Title

Embedding recovery based approaches into mental health nurse training- a reflective account

Oladayo O. Bifarin

Dr Steven Jones Programme leader, Edge Hill University, Post Graduate Medical Institute.

Corresponding author E-mail: Oladayo.bifarin@go.edgehill.ac.uk

Abstract

Background; Mental health nursing has undoubtedly progressed as a profession but is at a hiatus that is not assisted by government policy and decreased resources. Aims; this reflective account account explores some of the considerable expectations placed upon qualified nurses and the real tensions that influence care delivery standards. Methods; Reflecting on experiences gained in clinical settings, underpinned by literature on recovery, examining some of the expectations placed of qualified nurses in contemporary mental health service delivery. Conclusion; Mental health nurse training should have recovery models and clinical staff input at the centre of education practice, promoting evidenced based practitioners. Education and clinical practice areas should continue to move towards each other and cease every initiative to ensure both are on the same page.

Introduction

Much debate continues to surrounds the suggested changes to the undergraduate nurse education curriculum (Ion and Lauder, 2015; Hemingway et al, 2016; McIntosh, 2017). In addition, limited resources invested in mental health services by the government as well the impact of negative professional socialization has been prominent in mental health service delivery discourse (Ion et al. 2015; Quaile, 2017). Integral to these commentaries, is the subtle but crucial advocacy for service users' personal recovery. In the United Kingdom (UK), personal recovery is strongly advocated for, within mental health service delivery policies such as No Health without Mental Health (Department Of Health, 2011) and Five Year Forward View for Mental Health (National Health Service, 2016a). However, we argue that a dichotomy exists between personal recovery frameworks and what university lecturers deliver that transfers into practice. Personal recovery will also be considered through the role of Care Programme Approach (CPA) with service user's recovery forming a central tenant. Personal reflection as a mental health student nurse will be used to contextualize the subject of recovery; as universities work on necessary modalities needed to facilitate the draft and components of *Standards of proficiency for registered nurses* (NMC, 2017). It seems reasonable therefore that clinical practice areas and University curricula should be more closely aligned, with an underpinning approach that both can learn from each other. It is important to first outline underpinning approaches/ models and influences in mental health care before reflecting on education and recovery practice.

Physical and mental health recovery

The recovery-orientated model of care delivery has existed for over two decades and was developed through self-report of people who had lived with mental health conditions (Deegan, 1988). Contemporary nursing has consequently adopted the term 'recovery-focused practice' (Ramon et al 2007), with government's mental health policies in the UK such as *No Health without Mental Health* (DOH, 2011) following (Davidson et al 2005). Therefore, these key documents emphasise the need to promote personal recovery in service users.

The essence of the recovery model is essentially to empower, and strengthen the self-esteem of service users' (McCranie, 2011; Slade et al, 2014) creating an alternative pathway by augmenting the prominent medical model in contemporary nursing. Despite this policy approach, people living with severe mental health conditions are likely to have a significantly shorter life span (Crump et al, 2013; Nwebe, 2017). For instance, obesity in mental health service users is not uncommon, attributed to prescribed antipsychotic medications, as people living with severe mental health conditions are highly predisposed to significant physical health challenges, when compared with the general population (Glasper, 2016). Importantly, other risk factors such as smoking identify that mental health services users prone to cardiovascular disease (Ratcliffe et al, 2011; Collins et al, 2013). As such, questions can be asked with regards to the place of recovery as mortality rates must be reduced for people living with severe mental health conditions to be able to contribute to the economy and an improved quality of life (NHS, 2016a).

Physical health problems are well documented that often accompany

the undesirable side effects of prescribed antipsychotic medications (Lambert et al 2004). Moreover, an apparent lack of physical health skills in mental health nurses has been identified as problematic and it remains unclear whether it is negative practitioner attitudes towards physical health or a curriculum-based issue (Blythe and White, 2012; Walker and McAndrew, 2015). Recovery is subjectively unique to individuals, its' components are sometimes vague and very difficult to quantify. The recovery model helps challenge such negative attitudes and assumptions that people living with severe mental health conditions can only get worse (Farkas, 2007). As such, it is imperative to note that as much as the recovery model embraces service user involvement in their care, dependent on the process of care planning, it must be embedded in the therapeutic relationship (Grundy et al 2016). Ambiguities do exist regarding the implementation of the recovery model considering dependence upon the treatment of mental health conditions on the bio-medical model (Kidd et al, 2014).

