Defensive practices in Mental Health Nursing: Professionalism and poignant tensions.

Abstract

Mental Health Nursing is a skilled profession, well-positioned to support patients towards recovery with evidence-based therapeutic interventions. However, the profession continues to be challenged by tensions surrounding the delivery of restrictive interventions and concerns over tendencies towards defensive practices. This paper examines the ambiguity this creates within the mental health nursing role. Organisational cultures that overvalue metrics and administrative tasks create barriers for therapeutic engagement whilst contributing to role confusion and stress within nursing. We need to address such structural constraints on nurses as mental health nurses' well-being is crucial to service delivery and the realisation of therapeutic goals. From the UK perspective, authors argue that there is a need to examine service structures that foster compassionate and transformational leadership to enable mental health nurses to exercise the agency to practice therapeutically. Education and quality nursing research have a pivotal role to play in enabling this shift.

Keywords: Mental Health Nursing, role concept, risk, restrictive practice

Introduction

Central to the role of mental health nursing is enabling the recovery of patients through collaborative safety management. Emotional intelligence, self-awareness and resilience are crucial skills for nurses to facilitate patients' recovery (Cleary et al., 2018b). Despite recovery dominating the policy agenda and professional education frameworks for over a decade in several western jurisdictions (Department of Health 2006, Australian College of Mental Health Nursing (ACMHN) 2010, Butterworth and Shaw 2017), being risk aversive is still recognised as a common characteristic of mental health nursing (Bifarin & Jones, 2018). Although therapeutic, recovery orientated values are recognised as the profession's core, mental health nurses can struggle to realise these within increasingly challenging conditions (McKeown and White 2015). In the UK, recent policy signalled a much-needed investment within mental health (NHS England 2015). However, in the context of socio-economic and political challenges, workforce gaps and a high volume of unmet needs remain with a significant demand on existing mental health services (NHS Providers 2019). Such conditions can impact on self-efficacy, creates barrier to practising in line with therapeutic values and trigger stress for nurses (Hazel & Bifarin, 2020). In such situations, the role of mental health nurses is impeded further, limiting their full therapeutic potential (Hurley & Lakeman, 2021). Using the UK experience, we argue that these tensions create a lack of identity for mental health nurses and push nursing into a liminal space. The overarching aim is to examine the organisational and professional factors that influence such tensions for the profession.

BACKGROUND

Contemporary context of mental health nursing

Social, economic, and political interests are standard features in the history of mental health nursing (Barker and Buchanan-Barker, 2011). In the context of growing health inequalities, and a high need for mental health care (NHS Providers 2019), such factors continue to influence contemporary nurses as they are deemed responsible for delivering high standards. Nolan (2017) highlights that in the absence of adequate professional support needed to enable nurses deliver high standards of care, there is a tendency to substitute nurses for 'social assistance' measures rather than being specialists who promote and facilitate the recovery of patients. In the United Kingdom (UK), there is a chronic shortage of nurses (NHS England 2019). Workforce numbers and skill mix of staff could undermine the role of nurses and draw nurses further away from utilising specialist therapeutic skills to support patients (Mckeown et al. 2015, McKeown et al., 2019). A qualitative study investigating nurses' perspectives regarding their role (Terry, 2019) showed that nurses are frustrated by the limitations that time places on them. The study noted that this often has an adverse implication on building therapeutic relationships, with reduced opportunities to fulfil their role in providing evidence-based psychosocial interventions (Terry, 2019). The study highlighted that the role of nurses could be convoluted as they tend to perceive their occupation as a combination of many other roles, such as occupational therapists, physiotherapists, doctors, and social workers (Terry, 2019, Hurley 2009). Mental health nurses, therefore, may occupy a liminal position, characterised by obscurities and ambiguities. In a scoping review of existing evidence relating to the role and identity of nurses, Hurley and Lakeman (2021) asserted that in comparison to psychiatrists and psychologists, the role of nurses is complicated. The review

incorporated evidence from Australia, UK, Europe and the USA, and indicated that in the USA and Europe nurses could link their role with patients' recovery. However, in Australia and the UK, nurses can barely see any noticeable improvements in patients' experience through nursing care. In addition, limited time and staffing factors may dilute the mental health nursing role and create challenges for prioritising therapeutic interventions (McKneown et al., 2019b).

