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Helpful encounters with mental health nurses in Australia: A survey of service users and their supporters

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Accessible Summary

What is known about the subject?

Most nurses who work in mental health in Australia have completed a comprehensive nursing programme at a university. This training has been widely criticized and has not produced "job-ready" graduates. Public inquiries into mental health services have highlighted the need for transformation of mental health services and concern about future nursing shortages.

What the paper adds to existing knowledge?

This survey highlights what service users and supporters perceive are useful nursing skills and capabilities. The characteristics of helpful encounters with nurses are also described.

What are the implications for practice?

Helpful nursing practice is aligned with traditional nursing values and theory, rather than the performance of specific tasks. Improving the retention of nurses to this specialty area of practice requires educational processes to enable nurses to enact values, develop their therapeutic potential and undertake facilitative and supportive practices which are helpful to service users.

Abstract

Introduction: Successive inquiries into mental health services in Australia have identified the need for major reform of services and proposed a return to direct-entry nursing training.

Aim/Question: To identify what service users, family and supporters have found helpful in their encounters with nurses in mental health settings.

Method: A survey of 95 service users and supporters rated the importance of the capabilities and competencies of nurses. They also shared examples of helpful encounters with nurses which were subject to thematic analysis.

Results: The most highly rated competencies were around demonstrating caring, empathy and understanding, and responding effectively in crisis situations. Helpful encounters involved enacted values, highly skilful interpersonal and psychotherapeutic engagement and practices that were facilitative and supportive.

Discussion: The process and content of pre-registration nursing training needs to refocus on the nurse meeting the needs of service users and supporters, rather than the instrumental needs of services today.

Implications for Practice: Educational reform may be necessary but insufficient to address anticipated nursing workforce shortages. Policymakers and health service directors need to align services with mental health nursing values and promote practices aligned with what service users and their supporters report as helpful.

KEYWORDS
history of mental health nursing, nursing education, quality of care, service management and planning, workforce issues

1 | INTRODUCTION

The World Health Organization (WHO, 2022, p. 80) recognizes that many countries face huge scarcities of personnel trained to deal with mental health, with low-income countries having fewer than one mental health worker of any kind per 100,000 people. Most mental health workers are nurses (44% of the global workforce), although the WHO notes that the scarcity of skills are compounded by non-specialist doctors and nurses having inadequate training to treat patients with mental health conditions. Even in high resource countries in which specialist undergraduate preparation of mental health nurses has been preserved, anticipated workforce shortages have prompted reviews of the preparation of mental health nurses (Hemingway, 2016). In Australia, an anticipated shortage of "job-ready" graduates, and a series of inquiries into mental health services have led to calls for radical reform of the mental health system and the education of nurses.

Australia phased out "direct entry" undergraduate training in psychiatric/mental health nursing with the introduction of university-based, so-called "comprehensive nursing" pre-registration education (Happell, 2009). With the establishment of the Nursing and Midwifery Board of Australia in 2010, a nurse with a sole qualification in mental health nursing (generally obtained overseas) is registered with a notation indicating a limited scope of practice, rather than that nurse being considered a specialist. There is little evidence that comprehensive nursing education has contributed to improvements in services or better outcomes for service users in Australia (Happell & Cutcliffe, 2011). Australia has held over 55 public inquiries into mental health services over 30 years, with little material change, and no notable improvements in public mental health services or outcomes (Francis et al., 2022). Few recommendations have been implemented, including those which have sought to address issues relating to the supply and education of the mental health workforce. In response to anticipated workforce shortages in public mental health services, one recent inquiry (Productivity Commission, 2020) recommended within a range of options, that Australia adopt a 3-year direct entry pre-registration mental health nursing programme. In this paper, we make some critical observations about the context in which this call for change is made, and the position of mental health nursing in Australia at this point in time. We argue why the opinions of service users in Australia regarding the educational preparation of nurses matter. We then report findings from a national survey that sought to explore what service users and their supporters thought about the preparation of nurses and in particular, open-ended descriptions of encounters with nurses they had found helpful.

