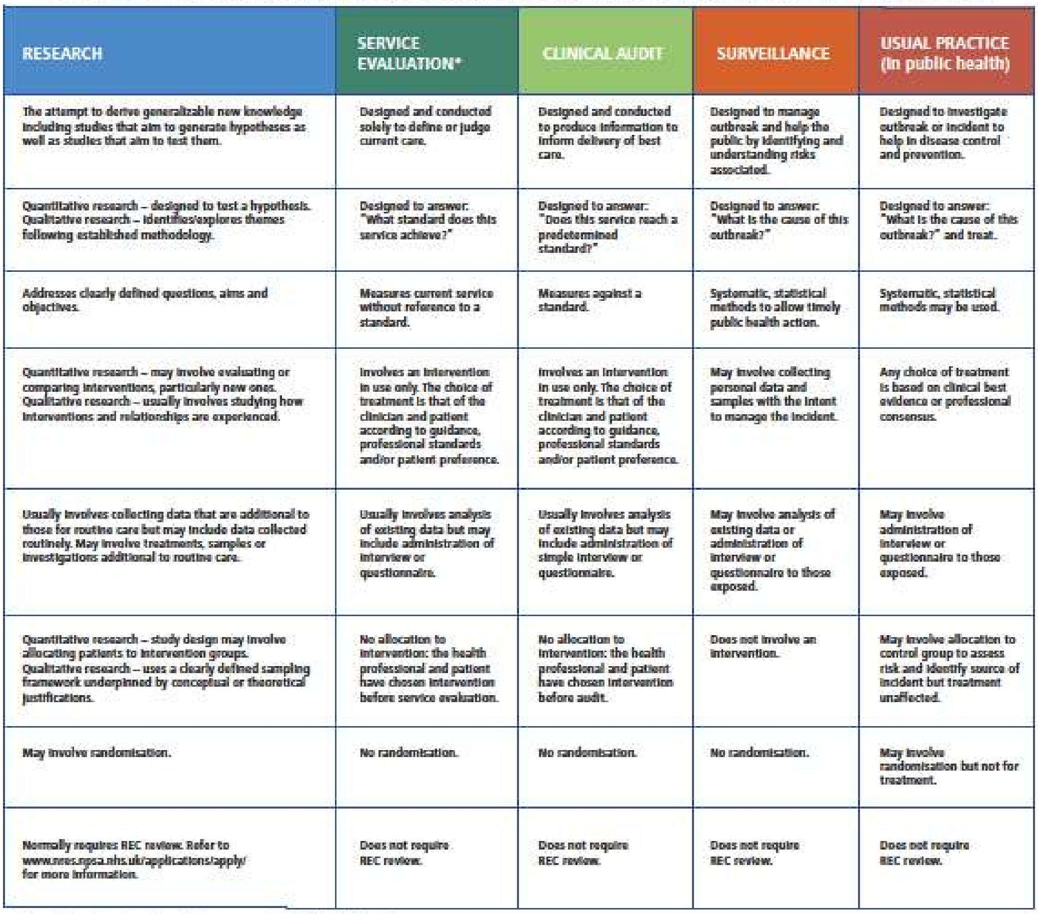
Yours sincerely,

INVESTORS IN PEOPLE
Healthy Working Lives
1

[redacted]