It is vital to explore the contexts in which nursing work occurs to understand the influences on this role ambiguity. Rio et al. (2020) provided evidence which showed that nurses are unable to exercise autonomy. Mental health services place emphasis on the completion of administrative processes including documentation and audit. Such a focus can be incongruent with the characteristic values of mental health nursing, relying on therapeutic engagement with the subjective experiences of another (Harris and Panozzo 2019). These needs are not mutually exclusive; however, the power dynamics between employers and employees appear influential in prioritising extensive bureaucratic tasks. The priority appears to be administrative tasks as an expectation of nurses' role due to the monitoring of quantifiable measures leaves nurses accepting that this is necessary to do an adequate job. Such employer-employee dissonance may create the perception that the role of nurses is 'administrator of care', underpinned by a sense of accountability and responsibility. Role enactment of their expertise in therapeutic interventions to support recovery, therefore becomes a challenge. Nurses become instrumental in supporting other multidisciplinary team members at the expense of focusing on their own expertise and, ultimately, their own professional experiences (Hurley and Lakeman 2021). Oversimplifying the role of nurses fails to put into context the extensive demand of managing clinical work expectations, resulting in physical, emotional, and

organisational burdens (Jackson, 2021). While the role of nurses is paramount within health and social care systems, the challenge for mental health nursing is sustaining the therapeutic and relational identity in the face of such constraints (Vincenti, Grech & Scerri, 2021).

Care systems and implications for mental health nursing

Inadequate resourcing of mental health services has significant implications for the nature of nursing work, magnifying the tensions between organisational expectations and nursing's therapeutic focus. Financial investment in mental health services is still recognised as lacking compared to other areas of healthcare (Gournay, 2017). A lack of adequate investment in mental health plays a significant role in creating organisational pressures for the nursing profession. With acute pressure to admit due to increase in demand for mental health services in the UK, lack of funding has the propensity to hamper requisite knowledge and skills of nurses due to constraints inflicted on time and the limited number of nurses available (McKneown et al., 2019b).

Given the unique subjective experience of mental distress, engagements within the therapeutic relationship will mostly be context laden. It is therefore crucial that nurses are well supported to pay close attention to the support needs of individual patients. For nurses to engage with a range of conversations around patients' needs, communication will play a central role, influencing patients' experience and sense of safety (Isobel and Delgado 2018). The clinical environment is complex and demands within this environment can be taxing for nurses. Inadequate staffing levels and lack of continuity of care could have adverse implications on therapeutic relationships. These issues may also leave patients predisposed to restrictive practices and threaten patients' sense of physical and psychological safety (Berzins et al. 2020).

In this context, nurses may practice defensively due to fear of making mistakes and being reprimanded, therefore feeling pressured by organisational expectations (Manuel and Crowe 2014). However, the defensive practice may be confounding when nurses perceive their role to be ambiguous. As a result, nurses may find themselves occupying a liminal space between organisational pressures and operating within their therapeutic values. This ambiguity could contribute to avoiding taking risks altogether. Sawyer (2017) highlights that the impact of such constraints on 'risk thinking' further reduces opportunities for therapeutic interventions and prioritises service rather than patient goals.

There are inherent complexities associated with changing care systems rapidly and frequently that can create discord (Bower et al., 2018). The confounding sensemaking of nurses' role impacts the quality of care afforded by their clinical environment. The unintended consequence is that nurses on the frontline are at risk of becoming disoriented. Additionally, nurses face emotional erosion due to exposure to aggression and violence, high-risk factors to burnout (De Looff et al. 2019), coupled with the tumultuous working environment (Emerson & Pollner, 2019). Putting all these together, being positioned to facilitate patients' recovery remains at a stage of infancy.

