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January 2024 / Volume 27 / Number 1 mentalhealthpractice.com

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EXPERT ADVICE

Psychedelic drugs

Evidence from the latest clinical trials on health benefits **p12**

PROFESSIONAL ISSUES

Patient suicide

How to cope in the aftermath and strategies to support you **p16**

PRACTICE QUESTION

Person-centred

Why the therapeutic relationship is essential for good outcomes **p19**


Nurse Researcher
Mixed methods
Learning Disability Practice
A good night
RCNi
Nursing Standard

This month...

January 2024 / mentalhealthpractice.com

STUDENTS

‘Mental health conditions are often highly stigmatised in Africa and developing countries’

p16

p8 How can nurses improve mental health services for children?

There has been a steep rise in the number of mental health referrals for children and a lack of capacity to deal with it. Dual registration could be the answer

Attitudes towards digital technology and mental health among children and young people. Evidence & practice, page 34

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On the web
Everything you need to know about revalidation:
rcni.com/revalidation

editorial

5 Mental health nursing: education revamp is boost to profession
Psychosocial intervention training can enhance therapeutic relationships

news

6 Round up
Warning on the use of nurses who lack the right skills
8 Analysis
How can nurses help improve mental health services for children?

feature

11 Coping strategies to help you deal with patient suicide
Patient suicide can adversely affect the mental health and well-being of nurses, and coping strategies and support are vital

opinion

14 Role of psychedelic drugs in treating mental illness
Experts stress caution in including the use of psychedelic drugs with other therapies in mental health treatments

students

16 How cultural taboos can affect mental healthcare
Nursing students may need support to challenge cultural misperceptions or unconscious bias about mental ill health

evidence & practice

18 Writing for publication
Write an abstract that grabs your reader’s attention
19 Practice question
What is the therapeutic relationship in mental health practice?
20 Education
Benefits of developing long-term relationships between trainee nursing associates and mental health experts by experience
28 Medications management
Deprescribing antipsychotics in adults with psychotic disorders – a literature review
34 Child and adolescent mental health
Exploring young people’s perspectives on digital technology and mental healthcare: pilot study findings

EDITORIAL

‘Mental health nursing lacks career development, especially at an enhanced level of practice’

p5

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Newsroom

at happens now: the state of nursing after the
VID-19 pandemic

nurse leaders discuss how the past 18 months have affected their
kplaces

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RCNi

Mental health nursing: education revamp is boost to profession

Mental health nurses recognise that psychosocial interventions are among the priorities for the profession, as well as for patients, service users and their families. In 2022 Health Education England published its review of mental health nursing Commitment and Growth: Advancing Mental Health Nursing Now and for the Future, which emphasises the importance of experiential knowledge, and the identification of core skills across all practice settings and age groups.

By Stephen Jones
head of nursing practice, RCN

The Nursing and Midwifery Council's Future Nurse: Standards of Proficiency for Registered Nurses also outlines why evidence-based communication and therapeutic interventions should be part of every nurse's repertoire. However, a 2023 RCN survey revealed that mental health nurses and students lack education in these interventions.

Mental health nursing lacks career development, especially at an enhanced level of practice. One reason for this is that the specialty can be difficult to define and lacks a universally agreed evidence base, which often leads to a misunderstanding of mental health nurses' role and capabilities. It is therefore crucial to ensure mental health nurses receive the necessary career development opportunities.

While there is currently no nationally recognised programme to improve therapeutic relationships in the context of psychosocial interventions, this is about to change. After two years of listening to, and engaging with, grassroots and senior nurse leaders and people with experience of services, the RCN has been commissioned by NHS England to revamp psychosocial interventions education, which was last delivered in the early 2000s.

This exciting profession-defining programme will be specially designed for post-preceptorship mental health nurses, with the first cohorts starting in mid 2024.

I am sure readers of Mental Health Practice will join me in welcoming this development.

> **'Mental health nursing lacks career development, especially at an enhanced level of practice'**

Further information

NHS Health Education England (2022) Commitment and Growth: Advancing Mental Health Nursing Now and for the Future. **tinyurl.com/NHSHEE-commiment-growth**

NMC (2018) Future Nurse: Standards of Proficiency for Registered Nurses. **tinyurl.com/NMC-future-nurse**

Our mission

Mental Health Practice aims to inspire professional excellence by informing, supporting and educating nurses throughout their careers.

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Mental Health Practice
RCNi, 20 Cavendish Square, Marylebone, London W1G 0RN
Mental Health Practice is indexed with British Nursing Index and Ovid

Subscription department
Royal College of Nursing Journal subscription department, Copse Walk, Cardiff Gate Business Park, Cardiff CF23 8XG.
Tel: 0345 772 6100

Print edition rates
Personal: from £73 a year in the UK and Europe, and from £121 a year in the rest of the world.
Institutional: from £446 a year
Email: institutions@rcni.com

ISSN 1465-8720 (print)
ISSN 2047-895X (online)
Printed by Stephens and George, Merthyr Tydfil, on acid-free paper

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Warning on the use of nurses who lack the right skills

RCN says some nurses could breach the Code, but NHS England denies inappropriate staffing in mental health services

By Alison Stacey

Mental health and learning disability nurses are reportedly being unlawfully replaced with adult or children's nurses due to staff shortages, prompting warnings of an NHS 'on the cusp of a national crisis'.

A survey of more than 600 members of the RCN's mental health forum found that some inpatient wards are being left without any appropriately qualified nursing staff during shifts, as units struggle to recruit amid rising vacancy rates.

Only 57% of respondents could confirm they had mental health and learning disability nurses on every shift over the past 12 months.

One third said they had witnessed at least one shift in the past 12 months where no registered mental health or learning disability nurses were present.

However, NHS England told Nursing Standard it rejected the findings of the survey, saying it is 'categorically not happening in our mental health and learning disability services'.

RCN interim head of nursing practice and UK lead on mental health Stephen Jones said that members – including nurses on the front line and some in strategic roles at trusts – have been raising concerns and their potential legal implications for more than a year.

The situation prompted the college to write to chief nursing officers and survey its membership.

Mr Jones said nurses could be at risk of breaching the Nursing and Midwifery Council (NMC) code as well as failing in legal duties outlined in the Mental Health Act (1983). 'Not having a mental health nurse on shift is – according to our interpretation of the legislation – unlawful, putting patients at risk and the registration of nurses.'

'Non-mental health or learning disability nurses cannot be used to close the workforce shortages. If providers are saying they "have to" then it would appear we are on the cusp of a national crisis.'

The act states that only nurses of a 'prescribed class' – meaning registered with a mental health or learning disability qualification – have the power to hold or detain an involuntary patient on a ward for up to six hours until they can be assessed by a doctor.

One mental health nurse working in an inpatient unit for adult men in central Scotland told Nursing Standard his trust had recently hired a number of adult nurses to staff wards as they 'just do not have enough mental health nurses'.

Without an approved mental health professional on site, said Mr Jones, an adult nurse will not be able to hold a patient, compromising safety.

He said: 'These environments are very restrictive, taking away people's autonomy and freedom, so we need to make sure that anyone making those decisions has a full understanding of the context and legalities of how that is undertaken and done.

'The lack of national investment in mental health nursing is why there is a recruitment and retention issue. If the true value of mental health nurses had been taken seriously over the past decade we would not be in this situation.'

NMC nursing education adviser Julie Dixon said that while nurses can work across different settings 'employers and managers also need to ensure the right skill mix of their teams on every shift'.

Mental health and learning disability vacancy data

- England: 13, 652 mental health nurse vacancies as of June 2023, but no data on learning disability nurse vacancies is available
- Scotland: 89 full time equivalent vacancies for learning disability nurses and 907 for mental health nurses as of September 2023
- Northern Ireland and Wales nursing vacancy data do not provide a breakdown by profession

RCN NURSING AWARDS 2023

This year’s winners in the mental health and student categories

Recipients of the prestigious RCN Nursing Awards 2023 were revealed at a ceremony at Liverpool Cathedral on 10 November. This year the awards attracted their highest-ever number of entries, and the judges commended the finalists for their dedication and compassion.

Senior staff nurse Michaela Heaton of Scarisbrick Inpatient Unit, Lancashire and South Cumbria NHS Foundation Trust, was awarded in the mental health category for the development of Bus Stop, a designated area for short therapeutic interventions. Originally a corridor where people stopped to talk to nurses sitting and writing up notes, the space has been transformed into a safe and sociable area through collaboration with Lancashire County Council and the companies Lush and Unilever.

Staff on the Scarisbrick mental health team (pictured, Ms Heaton fifth from left) deliver therapeutic activities in the space, resulting in a 60% reduction of self-harm among inpatients and 25% reduction in violence and aggression on the ward.

Meanwhile, nursing student award winner Leanne Howlett of Coventry and Warwickshire Partnership NHS Trust and Coventry University, was praised for developing a resource to support young people to reflect on their recovery.

The Discharge Wellbeing resource she developed will be rolled out across the entire child and adolescent mental health services at the trust. Patients who have already received the pack have reported it improved their discharge experience, helping to reframe it as something positive.

MENTAL HEALTH SURVEY

Nurses urged to give their views on care and job satisfaction

Mental health nurses are being urged to have their say on job satisfaction, well-being, burnout and care quality in a new survey.

Led by University of Southampton professor of nursing workforce policy Jane Ball, the survey aims to address national workforce challenges and seeks mental health nurses’ views on factors that affect their day-to-day job.

Researchers hope the findings will lead to local and national action being taken to improve nurses’ working lives, leading to better well-being and retention in the field.

Professor Ball told Nursing Standard: ‘We want to understand how much variation there is in the way different mental health staffing teams are made up as well as in their workload, the different pressures that mental health nurses describe and what they see as a possible solution.’

The 2022 NHS staff survey showed 49% of mental health nurses felt unwell because of work-related stress in the past 12 months and 45% reported often or always finding their work emotionally exhausting.

The survey is open to all mental health nurses on the UK register working in any setting for any health and social care provider and can be completed anonymously. It is open until Christmas.

Take part in the survey at **tinyurl.com/NIHR-survey**

STAFF WELL-BEING

‘Frightening’ mental health crisis looming among nursing staff

Nursing leaders are warning of a ‘frightening’ mental health crisis emerging among nursing staff as new data show calls to a helpline regarding suicidal thoughts have doubled since last year.

In the first ten months of 2023 there was a 98% increase in the number of nursing staff telling the RCN’s advice line they were having suicidal thoughts in an initial phone call, compared to the same timeframe last year. Data show an increase from 89 to 176 calls.

The college also reported a steep increase in the volume of calls from people reporting suicide ideation from an average of one per week in October 2021 to one per day in October 2023.

Funding cuts

Earlier this year the government cut funding to mental health hubs for NHS staff, with one third of them now closed. This has left an estimated one million health workers without local support.

The RCN referred to multiple studies that show nurses and other healthcare professionals are at higher risk of suicide due to stressful work environments exacerbated by excessive workloads, staffing shortages and poorly resourced workplaces.

In response to these latest findings, the RCN has commissioned research looking into the reasons why nursing staff are having suicidal thoughts and whether there is a disproportionate impact on those from marginalised groups.

The college called on the government to provide funding for dedicated mental health support for nursing staff, a sentiment echoed by NHS Providers.

How can nurses improve mental health services for children?

There has been a steep rise in mental health referrals for children and a lack of capacity to deal with it. Dual registration could be the answer

By Pavan Amara
nurse, midwife and
health journalist

More dual registered nurses must be trained to cope with a dramatic increase in the number or children with mental health issues, say senior nurses. They say that vulnerable children's needs are not being met, as young people with mental health needs are being forced into 'overwhelming' adult mental health settings or into general children's wards that struggle to provide appropriate care.

To deal with the scale of the issue, universities must run more courses that train nurses to work with children and in mental health, says Barts Health NHS Trust director of nursing for children Kath Evans.

'One reason that universities are not offering more dual training programmes nationally is because providers aren't asking for them,' she says.

'We need to be better at saying we need these programmes because our emergency department (ED) doors are open 24/7, and an increasing number of young people with mental health issues are coming in.'

Self-harm and suicide

In the year to March 2023 there were 21,555 urgent children's referrals to mental health crisis teams, up 46% compared to 12 months earlier, according to the mental health charity YoungMinds. These children were experiencing acute mental health symptoms and would otherwise need to attend hospital for psychosis, severe self-harm or suicide attempts.

Data suggest the COVID-19 pandemic and associated lockdowns may have played a part in the high numbers of young people experiencing mental health problems.

Figures from YoungMinds show that one in six children, aged five to 16, had a probable mental health problem in 2021, compared to only one in nine in 2017.

At the same time, 83% of young people with mental health needs agreed that the pandemic had made their mental health worse.

Mental health nurses say the increase is more complex than that, however, with many factors needing to be considered. Barts Health NHS Trust children and young people's mental health practice development nurse Amina Marzouki says that in her trust's area of London, social and economic factors all contribute to increasing mental health problems among young people.

'With social media like TikTok and Instagram there is this false idea of living a luxurious life,' she says. 'There are also many horrible websites that teach young people to inject insulin to lose weight and encourage anorexia.

'There are gangs that recruit young people in years five and six (aged nine to 11) to deliver drugs, and consuming drugs is common in children around the age of 12.

'The cost-of-living crisis has increased that pressure on some children to bring money home. There is also bullying and dysfunction in families, so there are many factors apart from COVID.'

Lack of trained staff

Ms Evans says that, although an increasing number of young people are attending the ED with mental health issues, a lack of staff trained in children's and mental health nursing means that 'capacity to deal with this is poor'.

'A lot of young people admitted into hospital with mental health issues are having to spend time in general children's settings or adult mental health settings,' she says.

'Adult settings are overwhelming for them. Their needs as children can't always be met. Dual registrants would bring a degree of flexibility – we'd have more choice in terms of where children are cared for, we could meet their holistic needs in those places and safeguarding would improve. It would make a significant difference.'

Ms Marzouki, who initially trained as an adult mental health nurse (RMN), agrees that dual registrants would have a better understanding of safeguarding needs.

Tips for practice – working with children experiencing mental health issues

» **You don't have to resolve everything or be an expert** Come with an open mind, listen carefully and tell the patient that you will come back to them if you do not know the answer

» **Give extra time when necessary** Time is in short supply, but children are more likely to engage if you do not appear rushed, and this can make a difference to receiving crucial information

» **Go at the young person's pace** Some young patients may be interacting with mental health services for the first time – when they disclose their experiences, say thank you for sharing and give them a moment before asking key questions

» **Think about language** Official terms can alarm or confuse younger people as they may be less familiar with them compared to adult users of mental health services. When using words like 'acute', for example, explain what that means

Source: Collated from interviews with the Barts Health NHS Trust and Lewisham and Greenwich NHS Trust nurses quoted in this article


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‘Most children’s nurses don’t have experience of caring for those in mental distress, and most RMNs have little experience with children. As a result, RMNs tend to find safeguarding difficult with children.

‘If a child makes an allegation of something, it’s different to if an adult does, and some RMNs don’t feel as comfortable handling that as they would with adults. It’s possible that dual registration could improve safeguarding and safety overall.’

Greater registration

There has been an increase in the number of children’s nurses registered with the Nursing and Midwifery Council (NMC) over the past decade, and in mental health nurses registered since 2014. This year there are 95,485 RMNs and 57,014 children’s nurses registered with the NMC.

These numbers do not necessarily reflect those in permanent roles or employed by NHS services. But Lewisham and Greenwich NHS Trust head of nursing for mental health Kevin Ramjeet says that RMNs coming into the workforce will not necessarily be well equipped to care for children.

‘When you’re doing RMN training, you might get an eight-week placement in an adolescent unit, but that does not equip you.

In the year to March 2023 there were 21,555 urgent children’s referrals to mental health crisis teams, up 46% compared to 12 months earlier

> **‘If we had a few dual registered nurses in each children’s ward it would make a significant difference to the service, and it would also encourage staff to be more thoughtful about what they’re doing’**
>
> *Kath Evans, director of nursing for children, Barts Health NHS Trust*

‘Different dynamic’

‘I worked in adult mental health and thought working with children would be a walk in the park. It was not. It was the toughest place I’ve worked. I thought I was resilient and knew what to say, but all that went out the window in a few weeks.

‘There is a different dynamic with children. There were 14 or 15 children on the ward I worked on and they all had their own issues; they all compete for your attention as a nurse in a different way to what adults would normally do.

‘You’re often working more with children’s families than you would be with the families of adult patients. That takes different skills; there can be a lot more emotion involved.

‘The things you say have to be thought through differently because children will often interpret things differently to adults. Things you think that are trivial, are not.

‘One clinician said to a child who had been self-harming “you’re so pretty, you don’t want to be scarred for life” and that was a trigger for that child and could have led to an escalation. Understanding mental health, but in the context of adolescence for example, is important.’

He adds that RMNs and children’s nurses may find children’s behaviour ‘surprising’ when they have mental health issues.

‘There can be an assumption about children’s mental health,’ he says. ‘So, when they see children smashing up a computer, self-harming, swearing and shouting, they won’t understand this is behaviour that they have learnt. General children’s nurses won’t be used to seeing this behaviour and RMNs won’t necessarily see the child’s trauma behind the behaviour.’

The main barrier to employing more staff who are children’s and mental health nurses, adds Mr Ramjeet, is that there are not many available, as dual training takes more time and money.

‘You would have to do a three-year course and then an 18-month course to be dual trained,’ he says. ‘It takes money to do that, but the starting salary won’t be any higher.