Helen Newbery
Scientific Officer
[redacted] Scotland Research Ethics Service

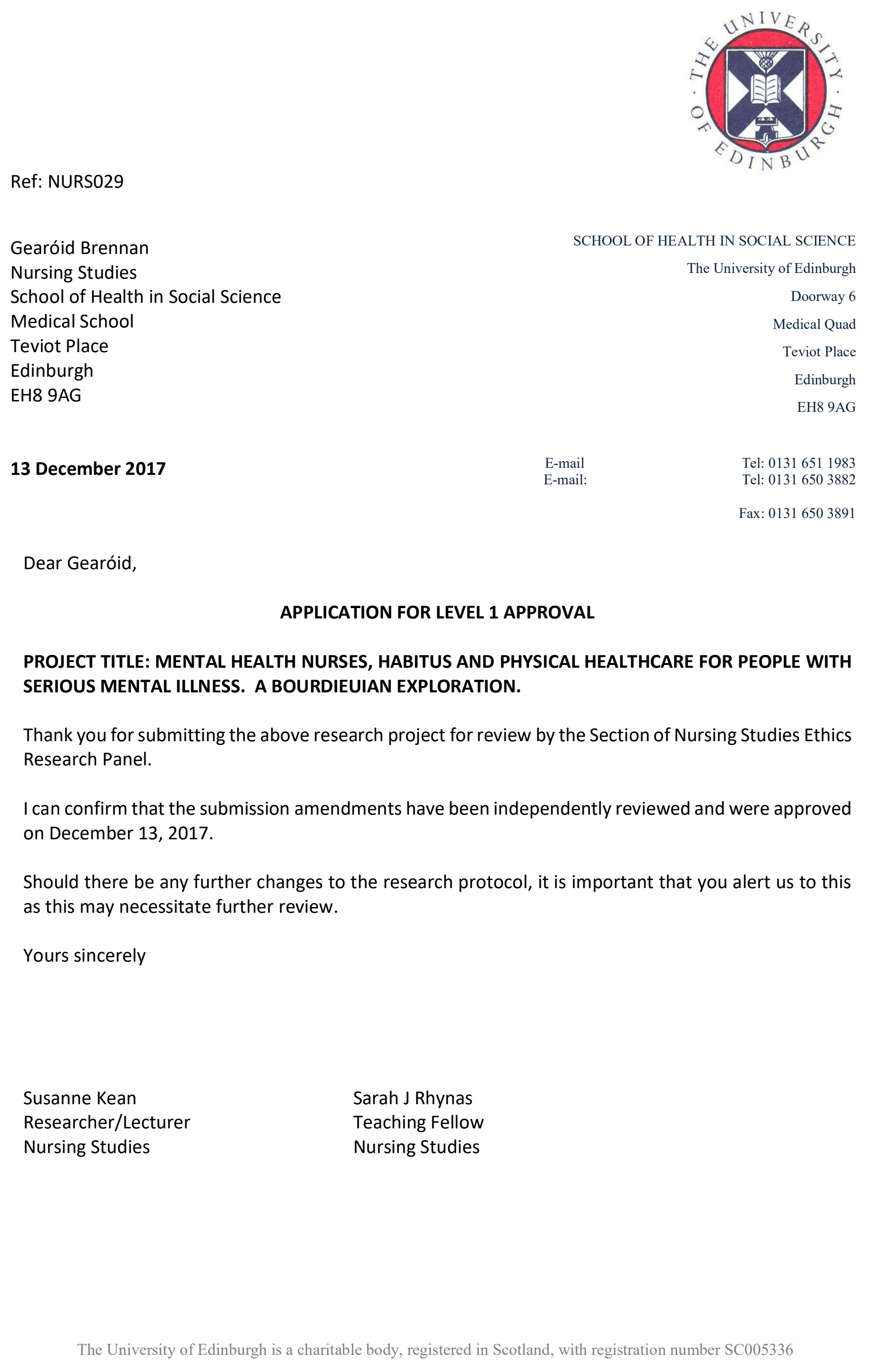
## Differentiating clinical audit, service evaluation, research and usual practice/surveillance work in public health



| RESEARCH | SERVICE EVALUATION* | CLINICAL AUDIT | SURVEILLANCE | USUAL PRACTICE (in public health) |
|---|---|---|---|---|
| The attempt to derive generalizable new knowledge including studies that aim to generate hypotheses as well as studies that aim to test them. | Designed and conducted solely to define or judge current care. | Designed and conducted to produce information to inform delivery of best care. | Designed to manage outbreak and help the public by identifying and understanding risks associated. | Designed to investigate outbreak or incident to help in disease control and prevention. |
| Quantitative research – designed to test a hypothesis.<br>Qualitative research – identifies/explores themes following established methodology. | Designed to answer: "What standard does this service achieve?" | Designed to answer: "Does this service reach a predetermined standard?" | Designed to answer: "What is the cause of this outbreak?" | Designed to answer: "What is the cause of this outbreak?" and treat. |
| Addresses clearly defined questions, aims and objectives. | Measures current service without reference to a standard. | Measures against a standard. | Systematic, statistical methods to allow timely public health action. | Systematic, statistical methods may be used. |
| Quantitative research – may involve evaluating or comparing interventions, particularly new ones.<br>Qualitative research – usually involves studying how interventions and relationships are experienced. | Involves an intervention in use only. The choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference. | Involves an intervention in use only. The choice of treatment is that of the clinician and patient according to guidance, professional standards and/or patient preference. | May involve collecting personal data and samples with the intent to manage the incident. | Any choice of treatment is based on clinical best evidence or professional consensus. |
| Usually involves collecting data that are additional to those for routine care but may include data collected routinely. May involve treatments, samples or investigations additional to routine care. | Usually involves analysis of existing data but may include administration of interview or questionnaire. | Usually involves analysis of existing data but may include administration of simple interview or questionnaire. | May involve analysis of existing data or administration of interview or questionnaire to those exposed. | May involve administration of interview or questionnaire to those exposed. |
| Quantitative research – study design may involve allocating patients to intervention groups.<br>Qualitative research – uses a clearly defined sampling framework underpinned by conceptual or theoretical justifications. | No allocation to intervention: the health professional and patient have chosen intervention before service evaluation. | No allocation to intervention: the health professional and patient have chosen intervention before audit. | Does not involve an intervention. | May involve allocation to control group to assess risk and identify source of incident but treatment unaffected. |
| May involve randomisation. | No randomisation. | No randomisation. | No randomisation. | May involve randomisation but not for treatment. |
| Normally requires REC review. Refer to www.nres.npsa.nhs.uk/applications/apply/ for more information. | Does not require REC review. | Does not require REC review. | Does not require REC review. | Does not require REC review. |

* Service development and quality improvement may fall into this category.

# Appendix B: Letter confirming favourable ethical opinion



Ref: NURS029

Gearóid Brennan
Nursing Studies
School of Health in Social Science
Medical School
Teviot Place
Edinburgh
EH8 9AG

SCHOOL OF HEALTH IN SOCIAL SCIENCE
The University of Edinburgh
Doorway 6
Medical Quad
Teviot Place
Edinburgh
EH8 9AG

E-mail
E-mail:
Tel: 0131 651 1983
Tel: 0131 650 3882

Fax: 0131 650 3891

**13 December 2017**

Dear Gearóid,

**APPLICATION FOR LEVEL 1 APPROVAL**

**PROJECT TITLE: MENTAL HEALTH NURSES, HABITUS AND PHYSICAL HEALTHCARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS. A BOURDIEUIAN EXPLORATION.**

Thank you for submitting the above research project for review by the Section of Nursing Studies Ethics Research Panel.