1.1 | Background

Mental health nurses (MHNs) by and large have limited say in their own preparation, and while increasing numbers of MHNs are working in the private sector and non-health sector roles, the fate of the majority remains tied to public mental health services. It is now widely perceived and asserted by the Australian Institute of Health and Welfare (2022) that a MHN is a nurse, enrolled or registered who simply works in mental health settings. Even highly qualified and experienced MHN psychotherapists are largely confined to working in hospitals and public mental health services, which rarely provide psychotherapy (Hurley et al., 2020). MHNs are excluded from providing even the lowest tier of subsidized service via the Medicare Benefits Schedule (MBS) in primary care which is available to general practitioners, and allied health practitioners (Lakeman, 2021). Access to the MBS scheme has led to a flourishing of allied health disciplines such as psychology, which now outnumber all doctors and nurses who work in mental health (Lakeman, 2021). The now largely defunded programme called the mental health nurse incentive programme led to highly successful outcomes, but the work of the nurse was obscured by assumptions that the nurse was working under the direction of a medical practitioner undertaking delegated medical tasks (Lakeman et al., 2014). This assumption that nursing work is merely an extension of medicine is deeply ingrained and misleading. One of the more recent inquiries which again foreshadowed a pending workforce shortage stated that nurses "perform tasks in the assessment and management of people's health" in contrast to psychologists who "provide assessment and therapy to people experiencing mental ill-health" (Queensland Parliamentary Select Committee., 2022, p. 136). The

inquiry recommended scholarships to assist nurses gain post-graduate qualifications in mental health, although what "tasks" they ought to be taught to perform was unclear.

The problem with reducing mental health nursing to a set of tasks of assistance to medicine, or as demanded by employers, is that this is hardly likely to be transformative of a system that has repeatedly been found to be coercive, ineffective and unhelpful. Australians are help-seeking in record numbers with over 11% of the population attending an MBS-subsidized mental health consultation and over 17% of the population filling a subsidized prescription for a mental-health-related medication in 2019–20 (Australian Institute of Health & Welfare, 2022). Rates of reported mental illness have increased in Australia to over one in five people reporting having a mental illness in a given year, and the most recent census found over 8% of the population reported being treated for a chronic mental illness (Australian Bureau of Statistics, 2022). The discourse around mental health in Australia is firmly biomedical but it is unclear whether this is helpful even for the large numbers of people voluntarily accessing treatment. As the WHO (2022, p. xiii) notes "Business as usual for mental health simply will not do" and mental health for all will not be realized by doing the same with mental health nursing education. However, nurses in mental health services are firmly located in this biomedical paradigm and play instrumental and important roles in relation to medication dispensing, monitoring, and assisting with the provision of somatic treatments. The most valued (well-remunerated) role a MHN may perform in the public sector in Australia is that of a nurse practitioner whose scope of practice includes prescribing. Such roles are valued and remunerated more highly than clinical nurse specialist positions which often also require master's qualifications and competency in the provision of psychotherapies.

In Australian public mental health services, the nurse also has tasks related to containing people who are coerced into care and compelled to receive treatment. In the State of Queensland, all mental health units are required to be locked and nurses do not even have the discretion to unlock a door (Gill et al., 2021) which is emblematic of how entrenched coercion is in mental health services (Sashidharan et al., 2019). A common pathway to hospital in Australia is via involuntary transportation initiated by ambulance or police services (Clough et al., 2022) with those presenting to emergency departments with mental health problems more than 10 times more likely to be brought in by police than attendees with other health problems (Australian Institute of Health & Welfare, 2022). A survey of rates of involuntary hospitalization in 22 European countries and Australia and New Zealand, found Australia had the second-highest annual incidence at 227.3 per 100,000 people (Sheridan Rains et al., 2019). In 2019-20 55.6% of patient days in admitted hospital acute units were for people with an involuntary mental health legal status (Australian Institute of Health & Welfare, 2022). This coercive context is radically different to countries such as Ireland (54.4 involuntary hospitalisations per 100,000 people) or the United Kingdom (107.9 per 100,000).