‘If there is one course to train in both areas, then that course may be longer, maybe four years, so those doing it are in the same situation of spending more time training but not having higher starting salaries.’

‘Glimmer of hope’

Lewisham and Greenwich NHS Trust’s head of nursing for children and young people Robert Cole says there is a ‘glimmer of hope’ with nurse associates, as they can be trained across mental health and children’s settings.

‘They would be able to carry out mental health interventions with children, consider developmental milestones and work with families too,’ he says.

‘Realistically it would be good to have dual trained nurses but, unlike adults, you see peaks and troughs with children’s mental health. Some dual trained nurses might find it unattractive to work in a paediatric area during those periods where they’re not using their mental health skills.’

Dual trained nurses would help improve care for children with mental health issues

There are 95,485 RMNs and 57,014 children’s nurses on the Nursing and Midwifery Council register in the UK. This number does not necessarily reflect those in permanent roles or employed by NHS services.

Last year, NHS England says it boosted staffing numbers in England’s children’s mental health services by 4,500, or about 40%, but how many of these were nursing jobs is unclear.

A handful of undergraduate and postgraduate courses enable registration as a children’s and a mental health nurse, including those at the University of West London, University of Leicester, the University of Birmingham, Dundee University and Anglia Ruskin University.

Ms Evans says the opportunity to register as both needs to be extended. ‘If we had a few dual registered nurses in each children’s ward it would make a significant difference to the service, and it would also encourage staff to be more thoughtful about what they’re doing.’

Further information

Anglia Ruskin University (2023) Nursing: Child and Mental Health. **tinyurl.com/ARU-child-mental-health**

Baeden A (2023) Number of children in mental health crisis at record high in England. The Guardian. **tinyurl.com/TG-mental-health-crisis**

Glasper A (2013) Should nurses work outside their own field of practice? British Journal of Nursing. 22, , 13. doi.org/10.12968/bjon.2013.22.13.790

NHS (2022) Children and Young People: Consent to Treatment. **tinyurl.com/NHS-children-consent-treatment**

Nursing and Midwifery Council (2018) The NMC Register. **tinyurl.com/NMC-register-2018**

Nursing and Midwifery Council (2023) The NMC Register. **tinyurl.com/NMC-register-2023**

University of Birmingham (2023) Nursing MNurs – Child and Mental Health (Dual). **tinyurl.com/UB-child-mental-health**

University of Dundee (2023) Child and Mental Health Nursing BSc (Hons). **tinyurl.com/UD-child-mental-health**

University of West London (2023) Nursing Dual Field (Children’s Nursing and Mental Health). **tinyurl.com/UWL-nursing-dual-field**

Young Minds (2023) Mental Health Statistics. **tinyurl.com/YM-mental-health-statistics**

Ms Evans’ colleague at Barts Health NHS Trust, associate director of safeguarding Clare Hughes, has overheard mistakes being made when nurses who are not dual registered care for young people with mental health issues.

‘I’ve heard comments like “they just need to get on with it” or “they just need to get a grip”,’ she says. ‘That doesn’t happen across the board, but if there was more mixed educational opportunity in children’s and mental health nursing that would improve.

‘We’ve heard staff tell young people they must be seen with a parent and that young person has disengaged as a result. This is a lost opportunity because if that young person can access care now, then their mental health is less likely to deteriorate as they enter adulthood and develop into behaviour that then requires more care.’

Language and tone

People aged over 16 do not need to be seen with a parent and children under 16 can consent to their own treatment if they are Gillick competent. Ms Hughes says that insisting young people are seen with a parent could cause them to disengage.

‘At the same time, you do need to ask about parents to pick up on safeguarding issues,’ she says. ‘If they tell you they’re not living at home, then where are they living and with whom?

‘Safeguarding is about listening, but also asking key questions without pushing. It’s a fine line. You need to keep children in hospital to do the interventions and that means keeping them calm.

‘But if you phone someone like me for advice, I need to know enough about it to give you the correct advice. It’ s often about how you ask children uncomfortable questions, the language and tone you use matters.’

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Coping strategies to help you deal with patient suicide

Patient suicide can adversely affect the mental health and well-being of nurses involved in that person's care, and coping strategies and support are vital

By Pavan Amara
nurse, midwife and
health journalist

Nurses say they have been changed forever after a patient in their care died by suicide, yet what have been described as toxic workplace attitudes mean that some are blamed and scapegoated for the incidents, despite being left with serious mental health problems themselves.

The legal consequences and organisational processes that follow a patient's suicide – such as NHS serious incident investigations and inquests – are also traumatising and can leave long-term scars for nurses, with most not trained to navigate them until they occur.

'For some nurses, experiencing a patient's suicide has led to them developing their own mental health problems, especially if they feel blamed for the death,' says University of Salford associate professor in mental health nursing Gemma Trainor.

'It can change staff for the rest of their lives and result in issues such as post-traumatic stress disorder (PTSD),' she adds.

Guidelines for recovery

Research has found that support is patchy across NHS organisations and too often grieving nurses are blamed by the organisation employing them.

'How staff cope in the short and long term is often down to the organisational response,' says Dr Trainor. 'It can depend on whether there is a fear of litigation or anxiety about informing the patient's family.'

It is estimated that those working in mental health will lose as many as four patients to suicide over the course of their career.

Most are unprepared for it and until last year there were no guidelines for the recovery of NHS employees affected by suicide. However, in 2022 the Royal College of Psychiatrists (RCP) published Supporting Mental Health Staff Following the Death of a Patient by Suicide: A Prevention and Postvention Framework.

In addition, in July 2023 researchers at Keele University and the universities of Surrey and Birmingham wrote Postvention Guidance: Supporting NHS Staff After the Death by Suicide of a Colleague.

One mental health nurse, Julie, whose name has been changed, says the first time she experienced a patient's suicide was after 23 years in the job. 'It changed my life forever,' she says.

The death occurred on the ward Julie worked on, and she tried to save her patient by performing cardiopulmonary resuscitation. The woman was later declared dead in the emergency department (ED).

'I had a sense of guilt, as though my actions and words had caused this,' she says. 'That feeling continued on my return to the ward and while I gave statements to the police.'

Julie was then asked to identify her patient in the ED as the family could not. 'I was shocked to see the physical post-mortem changes in the patient's face and colouring as I was not aware that this extremity would occur.'

Legal duty of care

It was 20 months before an inquest was held. 'I felt sorry for the patient,' she says. 'Also, very alone myself, paranoid, angry that her self-harming had resulted in her death on my shift and sometimes blind panic, and a helpless anxiety.'

Dr Trainor says she knows of several nurses who were diagnosed with PTSD after a patient's suicide. 'It contributed negatively to their own relationships and families for years afterwards.

'The process can be traumatic. Nurses have their own triggers and you don't know what's happened in their personal lives. I know of cases where a patient's suicide has set off intrusive thoughts, hypervigilance, their own suicidal thoughts.'

The 2022 RCP report drew attention to the fact that organisations have a legal duty of care to their employees.

Mental health nurses across settings are affected. Between 2010 and 2020 more than one quarter of patients who died by suicide were in acute care settings, and roughly half of these occurred when the patient was on agreed leave from the inpatient unit.

Community mental health nurses were affected too, with the highest number of deaths occurring on day three post-discharge from inpatient care, according to the National Confidential Inquiry into Suicide and Safety in Mental Health 2023 report.

Rich Evans, a senior lecturer in mental health nursing, says: 'I've had to break the news of a patient suicide to colleagues on a number of occasions.'

Mr Evans, who works at the University of the West of England in Bristol, led his former NHS trust's suicide prevention strategy for five years.

'It can happen when the staff who are closest to that patient are on a day off. You're then in a dilemma of whether you wait for them to come back to work or contact them,' he says.

'The problem is, if you leave it too long they can find out anyway.'

Mr Evans' wife, who is also a mental health nurse, was on maternity leave when she found out that a patient of hers had died by suicide – but from a news report, rather than a manager calling her.

He says: 'You can't control many factors: how the news is reported, when it's shared and who sees it. There is no perfect way of delivering the news.

'Some people will want to keep their personal and work lives separate and not be told until they return to work. Others will want to be connected to their colleagues right away. It's difficult to know who's in which group.'

Emotional impact

Research from a number of studies shows that the way in which the news is delivered influences the emotional impact of the death. None of the studies recommends a specific method to inform staff, but compassion is emphasised in most of them.

In its report, the RCP recommends that staff should be informed of the death in a timely way. This should include those who are non-clinical, as well as trainees and students.

University of Nottingham associate professor of mental health Charley Baker, who is also academic lead for safeguarding, says nurses want to be supported in different ways. 'Having said that, what no nurse needs [after a patient's suicide] is someone coming in and demanding to know what went wrong,' she says.

'There are questions that need to be asked early to identify problems. Questions like who was involved with the person? What was our involvement with the family? Practically, if the death was

Further information

Gutin N (2019) Losing a patient to suicide: what we know. Current Psychiatry. 18, 10, 14-32. **tinyurl.com/MDE-losing-patient**

Whisenhunt J, DuFresne R, Stargell N et al (2017) Supporting counselors after a client suicide: creative supervision techniques. Journal of Creativity in Mental Health. 12, 4, 451-467. doi.org/10.1080/15401383.2017.1281184

NHS England (2023) Working Together to Prevent Suicide in the NHS Workforce: A National Suicide Prevention Toolkit for England. **tinyurl.com/NHSSE-suicide-prevention**

Cryan E, Kelly P, McCaffrey B (1995) The experience of patient suicide among Irish psychiatrists. Psychiatric Bulletin. 19, 1, 4-7. doi:10.1192/pb.19.1.4

Royal College of Psychiatrists (2022) Supporting Mental Health Staff Following the Death of a Patient by Suicide: A prevention and Postvention Framework. **tinyurl.com/RCP-patient-suicide**

Society of Occupational Medicine (2020) Responding to the Death by Suicide of a Colleague in Primary Care: A Postvention Framework. **tinyurl.com/SOM-suicide-response**

University of Surrey, University of Birmingham and Keele University (2023) Postvention Guidance: Supporting Nhs Staff after the Death by Suicide of a Colleague. **tinyurl.com/UoS-postvention-guidance**

'Look after your well-being and be aware of your limitations'

Lilian Hove (pictured) is a practice development nurse in West London forensic services, part of West London NHS Trust. She experienced two patient losses in a six-month period.

'As a ward manager I thought I was going to be blamed for the deaths and that I wasn't good enough to be a leader. I thought about stepping down from my role but I didn't want to walk away a failure.

'It was difficult to accept the loss, but I had to be kind to myself, and I learned to accept that there are some things that you cannot change. I needed to be there for my team, who were also going through the grieving process.'

For confidentiality reasons, she could not discuss the deaths with her friends or family, which made her feel isolated: 'I didn't want them to influence my decision about whether to remain in my job.

'The first thing you need to do is look after your well-being and be aware of your own limitations.'

predictable then changes to practice need to be made.

'But we need a culture that doesn't blame and instead acknowledges that sometimes we get it wrong. That isn't something that's well embedded in the NHS, or even in private organisations. There's far more blame than acknowledgement.'

Mental health nurse Julie says that when she gave evidence at the inquest, 20 months after her patient's death, she was made to feel like she was 'being tried for murder'.

'I was on the witness stand for eight hours and felt, due to the questions asked, like I was a pariah. The coroner thanked me for my honesty, but it didn't allay my feelings that I was being made a scapegoat.'

Julie says her own mental health was seriously affected and that eight years on she still thinks about the patient's death every day.

'After the inquest I became very flat in mood, dreamed lurid dreams of horrible events, but never the original incident.

'I developed rituals where I insisted that certain useless items were not moved, or I would open a drawer in a certain way or make a particular gesture when passing somewhere.'

Professional sanctions

The RCP report noted that clinicians have faced professional sanctions, such as referral to the Nursing and Midwifery Council , when a patient's suicide occurs on their shift. It recommends that managers should 'strongly consider' intervening to avoid professional sanctions for an individual.

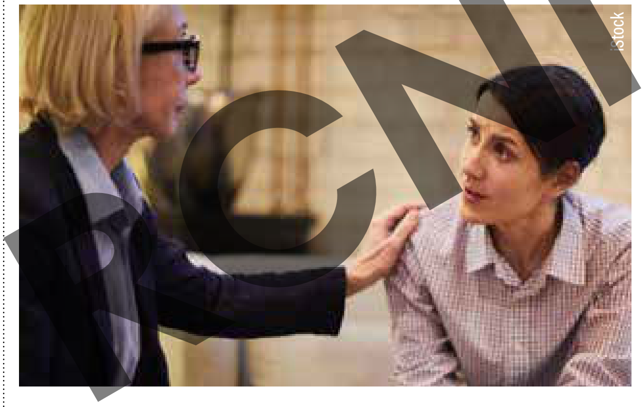
Mr Evans says the process after the death can go on for longer than most nurses expect.

'Unfortunately, it's not unusual to attend a coroner's court 18 months after the incident,' he says. 'It is stressful and sometimes talking people through the process of the inquest or attending a coroner's court before the actual giving of evidence can help.

5 tips on how to cope when you lose a patient to suicide

1. Allow others to look after you. Being vulnerable is not a weakness but a strength. Give yourself permission and time to grieve, and talk about loss if it helps
2. Use any support that is available or has been offered to you and do not blame yourself. Remember that sometimes serious incidents are unavoidable
3. Be prepared to have difficult conversations with families, at fact-finding meetings and at the coroner's court
4. If it helps, go to see the coroner's court before you have to give evidence. For some, becoming familiar with the physical space may remove some of the anxiety
5. Remember that you were one part of that patient's life. There will be many factors of which you are not aware

Sources: Lilian Hove, practice development nurse, West London Forensic Services; and Rich Evans, senior lecturer in mental health nursing, University of the West of England Bristol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Nurses can speak with 'buddies' who have experience of patient suicide

'Sometimes, hearing particular questions or statements of fact that are not intended to blame can feel like blame.'

Mr Evans and Dr Baker agree that learning to navigate inquests and investigations following a patient's suicide should be included as part of mental health nurse training.

Dr Baker says: 'It's important to know about the different types of inquests and how to prepare for one, because so many mental health nurses will experience this in their career.

'Work is being done on mock inquests as part of nursing and midwifery training, so they are prepared for what it will feel like, even if it's not exactly the same as the mock.'

A healthcare organisation may also carry out a formal investigation to learn how it can provide better care. through systemic changes rather than individuals' actions. Only the inquest, in a coroner's court, should determine how, when and where a person died.

Pastoral suicide lead

In the past year, three suicide prevention strategies have been published. As well as the RCP report and guidance from researchers at Keele University and the universities of Surrey and Birmingham, NHS England released a national suicide prevention toolkit.

'Some of the reports have mentioned the idea of a pastoral suicide lead in organisations,' Mr Evans says. 'Someone who looks at suicide prevention, and recognises that we will have tragedies and staff need support in the aftermath. That pastoral lead won't investigate or prepare nurses for inquests, or look at clinical practice, but just support.

'As a result, if it hasn't started already, we will see lots of advertisements on the NHS Jobs website for multiple mental health organisations.

'Once these people are in post, that will benefit staff after a suicide.'

He says reflective practice in teams enables an openness about the impact of a patient's suicide. The RCP also recommends speaking with a 'buddy' who has experienced the same thing.

'The impact of a suicide on staff is a specific category,' he says. 'You need that space and understanding. Using professionals in your team, such as psychologists, who can guide through difficult situations.'

Dr Baker says: 'The problem is that often these things are offered, but at one time. You need these things available when needed and that may not be immediately.'


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Role of psychedelic drugs in treating mental illness

Experts stress caution in including the use of psychedelic drugs with other therapies in mental health treatments

By Nick Evans
health journalist

Growing interest in the use of psychedelic drugs to treat mental illness is reflected in trials being held worldwide. And this year Australia become the first country in the world to legalise their use as a mental health treatment.

Here we look at what the evidence shows and what those working with patients need to know.

Psychedelic drugs, also known as hallucinogens, affect a person's mind by altering perception, mood and thoughts.

Many psychedelic drugs are found in nature, in fungi, cacti and seeds, while others are created synthetically in laboratories. When they are used recreationally they can be taken orally, smoked, snorted or injected, but they are illegal.

Well-known psychedelics being investigated for their medicinal properties include psilocybin (sometimes referred to as magic mushrooms), LSD, MDMA (also known as ecstasy) and ketamine.

The drugs affect brain receptors in the prefrontal cortex, the part of the brain that is linked to conditions such as schizophrenia, depression and anxiety. Advocates argue this may create an opportunity to treat mental health by making the brain more flexible or encouraging the regrowth of receptors.

Medical research into the therapeutic benefits of psychedelics started gathering pace in the 1950s, before tighter regulation – particularly in Europe and the US in the 1970s – stopped much of it.

That has begun to change in recent years, however. Restrictions have started to be eased in some places, including the US, and, while tight rules remain in place in the UK, trials have been allowed under a Home Office licence.

This change has encouraged the drugs industry to invest more – Clerkenwell Health, the first European organisation dedicated to running clinical trials on psychedelic drugs, established a base in London in 2022.

Use of ketamine

The surge in interest has been about three drugs in particular – ketamine, psilocybin and MDMA. The focus has been on major mental health conditions in people where previous traditional treatment has failed. A number of studies have found that psilocybin, given in combination with psychological support, is effective at treating anxiety and depression.