I can confirm that the submission amendments have been independently reviewed and were approved on December 13, 2017.

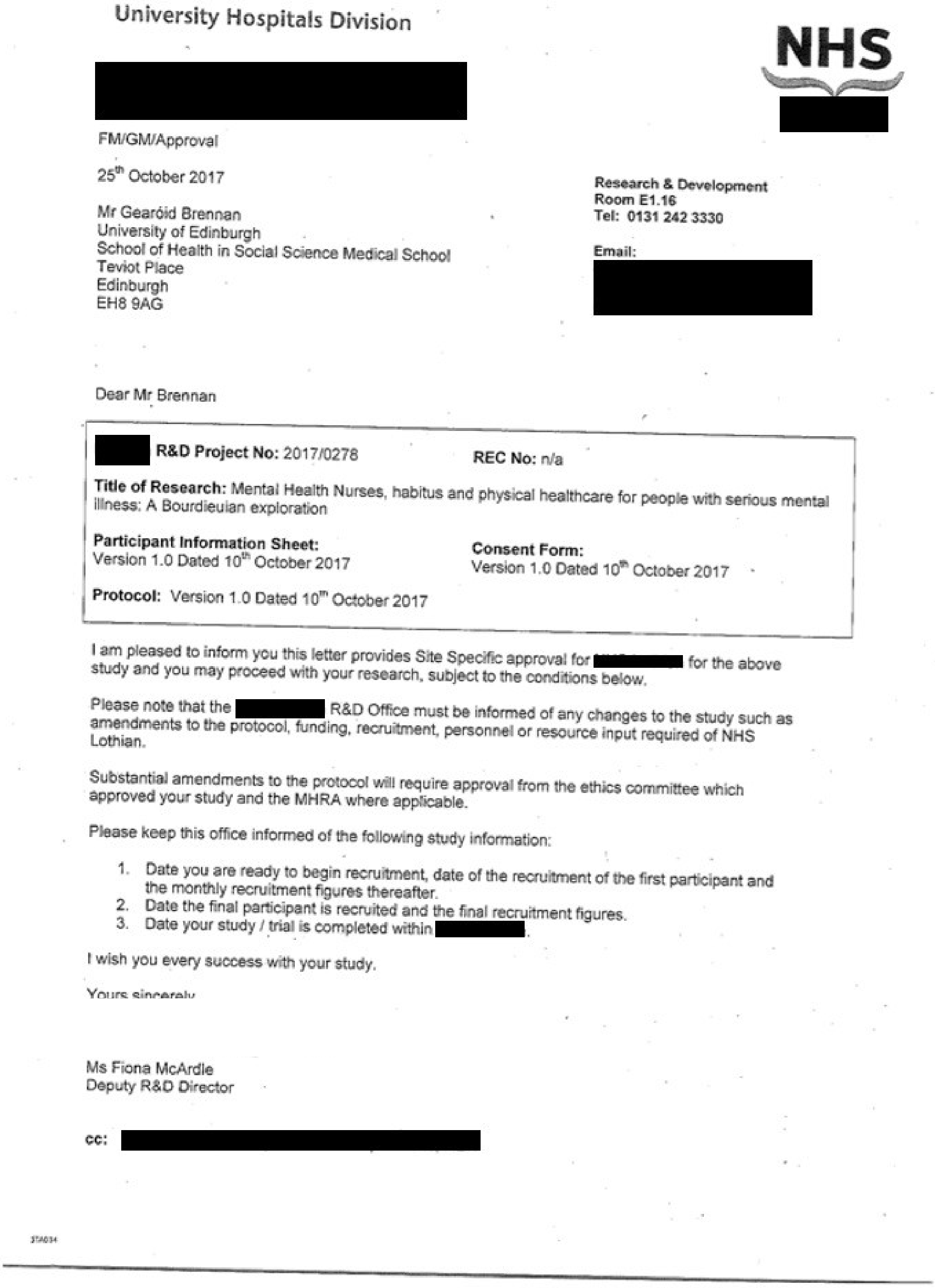
Should there be any further changes to the research protocol, it is important that you alert us to this as this may necessitate further review.

Yours sincerely

Susanne Kean
Researcher/Lecturer
Nursing Studies

Sarah J Rhynas
Teaching Fellow
Nursing Studies

# Appendix C: Letter confirming R&D approval



University Hospitals Division

[redacted]

[redacted]

Research & Development
Room E1.16
Tel: 0131 242 3330

Email:
[redacted]

FM/GM/Approval

25th October 2017

Mr Gearóid Brennan
University of Edinburgh
School of Health in Social Science Medical School
Teviot Place
Edinburgh
EH8 9AG

Dear Mr Brennan

[redacted] **R&D Project No:** 2017/0278 **REC No:** n/a

**Title of Research:** Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuian exploration

**Participant Information Sheet:** Version 1.0 Dated 10th October 2017

**Consent Form:** Version 1.0 Dated 10th October 2017

**Protocol:** Version 1.0 Dated 10th October 2017

I am pleased to inform you this letter provides Site Specific approval for [redacted] for the above study and you may proceed with your research, subject to the conditions below.