Recovery in mental health and Risk

The bio-medical model within the healthcare context provides instances whereby doctors diagnose and prescribe medication(s) solely based on physical symptom presentations (Hamilton and Price, 2013). Additionally, diagnosis appears to be motivated by the wish to treat and possibly cure, hence the bio-medical model is an arguably easier option in terms of implementation (Paris, 2017). Viewing individuals from a holistic vantage point is important with the stress-vulnerability model and engineering problem solving skills provided by nurses becomes fundamental (Barrett et al 2012; Yura and Walsh 1967; Zubin et al, 1977; Melin-Johansson et al, 2017).

However, these are not considered in any further detail in this work with the focus remaining on education and clinical practice exploration.

All nurses should be conversant with the elements of nursing process ASPIRE (Assessment, Systematic nursing diagnosis, Planning, Implementation, Recheck and Evaluation) (Barrett et al 2012) and within mental health service delivery the Care Program Approach (CPA) must be integral (Department of Health, 2008). The concept of recovery is well integrated within CPA and promotes systematic and holistic assessment of health and social needs to create an individualised care plan and process of review (Williams, 2013). However, the CPA framework has been criticised as being a managerial tool that has been undermined by many onerous administrative demands (Rinaldi and Watkeys, 2014; Williams, 2013).

It is the nurses' responsibility to help service users in the context of their recovery, through assessment and positive risk as opposed to the negative effects of endeavoring to avoid risk altogether (Joseph Rowntree Foundation, 2014). Reinforcing therapeutic risk taking involves consciously exploring what service users' capabilities and means are (Bifarin, 2017), as against their deficiencies and focusing extensively on the need to demonstrate compliance and conformity (Stickley and Felton, 2006; Ward, 2017). Positive risk taking is a fundamental step towards achieving personal recovery, perhaps due to the complexities associated with promoting therapeutic risk taking (Felton et al. 2017b). Some evidence exists that a preoccupation with risk management can be counterproductive (Szmukler and Rose, 2013). Questions should be continuously asked with regards to how genuine recovery of service users can be made viable in contemporary

nursing that involve positive risk taking environment for exploring holistic care. The above considers influences on nursing practice and frameworks that may guide and structure practice. The next section considers reflections those influences upon clinical practice staff.

Reflection: Nurse Education and Professional Socialization.

Levett-Jones and Lathlean (2009) suggest that student experiences and improving experiences is an integral part of effective pedagogy. A series of support mechanisms have been put in place to safeguard and improve the experiences of nursing students, especially while on placement via the Practice Education Lecturers (PELS) and the Practice Education Facilitators (PEFS). This has been of help with author's professional socialization, however, due to broad differences in the personal and professional experiences of mentors. These implicit and explicit value differences in delivering mental health care should be explored and questions raised pertaining to student nurses' belongingness and professional identity linked to the quality of care delivered and overall job satisfaction (Bifarin, 2016).

Additionally, as much as long-term experiences of mentors can be considered to be a great advantage, there is a possibility that this could also make mentors become cynical in their approaches by overgeneralizing the demands of care delivery (Hellzén et al, 2003). Perhaps, the dominance of the 'top-down' approaches adopted within health and social care reform, disregarding the complex adaptive characteristics of contemporary nursing, to a large extent (Sturmberg and Njoroge, 2016). Regardless of constraints, it is vital to accentuate that the personal recovery of service users is central to

mental health care delivery, which is directly proportional to effective therapeutic relationships between nurses and service users. The role of mental health nurses in terms of treating service users as 'co experts' in their own care and promoting clinical governance is paramount (Simpson et al, 2016). Felton et al (2017) suggest that the nursing process, which helps facilitate decision-making, could be focused on the deficits in service users, to a degree that could be detrimental for their recovery journey. It could further argued that this may result in non-therapeutic defensive practices such as obsessive documentation (Manuel and Crowe, 2014) to such an extent that the idea of positive risk taking becomes an obscure concept (Henderson and Jackson 2017), which is at odds to the concept of personal recovery.

Practitioners appear to be demoralized as there is evidence of moral distress (Bifarin and Stonehouse, 2016), disputably responsible for the increase in mental health staff attrition as the number of nurses leaving mental health trusts have increased from 10.5% to 13.6% (Health Education England, 2017). There are concerns that these changes will certainly erode the quality of care received by service users (Liang and Nolan, 2015).