There have been similar findings for ketamine, which is approved for use as an anaesthetic. It is being used off licence for treatment-resistant mental health problems by Awakn Clinics in London. Meanwhile, a recent paper in Nature Medicine, MDMA-assisted therapy for moderate to severe PTSD: a randomized, placebo-controlled phase 3 trial, found MDMA coupled with talking therapy could help treat moderate to severe post-traumatic stress disorder

Psilocybin – sometimes referred to as magic mushrooms

‘These drugs are not regulated and are illegal. There is no quality checking and no guarantee what people take is what they think it is’
Ian Hamilton, senior lecturer in addiction and mental health, University of York

MDMA – also known as ecstasy

(PTSD). In the study a measurable improvement was found in 86.5% of the MDMA group, compared with 69% in the placebo group.

The research has been enough to persuade Australia to allow MDMA to be used for PTSD and psilocybin for severe depression where other treatments have not worked. Like any medical treatment, the use of psychedelic drugs is not without risks. Common adverse effects, even under clinical supervision, include increases in fear, heart rate and blood pressure.

Repeated hallucinations are another risk, although rare in those given them under clinical supervision. Recent research has not reported any long-term harm.

King’s College London senior lecturer in psychopharmacology and mood disorders James Rucker says there is encouraging evidence being found. But he says one of the problems in trials is that the numbers involved are not large enough to detect rarer side effects, because of the restrictions in place.

‘This needlessly drives up the costs of MDMA clinical trials which, in turn, reduces the number of participants that can be recruited,’ says Dr Rucker. ‘The overall effect is that patients have to wait longer for new treatments to be developed based on Schedule 1 drugs.’

University of York senior lecturer in addiction and mental health Ian Hamilton agrees that there seems to be some potential , which is causing much excitement in the field. ‘We have not had any breakthroughs in mental health medication since selective serotonin reuptake inhibitors,’ he says.

Randomised control trials

Mr Hamilton would also like the rules to be relaxed to allow more research, but says one problem is that it is difficult to do a proper randomised controlled trial. ‘It quickly becomes obvious which arm (of a trial) a person is in as the placebo cannot mimic the drug.’

Given the growing interest in the therapeutic benefits of psychedelic drugs, it should come as no surprise that some people have started using them themselves for their mental health.

Tesla and SpaceX founder Elon Musk, for example, reportedly microdoses with ketamine to manage depression, arguing it is better than using antidepressants.

Mr Hamilton says this can present a dilemma for mental health staff. ‘Mental health nurses must be careful if patients ask about this. These drugs are not regulated and are, of course, illegal. There is no quality checking and no guarantee what they may take is what they think it is.

‘But equally it is important not to shut the conversation down or be judgemental. If patients are going to take these drugs, clinicians need to know about it. They could interact with the treatments they are already on. Getting the patient to talk to their psychiatrist or GP is important,’ says Mr Hamilton.

Further information

BBC News (2021) First Ketamine-Assisted Psychotherapy Bristol Clinic Opens. **www.bbc.co.uk/news/uk-england-bristol-56170592**

Home Office (2022) List of Most Commonly Encountered Drugs Currently Controlled Under the Misuse Of Drugs Legislation. **tinyurl.com/HO-controlled-drugs**

McCrone P, Fisher H, Knight C (2023) Cost-effectiveness of psilocybin-assisted therapy for severe depression: exploratory findings from a decision analytic model. Psychological Medicine. 1-8. doi: 10.1017/S0033291723001411

Mitchell, J Ot’alora M., van der Kolk B et al (2023) MDMA-assisted therapy for moderate to severe PTSD: a randomized, placebo-controlled phase 3 trial. Nature Medicine. 29, 2473-2480. doi: 10.1038/s41591-023-02565-4

Ng K (2023) Elon Musk ‘microdoses ketamine to manage depression,’ report says. Independent. **tinyurl.com/l-musk-ketamine**

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How cultural taboos can affect mental healthcare

Nursing students may need support to challenge cultural misperceptions or unconscious bias about mental ill health

By Emmanuel Obimah
mental health nurse,
East London NHS
Foundation Trust

Growing up in a rural village in Nigeria, I thought of mental illness as a disease to be dreaded. Mental health conditions are often highly stigmatised in Africa and other developing countries, with understanding and attitudes influenced by traditional beliefs that mental ill health has supernatural causes and should be feared.

Research has shown that traditional belief systems in Africa play a key role in the perception and management of mental illness. Traditional healers – also known as native doctors – are considered the experts on mental health and are often the exclusive providers of mental healthcare. They operate from what are known as healing homes and chant incantations while calling for oracles to ‘heal’ their clients.

Recognising symptoms

When I moved to the UK with my family in 2021, I was shocked by how open people are about mental health conditions or problems because such issues are seen as taboo in Nigeria.

Discussions about mental health are common in the UK media and among health professionals, with ongoing conversations that seek to normalise mental illness and encourage people to seek help.

In many parts of Nigeria, the understanding of mental illness is limited to psychosis, and people who present with symptoms of psychosis are often restrained while they undergo treatments from traditional healers.

After hearing about other mental health conditions in the UK, such as depression and schizophrenia, I started to recognise the symptoms of these conditions in people back home who had been poorly treated and stigmatised. My desire to learn more and support people with mental health conditions led me to pursue a master’s degree in mental health nursing and, in September 2021, I started a two-year course at City, University of London.

Coming from a cultural background in which people living with mental health issues are largely discriminated against, I knew I needed to unlearn some of the unhealthy beliefs that I had developed and for which there is no evidence.

Through my own research, academic work and practice placements, my knowledge of mental health increased dramatically. I learned about the causes of mental health conditions and the treatments available, such as talking therapies, and more informed, evidence-based ways of explaining mental ill health. Crucially, I learned about compassion and empathy in caring for people with

How to unlearn unhealthy beliefs

- **Do your research and use the evidence base to expand your knowledge** Use the evidence to inform and improve your practice to ensure you are delivering truly person-centred care
- **Talk to patients about their experiences and practice active listening** Learning from lived experience offers valuable insights into patient journeys and what it is like to live with one or more health conditions
- **Be aware of unconscious bias** Your judgement is influenced by your background, personal experiences or culture. Not letting them affect your care can make you a better practitioner
- **Be brave** It is not always easy to accept that long-held beliefs have no evidence base but being open and honest is essential. Talk to someone you trust who can help advise you
- **Educate others** As nurses, we are always learning, so share your experiences and views with colleagues to help them improve their knowledge. This will also improve your communication skills and increase your confidence. Set up education sessions at your university if you can, where you can explore any issues in a safe space and learn what best practice looks like

mental health issues. This contrasts with attitudes I had witnessed in my home country, where there is a blame culture around mental health issues and people are treated poorly and often dehumanised in an attempt to 'cure' them, although there are initiatives that aim to change this.

Trying to untangle your mind from previously held beliefs and practices is not easy. I realised there may be other students at my university with similar experiences, so I decided to set up education sessions where I could share my knowledge and support others.

The aim of the sessions was to provide a safe space for students to explore cultural sensitivities and unconscious bias and have open conversations about their experiences and understanding of mental health issues. We ran two face-to-face events at the university where students from diverse cultures, including Africa and South America, were invited to share experiences regarding mental illness from their culture.

Culture of respect

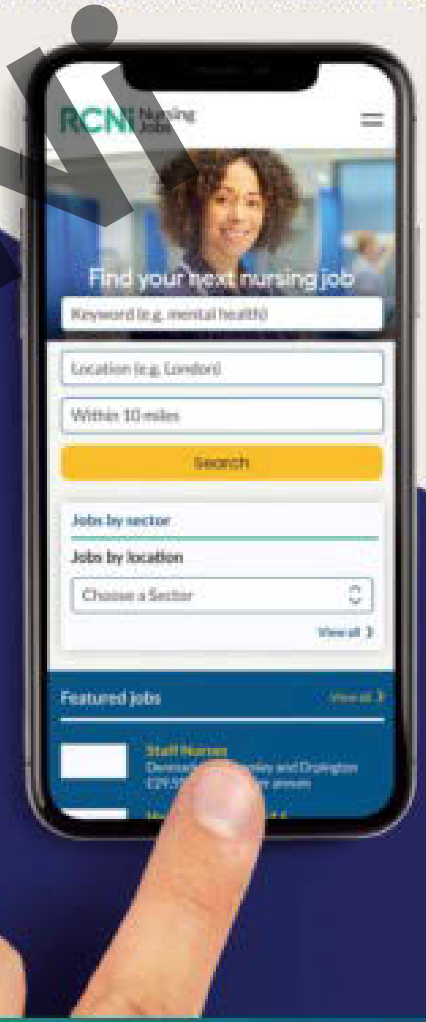
Mental health professionals from different cultural backgrounds talked to students about their experiences and the importance of evidence-based practice, caring with compassion and embracing a culture of respect and inclusivity for people with mental health problems.

About 40 students attended the sessions and feedback from the students was positive – many shared similar experiences of cultural attitudes about people with mental health issues, and they appreciated the opportunity to gain a better understanding of unconscious bias and how it can affect patient care. It was also beneficial for the students to hear from registered mental health practitioners who came from countries where mental health is stigmatised and how they use the evidence to inform their practice.

Challenging my beliefs about mental health issues was difficult, but by using the evidence I gained a better understanding of what mental health issues are – and what they are not – and it became easier to see patients as human beings first. Getting help on time can be the difference between recovery and deteriorating health, but there is still a stigma attached to mental illness.

As nurses, we must do all we can to raise awareness of mental health, practising non-judgemental nursing care and ensuring all our patients and service users are treated with empathy, compassion and respect.

This is an abridged version of an article at **rcni.com/cultural-taboos**



SKILLS

Write an abstract that grabs your reader's attention

If you are writing an article for the peer-reviewed section of an RCNi journal, you'll need an abstract – essentially a summary of your article.

Writing for publication is all about the reader and, as an author, you want the reader to journey through your article from start to finish with as few obstacles, forks in the road and dead ends as possible. Think of the abstract as a guide to this journey.

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Highlight what you think is important

An abstract explains what lies ahead, it highlights important features or findings and it describes the end point.

A well written abstract can make the difference between readers reading your article and reflecting or acting on it, and their abandoning the journey before it has begun.

Write the article before the abstract

You cannot summarise what you have not yet written. Stick to the guidelines. Abstracts in RCNi journals have between 80 and 150 words. Anything longer is likely to be cut so make every word count.

Follow the same order of topics in the abstract as you do in the article. But write the abstract separately rather than cutting and pasting chunks of text from the article.

Not too much detail

Describe your article's main arguments and findings broadly. The detail should be in the article itself.

All abstracts should be followed by a list of five or six keywords. These will help online searchers to find your article once it is published.

When choosing keywords, think about the article's subject matter, the setting, the target group of patients or clients, the healthcare professionals involved, the techniques described and so on. For example, a typical set of keywords is: 'depression', 'nursing homes', 'older people', 'community mental health nurses', 'cognitive behaviour therapy'.

What matters?

When writing the abstract, think about the article's purpose. Be clear about the issue you are trying to address. What does it add to the sum of existing nursing knowledge? How is it likely to influence nursing practice? The abstract should give readers a reason to read on. Avoid jargon and unexplained acronyms. This applies to the main text as well as the abstract, but the abstract should 'sell' the article to readers so it is important not to litter it with words and phrases that confuse and discourage.

For a comprehensive range of free author resources go to ***rcni.com/publish-article-with-rcni***

Also in this issue

EDUCATION

Benefits of developing long-term relationships between trainee nursing associates and mental health experts by experience
p20

CHILD AND ADOLESCENTMENTAL HEALTH

Exploring young people's perspectives on digital technology and mental healthcare: pilot study findings
p34

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

PRACTICE QUESTION

What is the therapeutic relationship in mental health practice?

How a positive relationship between nurse and patient is vital for achieving good outcomes

The therapeutic relationship was described by Peplau (1952) as the foundation of mental health nursing. The therapeutic relationship continues to be the bedrock for achieving good outcomes with patients who have mental health issues (Sosnowska et al 2013), more so than the actual intervention or therapy used (Hartley et al 2020).

The therapeutic relationship is where ‘the nurse acts as their own instrument of care, using themselves in their practice and thereby developing person-centred care on a human level’ (Wright 2021). The therapeutic relationship is the ‘application of human skills by a knowledgeable professional’ (Scanlon 2010) and the main tool mental health nurses have for their work is themselves. Therefore, their skills need to be well developed and reflexive, allowing a ‘spontaneously adaptive’ (Scanlon 2010) response to a dynamic situation.

Moyle (2003) suggests that without the therapeutic relationship, the required deliverable results may be less likely to happen. Therefore, the therapeutic relationship is an essential element of mental healthcare, especially the care delivered by nurses.

Peplau (1997) suggested three stages of therapeutic relationship: orientation, working and termination. All these stages can occur in a single short intervention or over a longer time frame.

Good social skills

Engagement is a precursor to the therapeutic relationship (Kornhaber et al 2016) and this requires good social skills. Forming a connection between nurse and patient at a far deeper level than that present in ordinary social interactions (Scanlon 2010), the nurse gives something of themselves in the work, but only in a professional and helpful way. It requires the creation and maintenance of professional boundaries, including the nurse being able to manage their own emotional reactions.

The therapeutic relationship is more than just the nurse being personable. It requires a person-centred approach, with humanistic attributes such as empathy, unconditional positive regard and genuineness (Moyle 2003).

Scanlon (2010) described a fine balancing act of ‘getting as close as you can to a patient but keeping your distance’; an activity that, in mental health, requires skill, judgement and constant awareness.

The ending of the therapeutic relationship is as important as any of the other stages. This occurs when the patient no longer has need of the nurse or their goals have been achieved (Peplau 1997).

Having clear boundaries and establishing joint expectations and agreements at the start of the relationship will enable better endings. Supporting the patient’s independence throughout the therapeutic process will assist them to navigate this stage – which is often the most difficult – in a useful way.

Reflection-on-action, including in clinical supervision, is essential for the use of the therapeutic relationship and is a requisite for the therapeutic relationship which requires flexibility in the moment from the nurse to alter their stance and responses (Schön 1983).

Finally, feedback from patients is key for nurses’ development, including their use of therapeutic relationships. It also aids job satisfaction and continued feelings of positivity towards patients (Moyle 2003).

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Bronwen Williams is a mental health nurse and educator, Bronwen Williams Development Training & Consultancy, Herefordshire, England

This is an abridged version of an article at **rcni.com/mh-therapeutic-relationship**

Further information

Hartley S, Raphael J, Lovell K et al (2020) Effective nurse-patient relationships in mental health care: a systematic review of interventions to improve the therapeutic alliance. International Journal of Nursing Studies. 102, 103490. doi: 10.1016/j.ijnurstu.2019.103490

Kornhaber R, Walsh K, Duff J et al (2016) Enhancing adult therapeutic interpersonal relationships in the acute health care setting: an integrative review. Journal of Multidisciplinary Healthcare. 9, 537-546. doi: 10.2147/JMDH.S116957

Moyle W (2003) Nurse-patient relationship: a dichotomy of expectations. International Journal of Mental Health Nursing. 12, 2, 103-109. doi: 10.1046/j.1440-0979.2003.00276.x

Peplau HE (1952) Interpersonal Relations in Nursing. Putnam & Sons, New York NY.

Peplau HE (1997) Peplau’s theory of interpersonal relations. Nursing Science Quarterly. 10, 4, 162-167. doi: 10.1177/089431849701000407

Scanlon A (2010) Psychiatric Nurses Perceptions of the Constituents of the Therapeutic Relationship. Nova Science, New York NY.

Schön DA (1983) The Reflective Practitioner: How Professionals Think in Action. Basic Books, New York NY

Sosnowska M, Prot-Klinger K, Scattergood M (2013) The therapeutic relationship and patients’ experience of interpersonal bonds – research conducted in outpatient mental health care. Archives of Psychiatry and Psychotherapy. 15, 1, 11-18. (Last accessed: 6 November 2023.)

Wright KM (2021) Exploring the therapeutic relationship in nursing theory and practice. Mental Health Practice. doi: 10.7748/mhp.2021.e1561 (Last accessed: 6 November 2023.)

Why you should read this article:

- To acknowledge the need for trainee nursing associates to develop their understanding of person-centred mental healthcare
- To recognise the benefits of involving mental health experts by experience (EBEs) in the education of nursing staff
- To read about a project involving the development of long-term one-to-one relationships between trainee nursing associates and EBEs

Benefits of developing long-term relationships between trainee nursing associates and mental health experts by experience

Katy Willmont, Marie Clancy, Sam Chapman et al

Citation
Willmont K, Clancy M, Chapman S et al (2023) Benefits of developing long-term relationships between trainee nursing associates and mental health experts by experience. Mental Health Practice. doi: 10.7748/mhp.2023.e1679

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

Accepted
31 July 2023

Abstract

Stigma around mental illness persists in healthcare practice and education. This article details a project undertaken to develop long-term relationships and facilitate learning between trainee nursing associates and mental health experts by experience (EBEs). The project was evaluated using questionnaires and feedback from the students and EBEs involved. The relationships that developed between students and EBEs had many positive implications for students' future practice, with benefits including enhanced understanding of person-centred care, the importance and development of communication skills, holistic views of long-term conditions and increased motivation for undertaking a nursing role. The project also had benefits for the EBEs, such as reciprocal learning opportunities, employment experiences and improved health and well-being. The authors suggest that instead of didactic or one-off encounters with EBEs in education settings, long-term EBE involvement should be implemented. This could help to achieve sustainable reductions in the stigma around mental health and increase students' knowledge of mental health, mental illness and recovery.