Despite many submissions to the Queensland Parliamentary Inquiry (Australia's most recent inquiry) regarding coercion, and some which pointed out that working in a highly coercive system was unlikely to entice nurses to pursue a career in mental health, there was no discussion of the coercive nature of people's engagement with the public mental health system (Queensland Parliamentary Select Committee, 2022). Nurses themselves, have little professional autonomy in this coercive context with their work and that of others being increasingly driven by centralized protocols which in Queensland at least demand that most of the working day is spent entering information into centralized databases (Lakeman, 2020b). There is tension regarding nurses being perceived as merely instrumental to the work of the institution when that work has been found wanting, and the parallel rhetoric around the need for trauma-informed care supportive of personal recovery. In Australia, there is little agreement on what ought to be taught to pre-registration nurses or how, although there is near consensus that the mental health content in comprehensive nursing curricula is woefully inadequate and radical change is needed (Happell, 2010; Happell et al., 2020) in parallel with service reform. To address workforce inadequacies, many health services have instigated transition to practice programmes whereby new graduate registered nurses receive In-service education and supervision in their first year of practice (Procter et al., 2011).

A starting point in considering what training or education is needed of mental health nurses is to consider what service users need or have found helpful in the healthcare system. In the UK, this kind of inquiry led to the development of the Tidal Model (Barker, 2001) in which lived-experience and person-centredness were the central concerns of nursing processes. At least by some accounts, the model as implemented internationally in highly coercive environments such as forensic units, has led to cultural shifts and a greater support for people's recovery (Cook et al., 2005). Although some commentators have questioned the compatibility of a highly humanistic, person-centred value-based model with the coercive nature of the total institution and the institutional roles required of nurses in forensic settings (Jacob et al., 2008). Barker (2002, p. 233), however, was pragmatic in asserting that the tidal model is a philosophical approach which assumes "… that people know what their needs are, or can be helped to recognize or acknowledge these, and that from this minimally 'empowered' position, may be helped to meet these needs, in the short-, rather than in the medium- or longer-term".

With the exceptions of the Safewards model (Fletcher et al., 2019), few distinctly nursing models now have any organizing influence in Australian mental health services. An Australian model of nursing care, grounded in the lived experience and expertise of service users known as "partnership in coping" (Shanley et al., 2003) gained little long-term traction. Nevertheless, the Australian College of Mental Health Nurses (2010) Standards of Practice firmly assert that nurses ought to respect people's choices and support people in their recovery as defined by them. It requires that care is collaboratively negotiated and that "people with mental health issues identify that their mental, physical, spiritual, emotional, social and cultural needs have been consistently considered" (p. 11). To do less than this in Australia is to be in breach of mental health nursing standards.

Nursing models of care and standards of practice may not directly address the realities of the lived experience of engagement with mental health services, but they do consistently give primacy to respecting the voice of service users. This paper arose from a need to explore the perceptions of service users and their supporters (people who may identify as carers, family members, friends or allies) regarding proposed reforms to the educational preparation of nurses in Australia. Their opinions regarding the process of nursing education is addressed in a further paper by Hurley, Foster, et al. (2022). Specifically, this paper reports on the responses to two questions: The first asked for perceptions of the importance of tasks, skills or competencies; The second elicited examples of helpful nursing practice. The aim was to synthesis these findings in order to inform discussion and decisions about the process and content of nursing education in Australia.

2 | METHODS

A cross-sectional survey design was used. The project team consisted of senior mental health nursing academics and lived-experience academics. The survey instrument was developed collaboratively. A list of mental health nursing tasks, skills or attributes was initially drawn from a recent review relating to mental health nursing identity and roles (Hurley, Lakeman, et al., 2022). These were collapsed over a series of collaborative meetings, in order to reduce the list to a manageable size, ensuring that the list was inclusive of contemporary Australian concerns (e.g. undertaking therapy under a mental health plan refers to an MBS subsidized service) and that the roles were reflective of the desired qualities of MHN as already articulated by mental health nurses (Horgan et al., 2021). Further questions (reported here) asked if the person had a helpful experience with a mental health nurse, and if so, they were asked "What did the nurse do that you found helpful?"