Reflection and learning

On reflection as a student nurse, knowing that no single theory can be used to explain the aetiology and pathogenesis of mental health illnesses (Hickie et al. 2013) and preferable to adopt a model that wholly supports the concept of recovery, influenced by service users (Jacobson and Greenley, 2001; Leamy et al, 2011). However, nurse education frameworks could undermine the importance of psychosocial interventions in the context of psychiatry though the lack of knowledge or exposure amongst student nurses,

hindering them from addressing all clinical possibilities, as the framework appears to be generic centric, and there is a huge disparity between theory and practice (Gray ,2015). This disparity can be baffling and knowing that the principles of personal recovery perfectly align with the research approach of phenomenology (Cutler et al. 2017). Questions should be asked why researchers are not exploring this gap between theory and practice in more detail, in order to provide a panacea.

The experiences I have encountered have been very different to my expectations before I enrolled for the Pre-registration nursing course. However, I have learnt to embrace these challenges as I am about to transition to a Registered mental health nurse but importantly, there is an urgent need to enhance the training of future mental health nurses, with particular reference to psychosocial interventions. Knowing that the nurse education curriculum is about to be urevised, it is important that future mental health nursing education is not underestimated as it could be argued that hopes of some service users, who expect improvement in their mental health interventions with the 'Improving Access to Psychosocial Therapies Programme (IAPT)', have been dashed. More importantly, the end goal after qualification should be to enable mental health nurses to be able to adhere by the professional values underpinning their duty of care and yet be creative and confident enough to wholly embrace the concepts of personal recovery.

Prominently, there might be need for changes to be made pertaining to how competency is to be ascertained within the nurse education framework. The competency framework could be arguably likened to be a reductionist model, as human and institutional attributes can be over-rationalized and

complex practices can also be reduced to a set of skills and at the same time disregarding less noticeable qualities such as accrued experience, implicit knowledge and instinct (Antonacopoulou and FitzGerald, 1996). Importantly, Lingard (2009:627) based on social learning theories argued for a 'collectivist discourse of competence that move our focus beyond capturing, codifying and documenting knowledge of individuals, and towards the ways through which knowledge is shared, discussed and innovated in a collective setting'.

In this premise, it could then be argued that mental health student nurses in the UK will benefit from innovative mental health clinical placements such as recovery camps; designed to embed student nurses in the reality of people living with mental health conditions, in order to enable student nurses to participate in immersive and collaborative care provision, which hinges on building therapeutic relationships with service users, which can promote the person-centred care ideology (Perlman et al. 2017). Perhaps, this approach could help ingrain the concept of recovery by turning attention away from 'patients', 'service users' to persons (Peplau ,1995), which echoes a concept Barker (1989:138) described as 'trephotaxis', a Greek word, meaning 'provision of the necessary conditions for the promotion of growth and development'.

This may clarify what mental health nursing entails for people who seek to undermine the significant role this professional ought to play if adequately supported. Importantly, this idea of recovery based camp placements could align with the idea of being an 'expertise by experience' (Oates et al. 2017) by enabling student nurses to focus on salutogenic dimension to treatment as against the pathogenic viewpoint (Jormfeldt 2011). As such, help foster the

notion of belongingness; based on the different type of exposure these student nurses will gain which will be somewhat different from what current placements offer. Practitioners must strive to be at the leading edge of their practice, with their practice routed in a contemporary evidence base. It is also desirable that staff and service users inform and contribute to the evidence base equally (Jones et al, 2010).

This will significantly help place genuine recovery at the heart of contemporary mental health nursing (Henderson and Jackson, 2017). Nonetheless, this is a situation that could help in building competence, capabilities to identify and address variations in care delivery, which is a commitment identified within the National Nursing and Midwifery strategy (NHS, England, 2016b).

Anderson et al. (2013) asserted that mental health nursing is going through a very difficult phase. Following the Francis (2013) report, Csipke et al. (2016) proposed that service users' experiences are not improved and the triage system designed to take pressure off hospital beds, but have been detrimental to staff. Burnout in mental health nurses is becoming more the norm, perhaps due to reduced support mechanisms, policy compliance, staffing levels and training for the role. Rose et al (2013) suggested that emotional exhaustion in staff members can be attributed to lack of adequate knowledge and limited internal coping skills associated with managing difficult situations. It follows that emotional intelligences which encompasses the concepts of self awareness, self regulation, motivation, empathy, and social skills (Goleman, 1999:318), are an invaluable asset in mental health nursing and student nurses will benefit from resilience work, as equanimity will go a

long way in helping professions think critically about care provision, on the grounds of service users' personal journey to recovery. This in turn will potentially improve the experiences of service users. It is not unreasonable to suggest that there are hard financial and resource limitations ahead within health care, and mental health nurses are under increasing pressures, whilst at the same time having to raise the quality bar in patient centred planning(Jones et al, 2010). We suggest that mental health nurses should be involved and provide the evidence of efficacy of interventions. It has to better that we shape the profession based upon our experiences engaging service users in that process and contribute to the evidence base, the alternative is others do that for us.