Please note that the [redacted] R&D Office must be informed of any changes to the study such as amendments to the protocol, funding, recruitment, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please keep this office informed of the following study information:

1. Date you are ready to begin recruitment, date of the recruitment of the first participant and the monthly recruitment figures thereafter.
2. Date the final participant is recruited and the final recruitment figures.
3. Date your study / trial is completed within [redacted].

I wish you every success with your study.

Yours sincerely

Ms Fiona McArdle
Deputy R&D Director

**cc:** [redacted]

# Appendix D: Participant Information Sheet

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

## Participant Information Sheet

Study Title: **Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuian exploration.**

Name of Lead Researcher: **Mr. Gearóid Brennan**
PhD Student, Department of Nursing Studies.

I would like to invite you to take part in a research project. It is important that you read and understand the following information about the project before you decide if you would like to take part or not. Please feel free to ask me any questions about the information in this sheet or the project. You can contact me using the details found at the end of this information sheet or if you see me visiting your area of work.

**1. What is the purpose of the study?**
This research project aims to find out how mental health nurses think about physical healthcare and how this relates to their day-to-day practice. The project wants to find out nurses' experiences and the things that help or hinder them in meeting their patients' physical healthcare needs. This study will form part of the requirements for a PhD degree.

**2. Who will conduct the research?**
The research will be conducted by Gearóid Brennan. Gearóid is a PhD student at the School of Health in the University of Edinburgh. Gearóid is a registered mental health nurse and works clinically [redacted] The research will be supervised by Dr. Rosie Stenhouse, Lecturer at at the School of Health, University of Edinburgh and Professor Graeme D. Smith, based at Edinburgh Napier University.

**3. Why have I been invited?**
You have been asked to take part because you are a registered mental health nurse, working with adults with serious mental illness. These are conditions such as psychosis, bipolar affective disorder, clinical depression and personality disorders. You work in 'general adult psychiatry' services, either in the community, in inpatient services or in a crisis intervention team. Nurses who are dual trained (RMN/RN or RMN/RNLD or RMN/RCN etc.) can also take part.

**4. Do I have to take part?**
No. You are under no obligation to participate in the project. It is up to you if you want to take part or not. The project is completely separate from the NHS. Your decision to take part will not affect your employment within the health board.

**5. What will happen if I do decide to take part?**
If you do decide to take part, you will be given this information sheet to keep. Then;

*Giving consent*: Gearóid will meet with you to discuss the study and what it will involve.

*...cont/*

*…cont/*

*Background information:* You will also be asked to fill in a very short questionnaire that will ask you for some background information, such as how long you have been a nurse etc.

*Interview:* Gearóid will meet with you once for a single interview. The interview will be loosely structured and you will be asked talk about your own thoughts, feelings and experiences of providing physical health care for people with serious mental illness. The interview will be held at a time and place that is suitable to you. Some people may choose to be interviewed in their place of work, a place near the hospital or in the university. In total, it should take no longer than an hour and a half (90 minutes) to complete the whole process.

*Findings:* Gearóid will provide you with a brief summary of the main findings when available and can discuss them further with you, if you wish.

You are free to withdraw at any time and you do not have to give a reason for doing so. Your decision will not affect your employment.

**6. What are the possible risks or disadvantages of taking part?**

The main risk may be the burden on your time. The interview itself is meant to be a relaxed process. Another risk may be if you disclosed something such as committing a serious crime or disclosed something that might make the researcher think there was significant risk to you or someone in your care. If this did happen, confidentially would have to be broken.

**7. Are there any possible benefits to taking part?**

Participants will have the opportunity to discuss and reflect on their work, which has been found to be helpful in developing practice. In the longer term, it is hoped that physical healthcare for people with mental illness will be better understood and therefore improved.

**8. What happens when the study ends?**

When all the interviews are finished, the researcher will analyse the data and divide the data into 'themes' which will help us answer the project aims.

**9. Will my taking part in the study be kept confidential?**

Yes. Your participation will not be discussed with anyone else except the researcher's supervisor at the University of Edinburgh. The supervisors will only know participants by their participant number and not their names.

Your employer or your work colleagues will not be told that you participated. As the focus of this study is on the experiences of mental health nurses, you will be asked to anonymise any references to individual patients. The researcher is a registered nurse just like you. The only time they would break confidentiality if they felt there was a serious risk to the well-being of you or someone else.

Your interview will be recorded. The recording will be listened and transcribed by Gearóid. The auto-recording will be stored on university computer server which is encrypted and password protected and only accessible by the researcher. Interview transcriptions will be anonymised so that no individuals may be identified. 'Hard copy' data (e.g. data on digital voice recorders, printed documents, handwritten documents) will be stored in a locked cupboard in the School of Health at the University of Edinburgh. The cupboard is only accessible by the researcher and is located in a keypad-entry office. All data connected to the study will be managed in accordance with the University of Edinburgh Data Management Guidelines. Anonymised data will be held for three years after collection. This is in order to comply with the university's guidelines.