2.1 | Data collection

The survey was deployed on the QUALTRICs system and trialled with a small team of service users before the project received approval from the Southern Cross University Human Research Ethics Committee (2021/114). Participants were recruited via the "snowballing" technique (Sixsmith et al., 2003). That is, the researchers sent an email invitation to their networks of service users and supporters/carers and relevant consumer/carer organizations across Australia and invited them to forward the invitation to others.

2.2 | Data analysis

Quantitative data were analysed using descriptive statistics with the assistance of the software package JASP. The qualitative open-ended data was subject to thematic analysis as described by Crowe et al. (2015). The first author (RL) reviewed all responses and coded each statement with the question in mind "What was helpful about this?" and "What does this represent?" This was an iterative process, assisted by the use of NVIVO. Some statements as illustrated in the verbatim examples were coded in multiple ways. For example, some descriptions of helpful encounters included the articulation of an interpersonal skill such as the communication of empathy, or teaching a skill, and also a description of a value or attribute such as patience. The service user and supporters' examples were initially coded separately but were remarkably similar, so the entire data set was combined. The NVIVO file was shared with a second researcher (JH), and both determined independently that the codes clustered around three broad themes illustrated by some of the verbatim quotes in the analysis.

2.3 | Respondent characteristics

A total of 95 people completed all questions and were included in the analysis. Thirty (32%) identified as family members, supporters or carers. They reported an average of 21.3 years of experience interacting with mental health services (3–43 years, SD = 12.2 years). Seventy-three percent ($n = 22$) of supporters reported encountering nurses working in mental health services within the last 3 years and 23% ($n = 7$) between 3 and 10 years. Twenty-three (77%) of supporters reported having a helpful experience with a mental health nurse (7 reported they did not, 23%).

Eighty respondents identified as patients, service users, clients, or consumers. These respondents reported an average of 17.7 years of experience interacting with mental health services (0–50 years, SD = 10.5 years). Fifty-seven percent ($n = 57$) of service users reported having encountered nurses working in mental health services within the last 3 years, 37% ($n = 24$) between 3 and 10 years, and 6% ($n = 4$) over 10 years ago. Fifty (62.5%) service users reported a helpful experience with a mental health nurse (15 reported that they did not, 19%).

3 | FINDINGS

Respondents were asked to rate the importance of selected skills, competencies and attributes. The percentage of all responses on the five-point Likert scale are illustrated in Table 1. All were rated as moderately to extremely important by most participants. The only significant difference in mean scores between supporters and service users on ratings of the importance of skills was that supporters rated working with families, carers or the persons supportive network (M = 4.7) somewhat higher than service users (M = 4.3, $t = -2.324$, df = 93, $p = .022$). The most highly rated capacities were to "demonstrate caring, empathy and understanding", followed by the capability to respond effectively to people in crisis. The lowest rated capacity was undertaking psychiatric assessments and providing psychological therapies under a mental health plan.

Helpful experiences recounted by service users and their supporters did not differ significantly from each other. These typically took a narrative form and often described enacted values, interpersonally

TABLE 1 Aggregate ratings of importance of skills/competencies of mental health nurses.