The role of mental health nurses: decision making context

Compulsory care and enacting restrictions are a reality of the mental health nursing role. Delivering care involving these practices can impact on nurses emotionally alongside contributing to tensions nurses experience while managing organisational constraints and implementing recovery-focused therapeutic interventions. A recent literature review explored the concept of restrictive practices within acute wards and Psychiatric Intensive Care Units (PICU). The findings showed that when nurses are

not self-aware, they may express this by applying blanket rules and perceive themselves being under pressure from other colleagues to set boundaries where they do not recognise such a need (Doyle & Clark, 2020). The professional codes prescribed by the Nursing Midwifery Council (2018) and ACMHN (2010), implores nurses to be flexible and accommodating of the needs of patients. However, in Doyle and Clark (2020) study, nurses who ascribed to the professional codes felt that other staff members considered them weak if they failed to enforce rules. The role of nurses could therefore be perceived to be adversely impacted by tension that arises from the balancing of the expectations of contemporary and archaic cohesive practices (Cleary et al., 2018).

Physical, chemical, environmental, psychological, mechanical restraints and seclusion are common interventions used in mental health care (CQC, 2017, Power et al. 2020). It is evident that these restrictive interventions can be discrete or continuous in nature and can create poignant tensions between patients and nurses. These tensions can be particularly challenging given patient outcome is contingent upon building therapeutic relationships (McAndrew et al., 2014). Carrying out restrictive interventions on patients creates a range of complex emotions for professionals involved in this process. Nurses recognise restrictive practices as contrary to recovery-orientated care's therapeutic values. Yet, they identify restrictive interventions as necessary for maintaining safety (Muir-Cochrane et al., 2018). In terms of resources afforded to nurses within the clinical environment, McKneown et al. (2019) highlighted that lack of resources, environmental constraints and culture within organisations predispose nurses to defensive practices. Patients could feel that care services are impersonal, and nurses could fixate on justifying their actions. In line with this, nurses could use restrictive practices to mitigate risk on both patients and staff to respond to

perceived threats from patients. When nurses have to negotiate between their personal resources, resources afforded by their organisation, and patients' care preferences daily, this can be a source of stress (Power et al., 2020). Stacey et al (2016)’s research in acute mental health care also emphasised the emotional burden of adopting restrictive practices for nurses. The study highlighted that nurses claimed they implemented coercive decisions at the recommendations of those with authority in the occupational hierarchy. Thereby suggesting that despite support in the profession for reducing restrictive practices, tension remains for nurses who fear blame for possible consequences of reduced restraint and concerns for their safety (Muir-Cochrane et al., 2018).

Tensions relating to coercion and patient safety within the context of the social environment in clinical settings continue to be of concern (Simpson et al., 2016). For example, in a recent qualitative study (Berzins et al. 2020), patients experienced a lack of meaningful activities. In addition, they noted that their psychological safety was not prioritised, which often resulted in hospitalising them for needing support. Generally, patients felt judged by mental health practitioners, as a result, they continue to avoid some services to preserve their safety. (Berzins et al., 2020). In addition, patients feared that staff would undermine their lived experiences, arguably due to the minimal resources afforded to nurses in the current context of service delivery.

Practices that compromise the freedom and rights of patients have been recognised as emotionally challenging for nurses. These occur in the context of organisational and resource constraints that make it difficult for mental health nurses to protect time for appropriate, supportive psychosocial interventions. Thus, organisations must prepare to rise to the demands of their role and adequately train nurses to do the

same. Henceforth, a substantial amount of effort around mastering the art of therapeutic relationships is required. A study in Australia explored the efficacy of using emotional intelligence training to improve the resilience of student nurses. Findings from the study suggested that preparedness levels are crucial to transitioning into capable qualified staff and would enhance the quality of care provided (Hurley et al., 2019).