*…cont/*

*…cont/*

**10. What happens to the results?**
If you wish, the researcher can contact you when the final results are available and inform you what they are. This will be in the form of a short summary. The findings will be published in peer-reviewed academic journals and presented at some nursing conferences. You will not be identifiable from any of the data presented.

**11. Who is funding the project?**
This research project is part of a PhD study. The researcher's PhD is funded by a scholarship from the University of Edinburgh.

**12. Who has reviewed this study?**
This project has been reviewed by School of Health in Social Science Research Ethics Committee. It also has NHS management approval.

If you wish to make a complaint about this study or the conduct of the researcher, please contact the University of Edinburgh's Research Governance team via email at: resgov@accord.scot

**13. Contact information for further information?**
If you wish to discuss any aspect of this study with someone who isn't part of the research team, please get in touch with:

Dr. Sarah Rhynas, Teaching Fellow, Department of Nursing Studies
Telephone: 0131 650 3882 or email:

If you would like any more information, please get in touch with the lead researcher:

**Gearóid Brennan**
**PhD Student**
**School of Health in Social Science,**
**Department of Nursing Studies,**
**Medical School,**
**Teviot Place,**
**Edinburgh,**
**EH8 9AG.**

**Email:**

The project is supervised by:

| | | |
|---|---|---|
| Dr. Rosie Stenhouse | | Professor Graeme D. Smith |
| Telephone: 0131 651 5160 | & | Telephone: 0131 455 5620 |
| Email: | | Email: |

**Thank you for taking the time to read this information sheet.**

# Appendix E: Consent form

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

## Consent Form

**Participant number:**

☐ -- ☐☐

Study Title: **Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuian exploration.**

Name of Lead Researcher: **Mr. Gearóid Brennan**
PhD Student, Department of Nursing Studies.

**Please initial boxes**

| | | |
|---|---|---|
| 1. | I have read and understood the information sheet ( version 2, 12-DEC-2017) about the 'Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuan exploration' study. | ☐ |
| 2. | I have had an adequate opportunity to ask questions and these have been answered to my satisfaction. | ☐ |
| 3. | I understand that my participation is voluntary and I am free to withdraw from the study at any time without giving any reason and without my employment and/or legal rights being affected. | ☐ |
| 4. | I agree to my interview being audio recorded. | ☐ |
| 5. | I understand that my anonymised data will be securely stored by the University of Edinburgh for three years after the completion of the study and will then be destroyed in line with university guidelines. | ☐ |
| 6. | I understand that relevant sections of data collected during the study may be looked at by individuals from the Sponsor(s) ([redacted] and the University of Edinburgh). I give permission for those individuals to have access to my data. | ☐ |
| 7. | I understand that any quotations from the interview, used by the researcher in their written accounts of the research, will be fully anonymised. | ☐ |
| 8. | I understand that the interviews are confidential and will not be discussed outwith the interview itself except for their presentation as part of reports or peer-reviewed papers from the study where they will be fully anonymised. | ☐ |
| 9. | I agree to take part in the above study. | ☐ |

| | | | |
|---|---|---|---|
| **Person giving consent:** | ________________________<br>Name (Printed) | _________________________<br>Signature | ___________<br>Date |
| **Person taking consent:** | ________________________<br>Name (Printed) | _________________________<br>Signature | ___________<br>Date |

***1 x original- into project file; 1 x copy- to the participant***

Mental health nurses, habitus & physical health
Version 2, 12-DEC-2017
IRAS #: 233898 ConsentForm_20171212_v2 Page 1 of 1

# Appendix F: Data Management Plan

THE UNIVERSITY *of* EDINBURGH

DMP ONLINE

## DATA MANAGEMENT PLAN

### A. ADMIN DETAILS

**1. Project Name**: Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuian exploration.
**2. Principal Investigator / Researcher:** Gearoid Brennan
**3. Co-Investigator / Researcher(s):** Dr. Rosie Stenhouse, Professor Graeme D. Smith
**4. Institution:** Department of Nursing Studies, School of Health in Social Science
**5. Funding:** University of Edinburgh Principal's Career Development Scholarship
**6. Description:** This research project is being undertaken as part of a PhD study in Nursing Studies in the School of Health in Social Science. The research project is exploring how mental health nurses working within one Scottish NHS health board perform their role regarding physical health care for people with serious mental illness. The project aims to address the following questions;

- Find out how relationships and structures within the work environment impact on mental health nursing practice?
- In what way do educational experiences and competencies assist mental health nurses in performing their role?

The data being collected are qualitative data in the form of interviews. There will also be some brief demographic details recorded. The data is being collected so it can be properly analysed in order to answer the above questions. The researcher will also keep a reflective diary to help create rigour and quality. This process is help to clarify the position of the researcher within the study.

### B. DATA CAPTURE

**1. What data will be generated or reused in this research? Outline the volume, type, format etc.**

There are three main forms of data being collected in this project;

*1. Demographic details*: This will be collected via a short, paper-based questionnaire. It will ask questions about participants' educational background, nurse registration(s) and area of clinical practice. No personal identifiable details such as names or phone numbers will be asked. Demographic data will be transcribed into a Microsoft Excel spreadsheet to aid presentation in write-ups.

*2. Semi-structured qualitative interviews*: This will be the main form of data generated. Interviews will be recorded on an approved, encrypted digital recorder, provided by the School of Health in Social Science. Interviews will be transcribed and anonymised before being uploaded to NVivio qualitative analysis software. The project aims to interview approx. 12-16 nurses. Interviews should last no more than one hour.