Rating of the importance of skills/ competencies in mental health nursing	Not at all important (1)	Slightly important (2)	Moderately important (3)	Very important (4)	Extremely important (5)	Mean score for service users	Mean score for supporters
Counselling	1%	10%	18%	32%	39%	4.0	4.0
Knowledge of medications used in mental health	0%	1%	11%	32%	57%	4.4	4.6
Work with families, carers or the person's supportive network	0%	2%	12%	31%	56%	4.3	4.7
Undertake psychiatric assessments	4%	15%	24%	32%	25%	3.4	3.9
Undertake risk assessments	1%	6%	20%	31%	42%	3.9	4.0
Respond to and intervene to prevent suicide	1%	6%	20%	31%	42%	4.5	4.5
Physical health assessment and intervention	0%	6%	19%	41%	34%	3.9	4.2
Navigate the mental health system	0%	5%	8%	29%	57%	4.3	4.5
Work with children and youth	0%	1%	26%	33%	40%	4.0	4.3
Provide specialist advice to general practitioners and other non-specialists	1%	5%	17%	36%	40%	4.0	4.2
Support decision making in human rights and legislation	0%	1%	17%	24%	58%	4.4	4.4
Advocate for consumers	0%	1%	13%	31%	55%	4.4	4.3
Critical thinking and self-reflection	1%	0%	13%	31%	55%	4.6	4.4
Demonstrate caring, empathy and understanding	0%	0%	3%	11%	86%	4.9	4.8
Respond effectively in crisis situations	0%	0%	3%	19%	77%	4.7	4.8
Work with people in their own home	1%	5%	27%	31%	35%	3.8	4.2
Provide psychological therapies under a mental health plan	6%	11%	23%	30%	30%	3.6	3.7
Work with people from diverse backgrounds and experiences	0%	3%	5%	23%	68%	4.6	4.5

skilful engagement, genuine empathy and understanding, and the facilitation of timely care and treatment. Consistent with the rank ordering of skills, competencies and attributes, most narratives emphasized important qualities of the helpful nurse and the nature of the relationship, rather than the completion of tasks. Whilst not the focus of this analysis, some respondents liberally described poor care, a system which they perceived to be "broken," coercive processes, harmful or disrespectful practices, and nurses being inaccessible. The following is an extract of what one person found unhelpful with suggestions on how mental health nursing could be improved:

> …They need to understand that healing happens in relationships. They need to be "on the floor", talking to us. They need to want to interact with us, not hide in the office. They need to understand that we are adults. They need to stop trying to manage "risk" by seeking to control us. They need to stop taking things away and locking everything up. They need to understand that seclusion and restraint aren't therapeutic. They're breaches of our human rights. They're a disgusting abuse of power. They need to understand that mental health has been over-professionalized and over-complicated. An assessment is not a discrete event. It's using all of your senses to understand what's happening for the person. It cannot take place from behind a glass nurse's station. It needs to take place over time. It involves spending time and talking to the person. They need to facilitate (non-patronizing) activities and groups. They need to treat us like humans as they'd wish to be treated themselves. They need to advocate for us to be included in our own treatment and care. They need to stand up against doctors. They need to stand up for our rights.

More commonly, respondents contrasted the helpful nurse with the conduct or behaviour of others:

> The registrar and psychiatrist in the mental health unit did not listen to me and did harm. One nurse gently helped me to open up about my childhood trauma and abuse. She was also understanding during my difficult times.

A further respondent acknowledged that the quality of nursing care in Australia had diminished, and nurses appeared to be preoccupied with medical tasks:

> … nurses focus on giving out pills for every little distressing setback, measuring blood pressure, sugar levels, temperature, getting samples etc. Its general nursing, but often not what is needed, or it is not enough. I am alive and thriving today because of good mental health nursing, and despite bad mental health nursing.

3.1 | Enacted values

Helpful experiences of mental health nursing by both service users' consumers and supporters were based upon enacted core values. These values then enabled effective and skilful relating that was then used to offer helpful clinical, social and in some cases transformational interventions:

> …kept me safe at a time when that was what I needed (but did not want), helped me to find a way to be with my family that worked for us all, taught me kindness and compassion for myself, taught me how to regulate my emotions- and kept their patience when I 'did not get it' for so long, sat on the floor with me in the small hours of the morning and showed me that the dawn would come, made me eat and drink at a time when I could not find safety in it, understood and forgave me when I through it at them, helped me to laugh at life…

> …She made me feel connected when I felt alone. She took the time to follow up on me later in the evening which helped me develop trust and eventually I was able to disclose trauma to her…, which she handled well…no judgement.