Conclusion

Governmental policy may limit the impact of service user care and treatment and nurse curricula should take this into account to ensure the mental health nursing workforce have realistic roles and expectations. Austerity and policy may impact significantly on trained staff ability to meet care standards and service user minimum targets as mental health care becomes increasingly target driven. The future MH nursing workforce must take serious regard and keep service users at the centre of care and the decision making process. Pre and post registration training provisions must be informed and closely aligned to clinical practice.

This reflective account suggests that mental health nursing must be intertwined with the values of the nursing process, sometimes marginalized by virtue of the conscious and/or unconscious efforts of mental health nurses. Promoting personal recovery of service users is key to professional identity

and positive professional socialization of student nurses. Importantly, it is about time student nurses paid attention to changes that should be made in practice; not necessarily bad practice but perhaps critically thinking about available pathways associated with mental health condition treatments. This in turn, will help with regards to safeguarding the future of mental health nursing in the United Kingdom in all ramifications, which may restrict the creativity of mental health nurses. Questions should be asked why researchers are not exploring this gap between theory and practice in more detail, in order to provide a panacea.

Reference.

Anderson D, Connelly P, Meier R, McCracken C (2013) Mental health service discrimination against older people. *The Psychiatrist* 37: 98–103

Antonacopoulou E, FitzGerald L (1996) Reframing competency in management development. *Hum Resour Manage*. 6: 27-48.

Barker P. (1989) Reflections on the philosophy of caring in mental health. *International Journal of Nursing Studies*, *26*, 131–141.

Barrett D, Wilson B, Woollands A. (2012) *Care planning: A guide for nurses.* 2nd ed. Harlow, England: Pearson Education.

Bifarin O (2016). Professional socialisation: The art in mental health nursing practice. *British Journal of Mental Health Nursing*, 5(5).228-231.

Bifarin O (2017) Reinforced therapeutic alliance: The way forward in nursing practice. *British Journal of Mental Health Nursing*. 6(2) 95-100.

Bifarin O, Stonehouse D (2016) Moral distress: recognition and prevention for the support worker. *British Journal of Healthcare Assistants*, 10(11), 546-549.

Blythe J, and White J (2012) Role of the mental health nurse towards physical health care in serious mental illness: An integrative review of 10 years of UK literature. *Int J Ment Health Nurs* 21(3): 193–201.

Collins E, Drake M, Deacon, M (2013) *The Physical Care of People with Mental Health Problems: A Guide for Best Practice*. London: SAGE Publications.

Crump C, Winkleby M, Sundquist K, Sundquist J (2013) Comorbidities and mortality in persons with schizophrenia: A Swedish National Cohort Study. American Journal of Psychiatry, 170, 324–333.

Csipke E, Williams P, Rose D, et al (2016) Following the Francis report: investigating patient experience of mental health in-patient care. *The British Journal of Psychiatry*. 209(1).35-39.

Culter N, Moxham L, Stephens M (2017) Phenomenography: Alignment with personal recovery in mental health nursing. *British Journal of Mental Health Nursing.* 6(5). 234-238.

Davidson L, O'Connell M, Tondora J *et al* (2005) Recovery in serious mental illness: a new wine or just a new bottle? *Professional Psychology, Research and Practice* 36, 480–487.

Deegan P (1988) Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal* 11, 11– 19.

Department of Health, 2008. *Refocusing the Care Programme Approach.* DH, London.

Department of Health (2011) *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. TSO: London.

Farkas M, (2007) The vision of recovery today: what it is and what it means for services. *World Psychiatry* **6**, 68

Felton A, Repper J, Avis M. (2017) Therapeutic relationships, risk, and Mental Health Practice. *International Journal of Mental Health Nursing.*

Felton A, Wright N, Stacey G (2017b). Therapeutic risk-taking: a justifiable choice. *BJPsych Advances.* 23(2) 81-88.