*3. Reflective diary*: The purpose of the reflective diary is for the researcher to record their thoughts and opinions throughout the research process. It is a commonly used technique in qualitative research. The diary is mainly for the researcher, to help them make sense of their decision-making processes, as well as allowing them an outlet to reflect on their position within the research process and how it might impact on data collection and analysis.

Electronic data will be saved in the following format, as per UK Data Archive guidelines (Please see: http://www.data-archive.ac.uk/create-manage/format )

| | |
|---|---|
| Demographic data spreadsheet | .elsx |
| Digital recordings | .WAV or .mp3 |
| Interview transcriptions | .rtf or .pdf |
| Project documentation (protocol, consent forms etc.) | .rft or .pdf |
| Project write-ups | .rtf or .pdf |
| Document control database | .elsx |

The project does not plan on using any third party data beyond readily available health data that is published in official Scottish or UK government reports or NHSScotland. If these are used in the project write-up, they will be appropriately cited and referenced.

**2. How much data will be generated?**

- 500 GB - 2 TB

It is difficult to answer due to the nature of qualitative interviews. The project aims to interview approx. 12-16 nurses. For each interview there will be the digital recording and the interview transcript. The University has committed 0.5TB (500GB) of high quality storage with guaranteed backup and resilience to every active researcher. It is not intended to exceed this limit.

## C. DATA MANAGEMENT

**1. How will the data be documented to ensure it can be understood?**

The data collected will be the easily readable, as it will be the spoken word or transcripts of same. To help make data easily understood, the following will be adopted;

*Participant number*
On entering the study, each participant will be identified with a participant number. This will take the form of 'X-00'. The Letter will be used to identify their area of work (H= Hospital/Inpatient or C= community setting). The distinction between areas of work is to assist in analysing the data and addressing the research aims.

*Version control*
A Microsoft Excel spreadsheet will be kept for each project document, detailing the document version, the date amended and a brief note of any changes made. All versions of documents will be kept and stored for the duration of the project.

*File names*
All files relating to the project will be labelled as per the following examples;

| **Document** | **File name format and example** |
|---|---|
| Interview transcript | InterviewTranscript_Participant_YYYYMMDD_v1<br>*e.g. InterviewTranscript_H02_20170924_v1* |
| Interview audio | InterviewAudio_Participant_YYYYMMDD_v1<br>*e.g. InterviewAudio_H02_201709024_v1* |
| Consent form | ConsentForm_YYYYMMDD_v1<br>*e.g. ConsentForm_20170330_v1* |

*Directory*
Documents will be saved in the following directory system:
U:\Datastore\CHSS\hiss\s1462669\
Files will be arranged into folders, according to data type and will adopt the following directory structure;

U:\Datastore\CHSS\hiss\s1462669\PhDProject**InterviewTranscripts**
U:\Datastore\CHSS\hiss\s1462669\ PhDProject**InterviewAudio**
U:\Datastore\CHSS\hiss\s1462669\ PhDProject**ProjectDocuments**
U:\Datastore\CHSS\hiss\s1462669\ PhDProject**DataAnalysis**
U:\Datastore\CHSS\hiss\s1462669\ PhDProject**WriteUps**

**2. Where will the data be stored and backed-up?**
A) Paper records: Demographic questionnaires, consent forms and reflective diary
These will be stored in a locked filing cabinet that can only be accessed by the project PI. This cabinet is located in the Postgraduate Research Student office in the School of Health in Social Science, Teviot Place. Entry to this room is restricted via 'swipe access'. Consent forms, which contain participant signatures will be held in a separate locker within the same room. Only the Principal Investigator will have access to these storage lockers/cabinets.

B) Digital and electronic records: Interview digital/audio recordings, transcripts:
Such research data will be stored in DataStore. This is the University of Edinburgh's file storage system for active research data. It is stored on the School of Health in Social Science server, which is supported by the University of Edinburgh's Information Services. All data on this server is held securely and is automatically replicated to an off-site disaster facility and backed up with a 60-day retention period, with 10 days of file history visible online. This process is managed by the University of Edinburgh Information Services. All digital files will be encrypted as per University of Edinburgh guidelines and files will also be password protected. All data will be accessed via a secure password-protected recorder. All interviews will be recorded on an encrypted digital recorder which is also protected by a PIN code.

## D. INTEGRITY

**1. How will you quality assure your data?**
For further information of the quality measures for this project, please see the study protocol. This project will use reflexivity as a way of ensuring quality. This involves the researcher exploring the subjective nature of the study and their own influence on the process. Finlay (2003)[1] states there are numerous kinds of reflexivity. The one most relevant for this study is intersubjective reflexivity. This helps explore the mutual meaning involved in the researcher/participant relationship. It can help identify the nature of the relationship and the unconscious processes that structure it (Finlay 2003). It also takes account of the researcher's own emotional investment in the process (Finaly 2003, p8).

These reflections will be recorded in a diary so the researcher records thoughts and opinions regarding the process of collection and analysis, including the decision-making processes throughout the research process. This should also assist the researcher in viewing situations from different perspectives. Reflections will also include the researcher's own ambitions in the research agenda as well as identifying any power imbalances in relationships. The diary should make the researcher aware of their data interruption and how their own bias may affect meaning. The diary will be used as a basis for supervision meetings throughout the process.