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Keywords

career pathways, education, mental health, nursing associates, patient experience, patients, person-centred care, stigma, support staff

Background

Stigma around mental illness is considered to be a cultural issue across healthcare and is not limited to occasional suboptimal practice (Knaak et al 2017). Evidence has shown that the consequences of this stigma for those receiving mental healthcare are considerable and may include low-quality care and negative effects on nurse-patient relationships (Tyerman et al 2021, Thornicroft et al 2022).

One approach to addressing such stigma is the inclusion of experts by experience (EBEs) in nurse education curricula. EBEs are people who have recent personal experience of using, or caring for someone who uses, health and/or social care services (Care Quality Commission

(CQC) 2022). EBEs may have accessed services delivered by staff from one or more of the four fields of nursing. It has been suggested that their experience can bring a high level of expertise, enabling students to develop as critical thinkers, increase their knowledge on the wider application of mental health skills across healthcare services, and gain an understanding of and appreciation for mental health nursing (Horgan et al 2018, Happell et al 2021a, CQC 2022). The Nursing and Midwifery Council (NMC) (2018a) states that involving people with lived experience in the co-production and delivery of preregistration training is a fundamental requirement.

Despite general positivity towards the involvement of EBEs in nurse education, criticisms have included the sometimes tokenistic and limited remit afforded to EBEs in curricula, and the many missed opportunities to share knowledge (Knowles et al 2021). Findings from a study conducted by Blackhall et al (2012) suggested that EBE involvement in taught sessions can help to challenge negative preconceptions about mental illness and mental health. However, Fukuo et al (2020) suggested that EBE involvement needs to be long term to enhance understanding, which is unlikely to be achieved through one-off encounters.

Challenges with EBE involvement in nurse education appear to be more complicated than simply creating space for EBEs in timetables and curricula. A study by Happell et al (2022a) found that some academic staff struggled to appreciate EBEs' contributions and often experienced unease when EBEs recollected negative experiences of services and care, which some staff saw as unrepresentative – particularly when they had first-hand insight into the experiences being shared. However, other academic staff discussed the importance of hearing EBEs' experiences, even if these differed to those of healthcare professionals, and suggested that students would be able to manage differing views (Happell et al 2022a).

This article discusses the implementation of a two-year relational EBE project which offered an opportunity for trainee nursing associates to gain a lived-experience perspective of mental health, mental illness and recovery. It presents a service evaluation of the project based on feedback from the trainee nursing associates and EBEs involved. Nursing associate training provider Birmingham City University and employers from five West Midlands NHS trusts partnered to provide this innovative longitudinal learning opportunity for trainee nursing associates. Birmingham and Solihull Mental Health NHS Foundation Trust led the project, and the service evaluation was facilitated by those in this trust and the university.

To become a registered nursing associate, an individual is required to gain new knowledge, skills and behaviours in all fields of nursing (NMC 2018b). The nursing associate role aims to bridge the gap between healthcare support workers and registered nurses, delivering hands-on care as part of a multidisciplinary team in a range of settings. Nursing associates gain a foundation degree awarded by an NMC-approved provider, which typically involves two years of study.

Co-production was an important feature of the EBE project, drawing on the idea that relationships between professionals and EBEs should be equitable (Meddings et al 2014). After the first year of the project, a team of EBEs were involved in the recruitment of new EBEs and the co-design, co-teaching and co-production of project documents and training. Following a similar ethos, an EBE was part of the writing team for this article. These aspects of co-production enabled EBEs to contribute to every aspect of the project (Redman et al 2021).

Aim

To evaluate a project that was implemented to develop long-term relationships and facilitate learning between trainee nursing associates and mental health EBEs.

Method

A project coordinator (KW) with experience of mental illness was appointed to lead the project. An initial cohort of 81 trainee nursing associates and a second cohort of 84 trainee nursing associates participated in the project. The project started in June 2020 and was evaluated in November 2020 and September 2021 with the support of the trust's service evaluation team. A total of 50 EBEs with a range of experiences, including of community mental healthcare, inpatient stays and recovery, were recruited to the project with an application form, interview and training session. The project coordinator considered each EBE's ability to access the recruitment stages and met their individual needs by offering telephone, online and face-to-face support with application writing to optimise inclusivity.

It was envisaged that the project would enable trainee nursing associates to develop their understanding of person-centred care and gain significant and meaningful exposure to different perspectives. Matching each trainee

Key points

- **One approach to addressing the stigma around mental illness is the inclusion of experts by experience (EBEs) in nurse education**
- **Involving people with lived experience in the co-production and delivery of preregistration nursing programmes is fundamental**
- **Trainee nursing associates can benefit from being exposed to different perspectives on mental health, mental illness and recovery**
- **Participating in educational projects can have various benefits for EBEs, such as reciprocal learning opportunities, employment experiences and improved health, well-being, confidence and self-esteem**

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nursing associate with an EBE took place following the completion of a form by each student detailing their previous experiences and asking them to name any areas they would like to learn more about. Each student was individually matched with an EBE whose mental health needs and physical health comorbidities they were relatively unfamiliar with. Each student and their EBE had an hourly meeting every three months over the course of the year. The students and EBEs took part in training sessions before starting their meetings and received a project guide containing ideas for discussion, reflection pages and up-to-date information such as contact details. The project guide is available to readers upon request to the authors or the journal.

Matching EBEs to students and using risk assessment criteria to ensure EBEs were well enough to participate helped students to feel reassured that their learning and safety were paramount. Risk assessments were initially conducted based on the EBEs' application forms, in which they detailed their recovery. EBEs were advised that, to participate in the project, they needed to engage with mental health community services and have had at least six months without hospitalisation. Emergency contact details were obtained from the EBEs in case there were any concerns about their well-being. During the training sessions, the EBEs and students discussed safeguarding processes and were advised to contact the project coordinator if they became concerned about their partner's health and well-being. To this end, the consistency and accessibility of a dedicated project coordinator were crucial to the project's success, despite resource limitations.

The EBE project pathway is summarised in Box 1.

Box 1. Expert by experience (EBE) project pathway

- June 2020 – project coordinator appointed
- August 2020 – EBE role description and advert designed
- September 2020 and 2021 – advert released
- October-December 2020 and 2021 – suitable EBEs invited to attend an interview
- January 2021 and 2022 – appointed EBEs attended a training session
- December 2020 and 2021, January 2021 and 2022, and March 2021 and 2022 – students attended three training sessions
- February 2021 and 2022 – lists of students' information collated, for example previous work experience and current workplace
- March-April 2021 and 2022 – each student was matched with an EBE and contact details were shared
- March 2021 and 2022 – project guides given to the EBEs and students
- April 2021 and 2022 onwards – spreadsheet created to log the dates of each meeting and the evaluation forms received
- Monthly – support sessions provided for the EBEs to keep up to date on progress
- Every three months – university check-in sessions provided for the students

Data collection and analysis

The EBE project was evaluated using a questionnaire developed by the project team that comprised Likert scales and open-ended questions to gather quantitative and qualitative data. The evaluation included service and education evaluations, since trainee nursing associates are employed by their trust but are also students during their training. Out of a total of 165 trainee nursing associates across the two cohorts, 115 completed a pre-project survey and an evaluation of the project after one year of involvement, which represented a 70% response rate. Topics for the questions included: the length of and preparation for their meetings with their EBE; if they had learned anything about person-centred care; and if there were any topics that might be built on or discussed at subsequent meetings.

The EBEs also evaluated each meeting via written questionnaires and were asked to provide feedback on the students' communication skills and understanding of the values of person-centred care. The project coordinator encouraged the EBEs to share this feedback with the students. General feedback was also gathered, for example verbal comments during support sessions with the EBEs or following communication from university staff. These aspects contributed to the evaluation of the project. The questionnaire responses were analysed by the project team using Braun and Clarke's (2022) framework for descriptive thematic analysis, alongside quantitative analysis of the Likert scale results.

Ethical considerations

Ethical approval was gained from the mental health trust involved in the project. Informed consent was obtained from the students and EBEs involved to evaluate and share their experiences. Students and EBEs were assigned numbers to preserve their anonymity.

Findings

Impact on learning for trainee nursing associates

The following four themes were identified:

- Enhanced understanding of person-centred care.
- Importance of communication skills.
- Holistic views of long-term conditions.
- Increased motivation for undertaking a nursing role.

Enhanced understanding of person-centred care

The main effect of the EBE project on the students' learning was increased understanding of person-centred care. Students' confidence was initially low, with only 22% (*n*=25/115) rating their understanding of person-centred care as 'strongly excellent' before the project. However, by the end of the project, this had increased to 68% (*n*=78/115). For example, students described this increasing awareness as follows:

'[The EBE project] has helped me to understand what is meant by good patient care and it has made me realise that the smallest gestures mean a lot to people.' (Student 1)

'My meetings taught me just how important person-centred care is for the patient and how much of a difference and positive impact it can have.' (Student 2)

Importance of communication skills

Students recognised the importance of communication skills in nursing, especially listening:

'Just listening to how a person feels and how they would like to be treated is just so important.' (Student 5)

'What I learned was that communication and trust are the main key to delivering excellent care.' (Student 7)

This is particularly important when considering the concerns raised about patient mistreatment at the Edenfield Centre – a mental health unit in Greater Manchester, England – which were linked to toxic and closed work cultures (Baines 2022).

Holistic views of long-term conditions

Students described learning from their EBE about long-term health conditions that they had not encountered before:

'I really feel if it hadn't been for this project that I would not have had the interest in mental health that I have today. In fact, I felt quite scared before when dealing with issues and patients with mental health conditions.' (Student 10)

'I have gained so much insight into not only mental health issues but also physical health issues, which aided my learning and developed my skills further.' (Student 10)

Increased motivation for undertaking a nursing role

After the meetings with their EBE, many of the students felt more passionate and motivated in relation to their nursing role. The project also appeared to have lasting effects, which demonstrates its sustainability:

'This [project] has changed me as a person generally and also for my future nursing career, and I will remember this for life.' (Student 11)

'It was a pleasure meeting with my EBE. I know some things she said will stay with me throughout my career.' (Student 12)

'I was so interested in what my EBE was saying because it was her life experience, and I knew it would help me to be better with even one patient.' (Student 15)

As part of the evaluation, students were asked to describe the EBE they had been matched with, and their answers illustrated the emerging close relationships that students were forming with EBEs.

Impact for the experts by experience

EBEs provided feedback following each of the meetings via written questionnaires. Analysis of their responses revealed some unanticipated outcomes. EBEs discussed experiencing various benefits resulting from their involvement in the project, such as reciprocal learning opportunities, employment experiences and improved health and well-being:

'I have found it rewarding, I hope that I have truly helped the students I have worked with and it has benefited me mentally and socially.' (EBE 7)

'I am now marking and co-facilitating some sessions of teaching in research and it's been a spring for being involved with other things too.' (EBE 14)

As a result, many of the EBEs increased the number of students they were supporting, which was indicative of their increasing enthusiasm. The EBEs enjoyed seeing the students incrementally develop their nursing identity and positive attitudes towards mental health throughout the project:

'It was good to see them become more confident to ask me questions about my experiences and how they would ensure they look at patients as a person not an illness.' (EBE 2)

Around 75% of the EBEs (*n*=24 of the 32 who responded to the question) agreed that their role was nurturing and the influence they had in helping to develop future nurses was empowering for them:

'By sharing my personal experiences of NHS services, students can understand what it can be like to be on the receiving end of treatment… Sharing my lived experience means I am affecting positive change within health services.' (EBE 15)

'I feel I am able to make the students more aware of the involvement and importance of the families of patients in many cases.' (EBE 11)

Around 72% of the EBEs (*n*=23 of the 32 who responded to the question) reported that this project had increased their confidence and self-esteem and had given them a renewed sense of purpose:

'My student made me feel as though I had something worthwhile to contribute… obviously it has not cured me, but the EBE project has really helped me to recover my self-esteem and confidence in my ability to do various tasks I thought I couldn't do anymore.' (EBE 1)

'Working on this project has personally made me proud of myself and made me realise that I can achieve goals which were personally out of my reach. This opportunity has opened other avenues of employment at two other local universities as a paid service user representative and an advocate of mental health.' (EBE 6)

Furthermore, some EBEs said that the project helped them in their ongoing recovery. Feeling valued, becoming part of a community with shared experiences and working towards common goals appeared to be significant for them:

'Stories make an impact and so does real-life insight. Recovery is a journey and being able to contribute towards improvements in future nursing feels like a positive use of my experience and helps to consolidate the time when I was particularly unwell.' (EBE 9)

'It's enabled me to be able to process some of the things that I've been through, knowing that future healthcare professionals might benefit from hearing about them if presented in an appropriate way.' (EBE 13)

Discussion

The implementation of this project adds to the body of knowledge on work and practices involving EBEs detailed in the literature. This project presents additional findings due to its longitudinal nature and the matching techniques used to pair EBEs with students for the duration of their course. Fukuo et al (2020) reported on a five-week mentor programme that was similar to this project, in which people with lived experience of mental illness were paired with undergraduate nursing students. While both projects shared similar findings in relation to reducing mental health stigma, Fukuo et al (2020) found that, at a one-month follow-up, the outcomes were not maintained. Conversely, feedback from trainee nursing associates on this project described the experience as life changing and something that they will not forget. The long-term nature of the relationship developed between the students and EBEs appeared to have a significant effect on students' learning.

The matching of EBEs to students, the careful recruitment process and the project coordinator's training and mentoring of EBEs and students were all essential to the success of this project. These themes are shared by Happell et al (2022b), whose research sought to identify how EBE 'allies' have been successful in implementing and sustaining positions for EBEs in mental health education. Further literature on co-production has discussed the strengthening of relationships between EBEs and academic staff that is required, including the development of trust (Happell et al 2022b) and the importance of creating a supportive and cohesive working environment in which EBEs can contribute (Arblaster et al 2023). Meeting with individual EBEs regularly on a one-to one basis and over a longer period appeared to give the students access to different perspectives through the lens of real-life experience. Similar findings have been identified in other successful work with EBEs (Happell et al 2021a, 2022a).

The findings of this project also indicated many unanticipated benefits for EBEs in terms of well-being, employment and feeling part of a team. Such findings are reflected in the literature; for example, a qualitative study by Watson et al (2022) found that engaging in educational projects improved EBEs' confidence in their abilities and resulted in them feeling increasingly valued and respected. Furthermore, Watson et al (2022) suggested that those who facilitate EBE involvement in nurse education may also benefit from the wider perspectives of care that EBEs can offer.

A further finding from this project was that the meetings with EBEs provided a safe space for students to discuss their own well-being and mental health. These encounters enabled them to access support from their EBE and wider services. Happell et al (2021b) shared similar findings and discussed how EBEs can promote recovery and break down barriers for students with mental health needs.

Challenges experienced in the project

Evaluations of this project have enabled the authors of this article to collate the lessons learned by the project team, such as the importance of the timing of implementation in a sensitive and supportive environment. When the EBE project was first implemented, students' verbal feedback indicated that they initially viewed it as overwhelming. Following this feedback, a staged approach to learning about EBEs and the project was introduced to aid understanding of areas such as terminology and the practicalities of the meetings with EBEs. Offering multiple training sessions about the project provided several opportunities for students to share their concerns, and the meetings could be scheduled alongside a person-centred academic module. Additionally, by including a meeting with an EBE early in their teaching schedule, students could see the potential effect EBEs may have on their understanding, thus making them more receptive to the project. The project coordinator regularly met the students and this enabled them to voice their concerns, which mostly centred on fear of the unknown and the potential risks involved:

'I felt very anxious at the beginning, which was a personal challenge, but my EBE made me feel completely at ease.' (Student 6)

Meetings between EBEs and students were initially conducted face to face on NHS trust sites but moved online due to the coronavirus disease 2019 (COVID-19) pandemic. When meetings were face to face, several students found it challenging to find the time for a meeting during work hours and to find a private room. This became easier when time was incorporated into the university schedule and all meetings were moved online. However, students and EBEs reported that having remote meetings made it feel less personal.

While some students struggled to see the relevance of the project to their assessments, others saw the direct link to their university modules:

'[The topics of our discussions] were part of my current module at university so was helpful to hear about my EBE's experiences. I would like to keep in line with my modules so the next meeting I will talk about types of medications.' (Student 7)

For future iterations of the project, the links to students' academic modules need to be made explicit during the introduction to the EBE project. Another future consideration would be aligning the EBE project to a specific assessment, such as an objective structured clinical examination (OSCE). Additionally, some students found it challenging to communicate effectively and be professional with their EBE, so an additional training session was delivered on these topics.

A further consideration was the need to reward the EBEs with financial recognition for their time and expertise. EBEs were paid £10 per hour for meetings with students as well as any project meetings and training sessions. This was guided by the mental health trust's reward and recognition policy. EBEs were patient and public involvement members of the trust, and were supported by either the project coordinator or lecturers in the classroom setting. Support from the national charity Turn2us was given when EBEs needed to consider financial issues, such as claiming benefits. While the rewards offered had financial implications for the project, they also emphasised the value of the EBEs' contribution, which facilitated the development of more equal partnerships based on trust (Knowles et al 2021). Furthermore, the EBEs' involvement in the development and design of the project provided opportunities for improvements and offered reciprocal benefits, since EBEs received training as part of the project. Such reciprocal arrangements are advocated by Health Education England (2015).