Francis R, (2013) *Mid Staffordshire NHS Foundation Trust Public Inquiry*. The

Stationery Office, London.

Glasper A (2016) Caring for adults with severe mental illness and physical health problems. *British Journal of Nursing*. 25 (22).1266-1267.

Goleman D. (1999) *Working With Emotional Intelligence*. Bloomsbury, London

Gray R. (2015) Transforming nurse training to address multi-morbidity: the missed opportunity of the shape of caring review. *Journal of Psychiatric and Mental Health Nursing* 2, 653–654.

Grundy A, Bee P, Meade O et al (2016). Bringing meaning to user involvement in mental health care planning: a qualitative exploration of service user perspectives. *Journal of Psychiatric and Mental Health Nursing*, 23(1), 12-21.

Hamilton P, Price T (2013) The nursing process, holistic assessment and baseline observations. In: Brooker C, Waugh A (eds) *Nursing Practice: Fundamentals of Holistic Care*. Mosby Elsevier, London. 303–36.

Health Education England, (2017). Stepping forward to 2020/21: the mental health workforce plan for England Available from: https://www.rcpsych.ac.uk/pdf/FYFV%20Mental%20health%20workforce%20 plan%20for%20England%20FINAL.pdf (Access 30th January, 2018)

Hellzén O, Kristiansen L, Norbergh K (2003). Nurses' attitudes towards older residents with long-term schizophrenia. *Journal of Advanced Nursing*. 43(6), 616-622.

Hemingway S, Clifton, A, Edward, K (2016) The future of mental health nursing education in the United Kingdom. *Journal of Psychiatric and Mental Health Nursing.* 23, 331-337.

Henderson P, Jackson, W. (2017) Recovery in mental health: examine the reality for professionals and service users. *Mental Health Nursing.* 9-13.

Jacobson N, and Greenley D (2001) What is recovery? A conceptual model and explication. *Psychiatric services* 52, 482–485.

Hickie I, Scott J, Hermens D, et al. (2013) Clinical classification in mental health at the cross-roads: which direction next?. *BMC Medicine*, 11(1).

Ion R, Lauder W, (2015) Willis and the generic turn in nursing. *Nurse Education Today*, 35(7).841-842.

Ion R, Smith K, Nimmo S, et al (2015). Factors influencing student nurse decisions to report poor practice witnessed while on placement. *Nurse Education Today*, 35(7), 900-905.

Jones, S. Orrell, N and Hughes, L. (2010) Embedding the Care Programme Approach into practice. *Mental Health Nursing.* Vol. 30 (5) 8-10.

Jormfeldt H. (2011). Supporting positive dimensions of health challenges in mental health care. *International Journal of* Qualitative *Studies on Health and Well-Being.* 6(2).

Joseph Rowntree Foundation (2014). How can 'positive risk taking help build dementia- friendly communities. Available: https://www.jrf.org.uk/report/how-can-positive-risk-taking-help-build-dementia-friendly-communities (Accessed 30th, January, 2018)

Kidd S, McKenzie K, Virdee G (2014) Mental health reform at a systems level: widening the lens on recovery- oriented care. *Canadian Journal of Psychiatry.* **59**, 243.

Koontz A, Mallory J, Burns J, Chapman S (2010) *Staff nurses and students: the good, the bad and the ugly. Medsurg Nurs* **19**(4): 240–6.

Lambert T, Chapman L, Bell S, et al (2004) Diabetes, psychotic disorders and antipsychotic therapy: a consensus statement. *Medical Journal of Australia* **181**, 544–548.

Leamy M, Bird V, Le Boutillier C, Williams, J. and Slade, M. (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), pp.445-452.

Levett-Jones T, Lathlean J (2009) 'Don't rock the boat': nursing students' experiences of conformity and compliance. *Nurse Education Today*. 29(3): 342–349.

Liang K and Nolan P (2015). Nurses' perceptions of mental health nursing. *British Journal of Mental Health Nursing.* 4 (3) 116-121.

Lingard L (2009) What we see and don't see when we look at 'competence': notes on god term. *Adv. Health Sci. Education Theory Pract.* 14:625-8.

Manuel J, Crowe M (2014) Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing.* 23. 336-343.