Almost all of the examples of helpful nursing practice referred to individual nurses who came to know individuals and families intimately and personally. Respondents reported that they were firstly treated with respect, and as a person rather than the nurse focusing on their diagnosis or symptoms.

> … focused on me as a person rather than me as a set of symptoms. Took my life circumstances (parent, student, employed) into account when working with me. Offering advice beyond the realm of mental health.

> …The nurse treated me like an ordinary person. They gave me hope for the future and enabled me to demonstrate that I could achieve things even when unwell by undertaking activities while on the ward.

> Was just there and treated me as a human being and not a diagnosis.

Compassionate, kind, genuine and patient were some of the adjectives used to describe helpful nurses. Respect was conveyed in numerous ways such as checking in with people, spending time with them,

being non-judgemental, and one respondent stated that the nurse expressed admiration for them.

> The nurses were kind and caring towards me. They were compassionate and non-judgemental whilst offering me solutions to my problems. They did not minimize how I was feeling and they treated me with dignity.

> ...They took the time to listen to me with respect, even though what I spoke about was not lucid at all.

3.2 | Interpersonally effective

Accounts of helpful nursing care often referred to nurses taking time to build rapport and gain the trust of service users and their supportive networks.

> Built a rapport with me from the start and took time to make me comfortable and introduce herself and kept me informed of any change/update as soon as she was able to...

Some reiterated that nurses related to them as "ordinary people" or "equals" and spent time with them chatting about every-day life (not just matters relating to mental health) and conveyed a genuine interest in them. Helpful nurses maintained a calm presence, were perceived as being fully present and attentive, they primarily listened and conveyed understanding and hope:

> ...Sat and listened, showed empathy and compassion without judgement. Provided me with a safe space to vent without fear of consequences. She made me feel connected when I felt alone. She took the time to follow up on me later on in the evening which helped me develop trust and eventually I was able to disclose trauma to her, which she handled well - no judgement and reinforced that I was a victim. She also worked with my doctor to put me in touch with specialized care.

Empathy and understanding were mentioned by most respondents. Supporters also expressed appreciation for time spent with them and empathy for those whom they cared for. Empathy often took the form of attentive listening and reflecting back what was perceived to be a genuine understanding or astute insight into the person's situation. Others reported that helpful nurses were able to remain calm and communicate with people experiencing extreme states:

> The ability to be calm and centred and constructively communicate with very distressed and psychotic patients... genuine respect and empathy for patients.

> She demonstrated true empathy and care during a period of great distress and difficulties. Even though it's been over 20 years now I still remember her full name.

Some respondents expressed gratitude for the counselling they received from particular nurses. Some recalled sophisticated psychotherapeutic interventions. One family member who reported being traumatized by involvement with several family members being involuntarily hospitalized in locked wards described the personal impact of receiving a therapeutic letter:

> I found it difficult to engage with the treating team out of fear most times, but I will never forget a personal letter that was written to me by a nurse from the ward. This was an empathetic / therapeutic letter, and the letter not only enabled me to make sense of what my father was experiencing in "jargon" free language, but moreover the letter conveyed, empathy, warmth and heart. This letter enabled me great insight into what was happening for my father. The letter also validated the depth of my own distress and provided much solace. This was an extraordinary healing exchange. This letter was the starting point of me healing...

3.3 | Facilitative and supportive interventions

Few accounts of helpful nursing practice appeared to involve discrete or clear-cut interventions. There were, however, many examples of nurses acting in facilitative ways. These included facilitating a sense of safety, facilitating involvement of family and supportive networks in helpful conversations, and promoting engagement in therapeutic activities.

> ...Provided opportunity for whole family to gather and gave calm, clear information when my son was diagnosed with bipolar affective disorder. [I] felt they had our backs...

Respondents valued the advocacy work of nurses to access services, obtain benefits, meet basic needs and obtain the professional help in a timely way. Some perceived that the nurse made every effort to work with and within the system to deliver the best outcomes and individualized care.

