In Brooker C & White E (eds.) *Mental Health Nursing: from the outside, looking in*. Cheshire: White Winstanley, pp. 121-124. https://whitewinstanley.com/MHNmonograph

A career of some thirty years in mental health nursing practice and education leads one to wonder have there been advances since Barker (1990) and Gournay (2001), amongst others, were discussing the role and identity of mental health nurses and the ideological tussle between the *art* and the *science* of mental health nursing. As a student nurse of the late 80's brought up on a diet of Maudsley encounter groups, punctuated with clinical practice in nurse led teams, the tussle made sense. And still does.

Influences on professional characteristics are often local to our known world. In the late 1990's health and politics were perhaps not as entwined as they are now but nevertheless, there was a whiff of new opportunities in the air. The Labour party first term of office began in 1997 and Scotland celebrated its identity as a devolved nation in 1999. After years of the Thatcher government there was a fresh brightness and a sense of freedom to fully embrace values of equality and social justice. Community mental health services grew and community schools opened, offering learning and support for all age groups. Places for everyone to gather and share the universal provision of health and social care. The country had moved way beyond the language of deinstitutionalisation to understanding that mental ill health was a human experience that nurses could engage with relatively easily, and with humanity.

Around this time, Edinburgh was given the opportunity to bring some of these ideologies into medical and psychiatric service provision. Although the first case of AIDS was identified in 1982 it wasn't until the 1990's, when Edinburgh notoriety as the AIDS capital of Europe stuck fast, that efforts were made to respond to the complex psychological needs of the infected injecting drug using community. Along came innovative palliative care; addictions services; and community support teams. Largely facilitated by mental health nurses, these services were established to delve into the duality of the Edinburgh scene; not the castle and the beautiful houses of the new town, but the abject poverty, second and third generation unemployment, older siblings parenting younger siblings. Acute physical ill health in combination with injecting drug use, HIV infection and complex psychological issues resulted in many difficulties in the provision of mental and physical care and support (Brettle, 1995).

This was the post Thatcher legacy and mental health nurses were somewhat out of their depth, having been moved out of acute services and dropped into the quagmire of societal mess. It was a small crumb of comfort that such severe social and economic deprivation gave mental health services the opportunity to develop beyond the simple models of community care. The desperate plight of many of those infected and affected by HIV and AIDs paradoxically provided that opportunity. Many nurses were at the forefront of responding to complex social, and physical needs, with mental health needs being the most pressing (Sandeman & Conlon 1996; Pratt 2003; Hodgson 2014).

As Gournay comments in 2001, nursing and mental health services generally were still driven by their noses rather than the research. So, the nursing workforce continued to be undertrained and prepared for incredibly complex care scenarios. The work in communicable diseases was no different. However, in the HIV community, the voice of the service user in the shape of third sector organisations such as 'Positive Help'; 'Waverley Care' and displays of the 'Memorial Quilt' was beginning to be heard. Intuitively, one knew that language of 'patient' or 'sufferer' was not ethically right nor grammatically accurate. Patients are people, people are nurses, and nurses are patients. We are all one homogenous group.

Did this ethos transfer to the more everyday mental health services? It took a little time before, there was comfort in the language of the 'client' or the 'person', and the mental health nurse rather than the 'psychiatric' nurse and the recognition that 'diagnosis' was not the only game in town. Once again, Scotland led the way with the most progressive piece of mental health legislation in Europe. The

Mental Health (Care and Treatment) Scotland Act (2003) was formed from the work of the Millan Committee. The group set to paper the ten core principles, with the 'least restrictive alternative' and reciprocity at its heart (Lyons 2008). The voice of the service user was central to the construction of the legislation. In 2006, *Rights, Relationship and Recovery* called on educationalists and mental health practitioners to actively and decisively adopt a recovery focused, values-based and person centred approach to all mental health services. The voice of experience was not that of the mental health nurse or doctor, but that of the person. The person who has a diagnosis or not. The person experiencing mental distress. Rights, Relationships and Recovery arrived just at the peak of the Mid Staffs scandal. Once again, nurses were empowered by the political and social policy, but slammed by the systemic failures of failing institutions.

Nevertheless, it was a catalyst for a much needed push forward towards refocusing practice on the building of relationships. A welcome return to the days of Annie Altshchul, a professor of nursing at Edinburgh and respected proponent of the 'ordinary' in the nurse patient relationship (Winship 2009). Higher education institutions became more confident in finding alternatives to the teachings of diagnostic criterion by instead working with the voice of the expert service user. The pioneering work of Rogers and Pilgrim (2003), *Mental health and Inequality* as well as that of Wilkinson and Pickett in *The Spirit Level* (2009), provided mental health lecturers the opportunity to teach to the evidence as well as the ideology, of social justice.

Scotland is hanging on in there to retain its place as one of the more progressive countries in relation to health and social care policy and mental health legislation. However, austerity continues to bite hard and politicians ignore the belief of at least half of the Scottish population; that poorer health is a result of an unjust society (ScotCen 2018). There remains some relatively liberal social policy. Free prescriptions for all, free public transport to the over 60's, and these are all to be welcomed. In addition, the pervasive infiltration of the private sector has not impacted core mental health services in Scotland to the same degree as it has in the in the rest of the UK.