While co-production was crucial to developing insight and understanding during this project, working with EBEs can significantly increase the time needed for project development. Collaboration has to meet the needs of the EBEs and this may mean changes to the timings and nature of meetings. The additional time taken to work with EBEs in a meaningful way needs to be a consideration in all projects involving EBEs (Health Education England 2015).

Implications for nursing practice and future areas of evaluation

The findings of this project suggest that developing long-term one-to-one relationships between EBEs and trainee nursing associates is particularly valuable. Such relationships can offer unique learning spaces that encourage the development of acceptance, reduce the stigma surrounding mental health and support a focus on person-centred care. It has been suggested that mutual respect is a prerequisite for beneficial supportive relationships (Holst et al 2017) and it appeared crucial to the learning seen in this project. Reflexivity, including self-reflection and understanding of personal bias, and positive perceptions of mental health were also important (Happell et al 2019).

During this project, the trainee nursing associates developed their communication skills, empathy and openness to working with people with mental health needs. These developments reflect findings from practice, where staff have reported that, following encounters with EBEs, students were sensitive to the needs of others and confident advocates for patients (Happell et al 2021a). This project emphasises the importance of offering additional perspectives and diversifying the understanding of mental health, mental illness and recovery, as well as the importance of developing relationships and rapport with service users. The authors suggest that these aspects may benefit future clinical encounters and healthcare professionals' receptivity to providing mental healthcare.

Limitations

One limitation of the evaluation of this project is that some of the findings cannot be separated from other aspects of the trainee nursing associate course; for example, the students' learning may be due to the theoretical and practice-based elements of the programme as well as the meetings with EBEs. Furthermore, the project is still early in its development, so practice perspectives have not yet been determined. Therefore, in the next phase of this project, it would be important to identify staff and service user perspectives through evaluation methods such as focus groups and individual interviews.

The COVID-19 pandemic resulted in all meetings being conducted online, which was considered less personal than face-to-face meetings so may have adversely affected the development of relationships between students and EBEs. However, conducting meetings online enabled EBEs from wider geographical areas to be involved in the project and increased availability and accessibility for the students and the EBEs.

Conclusion

Stigma surrounding mental illness remains prevalent in health and social care. Creating opportunities for EBEs to have an active participatory influence is crucial to address this stigma and challenge negative perceptions of people with mental health needs. The EBE project detailed in this article aimed to offer a different approach to mental health education for trainee nursing associates through the establishment of long-term one-to-one relationship with EBEs. The project used an identified project coordinator, risk assessments and EBE-student matching to optimise outcomes.

While engagement in the project was challenging for some students, listening to their concerns and providing additional communication training to aid preparation was beneficial. Incorporating EBE meetings into university time and making links to students' academic modules and assessments was also helpful in enhancing students' perceptions. The EBEs who participated in this project also experienced various benefits, including reciprocal learning opportunities, employment experiences and improved health, well-being, confidence and self-esteem. They also reported an enhanced sense of purpose because they felt empowered in their role to influence positive change in nursing.

Overall, the EBE project increased students' knowledge of mental health, mental illness and recovery, developing therapeutic relationships and recognition of the interplay between physical and mental health.

References

Arblaster K, Makenzie L, Buss N et al (2023) Co-design and evaluation of multidisciplinary teaching resource on mental health recovery involving people with lived experience. Australian Occupational Therapy Journal. 70, 3, 354-365. doi: 10.1111/1440-1630.12859

Baines E (2022) Nurses Investigated Amid Abuse at Manchester Mental Health Hospital. www.nursingtimes.net/news/mental-health/nurses-investigated-amid-abuse-at-manchester-mental-health-hospital-29-09-2022 (Last accessed: 22 September 2023.)

Blackhall A, Schafer T, Kent L et al (2012) Service user involvement in nursing students' training. Mental Health Practice. 6, 1, 23-26. doi: 10.7748/mhp2012.09.16.1.23.c9280

Braun V, Clarke V (2022) Thematic Analysis: A Practical Guide. SAGE Publications, London.

Care Quality Commission (2022) Experts by Experience. www.cqc.org.uk/about-us/jobs/experts-experience (Last accessed: 22 September 2023.)

Fukuo JF, Maroney MM, Corrigan P (2020) Pilot of a consumer based anti-stigma mentorship program for nursing students. Journal of Public Mental Health. 19, 1, 51-61. doi: 10.1108/JPMH-02-2019-0020

Happell B, Bennetts W, Tohotoa J et al (2019) Promoting recovery-oriented mental health nursing practice through consumer participation in mental health nursing education. Journal of Mental Health. 26, 6, 633-639. doi: 10.1080/09638237.2017.1294734

Happell B, Waks S, Bocking J et al (2021a) 'But I'm not going to be a mental health nurse': nursing students' perceptions of the influence of experts by experience on their attitudes to mental health nursing. Journal of Mental Health. 30, 5, 556-563. doi: 10.1080/09638237.2019.1677872

Happell B, O'Donovan A, Sharrock J et al (2021b) They are a different breed aren't they? Exploring how experts by experience influence students through mental health education. International Journal of Mental Health Nursing. 30, Suppl 1, 1354-1365. doi: 10.1111/inm.12881

Happell B, Warner T, Waks S et al (2022a) Something special, something unique: perspectives of experts by experience in mental health nursing education on their contribution. Journal of Psychiatric and Mental Health Nursing. 29, 2, 346-358. doi: 10.1111/jpm.12773

Happell B, O'Donovan A, Warner T et al (2022b) Creating or taking opportunity: strategies for implementing expert by experience positions in mental health academia. Journal of Psychiatric and Mental Health Nursing. 29, 4, 592-602. doi: 10.1111/jpm.12839

Health Education England (2015) Pathways to Embed Patient and Public Involvement in Healthcare Scientist Training Programmes. nshcs.hee.nhs.uk/wp-content/uploads/2019/08/hcs-pathways-and-ppi-report.pdf (Last accessed: 22 September 2023.)

Holst H, Ozolins LL, Brunt D et al (2017) The learning space-interpersonal interactions between nursing students, patients, and supervisors at developing and learning care units. International Journal of Qualitative Studies on Health and Well-Being. 12, Suppl 2, 1368337. doi: 10.1080/17482631.2017.1368337

Horgan A, Manning F, Bocking J et al (2018) 'To be treated as a human': using co-production to explore experts by experience involvement in mental health nursing education – the COMMUNE project. International Journal of Mental Health Nursing. 27, 4, 1282-1291. doi: 10.1111/inm.12435

Knaak S, Mantler E, Szeto A (2017) Mental illness-related stigma in healthcare: barriers to access and care and evidence-based solutions. Healthcare Management Forum. 30, 2, 111-116. doi: 10.1177/0840470416679413

Knowles SE, Allen D, Donnelly A et al (2021) More than a method: trusting relationships, productive tensions, and two-way learning as mechanisms of authentic co-production. Research Involvement and Engagement. 7, 34. doi: 10.1186/s40900-021-00262-5

Meddings S, Byrne D, Barnicoat S et al (2014) Co-delivered and co-produced: creating a recovery college in partnership. Journal of Mental Health Training, Education and Practice. 9, 1, 16-25. doi: 10.1108/JMHTEP-04-2013-0011

Nursing and Midwifery Council (2018a) Raising Professionalism: Standards for Education and Training. Part 1: Standards Framework for Nursing and Midwifery Education. NMC, London.

Nursing and Midwifery Council (2018b) Standards of Proficiency for Nursing Associates. NMC, London.

Redman S, Greenhalgh T, Adedokun L et al (2021) Co-production of knowledge: the future. BMJ. 372, n434. doi: 10.1136/bmj.n434

Thornicroft G, Sunkel C, Aliev AA et al (2022) The Lancet commission on ending stigma and discrimination in mental health. The Lancet. 400, 10361, 1438-1480. doi: 10.1016/S0140-6736(22)01470-2

Tyerman J, Patovirta AL, Celestini A (2021) How stigma and discrimination influences nursing care of persons diagnosed with mental illness: a systematic review. Issues in Mental Health Nursing. 42, 2, 153-163. doi: 10.1080/01612840.2020.1789788

Watson FA, Glascott M, Eke A et al (2022) Key stakeholder perspectives on expert-by-experience involvement in the values-based recruitment of student mental health nurses: a co-produced qualitative study. Nurse Education Today. 118, 105513. doi: 10.1016/j.nedt.2022.105513

PEER-REVIEWED

Why you should read this article:

- To acquire critical perspectives on deprescribing antipsychotics in the context of recovery-oriented practice
- To enhance your knowledge of the risks and benefits of reducing or discontinuing antipsychotics
- To increase your ability to balance patient autonomy and risk mitigation when managing psychotic disorders

Deprescribing antipsychotics in adults with psychotic disorders – a literature review

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Citation
Painter JM (2023) Deprescribing antipsychotics in adults with psychotic disorders – a literature review. Mental Health Practice. doi: 10.7748/mhp.2023.e1670

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

Accepted
12 June 2023

Abstract

Despite evidence of adverse effects, continuous antipsychotic maintenance treatment is still often the preferred intervention for people with a long-term psychotic disorder. Antipsychotic treatment should be discussed with patients and the option of deprescribing should be explored. There is, however, a lack of guidance on antipsychotic deprescribing as well as a conflict in mental health services between recovery-oriented practice, which promotes collaboration and patient choice, and the more traditional approach of promoting adherence to the clinician's recommendation. The author conducted a literature review to gather clinical and academic perspectives on antipsychotic deprescribing in adults with a psychotic disorder in the context of recovery-oriented practice. Findings suggest that the adverse effects of long-term antipsychotic use are such that deprescribing should be considered, the challenge for nurses being to find a balance between patient autonomy and risk mitigation.

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Keywords

antipsychotics, clinical, medicines, medicines management, medicines review, mental health, prescribing, psychosis, schizophrenia

Background

The National Institute for Health and Care Excellence (NICE) (2014) clinical guideline on the prevention and management of psychosis and schizophrenia in adults advocates first-line pharmacological treatment with antipsychotics and provides comprehensive guidance on medicine initiation and review. NICE (2014) also recommends continuous antipsychotic maintenance therapy within the context of a broader package of psychosocial interventions, but is unclear on the duration of maintenance therapy, a question on which there is a lack of consensus in the wider literature (Emsley 2020).

Continuous antipsychotic maintenance therapy is still largely regarded as the preferred intervention for people diagnosed with a long-term psychotic disorder (De Hert et al 2015). Kuipers et al (2014) suggested that secondary care depends on antipsychotics as the sole long-term treatment for people with schizophrenia and Cooper et al (2020) identified that the evidence supporting the efficacy of psychosocial interventions without adjunctive antipsychotics is generally weak. Yet the long-term adverse effects of antipsychotics are well documented, including the disabling extrapyramidal side effects associated with conventional first-generation antipsychotics (Bahta et al 2021) and the increased risks of cardiometabolic disease and premature death associated with second-generation antipsychotics (Elkins 2019).

Contemporary policy on improving the physical health of people with serious mental illness – see for example Department of Health (2016) – has amplified the attention paid to the adverse effects of antipsychotics. Mental health services in the UK have evolved to adopt recovery-oriented values, including when prescribing medicines (Baker et al 2013). Theoretically, in a recovery-oriented approach, patient choice and self-determination are encouraged, yet some clinicians still regard a patient's choice to stop taking antipsychotics as a lack of adherence to their recommendation, which indicates that the principle of shared decision-making has not yet cascaded from policy to practice (Morant et al 2016). Attitudes among healthcare professionals may vary according to their profession; for example, Ross (2015) identified that mental health nurse prescribers regarded reducing or stopping medicines as a crucial part of their role in supporting patients to achieve a better quality of life.

Deprescribing refers to a process of withdrawing inappropriate medicines under the supervision of a healthcare professional (Reeve et al 2014). Deprescribing antipsychotics has been explored in some specialist areas. In Australia, the Halting Antipsychotic Use in Long-Term Care (HALT) trial achieved a successful reduction of the use of antipsychotics in long-term care residents living with dementia (Jessop et al 2017, Chenoweth et al 2018). In the UK, the 'Stopping over medication of people with a learning disability, autism or both' (STOMP) initiative (NHS England 2023) seeks to address the overuse of psychotropics to manage behaviour perceived as challenging.

NICE (2014) has identified the need for further research to understand how adults diagnosed with a psychotic disorder who choose not to take antipsychotics can be best supported. It has not determined parameters for reduction or discontinuation and has not supplied comprehensive guidance on deprescribing antipsychotics in that population.

Mental health nurses have a central role in identifying the risks associated with antipsychotic treatment and in supporting patients to make informed decisions (Nash 2023), which may include discontinuing treatment. However, the lack of guidance on antipsychotic deprescribing could reduce their confidence in promoting patient choice and incline them to revert to a paternalistic practice culture where shared decision-making is not encouraged (Bladon 2019).

Aims

The author conducted a literature review to:

- » Gather clinical and academic perspectives on deprescribing antipsychotics in adults with a psychotic disorder in the context of recovery-oriented practice.
- » Establish whether there is sufficient guidance to support the safe deprescribing of antipsychotics in practice.

Method

Literature was sourced, appraised and analysed to produce a qualitative synthesis of critical perspectives on the subject, an approach congruent with a narrative review methodology (Gregory and Denniss 2018). A search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, Cochrane and PubMed databases was undertaken. Search terms (antipsychotic*, neuroleptic* AND deprescribing, discont*, withdraw*, reduc*) and limiters (aged ≥18 years to exclude literature involving children, literature related to non-psychotic disorders excluded) were derived from the research question, which had been developed using the Population Exposure Outcome framework (Khan et al 2003):

- » Population: adults with a diagnosed psychotic disorder.
- » Exposure: antipsychotics.
- » Outcome: deprescribing.

The search generated 2,382 articles, of which 792 were subjected to screening guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) tool (Page et al 2021). This process resulted in ten articles for inclusion in the review.

Findings

Five of the ten reviewed articles were research. The other five were categorised by the author as 'practice literature' (Aveyard 2019). They were included because the aim was to gather perspectives on an intervention that is debated and on which there is a paucity of evidence. The five research articles were appraised using the Mixed Methods Appraisal Tool (Hong et al 2018). All five rated positively in terms of methodological quality and appropriateness but had some limitations. The five practice literature articles were assessed against the 'six questions for critical thinking' (Aveyard et al 2015), which focus on criticality, quality and value. All five provided valuable insight but none had followed a formal methodology.

The ten reviewed articles are summarised in Table 1.

The author analysed the findings and applied codes to relevant points before comparing and clustering the codes into themes and subthemes, as per the principles of reflexive thematic analysis described by Braun and Clarke (2021). Three themes, each with four subthemes, were identified (Table 2).

Key points

- The adverse effects of antipsychotics include extrapyramidal side effects and increased risks of cardiometabolic disease and premature death
- Clinicians may be reticent to deprescribe antipsychotics because of concerns about rebound or relapse and because of the lack of guidance
- Antipsychotic treatment should be reviewed collaboratively with patients in the context of a risk-benefit appraisal
- Successful antipsychotic deprescribing is likely to require intensified support, a strong therapeutic alliance, gradual dose tapering and non-pharmacological interventions