> ...Argued with my Psychiatrist and my GP on my behalf and made them listen to me.

Helpful nursing interventions including examples of facilitating or providing the right kind of support at the right time. Support included information about diagnosis, medication and coping.

> The nurse asked me whether I knew what I was diagnosed with. I did not. I'd been diagnosed with borderline personality disorder in my teens. I wasn't told until I was in my twenties. I started to read about BPD and suddenly everything made sense. Services had always treated me differently. I'd been refused admission to hospital, given dirty looks in ED…

Several respondents described how nurses facilitated coping with symptoms but also the enhancement of coping strategies generally.

> [The nurses] ran a series of programmes involving the development of tools for coping with daily living with a mental health condition including various therapies - e.g., CBT and DBT and ACT, distractions - e.g. journaling, art, walking, physical therapy - e.g. gym work, open group and one to one discussions which were non-judgmental and inclusive in nature.

Several respondents alluded to mental health nurses approaching problems in a different, pragmatic and more holistic way than other professionals which was inherently helpful:

> I've found mental health nurses offer realistic, pragmatic solutions that social workers, OT's, psychologist's etc aren't able to offer in the same way Nurses also are able to respond to problems with medications in a more specialized manner than other mental health focused disciplines. Nurses should develop their own strategies in a similar way to other clinicians in order to seek to understand the scope of what a person is going through, and also to take each case on its own merits, and not rely solely on doctors/managers and case notes to inform their practice and scope…

4 | DISCUSSION

It is unsurprising that all competencies were rated highly, and that caring, empathy, understanding were rated as most important and featured so prominently in examples of helpful nursing practice. Arguably these are generic nursing and mental health worker skills. In a Delphi study involving experts by experiences rating recovery competencies for mental health workers, the top-rated competencies "… emphasized mental health workers listening to and respecting the person's viewpoints, conveying a belief that recovery is possible and recognizing, respecting and promoting the person's resources and capacity for recovery" (Lakeman, 2010, p. 62). Horgan et al. (2021) explored service user-perceptions of the desirable qualities of mental health nurses and these were largely unremarkable such as the capacity to be with the person, demonstrate respect, empathy, compassion, understanding and foster hope for recovery. Given that public mental health services have proven immutable to radical, transformational change over time, it may be best to focus on assisting nurses to work on these basic relational skills and to learn from what service users have found helpful despite systemic problems which may be beyond the control of the nursing workforce, as they are presently positioned within mental health services.

These foundational helping concepts identified as helpful have a long pedigree and can be traced to Rogers (1957) who asserted the importance of congruency, unconditional positive regard and the communication of empathic understanding in a non-judgemental manner was necessary and sufficient for personality change. These interpersonal skills have also traditionally been the central focus of mental health nursing (Altschul, 1972; Peplau, 1952). It is important to emphasis the communicative element of empathy and that this interpersonal skill can be taught (Lakeman, 2020a), although the process of teaching these foundational skills may be at odds with contemporary pedagogical approaches to teaching in universities, which tend to emphasize content and assessment rather than process. However, exposure to lived experience expertise in mental health nursing education, which is presently showing promise in improving attitudes of health professionals (Happell et al., 2019) may assist in providing a foundation for the development and communication of empathy.

Many of the examples of enacted values reflected a recognition of a virtue in the nurse and behaviour congruent with that value. It stands to reason that people appreciate someone who is respectful, kind, empathetic, compassionate, and inspires hope. However, it is unclear how these values and behaviours can be taught. As Spandler and Stickley (2011, p. 555) note in relation to compassion, it "… must be nurtured in context, through relationships, cultures and healing environments. However, current mental health policy and practice does not appear to prioritise the development of such contexts." Many mental health services in Australia are far from being "healing environments" in which compassion is nurtured, and yet compassionate and highly skilful nursing practice does occur. However, to foster a nurturing context in which compassion can thrive will require more than a change in the quantity or quality of nursing education. This requires a shift in service culture towards the facilitation of healing environments.