---

[1] Finlay reference Finlay, L., 2003. The Reflexive Journey: Mapping Multiple Routes. In *Reflexivity*. Oxford, UK: Blackwell Science Ltd, pp. 3–20. Available at: http://doi.wiley.com/10.1002/9780470776094.ch1 [Accessed March 31, 2017].

Often the interviewer may experience difficult feelings and cannot identify why. Reflexivity may help resolve such feelings and reduce vulnerabilities (Thompson and Chambers 2012)[2]. The reflections will be used to demonstrate trustworthiness in the findings and extracts will be published to accompany any peer review journal articles. The study will also apply Braun and Clark's (2006)[3] 15-point checklist for good quality thematic analysis.

## E. CONFIDENTIALITY AND IPR

### 1. How will you manage any ethical and IPR issues?

All data collected will be kept confidential. As participants will be talking about direct patient care and their practice in mental health care, it is likely data will be sensitive. Confidentiality will be maintained by the use of participant numbers and not collecting or recording contact details. On entering the study, each participant will be identified with a participant number. This will take the form of 'X-00'. The Letter will be used to identify their area of work (H= Hospital/Inpatient or C= community setting). The distinction between areas of work is to assist in analysing the data and addressing the research aims.

Identifying information will be replaced with marked generic alternatives, indicated by square brackets. For example, “I worked in London” -> “I worked in [a large city]”
This will take place as the interview is being transcribed. The interview transcript will then be proof read to ensure there is no personal identifiable information.

Participants are free to participate and they can withdraw at any point in time. This will be explained to participants when they are recruited. All participants will be asked to sign a 'consent form'.

## F. PRESERVATION & SHARING

### 1. Which data do you plan to keep and for how long? Please note that this data should be recorded in Pure.

Data will be stored for a minimum of three years after the completion of the study. This is in accordance with the UK Research Integrity Office code of practice. This has been adopted by the University of Edinburgh. (Please see: http://www.ukrio.org/publications/code-of-practice-for-research).

### 2. Can you share your data? If not please clarify where it will be stored and preserved.

Data cannot be shared due to its sensitive nature. Data will be stored in Edinburgh DataVault on completion. This service has been jointly developed by the University of Edinburgh and the University of Manchester. It allows for the secure storage and encryption of research data.

### 3. Which data will be shared and how?

No data will be shared.

### 4. Are any restrictions on data sharing required?

No data will be made available on an open basis. Prior to dissemination in peer-reviewed journals or conference papers any identifiers will be removed from the data to protect the identity of the participants.

---

[2] Thompson, A.R. & Chambers, E., 2012. Chapter 3: Ethical issues in qualitative mental health Research. In D. Harper & A. Thompson, eds. *Qualitative Research Methods in Mental Health & Psychotherapy*. Chichester: John Wiley & Sons Ltd.

[3] Braun, V. & Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), pp.77–101. Available at: http://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa [Accessed March 31, 2017].

# Appendix G: Recruitment Poster

THE UNIVERSITY *of* EDINBURGH
School of Health in
Social Science

www.health.ed.ac.uk

## Are you a mental health nurse?

## Have you views about patients' physical health care?

**Research Opportunity**

## If you answered 'yes' then we would love to hear from you!

**Mental health nurses are needed to take part in a research study, exploring nursing roles in caring for people's physical health.**

**If you take part, you will be asked to complete a short questionnaire and give a face-to-face interview. Interviews should take no longer than an hour. You will be asked questions about your experiences and practice in caring for people's physical health needs**

For further information or to take part, please contact:
**Gearóid Brennan**
**PhD Student**
**gearoid.brennan@ed.ac.uk**

Photo courtesy of © iStock Images
The University of Edinburgh is a charitable body, registered in Scotland, with registration number SC005336

# Appendix H: Demographic Questionnaire

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

## Demographic background questionnaire

**Participant number:**

☐ -- ☐☐

| | |
|---|---|
| Study Title: | **Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuian exploration.** |
| Name of Lead Researcher: | **Mr. Gearóid Brennan**<br>PhD Student, Department of Nursing Studies. |

**1.** **What is your age?** ☐ years

**2.** **What is your gender?**

| | | |
|---|---|---|
| Female | ☐ | |
| Male | ☐ | |
| Other | ☐ | Please specify: |

**3.** **What is your current AfC banding?**

| | | |
|---|---|---|
| Band 5 | ☐ | |
| Band 6 | ☐ | |
| Band 7 | ☐ | |
| Band 8 (a, b, c or d) | ☐ | |
| Other | ☐ | Please specify: |

**4.** **How many hours do you work per week?** ☐ hours

**5.** **What year did you qualify as an RMN?** ☐

Mental health nurses, habitus & physical health
Version 2, 12-DEC-2017
IRAS #: 233898

**Participant no.:** ☐ - ☐☐

**6.** **How long have you worked as an RMN?** ☐ Years/months

**7.** **Which of these qualifications do you hold? Tick as many as relevant. Please also state;**

- **The year you achieved this?**
- **How long you worked in that field of practice after achieving the qualification?**

| | Year achieved | How long did you work in each one after qualifying |
|---|---|---|
| RNLD | ☐ | Years/months |
| RGN | ☐ | Years/months |
| RCN | ☐ | Years/months |
| RDN | ☐ | Years/months |
| RHV | ☐ | Years/months |
| Other | ☐ | Years/months |