Table 1. Summary of the ten reviewed articles

Authors, year of publication, country	Title	Type of article, research method, population and sample size	Main findings	Strengths and limitations*
Cooper et al (2021) UK	Opinion piece: the case for establishing a minimal medication alternative for psychosis and schizophrenia	Practice literature	Further research required to establish the effectiveness of alternative treatments and/or psychosocial interventions for people who wish to avoid using antipsychotics in the long term	» Draws on evidenced examples of practice in countries other than the UK rooted in a minimal medicine ideology » No formal methodology
Gupta et al (2018a) US	Deprescribing antipsychotic medications in psychotic disorders: how and why?	Practice literature	» Studies reporting high risk of relapse linked to discontinuation of antipsychotics are flawed due to the use of non-individualised approaches to withdrawal » Discontinuation should be considered because of concerns regarding efficacy and long-term side effects	» Includes a brief summary of evidence regarding withdrawal symptoms and non-pharmacological interventions » No formal methodology but includes a brief meta-analysis of studies examining relapse rates following discontinuation of antipsychotics
Gupta et al (2018b) US	Deprescribing antipsychotics: a guide for clinicians	Practice literature	Alludes to the development of deprescribing in psychiatry and the need to focus on quality of life, not only on symptom management	» Detailed reference to a range of evidence on the risks, benefits and ethics of prescribing and deprescribing » No formal methodology
Horowitz et al (2021) UK	A method for tapering antipsychotic treatment that may minimize the risk of relapse	Practice literature	» Makes the case for slow tapering to avoid withdrawal symptoms » Formal guidelines for tapering antipsychotics needed	» Clear evidence of scrutiny and consideration of a range of neuropharmacological data » No formal methodology
Landolt et al (2016) Europe	Predictors of discontinuation of antipsychotic medication and subsequent outcomes in the European First Episode Schizophrenia Trial (EUFEST)	Secondary quantitative analysis of data from a randomised controlled trial (RCT). Initial RCT (Fleischhacker et al 2005) involved 325 patients, 16% of whom had discontinued antipsychotics. Data relating to this 16% cohort were subjected to secondary analysis	» Outcome of discontinuation differed depending on the outcome definition used » Correlation between discontinuation and better quality of life » Further research needed	» Robust analysis » Sample for secondary analysis was not randomised. Data on participants who had discontinued antipsychotics were extracted as a cohort and compared with the rest of the initial RCT sample » Potential bias acknowledged
Larsen-Barr et al (2018) New Zealand	Attempting to stop antipsychotic medication: success, supports, and efforts to cope	Primary mixed-methods research (Experiences of Antipsychotic Medication Survey) with 105 people who had made at least one attempt at discontinuing antipsychotics and answered questions about their most recent attempt	» Wide range of coping strategies can be used to support discontinuation process » Supported withdrawal may be more successful than unsupported withdrawal and patients may be less prone to relapse » Further research needed	» Significant sample size compared with other reviewed research articles but still relatively small » Robust content analysis of responses to a short-answer survey with 97% agreement rate between the researchers » Variation between, and limitations associated with, categories of coping strategies were problematic; 'no strategies' and 'no strategies described' were grouped together » Presence of false negatives acknowledged
Le Geyt et al (2017) UK	Personal accounts of discontinuing neuroleptic medication for psychosis	Primary qualitative research (individual interviews) with 12 mental health service users	Staff need resources to facilitate patient choice about discontinuing antipsychotics	» Rigorous attempts to be reflexive and minimise the influence of the researchers' perspectives with acknowledgement that this cannot be completely avoided » Small sample size » Emphasis on narrative content so findings not generalisable » No consistent time frame for discontinuation among participants
Moncrieff et al (2020) UK	Barriers to stopping neuroleptic (antipsychotic) treatment in people with schizophrenia, psychosis or bipolar disorder	Practice literature	» Patients should have the right to make decisions about neuroleptic medicines in most cases » Risk of relapse may be mitigated by supported and gradual reduction	» Draws on wide-ranging evidence » No formal methodology
Salomon and Hamilton (2013) Australia	'All roads lead to medication?' Qualitative responses from an Australian first-person survey of antipsychotic discontinuation	Primary qualitative research (survey) with 98 mental health service users	» Context and relationships are important when considering discontinuation » Respondents' experiences of withdrawal varied hugely	» Primary and secondary researcher coding of themes was robust and supported by a software application for analysing qualitative and mixed-methods research » Small non-randomised sample » Convenience sampling – issue with representativeness and potential bias » Results not generalisable
Salomon et al (2014) Australia	Experiencing antipsychotic discontinuation: results from a survey of Australian consumers	Primary quantitative research (survey) with 98 mental health service users	Collaboration and information sharing regarding withdrawal syndrome and treatment duration are essential	» Same data set and sample as Salomon and Hamilton (2013) with the same limitations » Range of uncontrolled variables resulting in fragile correlation

* Practice literature articles were appraised using the 'six questions for critical thinking' (Aveyard et al 2015); research articles were appraised using Mixed Methods Appraisal Tool (Hong et al 2018)

Discussion

Rationales for deprescribing

The premise that the indefinite use of antipsychotics should be endorsed without question was challenged in all ten articles, five of which cited flaws in the evidence base. Gupta et al (2018a) asserted that the evidence supporting the long-term benefits of antipsychotic treatment should not be considered robust. Moncrieff et al (2020) noted that evidence that appeared to support the benefits of long-term antipsychotic treatment, which cited discontinuation as a catalyst for relapse, had failed to test outcomes beyond initial cessation. Gupta et al (2018b) noted that discontinuation trials often involve an abrupt cessation of the medicine. This could mean that relapse is indistinguishable from withdrawal issues (Moncrieff et al 2020) and result in incorrect inferences regarding the risk of relapse. Le Geyt et al (2017) suggested that the dominance of biomedical models of mental health results in a theoretical preference for antipsychotic treatment, with an implicit injunction to patients that they need to continue to take their medicines without question. However, flaws in the evidence base also mean that, as noted by Horowitz et al (2021), there is uncertainty about the proportion of patients who could stay well without antipsychotics.

All ten articles identified that the significant adverse effects of antipsychotics influence many patients' decisions to discontinue treatment. Several articles referred to the physical health complications and premature deaths associated with the use of antipsychotics (Gupta et al 2018b, Moncrieff et al 2020, Cooper et al 2021) and Horowitz et al (2021) described a range of adverse neurological effects, movement disorders and adverse effects on cognition. Moncrieff et al (2020) suggested that a reduction of the symptoms of psychotic disorders may not be of sufficient benefit to warrant the continuation of antipsychotics if continuation reduces the person's functional capacity. Gupta et al (2018b) concurred, asserting that considering the risks and benefits of antipsychotic treatment from within a recovery-oriented approach increases the value placed on quality of life over symptom reduction.

All ten articles described how the focus on recovery rather than remission reflects the opposition between psychosocial and biomedical approaches and a move away from the traditional, paternalistic approach to treatment in mental healthcare. Larsen-Barr et al (2018) stressed the need to address the imbalance in power dynamics in mental healthcare and empower patients in terms of choice. According to Larsen-Barr et al (2018), patients should be given all the available information so that they can make an informed choice about the use of antipsychotics. Similarly, Le Geyt et al (2017) emphasised the need to reduce long-standing power imbalances in mental health services, which result in a culture of coercion. Le Geyt et al (2017), Moncrieff et al (2020) and Cooper et al (2021) agreed that, given the extensive and well-documented adverse effects associated with long-term antipsychotic use, a patient's choice to discontinue treatment should be supported and not regarded as irrational or lacking in insight.

Risk and clinical anxiety

Gupta et al (2018b) cited the risk of relapse as one of the main barriers to deprescribing, relapse being a concern for clinicians and for patients. Several articles emphasised the difference between short- and long-term outcomes in relation to relapse. Cooper et al (2021) suggested that while relapse rates might increase in the short term following the discontinuation of antipsychotics, this did not necessarily mean poorer outcomes in the long term. Landolt et al (2016), in a secondary analysis of data from the European First Episode Schizophrenia Trial (EUFEST) (Fleischhacker et al 2005), found that after 12 months participants who had stopped taking antipsychotics did not experience relapse more often than those who were on antipsychotic maintenance therapy. Moncrieff et al (2020) asserted that societal and economic pressures to avoid relapse in the short term tend to take priority over the longer-term functional benefits of discontinuing antipsychotics. Horowitz et al

Table 2. Identified themes and subthemes

Themes	Subthemes
Rationales for deprescribing	» Uncertainty about antipsychotic maintenance therapy » Unwanted side effects » Recovery versus remission » Choice versus paternalism
Risk and clinical anxiety	» Relapse » Withdrawal or discontinuation syndromes » Clinical reticence » Lack of clear guidance
Safe deprescribing in practice	» Tapering » Collaboration and therapeutic alliance » Effective intervention » Individual prerequisites

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(2021) noted the difficulty in distinguishing the endogenous effects of relapse from the symptoms associated with withdrawal from, or discontinuation of, antipsychotics.

While there was broad acknowledgement, in the reviewed articles, that withdrawal and discontinuation syndromes have not been formally characterised or recognised, there were multiple references to symptoms that can occur when antipsychotics are deprescribed. Horowitz et al (2021) referred to the proposal that dopaminergic hypersensitivity contributes to the development of withdrawal symptoms, particularly in relation to rebound psychosis. Other articles cited effects such as heightened emotions and anxiety (Moncrieff et al 2020) and sleep difficulties (Gupta et al 2018b), while participants in the study by Larsen-Barr et al (2018) described a range of physical, emotional, cognitive and functional adverse effects.

The reviewed articles broadly acknowledged the difficulty of distinguishing between withdrawal, rebound and relapse on discontinuation of antipsychotics and called for further research. They also broadly agreed that concerns about the negative effects of either rebound or relapse are a significant factor in clinicians' reticence to deprescribe antipsychotics. This reticence is compounded by the lack of formal guidance on deprescribing (Salomon and Hamilton 2013, Cooper et al 2021, Horowitz et al 2021). Gupta et al (2018a) suggested that clinicians lack training and peer support to deprescribe and Le Geyt et al (2017) asserted that risk averseness among healthcare professionals creates a barrier to collaborative care and shared decision-making.

Safe deprescribing in practice

All articles mentioned strategies for safe deprescribing in practice. A dominant area of discussion was the rate of discontinuation in terms of timescale and dose. Horowitz et al (2021) made the case for prolonged tapering (gradual reduction over a long period of time), proposing that it reduces the likelihood and intensity of withdrawal symptoms. Other authors acknowledged that there is some evidence that tapering reduces the risk of relapse (Gupta et al 2018a, Moncrieff et al 2020, Cooper et al 2021). Gupta et al (2018b), however, cited a metanalysis that suggested there was no clear link between tapering and risk of relapse. There are no set timescales or formulae on which to base tapering and the process is subject to huge variability (Horowitz et al 2021). Horowitz et al (2021) suggested that tapering could be conceptualised as a method of determining a new minimum effective dose. Cooper et al (2021) agreed that for some patients, such a process of dose optimisation might be more acceptable than discontinuation.

The articles reviewed addressed the issue of abrupt cessation of antipsychotics in relation to the quality of clinical support provided to patients who want to stop taking antipsychotics. Salomon et al (2014) identified that clinical support is associated with a gradual withdrawal regimen while other authors suggested that people who discontinue their medicine covertly and in isolation are more prone to abrupt cessation, with an increased risk of suboptimal outcomes (Moncrieff et al 2020, Horowitz et al 2021).

Larsen-Barr et al (2018) cited a significant association between successful deprescribing and effective support, which persisted in the long term. Salomon et al (2014) asserted the need for clinicians to be trusted partners in the deprescribing process, while Gupta et al (2018b) suggested that the involvement of clinical staff and of patients' wider support networks is fundamental for successful deprescribing. Le Geyt et al (2017) suggested that a shared understanding between patients and clinicians regarding the effects of antipsychotics can reduce the perception that mental health services are biased towards antipsychotic treatment. This supports Salomon et al's (2014) view that a strong therapeutic alliance is essential. Salomon and Hamilton (2013) advocated a more person-centred and transparent approach to deprescribing, while Moncrieff et al (2020) suggested that supporting people to stop medicines can be considered a legitimate treatment option in the context of harm minimisation.

There was a view across the articles reviewed that successful deprescribing requires intensified support and non-pharmacological interventions. Furthermore, Salomon and Hamilton (2013) suggested that for some people the process of deprescribing itself can be a significant therapeutic step rather than a cause of harm, while for others it could be life-saving. In addition to intensified support during the deprescribing process, other factors contribute to a successful outcome. Landolt et al (2016) identified that social circumstances, particularly the amount and standard of general education a person has had, increased the likelihood of successful discontinuation of antipsychotics. Le Geyt et al (2017) regarded 'acquired knowledge' – that is, knowledge gained through personal experience over the course of treatment – as a prerequisite for success.

Non-pharmacological interventions may include ‘safety nets’ (Le Geyt et al 2017), such as support networks, practical resources and talking therapy. Some authors called for further research on how established non-pharmacological interventions can support patients to cope with the effects of discontinuation and how patients can be supported to manage the risk of destabilisation (Gupta et al 2018a, Moncrieff et al 2020, Cooper et al 2021).

Limitations

There was a small amount of literature that addressed the aims of this literature review, only half of which was primary research. Some authors had contributed to several articles, which confirms that this is a narrow field of interest and that more evidence is needed.

Conclusion

The adverse effects of the long-term use of antipsychotics are such that treatment should be reviewed collaboratively between healthcare professionals and patients in the context of a risk-benefit appraisal. While the process of deprescribing is not without risks, these can be mitigated by intensified support, the development of a strong therapeutic alliance, a gradual tapering of the dose and non-pharmacological interventions. The challenge for nurses is to find a balance between the autonomy of the patient and the mitigation of risk to ensure they provide safe and supportive care.

References

Aveyard H (2019) Doing a Literature Review in Health and Social Care: A Practical Guide. Open University Press, Maidenhead.

Aveyard H, Sharp P, Woolliams M (2015) A Beginner’s Guide to Critical Thinking and Writing in Health and Social Care. Open University Press, Maidenhead.

Bahta M, Ogbaghebriel A, Russom M et al (2021) Impact of adverse reactions to first-generation antipsychotics on treatment adherence in outpatients with schizophrenia: a cross-sectional study. Annals of General Psychiatry. 20, 27. doi: 10.1186/s12991-021-00348-0

Baker E, Fee J, Bovingdon L et al (2013) From taking to using medication: recovery-focused prescribing and medicines management. Advances in Psychiatric Treatment. 19, 1, 2-10. doi:10.1192/apt.bp.110.008342

Bladon H (2019) Avoiding paternalism. Issues in Mental Health Nursing. 40, 7, 579-584. doi: 10.1080/01612840.2019.1570405

Braun V, Clarke V (2021) One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qualitative Research in Psychology. 18, 3, 328-352. doi: 10.1080/14780887.2020.1769238

Chenoweth L, Jessop T, Harrison F et al (2018) Critical contextual elements in facilitating and achieving success with a person-centred care intervention to support antipsychotic deprescribing for older people in long-term care. BioMed Research International. 7148515. doi: 10.1155/2018/7148515

Cooper RE, Laxhman N, Crellin N et al (2020) Psychosocial interventions for people with schizophrenia or psychosis on minimal or no antipsychotic medication: a systematic review. Schizophrenia Research. 225, 15-30. doi: 10.1016/j.schres.2019.05.020

Cooper RE, Mason JP, Calton T et al (2021) Opinion piece: the case for establishing a minimal medication alternative for psychosis and schizophrenia. Psychosis. 13, 3, 276-285. doi: 10.1080/17522439.2021.1930119

De Hert M, Sermon J, Geerts P et al (2015) The use of continuous treatment versus placebo or intermittent treatment strategies in stabilized patients with schizophrenia: a systematic review and meta-analysis of randomized controlled trials with first- and second-generation antipsychotics. CNS Drugs. 29, 8, 637-658. doi: 10.1007/s40263-015-0269-4

Department of Health (2016) Improving the Physical Health of People with Mental Health Problems: Actions for Mental Health Nurses. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf (Last accessed: 11 August 2023.)

Elkins JC (2019) Metabolic effects of antipsychotic medications. Journal for Nurse Practitioners. 15, 8, 609-610. doi: 10.1016/j.nurpra.2019.03.014

Emsley R (2020) Guest editorial: special issue on maintenance treatment in schizophrenia. Schizophrenia Research. 225, 1-3. doi: 10.1016/j.schres.2020.03.029

Fleischhacker WW, Keet IP, Kahn RS (2005) The European First Episode Schizophrenia Trial (EUFEST): rationale and design of the trial. Schizophrenia Research. 78, 2-3, 147-156. doi: 10.1016/j.schres.2005.06.004

Gregory AT, Denniss AR (2018) An introduction to writing narrative and systematic reviews – tasks, tips and traps for aspiring authors. Heart, Lung and Circulation. 27, 7, 893-898. doi: 10.1016/j.hlc.2018.03.027

Gupta S, Steingard S, Garcia Aracena EF et al (2018a) Deprescribing antipsychotic medications in psychotic disorders: how and why? Current Psychiatry Reviews. 14, 1, 26-32. doi: 10.2174/1573400514666180612092055

Gupta S, Cahill JD, Miller R (2018b) Deprescribing antipsychotics: a guide for clinicians. BJPsych Advances. 24, 5, 295-302. doi: 10.1192/bja.2018.2

Hong QN, Fàbregues S, Bartlett G et al (2018) The mixed methods appraisal tool (MMAT) version 2018 for information professionals and researchers. Education for Information. 34, 4, 285-291. doi: 10.3233/EFI-180221

Horowitz MA, Jauhar S, Natesan S et al (2021) A method for tapering antipsychotic treatment that may minimize the risk of relapse. Schizophrenia Bulletin. 47, 4, 1116-1129. doi: 10.1093/schbul/sbab017

Jessop T, Harrison F, Cations M (2017) Halting Antipsychotic Use in Long-Term care (HALT): a single-arm longitudinal study aiming to reduce inappropriate antipsychotic use in long-term care residents with behavioral and psychological symptoms of dementia. International Psychogeriatrics. 29, 8, 391-1403. doi: 10.1017/S1041610217000084

Khan KS, Kunz R, Kleijnen J et al (2003) Systematic Reviews to Support Evidence-Based Medicine. How to Review and Apply Findings of Healthcare Research. Royal Society of Medicine Press, London.

Kuipers E, Yesufu-Udechuku A, Taylor C et al (2014) Management of psychosis and schizophrenia in adults: summary of updated NICE guidance. BMJ. 348, g1173. doi: 10.1136/bmj.g1173

Landolt K, Rössler W, Ajdacic-Gross V et al (2016) Predictors of discontinuation of antipsychotic medication and subsequent outcomes in the European First Episode Schizophrenia Trial (EUFEST). Schizophrenia Research. 172, 1-3, 145-151. doi: 10.1016/j.schres.2016.01.046

Larsen-Barr M, Seymour F, Read J et al (2018) Attempting to stop antipsychotic medication: success, supports, and efforts to cope. Social Psychiatry and Psychiatric Epidemiology. 53, 745-756. doi: 10.1007/s00127-018-1518-x

Le Geyt G, Awenat Y, Tai S et al (2017) Personal accounts of discontinuing neuroleptic medication for psychosis. Qualitative Health Research. 27, 4, 559-572. doi: 10.1177/1049732316634047

Moncrieff J, Gupta S, Horowitz MA (2020) Barriers to stopping neuroleptic (antipsychotic) treatment in people with schizophrenia, psychosis or bipolar disorder. Therapeutic Advances in Psychopharmacology. 10. doi: 10.1177/2045125320937910

Morant N, Kaminskiy E, Ramon S (2016) Shared decision making for psychiatric medication management: beyond the micro-social. Health Expectations. 19, 5, 1002-1014. doi: 10.1111/hex.12392

Nash M (2023) Severe mental illness: why is physical health monitoring vital? Mental Health Practice. 26, 1, 18-19. doi: 10.7748/mhp.26.1.18.s8

NHS England (2023) Stopping the Over Medication of People with a Learning Disability, Autism or Both (STOMP). www.england.nhs.uk/learning-disabilities/improving-health/stomp (Last accessed: 11 August 2023.)