Post-qualification, adequate investment in the workforce is crucial to practising defensibly, thereby demonstrating greater empathy and compassion. Irrespective of the impact of lack of funding within the profession, it is essential that future research studies pay closer attention to the implications of cultural complexities within clinical settings on nurses' attitudes and how they impact patients' personal recovery. Terry (2019) asserted that nurses must take control of their profession by clearly articulating their role and embracing the ambiguities that come with it. This clarity would be crucial in propelling the profession in the right direction. Doing this would be of great importance, as nurses would then generate needed conversations around resultant opportunities, threats, and possible strategies to harness liminality.

Nurses have a range of skill sets that could explain why they occupy a liminal space, making it crucial for them to bring critical discussions up in reflective times such as clinical supervision with clinical leads or peers. Demanding safe space for clinical supervision and holding leaders accountable are essential measures needed for effective practice. Clinical supervision, if facilitated appropriately, has been identified as a vital tool for improving patient experiences, increasing job satisfaction, and reducing moral distress when addressing issues relating to the accountability of nurses (Bifarin, 2017, Bifarin & Stonehouse, 2017). During clinical supervision, nurses and supervisors can address the incongruence in values/expertise between them and their

patients. The complexities associated with the logistics of implementing local policies, with results such as the suspension of norms, could also be explored. Furthermore, access to in-depth and rigorous clinical supervision remains limited for many mental health nurses, despite the complexity and emotional labour within the role. Despite the challenges faced by nurses, it is essential to state that 'being a professional' comes with opportunities. Nurses can develop strategies to harness liminality through innovation and creativity. However, issues around professional socialisation, passivity, impulsivity and learning must be acknowledged and addressed accordingly to ensure this development.

Mental Health nurses and service delivery

Cognitive dissonance could arise for nurses between their resources to cope adaptively (preparedness and expertise) and the effectiveness of the services model. The cognitive dissonance could compound when organisations use tokenistic approaches when commissioning services. In services focusing on an organisational management approach, sanctions or incentives based on agreed targets could hinder therapeutic relationships between nurses and patients (Rio et al., 2020). As the demand placed on nurses outweighs resources made available to them, it could often lead to organisations burdening nurses (Pazargadi et al., 2015). Arguably, being disoriented due to confounded sensemaking could be the latent driving force behind the frequent changes in national and local policies, relating to the need to curtail restrictive practice in mental health services in the UK. However, it is paramount to create discussions around the proportionality and appropriateness of interventions regarding patient safety.

The ambiguities surrounding nurses' roles perhaps emphasises issues concerning their professional identities (King, 2017), highlighting the importance of having the right nurse (expertise) to provide care at the right time. As such, Ellis and Day (2013) proposed a six-group classification for nurses within the context of developing therapeutic relationships with patients. These groups were: *The Expert* in which nurses see themselves as superior entities to their patients under their expertise; *The Friend* in which nurses develop a close personal bond with patients with blurred boundaries; *The Dependent* where nurses take excessive responsibility on behalf of patients; *The Adversarial* in which the nature of the relationship between nurse and patient is antagonistic in manner; *The Avoidant* where nurses are not emotionally or intellectually invested in the recovery of patients, and lastly *The Partnership* in which nurses can facilitate open and honest conversations with patients by recognising, conferring and overtly resolving issues or developing future action plans.