**Please specify:** ☐

**8.** **Are you a qualified non-medical prescriber?**

Yes ☐

No ☐

**9.** **How long have you worked in your current post?** ☐ Years/months

**10.** **How long have you worked for the NHS Lothian?** ☐ Years/months

**Please turn over** ☞

Participant no.:

☐ - ☐☐

**11. What is your highest academic qualification reached to date?**

| | |
|---|---|
| Diploma | ☐ |
| Bachelor (Ordinary/ SCQF Level 9) | ☐ |
| Bachelor (Honours/ SCQF Level 10) | ☐ |
| Postgraduate Certificate/Diploma | ☐ |
| Masters degree | ☐ |
| Doctorate/PhD | ☐ |

**12 Which of the following best describes your practice area?**

| | |
|---|---|
| Acute inpatient | ☐ |
| Rehab inpatient | ☐ |
| Community (Secondary care) | ☐ |
| Primary Care | ☐ |
| Intensive Home treatment | ☐ |
| Day hospital | ☐ |
| Other | ☐ |

**13. How important is it to <u>you</u> within your current role to address the physical health needs of patients with SMI? Please tick one box.**

| | |
|---|---|
| Very important | ☐ |
| Important | ☐ |
| Somewhat important | ☐ |
| Not important | ☐ |

**Please turn over ☞**

**Participant no.:**

☐ - ☐☐

13. **Are you familiar with any policy or guidelines relating to the physical health needs of individuals with serious mental illness?**

Yes ☐

No ☐

**If yes, please provide details:**

☐

14. **Did you have an adult /general nursing placements during your pre-registration education?**

Yes ☐

No ☐

15. **If you answered 'yes' did this practice impact on your future practice? How have you noticed that it has impacted on your practice?**

☐

# Thank you for completing this questionnaire

# Appendix I: Interview Guide

## Interview guide

**Ice-breaker**

Can you tell me about your current role?
Can you tell me about your typical shift?

**Understanding physical healthcare**

What do you think physical healthcare means?
What do you personally understand about physical health care for people with SMI?
Where did these ideas come from?
Can you give me three examples of times when you provided physical healthcare or missed the opportunity to provide physical healthcare or advice in your current role?
What is the main outside influence in determining how you think about physical healthcare?
What is the main internal influence in determining how you think about physical healthcare?
Do you think your own personal values influence your practice?

**Education**

Can you tell me a little about your training?
Can you tell me about your educational experiences which dealt with physical healthcare?
Do you think education has made a difference?
Have you done any education on it since?
How easy was it to put this education into practice?
Is it that students don’t have enough education or is it that they cannot put that education into practice? Why/Why not?

**Patients**

What kind physical health stuff do you discuss with your patients?
How often?
How do you think patients feel about your intervening about their physical health?

**Policy**

Are you aware of any policies or guidelines related to physical health care?
- Local
- National
- International?

How do you think policy has impacted on your practice?
In what way think the mental health act or other pieces of legislation have impacted on this area of practice?
In what way has a rights-based approach to care made an impact on addressing physical healthcare for people with SMI

**MDT roles**

What kind of physical health problems do you discuss with other members of the nursing team?
What kind of physical health problems do you discuss with other members of the MDT?
Have you worked alongside many dual trained nurses?
What do you think about a specialist nursing role for PHC?

**Organization**

What kind of things do you do in your ward/area to address the physical health needs of patients?
What kinds of resources are available to help you to find out more about physical health in mental health?
What support does your organization provide to you in order to carry out this area of practice?
How do you interact with other services (non mental health) in addressing the physical health needs?

**Prompts**

Is that helpful?
Has that been useful?
Did you enjoy/not enjoy?
Can you tell me a bit more about that?
How does that fit?
Why do you think that?

# Appendix J: Transcription Notation System

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

## Transcription Notation System

Study Title: **Mental Health Nurses, habitus and physical healthcare for people with serious mental illness: A Bourdieuian exploration.**

Name of Lead Researcher: **Mr. Gearóid Brennan**
PhD Student, Department of Nursing Studies.

| | |
|---|---|
| **(.)** | A micropause - a pause of no significant length. |
| **(0.7)** | A timed pause - long enough to indicate a time. |
| **[ ]** | Square brackets show where speech overlaps. |
| **> <** | Arrows showing that the pace of speech has quickened. |
| **< >** | Arrows showing that the pace of the speech has slowed down. |
| **( )** | Unclear section. |
| **(( ))** | An entry requiring comment but without a symbol to explain it. |
| **Underlining** | Denotes a raise in volume or emphasis. |
| ↑ | Rise in intonation |
| ↓ | Drop in intonation |
| → | Entered by the analyst to show a sentence of particular interest. Not usually added by the transcriber. |
| **CAPITALS** | Louder or shouted words. |
| **(h)** | Laughter in the conversation/speech. |
| **=** | Will be at the end of one sentence and the start of the next. It indicates that there was no pause between them. |
| **: : :** | Colons - indicate a stretched sound. |

# Appendix K: Diagram mapping of the field