National Institute for Health and Care Excellence (2014) Psychosis and Schizophrenia in Adults: Prevention and Management. Clinical guideline No. 178. NICE, London.

Page MJ, Moher D, Bossuyt PM et al (2021) PRISMA 2020 explanation and elaboration: updated guidance and exemplars for reporting systematic reviews. BMJ. 372, n160. doi: 10.1136/bmj.n160

Reeve E, Shakib S, Hendrix I et al (2014) Review of deprescribing processes and development of an evidence-based, patient-centred deprescribing process. British Journal of Clinical Pharmacology. 78, 738-747. doi: 10.1111/bcp.12386

Ross JD (2015) Mental health nurse prescribing: the emerging impact. Journal of Psychiatric and Mental Health Nursing. 22, 529-542. doi: 10.1111/jpm.12207

Salomon C, Hamilton B (2013) “All roads lead to medication?” Qualitative responses from an Australian first-person survey of antipsychotic discontinuation. Psychiatric Rehabilitation Journal. 36, 3, 160-165. doi: 10.1037/prj0000001

Salomon C, Hamilton B, Elsom S (2014) Experiencing antipsychotic discontinuation: results from a survey of Australian consumers. Journal of Psychiatric and Mental Health Nursing. 21, 10, 917-923. doi: 10.1111/jpm.12178

Why you should read this article:

- To enhance your understanding of young people's use of digital technology
- To learn how digital technology can be used to provide mental health services for young people
- To recognise the importance of considering young people's abilities and preferences when implementing digital interventions

Exploring young people's perspectives on digital technology and mental healthcare: pilot study findings

Cara Maddison, Heather Wharrad, Philip John Archard et al

Citation
Maddison C, Wharrad H, Archard PJ et al (2023) Exploring young people's perspectives on digital technology and mental healthcare: pilot study findings. Mental Health Practice. doi: 10.7748/mhp.2023.e1671

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

Accepted
3 July 2023

Acknowledgements
This study was supported by a postgraduate studentship funded by the National Institute for Health and Care Research and Health Education England. The authors wish to thank Susan Corr for her supervisory support as part of this studentship

Abstract

Background Digital technology affords opportunities to expand mental healthcare beyond the clinic setting, supporting sustainable delivery. A pilot qualitative study was undertaken with a view to using the experience gained from it to develop a substantive project in this area.

Aim To identify and better understand the perceived barriers and benefits to using digital technologies when delivering mental healthcare to young people.

Method In-depth semi-structured interviews were conducted with three young people under the care of a child and adolescent mental health service (CAMHS) team. The interview data were analysed thematically.

Findings Three main themes were identified from the interviews: digital identity and digital literacy; trusting and accessing digital health resources; and therapeutic relationships, choice and convenience.

Conclusion The findings of this pilot study reinforce the importance of avoiding a 'one-size-fits-all' approach to integrating digital technology in CAMHS. It was also identified that it is important to carefully consider the involvement of parents when conducting mental health research with children and young people.

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Keywords

adolescents, anxiety, child health, information technology, mental health, professional, professional issues, qualitative research, research, technology

Background

Mental health conditions in children and young people (aged between ten years and 19 years) are estimated to account for 13% of the global burden of disease and injury, with depression, anxiety and behavioural disorders among the leading causes of illness and disability (World Health Organization (WHO) 2021). It has been estimated that almost half of all mental health conditions occur before the age of 18 years (Solmi et al 2022), which has implications regarding access to treatment as well as the social and economic burden associated with suboptimal outcomes for these children in terms of educational attainment, future employment and comorbid physical health issues (WHO 2021). Estimates show that the prevalence of mental health conditions is increasing among young people (Bor et al 2014) and has risen considerably in the UK, in part because of the coronavirus disease 2019 (COVID-19) pandemic (Benton et al 2022, NHS Digital 2022a).

As a result of these issues, mental health services for children and young people are a priority for service improvement in the NHS. However, healthcare regulators view progress in this area as slow (Care Quality Commission (CQC) 2018). Long waiting lists, estimated increases in treatment costs and pressure to improve efficiency have all affected care delivery (Crenna-Jennings and Hutchinson 2020). Therefore, it is necessary to identify cost-effective solutions that address the needs of this population and manage the wider challenges of service delivery.

In child and adolescent mental health services (CAMHS), while face-to-face care delivery was traditionally preferred, there has been growing interest in harnessing digital technologies and the transition to remote care in outpatient settings (Department of Health and NHS England 2015, NHS Digital 2022b), which has increased further due to the COVID-19 pandemic. Digital technologies, especially teleworking and videoconferencing appointments, are seen as essential in reducing costs and improving quality of care, health outcomes and access arrangements (NHS Digital 2022b).

Despite the benefits of using digital technologies, many service users and healthcare professionals consider face-to-face care to be of value, so it is important to explore the views and preferences of children and young people. Smartphone ownership among young people is widespread and they regularly use the internet and social media, particularly for leisure and social activities (Grist et al 2018, Aschbrenner et al 2019, O'Reilly et al 2021). Furthermore, the evidence is clear that children and young people increased their reliance on online platforms following the onset of the COVID-19 pandemic (Trott et al 2022). However, uptake of digital interventions for mental health is variable and largely based on adults' preferences, rather than those of children and young people (Hollis et al 2017, Bergin et al 2020).

Existing evidence in children and young people shows varied perspectives on digital health interventions. For example, Grist et al (2018) surveyed 775 girls aged 11-16 years in England and found mixed views, with 44% expressing a preference for an in-person intervention over one that was delivered digitally, and only 5% reporting they had any physical or mental health apps installed on their devices. Benefits of digitally delivered mental healthcare cited by young people include the reduction of stigma as well as improved accessibility (Sweeney et al 2019). The use of smartphone apps can also complement traditional mental health practices, for example children and young people can use apps to track their mood or anxiety (Betton and Woollard 2018).

A systematic review by Liverpool et al (2020) identified that the method of digital delivery can influence an intervention's acceptability and usability, with young people generally preferring features such as video, personalised delivery, limited text and the ability to connect with others. This demonstrates the importance of listening to the voices of children and young people.

The pilot study reported on in this article was initiated and led by a practitioner-researcher (CM), and its aims were based on local service concerns (Shaw et al 2014, Lunt and Shaw 2017). By focusing on young people's perspectives of digital technology, the study responded to the need to examine blended forms of delivery, whereby face-to-face contact for group-based interventions is supplemented by digital resources accessed remotely. The pilot study was also conceived to inform the development of a proposal for a larger study and to consider issues related to the design of such research.

Aim

To identify and better understand the perceived barriers and benefits of using digital technologies when delivering mental healthcare to young people. Specifically:

» To explore young people's views and experiences of digital technology use in school, leisure, social and health contexts.
» To identify situations where in-person interaction is valued by young people.
» To consider the role of blended online and face-to-face care delivery in mental healthcare, including group-based interventions.

Implications for practice

- Digital technologies can provide a means to expand mental healthcare beyond the clinic setting
- The use of digital interventions could help to meet high service demands and support sustainable care delivery
- Digital health resources and technologies could enhance service users' relationships with healthcare professionals and aid recovery by providing increased choice and convenience
- It is important that nurses and other healthcare professionals avoid making assumptions about young people's abilities and preferences regarding digital technologies

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Method

To prioritise young people's perspectives, a qualitative approach involving in-depth semi-structured interviews was used. A convenience sampling strategy was adopted, which involved identifying prospective participants via the CAMHS team facilitating the study – a specialist multidisciplinary team providing group-based therapy and psychoeducation interventions to children, young people, parents and carers. Young people accessing this support were considered eligible for the study and approached by team clinicians between May 2019 and July 2019.

Three young people participated in this pilot study, all of whom were female, aged 13 years or 14 years, living at home with their families and attending secondary school. At the time of interview, two participants had recently finished a group-based intervention for difficulties relating to anxiety. The participants' characteristics are summarised in Table 1.

Interviews were conducted at participants' homes and audio recorded, with each lasting approximately 50 minutes. Two participants chose to be interviewed with a parent present – in both cases their mothers. The remaining participant was interviewed alone, with family members in nearby rooms.

The interviews comprised open-ended questions covering the core topics of the study, with follow-up prompts. The questions were based on the lead researcher's understanding of the literature reviewed for the study, practice concerns and input from a patient involvement group during the planning of the research. The interview schedule was revised following feedback from the patient involvement group and the lead researcher's supervisors. It included questions on: the types of digital technology accessed by the participants and the extent of use; changes in use over time since they had first been introduced to these technologies; the use of digital technology for support with mental health; and ways in which digital technology would be considered helpful or unhelpful with regard to group-based mental health interventions.

Table 1. Participants' characteristics

Participant pseudonym	Gender	Age (years)	Access to group-based interventions at the time of interview	Interview arrangement
Emma	Female	13	Recently attended a group-based intervention for difficulties relating to anxiety	Interviewed alone
Jade	Female	14	Accessing group-based intervention for difficulties relating to anxiety at the time of interview	Interviewed with a parent (mother) present
Sarah	Female	13	Recently attended a group-based intervention for difficulties relating to anxiety and was due to access another group-based intervention for mental health issues	Interviewed with a parent (mother) present

During the interviews, some questions were rephrased to aid participants' understanding. Various materials – namely pens, paper and images of technology – were made available to encourage the expression of ideas (O'Reilly and Dogra 2017).

Data analysis

Data were stored on a secure, password-protected server with access limited to the lead researcher and supervisory team. Once interview recordings were transcribed, a thematic analysis of the data was undertaken (Braun and Clarke 2022). This involved: reading the transcripts several times to generate initial ideas; preliminary open coding; exploration of relationships and similarities between codes; initial theme development and refinement; and development of core themes.

Researcher reflexivity – that is, the practitioner-researcher considering their role in the context of the research – was taken seriously for the study, as is required for this form of thematic analysis (Braun and Clarke 2022). Researcher reflections were gathered via field notes and a diary, and research supervision provided a space for the lead researcher to reflect on their dual role as clinician and researcher, as well as the power imbalance between themselves and the participants.

Ethical considerations

The study was sponsored by the University of Nottingham School of Health Sciences and was subject to review and approval by the research ethics committee before any participants were contacted. The study also received approval from the Health Research Authority, and local research and development department approval was provided by the NHS trust in which the CAMHS team facilitating the research was based.

Before the interviews were conducted, written parental consent was obtained, followed by written assent from each young person. In reporting the findings, identifying details have been removed and quotations anonymised, with pseudonyms used. Measures to protect participants' identities and maintain confidentiality, including reasons this might need to be breached, were discussed with them before the interviews. Separate participant information sheets were provided for the parents and young people, designed to be appropriate for each group.

Findings

Three main themes were identified from the interviews:

- Digital identity and digital literacy.
- Trusting and accessing digital health resources.
- Therapeutic relationships, choice and convenience.

Digital identity and digital literacy

This theme captured how the participants described their relationship with digital technology. All three participants reported owning or having access to a smartphone and tablet or laptop computer, which they used to engage in social and leisure activities. The participants also identified that they had developed aspects of a personal digital identity. Keeping digital content or apps and digital tools which held personal value or recorded some form of achievement, such as photographs or records of high-scoring games, were viewed as important.

However, the participants' comments indicated that they perceived their use of digital technology to be different from their peers, especially in their avoidance of digital communication. Ambiguity in text-based communication appeared to be a source of discomfort and anxiety for two participants, due to the lack of social cues and non-verbal communication:

'I prefer talking face to face, most people like me prefer the opposite, they prefer text with no signals [such as body language]. But I like knowing.' (Emma)

All the participants described actively avoiding social media due to perceived intrusiveness, or only engaging with it in moderation:

'I don't really look through my feed. I only scroll down a bit and then I don't do it anymore.' (Jade)

All three participants also spoke about viewing their peers' ability to navigate technology as superior to their own, both in a general sense and in relation to specific activities:

'I'm not very good at using technology really… I found that a lot of my friends just knew what they were doing instantly.' (Jade)

This social comparison of skills often left participants feeling that they lacked the necessary competencies to engage in technology in the same way as their peers, which appeared to complicate everyday online activities. Participants also repeatedly referred to assumptions being made by others based on their age. For example, Jade and Sarah spoke about the transition to secondary school and the inaccurate assumptions that teaching staff made about their level of competence in using online platforms:

'They had homework on Google classroom, but I did not know how to use it or download it or anything. I was supposed to know that in Year 7, so every time they asked to log into an app the school wanted us to use, [it would] be like "What's your email address?" and I didn't know. And then I just found out this year how to use my account properly… how to keep all my stuff on my account and hand stuff in. I worked out that a few months ago.' (Jade)

These assumptions about their digital abilities appeared to contribute to feelings of shame and being 'left behind', as Jade put it. The participants described seeking help with online activities, particularly at school, as contingent on having the confidence to ask and knowing who and what to ask:

'It's been awkward because whenever I used to have to go and ask the teacher and then they said to go to the IT teacher, and I would ask him and he would go "What's the problem?" But it's really hard to describe what's happening and the answer would always make me feel stupid, because it's a simple answer.' (Jade)

'I kept being logged out and then not doing my homework and getting into trouble and getting scared.' (Sarah)

Trusting and accessing digital health resources

There was scepticism among the participants regarding the value of digital health websites and apps, and they generally preferred resources that could be accessed offline:

'I prefer reading. I've got a few books on health because they normally have a better content, because it's written by people like dietitians, people who know what they are talking about rather than just an app that counts calories.' (Emma)

The participants considered the aesthetics of digital health resources – that is, the appearance, design and quality of the graphics or images – to be important, along with positive experiences during a trial period. Participants' perceptions about the trustworthiness of digital health resources, especially apps, also related to who they were recommended by. The participants viewed recommendations by a healthcare professional as confirmation that an app was safe to use and potentially helpful. However, while this appeared to motivate participants to download specific apps, it did not necessarily translate into these apps being used as advised:

'The school nurse told me to try [a self-harm app] out so I did. But it wasn't very helpful. I had it for about a month. I was like "Oh, [I] don't see the point in having this app, if it's not helping me".' (Jade)

Participants also valued recommendations from friends and other young people, but to a lesser degree; for example, they considered apps to be more credible if they were the same or similar to those used by friends or trusted others. All three participants appeared to have low awareness of, and motivation for, using digital health resources, as illustrated in the following exchange with Sarah:

Interviewer: 'Have you ever downloaded any other health apps to support how you physically feel or [for] your mental health?'

Sarah: 'No.'

Interviewer: 'What's stopped you?'

Sarah: 'I just haven't looked for any, I haven't really looked, I don't really know if there are any.'

Emma and Jade also expressed concerns about the safety and privacy of using apps and online mental health support. For Emma, these concerns related to security and personal information potentially being leaked online, while for Jade these concerns related to being self-conscious about having a mental health app on her phone, which appeared to be linked to a fear of stigma:

'I found it embarrassing having the app on my phone about self-harm, I didn't want my friends seeing it... If your friends did find out, they [would] maybe view you differently or something.' (Jade)

Therapeutic relationships, choice and convenience

The opportunity to access support in-person was highly valued by all three participants. One participant explained her preference for meeting in person:

'If I am talking about anything personal, like counselling, I couldn't really do Kooth [an online counselling service] or anything like that. I prefer in person, as [there is] more connection and I don't want to trust a random person on the phone, and give them all my details, as I don't know who they are.' (Emma)

The participants appeared to have differing views regarding the potential value of using digital interventions to engage with healthcare professionals, depending on the context in which digitally based support was used and how well it aligned with their perceived needs. Participants described digital resources and technology as primarily a supplementary means of support that could enhance their relationships with professionals and aid their recovery by providing increased choice and convenience:

'If you are going somewhere or travelling or you can't make it because you're sick, but need someone to talk to and can't make [an] appointment or don't want to go there, if you just do it at home, then it's just easier [for] both parties.' (Emma)

Participants described digital technology as affording different ways to access appointments, timely support and the potential for reviewing progress without being constrained by the need to attend a clinic setting. However, they also spoke about the integration of digital technology potentially being compromised by practical barriers, such as expectations about mobile phone access at school and home, or the effects on healthcare professionals' time:

'I don't really know though because [offering 24-hour access] would be quite hard to do... I think that would be useful, [but] I don't really know because if [young] people were... talking to [healthcare staff] all the time, wouldn't that be a bit hard on them?' (Jade)

At times there was also a mismatch between the expected function of digital resources and what healthcare professionals could or should provide, resulting in tensions in service user-professional relationships. For example, one participant spoke about an occasion where she felt upset and misunderstood after being directed to online resources by a school nurse because she interpreted the advice as indicating a lack of concern:

'When I was seeing the school nurse... she just told me to go online. It felt horrible because I was seeing her so she could help me, not so the internet could help me, because I had gone to see her because the internet could not help me, and it kind of felt that she did not care.' (Jade)

Regarding the role of digital technology in group-based interventions, one participant, Emma, suggested that receiving a pre-appointment phone call would be helpful because not knowing what to expect when attending pre-group assessments was a source of anxiety. The availability of printed resources in digital form alongside video content was favoured by all the participants, potentially with links to other websites and self-directed relaxation exercises.