Having established that there could be discrepancies between nurses' perceptions of their role, often exacerbated by the direction of local policies designed by organisations, which can be a source of stress, it is understandable that the expert relationship is one of the more common types of relationships that exists between nurses and patients (Ellis & Day 2013). In this case, these nurses draw on policies by designing care plans, writing relevant reports promptly, acting as positive role models to the patients, primarily by what they say, but such engagement is devoid of narrative understanding. Nurses that fall into this category often fail to advocate for patients or be supportive by providing daily practical care. They may also detach themselves from the world view held by patients. This stance creates less difficulty for nurses to adhere to the measurable demands of organisations, such as the monthly update of care plans, with or without patients' inputs. It also avoids any involvement with patients that

would require taking a positive risk, like empowering patients within the context of personal recovery. Nurses could also find themselves in a state of dilemma, distancing themselves from getting 'too' involved with patients, especially when risks are considered high. Risk plays a vital role in the decision-making process in mental health nursing (Felton et al., 2018). The contrast between the objective measurement of risk and complex adaptative characteristics associated with meeting the needs of patients are 'ill-suited to mental health care, as risk is dichotomous and not fixed' (Jones, 2020:98).

Felton et al. (2017) suggested that risk management heavily influences decision-making processes in mental health nursing to the extent that it could deprive patients of the opportunity to exercise their personal agencies. Services preoccupied with risk often lost the subjective experiences of patients. The absence of resources or adequate infrastructures to enable nurses to capture nuances and contextualise the experiences of patients or their observations would impede the process of making meaningful interventions. This would further contradict the ethos of the principles of personal recovery of patients with resultant effects, such as objectifying patients living with mental health conditions as being 'risky' (Felton et al., 2018). Nurses play a pivotal role in service provision, and positive risk-taking is paramount in mental health services, with the need to focus on practical recovery principles (Jones 2020). In terms of the identity of nurses within the context of building therapeutic relationships with patients and providing an enabling environment for people to thrive, there appears to be a disconnection with meeting the demands of risk management within the policies and procedures of organisations, placing more emphasis on public safety (Calaminus, 2013). This incongruence in the perception of risks could create tension. Yet the notion of risk management and personal recovery of patients are not reciprocally restricted,

as they can co-exist without losing sight of the principles of individualised care, especially as patients usually want to be safe and having conversations around safety is more encompassing than the use of 'risk' management (Jones, 2020).

Jones (2020) argued that focusing on patients' strengths with the context of safety, would enhance organisational procedures and processes that nurses engaged with on a daily basis. This in turn, would adequately inform leaders in organisations of the genuine needs of both patients and nurses. If patients continue to be objectified or judged by their 'risks', their personal recovery could be jeopardised. As patients' experiences of mental health services are contingent on their level of engagement with professionals, the expectation is that there is collaborative planning, decision making, and their capabilities must be drawn upon (Felton, Wright & Stacey, 2017). Equally, identity crises would continue to be a topical issue for nurses, and there must be a seismic change, deterring from risk management of patients and investing in infrastructures that would afford nurses the opportunity to take a positive risk. Therefore, the voices of nurses and their patients must inform local policies, as the absence of their voices could result in a repeat of avoidable incidences.

Nurses represent a significant part of the healthcare workforce and are being excessively taxed by the job demands, enduring role captivity, lack of support and aggravated by a pervasive blame culture in healthcare settings (Royal College of Nursing, 2019). In the light of the need for higher standards across Health Services, the Kings Fund (2019) proposed a need for compassionate and inclusive leadership in UK Health Services. To understand and address the factors relating to nurses, it is of utmost importance that we have leaders who are well equipped to have difficult conversations and are advocates of cognitive diversity in nursing. In addition, leaders who can embrace uncertainties and adequately communicate the future direction of

organisations, based on experiential evidence of nurses and those of patients and family members. The bottom-up approach is vital to achieving the goals set out in health policies in the UK to improve retention and ensure staff can effectively use their skills and experience for the benefit of patients (NHS England, 2019b).

Future of mental health nursing.