Examples of good mental health nursing included accounts of relationships with nurses which were explicitly qualitatively different from those with other health professionals. They often spent time with people, in quite ordinary ways, but also engaged in psychotherapeutic manner when needed with a high degree of sophistication. In some instances, nurses were valued for expressing "advanced empathy" (Lakeman, 2020a) in response to people in extreme states, and in others what appeared to be sophisticated and strategically chosen family therapy interventions, such as the "therapeutic letter" (Signs, 2015). In all instances, there was an expressed perception that the service user and supporters were listened to and understood,

and the right kind of support was facilitated in a timely way. Similarly helpful nursing care involved providing effective crisis intervention (Ford, 2021), being present and emotionally containing, facilitating coping and providing the right kind of support, or psychotherapeutic approach at the right time (Ford, 2021). Helpful mental health nurses were seen as being on the side of the service user, and able to get things done within the system. Curiously, undertaking psychiatric assessments and other explicit tasks were rated the least helpful, suggesting that this way of conceptualizing nursing (as a range of tasks) may be inherently unhelpful.

4.1 | Limitations

There are some limitations in this synthesis of examples of helpful mental health nursing practice. Firstly, the nature of the online survey and the snowballing sampling methodology, whereby the invitation to participate was sent to carer and service user organizations, likely biased the sample towards the technologically literate, and those actively involved in seeking to reform mental health services. Also, the accounts cannot be construed as an exhaustive taxonomy of helpful interventions, nor representative of any particular group. Nevertheless, the liberal description of both helpful and unhelpful nursing encounters, and the recency of contact with nurses does add credibility to these findings. It is also possible that presenting a list of skills, competencies or attributes of mental health nurses and asking people to rate their importance may have primed respondents to use some of the language in their description of helpful interventions.

5 | CONCLUSION

These accounts of helpful mental health care reported by service users and their supporters can usefully inform the development of mental health training content for nurses at both undergraduate and postgraduate level. They suggest the embodiment and enactment of core values, sophisticated interpersonal effectiveness, psychotherapeutic skills and the capacity to support and facilitate the necessary conditions to resolve crisis and realize recovery. Helpful mental health nursing care is entirely consistent with nursing philosophy (Barker, 2001), standards of practice (Australian College of Mental Health Nurses, 2010) and service user accounts of desirable qualities in mental health nurses (Horgan et al., 2021). However, these examples also lead to an uncomfortable juxtaposition of the coercive, instrumental roles required of nurses in contemporary public mental health services, mental health nursings subordinate positions to medical authority, and perceptions that nurses have little direct role in the therapy and outcomes of service users. In this context a direct entry mental health programme, or even increasing the quantity of undergraduate content is unlikely to lead to a transformation of service culture. Without recognition of the values and therapeutic potential of mental health nursing, recruitment and retention of nurses is likely to remain a problem. Consideration needs to be given to how and what nurses are taught, how values are attained and how they are enacted in practice. It may also be timely to revisit or rediscover nursing theory, nursing philosophy and espoused values, and promote these as central to curricula development, and perhaps more pivotally in public mental health services.

6 | RELEVANCE STATEMENT

Australia was an early adopter of comprehensive nursing training and phased out recognition of mental health nursing as a specialty. Anticipated workforce shortages of nurses and the proposed solution to return to specialist pre-registration mental health training needs to be understood in Australia's unique social and political context. Nurses are largely confined to instrumental roles in public health services that need reform. This paper highlights what service users have found helpful in their encounters with nurses in this context. What users of public mental health services need and find useful ought to guide both educational and service reform.

AUTHOR CONTRIBUTIONS

All authors were involved in the conceptualization and design of this study, questionnaire construction, composition and editing and review of the manuscript. Richard Lakeman and John Hurley undertook the qualitative analysis. Richard Lakeman undertook the descriptive quantitative analysis and undertook the initial drafting and final review of the manuscript.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

Author elects to not share data.

ETHICS STATEMENT

This project received approval from the Southern Cross University Human Research Ethics Committee (2021/114).

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