Other suggestions from the participants regarding the integration of digital technology with group-based interventions included the use of online messaging to communicate with the group facilitators, as well as the use of virtual reality simulators for exposure therapy and tracking of anxiety symptoms over time. Participants also expressed an interest in an online peer support discussion forum; however, they also expressed concerns about responding to peers appropriately without the oversight of a suitably qualified professional.

Discussion

This pilot study investigated young people's perspectives on the barriers and benefits to using digital technologies in mental healthcare delivery. Of fundamental value was that this study accessed a clinical population of young people whose voices are seldom reported (Bergin et al 2020). A practitioner-researcher led the study, which enabled close consideration of the implications for practice for each of the identified themes. Overall, various factors were identified regarding the participants' experience of digital technology and its use to support their emotional well-being. These factors related to their identity, confidence, needs and skills in using technology and the interrelations between these areas and the expectations they held about themselves.

Caution in assuming digital literacy among young people

The findings of this study reinforce the need to avoid making assumptions about young people and their levels of digital literacy to ensure they are able to engage effectively with digital interventions. Although digital technology is now embedded in most people's everyday lives, individuals' technology use and competencies will vary (Morris 2018), and digital abilities developed through everyday technology use may not be transferable to the use of other digital resources (Bennett and Maton 2010). It has been identified that adults often overestimate the digital abilities of children and young people, which fails to take into account variations in this population (Betton and Woollard 2018).

The study participants appeared self-conscious in relation to using digital technologies, particularly communication via social media, and a lack of confidence in this area appeared to contribute to concerns about how their skills compared with those of their peers. This finding was reflected by Bucci et al (2019), who identified various skills required to successfully navigate digitally mediated communication in mental healthcare and the need to develop an ability to mentalise (understand one's own and others' feelings, motivations and behaviours) online. This ability is developed through previous experiences and receiving empathy online and in person, although the ability to judge others' intentions and motivations online without contextual social cues potentially creates misunderstandings (Bucci et al 2019). Furthermore, in a non-clinical population, Kingsbury and Coplan (2016) found that symptoms of social anxiety correlated with a tendency to interpret ambiguous texts negatively. Therefore, while digitally mediated communication may particularly appeal to young people with social anxiety, their tendencies to misinterpret communication need to be considered.

Awareness of mental health apps and stigma

Fear of stigmatisation is a recognised barrier for young people seeking mental health support (Gulliver et al 2010), and digital interventions have been positioned as a means to partially ameliorate this as well as promoting health by offering greater ease of access and anonymity. The accounts of the participants in this study suggest that low awareness of digital health resources and concerns about negative labelling from peers may serve as barriers to even downloading mental health apps, findings which are reflected by other studies (Grist et al 2018, Ignatowicz et al 2018).

For the participants in this study, important considerations for using an app were its accessibility, design, perceived relevance, safety and privacy concerns, and the person recommending it. It should be noted that nurses and other healthcare professionals do not necessarily possess the skills to fully appraise the quality or safety of an app and may make recommendations based on limited evidence or simply a general impression that a particular app is suitable. In addition, mental health apps are not necessarily designed with children and young people in mind because the focus is on adult populations (Grist et al 2017). Healthcare professionals could potentially address or reduce these issues by ensuring they check the evidence base and suitability of apps.

Therapeutic relationships with professionals and blended care delivery

The quality of the relationship between service users and professionals has been identified as a crucial factor in the experience and outcomes of children and young people accessing CAMHS care (CQC 2018). Integrating online and face-to-face care delivery is a research priority in mental health services, which has grown in scope since the COVID-19 pandemic (Berry et al 2018). The findings of this study suggest that digital technologies have the potential to enhance the service user-professional relationship but can also alienate young people, depending on the purpose of the intervention and how well it aligns with the young person's preferences. All three study participants valued in-person contact, viewing remote or online support not as a replacement but rather as a complement to face-to-face care that could increase access to support outside of clinic-based appointments. While they are not representative of other children and young people involved with CAMHS due to the small sample size, this finding is supported by other research such as Ignatowicz et al's (2018) study, which found that the opportunity to develop a relationship with a clinician was a valued aspect of digital communication.

While access to support via digital means was viewed as desirable by the participants, they also recognised that this was not necessarily feasible due to clinical pressures. Similarly, healthcare professionals may also wish to have choice over the means used to deliver care (Feijt et al 2020, Bentham et al 2021), so healthcare professionals' and young people's familiarity with online social etiquette should be considered when planning care pathways. The study participants' views suggest that digital technologies have a role in group-based interventions for young people in CAMHS, but they should be introduced in a way that is cognisant of anxiety about their use and involves clear communication about their function (Ospina-Pinillos et al 2018).

Reflections on research methodology

This pilot study was conceived, in part, to develop a proposal for a substantive research project in this topic area, so issues relating to the research methodology and design were considered. While this research project has yet to be formally pursued, lessons learned from this pilot study have been fed back to the service involved. Based on the authors' experiences of undertaking the research, the in-depth interview approach appeared valuable for generating rich data with young people, whose perspectives are vital to ensure services are aligned with their needs, experiences, digital capabilities and confidence. Nonetheless, there were challenges in engaging this target population, particularly since young people can be hard to recruit for research given their age, vulnerability due to mental health issues, and the involvement of professionals, parents and carers as gatekeepers (O'Reilly et al 2013).

Two participants opted to have their mothers present for support during the interviews. Notes taken afterwards indicated that this parental presence afforded a deeper understanding of the young people's experiences, with the participants' mothers providing supportive comments and occasionally offering contextual clarification to the participants' responses. However, in one interview, managing the boundaries of parental presence was complicated by the mother answering some of the questions alongside her daughter. In this scenario, the interviewer's clinical experience was beneficial, since they were able to reflect on the dynamics present and use reflective comments to reorientate the conversation back to the young person. This experience indicated the potential need for any future research to consider a flexible arrangement regarding the presence of parents or carers during interviews, with young people being given the option to change their minds if they decide they no longer need such support. This could be facilitated by establishing times during each interview when the interviewer would 'check in' with the participant or observe whether the participant appeared relaxed.

Limitations

This was a pilot study involving interviews with just three young people, and it was undertaken before the COVID-19 pandemic and the subsequent widespread adoption of remote care delivery arrangements. Therefore, the findings reported in this article should be viewed with caution, since further exploration with a larger sample is required. The participants also represented a homogeneous group in terms of gender and age, meaning that the data cannot be generalised to other populations.

Conclusion

This pilot study provided an insight into how young people in a specialist CAMHS setting viewed digital technology, including forms of care delivery that combine online and in-person interventions. The findings suggest that it may be best to introduce digital technologies once a therapeutic relationship has been established between a young person and a healthcare professional, and that it is important to avoiding making assumptions about the young person's digital literacy and awareness of digital health resources.

References

Aschbrenner KA, Naslund JA, Tomlinson EF et al (2019) Adolescents' use of digital technologies and preferences for mobile health coaching in public mental health settings. Frontiers in Public Health. 7, 178. doi: 10.3389/fpubh.2019.00178

Bennett S, Maton K (2010) Beyond the 'digital natives' debate: towards a more nuanced understanding of students' technology experiences. Journal of Computer Assisted Learning. 26, 5, 321-331. doi: 10.1111/j.1365-2729.2010.00360.x

Bentham C, Driver K, Stark D (2021) Wellbeing of CAMHS staff and changes in working practices during the COVID-19 pandemic. Journal of Child and Adolescent Psychiatric Nursing. 34, 3, 225-235. doi: 10.1111/jcap.12311

Benton T, Njoroge WF, Ng WY (2022) Sounding the alarm for children's mental health during the COVID-19 pandemic. JAMA Pediatrics. 176, 4, e216295. doi: 10.1001/jamapediatrics.2021.6295

Bergin AD, Vallejos EP, Davies EB et al (2020) Preventive digital mental health interventions for children and young people: a review of the design and reporting of research. NPJ Digital Medicine. 3, 133. doi: 10.1038/s41746-020-00339-7

Berry K, Salter A, Morris R et al (2018) Assessing therapeutic alliance in the context of mHealth interventions for mental health problems: development of the mobile Agnew relationship measure (mARM) questionnaire. Journal of Medical Internet Research. 20, 4, e90. doi: 10.2196/jmir.8252

Betton V, Woollard J (2018) Teen Mental Health in an Online World: Supporting Young People around their Use of Social Media, Apps, Gaming, Texting and the Rest. Jessica Kingsley Publishers, London.

Bor W, Dean AJ, Najman J et al (2014) Are child and adolescent mental health problems increasing in the 21st century? A systematic review. Australian and New Zealand Journal of Psychiatry. 48, 7, 606-616. doi: 10.1177/0004867414533834

Braun V, Clarke V (2022) Thematic Analysis: A Practical Guide. SAGE Publications, London.

Bucci S, Schwannauer M, Berry N (2019) The digital revolution and its impact on mental health care. Psychology and Psychotherapy. 92, 2, 277-297. doi: 10.1111/papt.12222

Care Quality Commission (2018) Are We Listening? Review of Children and Young People's Mental Health Services. www.cqc.org.uk/sites/default/files/20180308b_arewelistening_report.pdf (Last accessed: 5 September 2023.)

Crenna-Jennings W, Hutchinson J (2020) Access to Child and Adolescent Mental Health Services in 2019. epi.org.uk/wp-content/uploads/2020/01/Access-to-CAMHS-in-2019_EPI.pdf (Last accessed: 5 September 2023.)

Department of Health, NHS England (2015) Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing. www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf (Last accessed: 5 September 2023.)

Feijt M, de Kort Y, Bongers I et al (2020) Mental health care goes online: practitioners' experiences of providing mental health care during the COVID-19 pandemic. Cyberpsychology, Behavior and Social Networking. 23, 12, 860-864. doi: 10.1089/cyber.2020.0370

Grist R, Porter J, Stallard P (2017) Mental health mobile apps for preadolescents and adolescents: a systematic review. Journal of Medical Internet Research. 19, 5, e176. doi: 10.2196/jmir.7332

Grist R, Cliffe B, Denne M et al (2018) An online survey of young adolescent girls' use of the internet and smartphone apps for mental health support. BJPsych Open. 4, 4, 302-306. doi: 10.1192/bjo.2018.43

Gulliver A, Griffiths KM, Christensen H (2010) Perceived barriers and facilitators to mental health help seeking in young people: a systematic review. BMC Psychiatry. 10, 113. doi: 10.1186/1471-244X-10-113

Hollis C, Falconer C, Martin J et al (2017) Annual research review: digital health interventions for children and young people with mental health problems – a systematic and meta-review. Journal of Child Psychology and Psychiatry. 58, 4, 474-503. doi: 10.1111/jcpp.12663

Ignatowicz A, Slowther AM, Elder P et al (2018) Ethical implications of digital communication for the patient-clinician relationship: analysis of interviews with clinicians and young adults with long term conditions (the LYNC study). BMC Medical Ethics. 19, 1, 11. doi: 10.1186/s12910-018-0250-0

Kingsbury M, Coplan RJ (2016) RU mad @ me? Social anxiety and interpretation of ambiguous text messages. Computers in Human Behavior. 54, 368-379. doi: 10.1016/j.chb.2015.08.032

Liverpool S, Mota CP, Sales CM et al (2020) Engaging children and young people in digital mental health interventions: systematic review of modes of delivery, facilitators, and barriers. Journal of Medical Internet Research. 22, 6, e16317. doi: 10.2196/16317

Lunt N, Shaw I (2017) Good practice in the conduct and reporting of practitioner research: reflections from social work and social care. Practice. 29, 3, 201-218. doi: 10.1080/09503153.2016.1193849

Morris ME (2018) Left to Our Own Devices: Outsmarting Smart Technology to Reclaim Our Relationships, Health, and Focus. The MIT Press, Cambridge MA.

NHS Digital (2022a) Mental Health of Children and Young People in England 2022 - Wave 3 Follow Up to the 2017 Survey. digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey (Last accessed: 5 September 2023.)

NHS Digital (2022b) Digital Inclusion for Health and Social Care. digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/digital-inclusion (Last accessed: 5 September 2023.)

O'Reilly M, Dogra N (2017) Interviewing Children and Young People for Research. SAGE Publications, London.

O'Reilly M, Ronzoni P, Dogra N (2013) Research with Children: Theory & Practice. SAGE Publications, London.

O'Reilly M, Dogra N, Levine D et al (2021) Digital Media and Child and Adolescent Mental Health: A Practical Guide to Understanding the Evidence. SAGE Publications, London.

Ospina-Pinillos L, Davenport TA, Ricci CS et al (2018) Developing a mental health eclinic to improve access to and quality of mental health care for young people: using participatory design as research methodologies. Journal of Medical Internet Research. 20, 5, e188. doi: 10.2196/jmir.9716

Shaw I, Lunt N, Mitchell I (2014) Practitioner Research in Social Care: A Review and Recommendations. National Institute for Health Research, London.

Solmi M, Radua J, Olivola M et al (2022) Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. Molecular Psychiatry. 27, 1, 281-295. doi: 10.1038/s41380-021-01161-7

Sweeney GM, Donovan CL, March S et al (2019) Logging into therapy: adolescent perceptions of online therapies for mental health problems. Internet Interventions. 15, 93-99. doi: 10.1016/j.invent.2016.12.001

Trott M, Driscoll R, Irlado E et al (2022) Changes and correlates of screen time in adults and children during the COVID-19 pandemic: a systematic review and meta-analysis. eClinicalMedicine. 48, 101452. doi: 10.1016/j.eclinm.2022.101452

World Health Organization (2021) Mental Health of Adolescents. www.who.int/news-room/fact-sheets/detail/adolescent-mental-health (Last accessed: 5 September 2023.)

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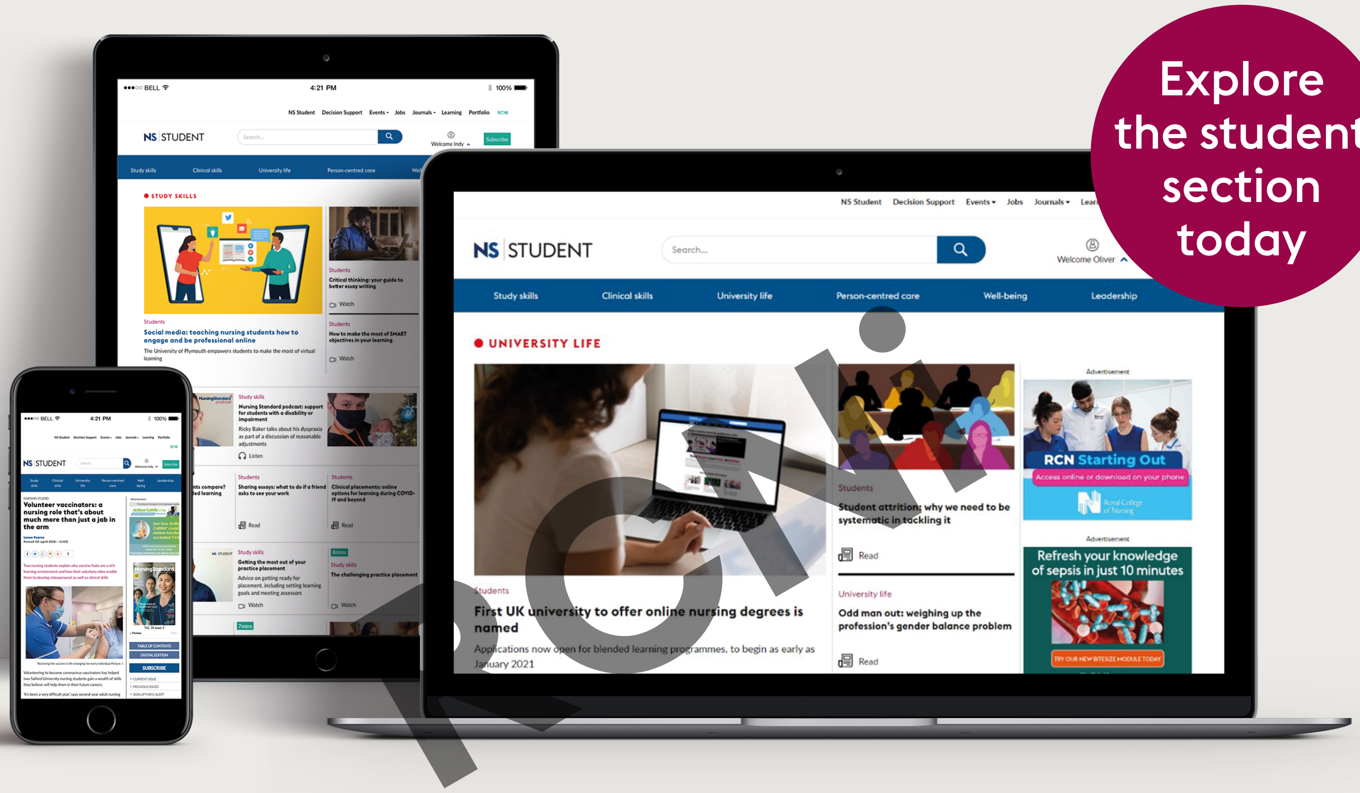

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