It is important to stress that the future of nursing would need health service leaders, Higher Education Institutions, and researchers to deepen their collaborative work (Lakeman and Molloy 2018). Socio-political attitudes are permeating through cultural environments. Thorne (2020) stated that nurses are becoming more comfortable with the notion of multidisciplinary ideologies, which may not always include core knowledge relating to a nursing discipline. This, in turn, could result in tensions for the new generation of nurses, in terms of discerning the ideal self: ideas we claim to share as nurses and the actual self: our individual core beliefs. Within the context of decision making, nurses must have autonomy within their profession. For patients and their carers to receive the 'right care at the right time from the right person in a safe, honest, open and caring environment' (McSherry & Pearce, 2011:30), the profession of mental health nursing must be self-sufficient. Autonomy for nurses would require more dedication from healthcare leaders to offer support, with the view of understanding the psychological responses of nurses, which can also be linked with patients' experiences. In essence, there is a need to adequately support nurses, so as to foster cultural environments, where patients' experiences and perceptions are genuinely valued and considered for the betterment of health care service provision.

Addressing the issues relating to nurses having autonomy and full accountability (Rio et al., 2020), some leaders are already showing commitment to reducing restrictive

practices, increasing awareness, and promoting psychological safety of staff members, addressing resourcing challenges and adopting a learning culture (Bowers et al. 2015). Strategies have included reducing the burden of administration, encouraging shared documentation with patients, and adopting value-based staff recruitment (Becket et al. 2013, Foster 2017). In addition, some organisations are taking the lead on developing a just and learning culture that normalises people speaking up (Mersey Care NHS Foundation Trust 2021). These initiatives place equal emphasis on accountability and learning, which enable staff and managers to examine all the factors that lead to mistakes so they can jointly find solutions (Dekker, 2016). The commitments shown by leaders of organisations and the initiatives discussed above are central to the personal recovery of patients, would create opportunities for nurses to hone their expertise and encourage positive role modelling (Cleary et al., 2018b).

Hurley and Lakeman (2021) emphasised that the role of nurses remains ambiguous to people outside the discipline and has adverse implications on the credibility of the profession. There is a need to enhance understanding of nurses' experiences in different settings within the context of decision making, drawing on subjectivist epistemological and relativist ontological viewpoints, to aid bottom-up recommendations for stakeholders and policymakers. Given that nursing does not exist in isolation, with attitudes and shifts in paradigms being key drivers (Jackson, 2021), an interpretive research approach might be a way to provide insights into interventions that most stakeholders in health and social care systems would be able to implement. Nurses must be enabled to play active roles in research, with the scope to leverage role demands and identify new possibilities, which will be a precursor to the success of rapidly growing interoperable systems in healthcare. By so doing,

intricacies regarding the use of time and exercising temporal agency are contextualised, as nurses' time should not be pre-defined. Such endeavour has the propensity of improving the experiences of particular groups of people, that is, providing sensitive care, improved access to care and reinforcing the mechanisms needed to build therapeutic relationships with patients.

CONCLUSION

Mental health nursing is a necessarily complex role. Throughout its history, the profession has grappled with the tensions between its responsibility to people in a mental health crisis, alongside more comprehensive social-political expectations regarding safety and control. Institutions and the government enact their attempts to fulfil the obligation and resolve said tension through policies and practices. The span of the resulting divide suggests that the profession exists in a liminal space. Furthermore, contemporary mental health nurses operate in environments with increasing pressures on resources and time, which creates an additional barrier to therapeutic work. Yet, the therapeutic core of mental health nursing persists. Leaders in organisations should challenge metric-driven quality measures and drive compassionate cultures to protect and enhance this core. This approach would arguably help with the pressing attrition rate, create better conditions to counteract moral distress within nurses and ultimately improve the experience of patients, as well as support mental health nurses to be more in control of their future.

RELEVANCE TO CLINICAL PRACTICE

Drawing upon UK expertise, this paper provides a contemporary examination of the mental health nursing role, acknowledging the challenges of the context in which we

conduct mental health nursing work. Finally, it offers some proposals for addressing these challenges with a particular focus on leadership.

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