McCranie, A (2011) Recovery in Mental illness: The Roots, Meanings, and Implementations of a New Services Movement. In: D PILGRIM, A ROGERS, and B PESCOSOLIDO. *The Sage Handbook of Mental Health and Illness.* London, California: Sage Publications Ltd. 471-489.

McIntosh B, (2017) The future of mental health nursing. *British Journal of Mental Health Nursing*, 6(1).8-10.

Melin-Johansson C, Palmqvist R, Ronnberg L (2017) Clinical intuition in the nursing process and decision-making—a mixed studies review. *J Clin Nurs* 1–14.

NHS England, 2016a. *The Five-Year Forward View for Mental Health.* Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV- nal.pdf   (Accessed 30 January 2018)

NHS England (2016b) *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff.* http:// tinyurl.com/h45wu74 (Accessed 30 January 2017)

NMC (2017) *Standards of Proficiency for Registered Nurses.* Available at:

https://www.nmc.org.uk/globalassets/sitedocuments/edcons/ec7-draft-standards-of-proficiency-for-registered-nurses.pdf (Accessed 02 February, 2018)

Nwebe H (2017) Physical health monitoring in mental health settings: a study exploring mental health nurses' views of their role. *Journal of Clinical Nursing.* 26 (20), 3067-3078.

Oates J, Drey N, Jones J (2017). 'Your experiences were your tools'. How personal experience of mental health problems informs mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing*, 24(7),471-479.

Peplau H, (1995) Another look at schizophrenia from a nursing standpoint. In: C. A. Anderson (Ed.). *Psychiatric Nursing 1946–94: The State of the Art.* (pp. 3–8). St Louis, MO: Mi: Mosby Year Book.

Paris, J. (2017) Differential diagnosis of bipolar disorder and borderline personality disorder. *Bipolar Disorders.* 19, 605.

Perlman D, Moxham L, Brighton R, Sumskis S (2017) Innovative Mental Health Clinical Placement: Developing Nurses' Relationship Skills. *Journal of Psychosocial Nursing and Mental Health services.* 55 (2) 36-43.

Quaile, A. (2017) Government's additional £1.3 billion for mental health services is misleading. *British Journal of Mental Health Nursing*, 6(5).202-203.

Ramon S, Healy B, Renouf N, (2007) Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal*

of Social Psychiatry. 53(2): 108-22.

Ratcliffe T, Dabin, S, Barker P (2011) Physical healthcare for people with serious mental illness. *Clinical Governance*, 16(1), pp. 20-28.

Rinaldi M, and Watkeys F (2014) Do our current approaches to care planning and the CPA enhance the experience and outcomes of a person's recover? *The Journal of mental health training, education and practice*. 9 (1), pp. 26-34.

Rose J, Mills S, Silva D et al (2013). Client characteristics, organizational variables and burnout in care staff: The mediating role of fear of assault. *Research in Developmental Disabilities*, 34(3), pp.940-947.

Simpson A, Hannigan B, Coffey M et al (2016) Recovery-focused care planning and coordination in England and Wales: A cross-national mixed methods comparative case study. *BMC Psychiatry*, *16*(1), 1–18.

Slade M, Amering M, Farkas M et al (2014) Uses and abuses of recovery: implementing recovery- oriented practices in mental health systems. *World Psychiatry*. 13 (1). 12-20.

Stickley T, Felton A (2006). Promoting recovery through therapeutic risk taking. *Mental Health Practice*, 9(8).26-30.

Sturmberg J, Njoroge A, (2016). People-centred health systems, a bottom-up approach: where theory meets empery. *Journal of Evaluation in Clinical Practice*, 23(2).467-473.

Szmukler G, Rose N 2013. Risk assessment in mental health care: Values and costs. *Behavioural Sciences and the Law*, *31* (1), 125–140.

Walker S, McAndrew S (2015) The same but different: discussing the literature regarding mental health nurses' difficulty in meeting the physical health needs of service users, regardless of differing education programmes. *J Psychiatr Ment Health Nurs* 22(8): 640–6.

Ward T (2017) Considering the culture of blame in mental health care and service delivery. *International Journal of Mental Health Nursing*. 26, 3-4.

Williams B (2013) Tick-box exercise. *Mental Health Pratice*. 16, 9.

Yura H, Walsh M (1967) *The Nursing Process*. Appleton Century Crofts, Norwalk CT.

Zubin J, and Spring B, *1977.* Vulnerability; a new view of Schizophrenia. *Journal of Abnormal Psychology; 86; 103-126.*