The future of the mental health nurse is uncertain. The invasion of the belief that one field of nursing or the 2+1+1 model suggested by Lord Willis in the report on the future of nurse education (2012) is percolating through the public and policy makers alike. In the uncertain climate of a post Brexit era, will we be able to sidestep the economic and politically convenient truth, that the NHS in the UK is dying on its feet? The growth in digital technology in healthcare offers liberation to practitioners and service users alike, but it also risks reducing the complexity of human psychology to metrics and outcomes. The sun on the horizon is the growing public understanding that care of our mental and emotional well-being requires parity of care with physical well-being.

Mental health is a concept we all now have some understanding of. It is almost becoming normalised in every day conversation. Trauma is now a word heard in schools and community groups. The Trauma Informed Training Plan (2018) reaches out to mental health nurses, police, teachers, social workers and all other front line professionals in an effort to reframe understanding from *'what's wrong with you'* to '*what's happened to you',* a powerful line of enquiry through which a person's story can be heard, affirmed and validated. In addition, the increasing influence of part popular psychology, part research, such that of Johann Hari's *Lost Connections* (2018) is spreading word and knowledge, that biological explanations are increasingly outnumbered by social and psychological explanations and that there are huge limitations to simply engaging with symptom control and medicine management.

It is unclear yet whether the service user movement, trauma informed and recovery focused practice will finally dispel the power of the medical model and whether mental health nurses will ever feel

legitimacy to practice to, not their own ideology, but that which reflects the values of the communities and societies they represent.

What is clear is that mental health nurses are hearing the dialogue that normalise the mental ill health too. The messages come from individuals they can relate to, those that are far removed from the life of a psychiatrist. Mental health nurses need to grasp this as an opportunity to step into the everyday world of the people they are supporting. It will take courage and passion to move beyond the continual din of clozapine, diagnostic criteria and jangling alarms but there are some being taken into that direction. Idealists, innovators and future influences, are moving to the third sector where the power imbalance is less acute and where their voice will be heard loud and clear. Let's hope we don't lose too man along the way because patients are people, people are nurses, and nurses are patients. We are all one homogenous group.

(1520)

References

Altschul, A. (1972). Patient-nurse Interaction: A study of Interaction patterns in Acute Psychiatric Wards. Harcourt Brace/Churchill Livingstone.

Barker, P. (1990). The conceptual basis of mental health nursing. *Nurse Education Today*. 10, 5. 339 – 348.

Brettle, R.P. (1995). Injecting drug use-related HIV healthcare-problems and management in Edinburgh. *International Journal of STD & AIDS*. 6(3) 188-196.

Gournay, K. (2001). The more it changes the more it remains the same. *Journal of Psychiatric and Mental Health Nursing.* Available from:

http://web.a.ebscohost.com.ezproxy-s1.stir.ac.uk/ehost/pdfviewer/pdfviewer?vid=3&sid=c280dc1a-352b-4cb2-bdf7-68af5b0287bd%40sessionmgr4006

Hodgson, I. (2014). HIV care and prevention: nurses still at the forefront. *HIV Nursing*. December 1st

Lyons, D. (2008). New mental health legislation in Scotland. *Advances in Psychiatric Treatment* vol 14 28-97

NHS Education for Scotland. (2018). *The Scottish Psychological Trauma Training Plan*. Edinburgh: NHS Education for Scotland.

Rogers, A and Pilgrim, D (2003). *Mental Health and Inequality*, Basingstoke, Palgrave/Macmillan.

Sandeman, D. & Conlon, M. (1996). Caring for the mental health needs of people with HIV/ADIS. *Mental Health Nursing* Nov. 16(6) 24-25

ScotCen (2018). Injustice on society is reason for poorer health, say Scots. ScotCen. Available from: http://scotcen.org.uk/news-media/press-releases/2018/june/injustice-in-society-is-reason-for-poor-health,-say-scots/

Scottish Government (2006). *Rights Relationships and Recovery. The Report of the National Review of Mental Health Nursing in Scotland*. Edinburgh: Scottish Government.

Pickett, K & Wilkinson, R. (2009). *The Spirit Level: Why equal societies always do better*. London: Penguin Books.

Winship, G. (2009). Collective biography and the legacy of Hildegard Peplau, Annie Altschul and Eileen Skellern: the origins of mental health nursing and its relevance to the current crisis in psychiatry. *Journal of Nursing Research*. 14(6) 505-517

Supporting Sources/Bibliography

Hari, J. (2018). *Lost Connections: uncovering the real causes of depression – and the unexpected solutions.* London: Bloomsbury

Positive Help www.positivehelpedinburgh.co.uk

The UK/ AIDS Memorial Quilt www.positivelyuk.org

Pratt, R. (2003). *HIV & AIDS: A foundation for nursing and healthcare practice*. Hodder Arnold.

Waverley Care www.waverleycare.org