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What is the content and process of a comprehensive mental health nursing assessment?

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What is the content and process of a comprehensive mental health nursing assessment?

A thesis submitted in fulfilment of the requirements for the award of the degree

Doctor of Philosophy

From

University of Wollongong

By

Tim Coombs

Nursing, Midwifery and Indigenous Health

Dedication

This thesis is dedicated to Carol for your love, belief and bringing me back to God.

Declaration

I, Tim Coombs, declare that this thesis submitted in fulfilment of the requirements for the award of the Doctor of Philosophy, in the school of Nursing, Midwifery and Indigenous Health, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged in this thesis.

This document has not been submitted for qualifications at any other academic institution.

Publications

This thesis includes chapters that have been written as the following journal articles.

Chapter 2: Coombs, T., Curtis, J., & Crookes, P. (2011) What is a comprehensive mental health nursing assessment? A review of the literature. *International Journal of Mental Health Nursing*, 20, 364-370.

Chapter 4: Coombs, T., Crookes, P., & Curtis, J. (2013) A comprehensive mental health nursing assessment: variability of content in practice. *Journal of Psychiatric and Mental Health Nursing*. 20(2), 150-155.

Chapter 5: Coombs, T., Curtis, J., & Crookes, P. (2012) What is the process of a comprehensive mental health nursing assessment? Results from a qualitative study. *International Nursing Review*. 60(1), 96-102.

Chapter 6: Coombs, T. Crookes, P., & Curtis, J. (2014) No model of a comprehensive mental health nursing assessment? Under review. Collegian

Chapter 7: Coombs, T. Crookes, P., & Curtis, J. (2013) The content and process of a comprehensive mental health nursing assessment: Is it recovery orientated practice? *International Journal of Mental Health Nursing*. Accepted for publication.

Chapter 8: Coombs, T. Crookes, P., & Curtis, J. (2014) Using standard measures to support consistency and a recovery orientation to mental health nursing assessment. Under review. Issues in Mental Health Nursing

As the primary supervisor, I, Associate Professor Janette Curtis, declare that the greater part of the work in each article listed above is attributed to the candidate, Tim Coombs. In each of the above manuscripts, Tim contributed to the study design, recruited participants, and was responsible for data collection and data analysis. The first draft of each manuscript was written by the candidate, and Tim was responsible for responding to the editing suggestions of his co-authors. The co-authors were responsible for assisting with data interpretation and editing the manuscripts. Tim was solely responsible for submitting each manuscript for publication to the relevant journals and was primarily responsible for responding to the reviewers' comments with the assistance of co-authors.

Tim Coombs

Associate Professor Janette Curtis

Candidate

Primary Supervisor

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I would like to thank the nurses who agreed to be interviewed as part of this study and the colleagues who listened to me talking about this work, especially when they really were sick of listening, thanks Rosemary and of course, Angela Nicholas for your valuable input.

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Glossary of Terms

This glossary provides guidance to the reader where different terms have been used to refer to the same type of activity, event or phenomena or to clarify terms used in this thesis.

Assessment: The gathering of information regarding a consumer's physical, psychological, social and/or spiritual status.

Ambulatory Services: Services delivered to a consumer who does not require admission for overnight inpatient care.

Casemix: refers to the type or mix of cases provided treatment by a mental health service unit.

Community Services: Services delivered to a consumer who does not require admission for overnight inpatient care.

Consumer: A person who uses or has used a mental health service. A term used regularly in Australia.

National Outcomes and Casemix Collection: A Nationally agreed collection of standard measures of outcomes and casemix in Australian public sector mental health services.

Outcome measure: A quantitative measure of the *change* in physical, psychological, social or spiritual status of the consumer.

Service user: A person who uses or has used a mental health service. A term used regularly in the United Kingdom.

Standard Measure: A quantitative measure of the physical, psychological, social or spiritual status of the consumer.

Abstract

The current study seeks to answer the question, 'What is the content and process of a comprehensive mental health nursing assessment?' Mental health nurses are required to undertake comprehensive mental health nursing assessments as part of their routine clinical practice. The current study was prompted by the author's experience of implementing standard clinical documentation and measures of health status to the clinical practice of mental health nurses and the reaction of nurse's to this implementation.

In a series of six articles the question is answered, the implications of the findings explored and a potential solution for the issues identified offered.

The first article is a literature review which failed to identify one study addressing the content and process of a comprehensive mental health nursing assessment. Therefore, in order to find out more about this topic, a qualitative study was undertaken. A qualitative approach is the best method for learning about a subject area where little is known. Eighteen interviews were undertaken with mental health nurses asking them to describe the content and process of a comprehensive mental health nursing assessment. These interviews were thematically analysed using a constant comparative method informed by grounded theory.

The results of this qualitative study are reported in articles two, three and four. Article two describes how the content of what constituted a comprehensive assessment varied from nurse to nurse. Article three describes the process of a comprehensive assessment which involves engaging with the consumer to enable problem identification, while article four identifies that no nurse in this study used a formal model to guide their mental health nursing assessment practice and explores the implications of this finding for mental health nursing.

The findings from this qualitative study are then explored in two additional articles. Article five explores the implications of problem identification in relation to the delivery of recovery orientated mental health nursing practice, while article six describes how standard measures of mental health status can be used to support consistency in assessment and recovery orientated nursing practice. This collection of six articles highlights the need for further research into mental health nursing assessment.

Chapter 1 Background

Introduction

This thesis documents a personal journey, a journey of reflection on individual practice as well as observing, and being involved in influencing, the practice of other nurses. As a result, I will often be found using first person pronouns (me, I etc.). This is deliberate for two reasons. Firstly, it is a convention found in most qualitative research (Nicholls 2009a), but more importantly, it places me as the researcher at the centre of the research and acknowledges the underlying philosophical assumptions that underpin this work.

It is important to make clear that this thesis is focused on practice as it is now occurring. I am not talking about the practice that is espoused by academics or educators who I have heard say with authority that the practice of nurses involves this or that particular approach. I am sure that academics, educators and managers can point to particular papers or policies that describe the content and process of a comprehensive mental health nursing assessment. The focus of this work is on the way that nurses themselves describe what it is that they do: what they say they do and what they think their practice entails.

This work began as a result of my role in the implementation of a standard suite of clinical documentation and standard measures of outcomes and casemix to the mental health workforce of New South Wales. The Mental Health Outcomes and Assessment Tools (MH-OAT) initiative was designed to enable the documentation of a comprehensive mental health assessment and the use of a standard suite of outcomes and casemix measures (Chipps et al. 2002). This standard suite of documentation grew out of a project that was looking specifically at the activities of acute psychiatric units (Sly et al. 2009, Carr et al. 2008b). The standard measures were a nationally agreed set that made up the National Outcomes and Casemix Collection (NOCC) (Department of Health and Ageing 2002a). The introduction of the MH-OAT suite began in 2001.

The MH-OAT standard suite of clinical documentation included modules that enabled the documentation of triage, assessment, care planning, review and discharge activities. The assessment module included current functioning, mental status examination, social and developmental history, and physical assessment. All disciplines would use these modules when working in public sector mental health services in New South Wales.

The suite also included standard measures of outcomes and casemix that were introduced to understand the complexity of the consumer's presentation and to monitor any change in that

presentation during contact with mental health services. The standard measures include both clinician-rated, and consumer-rated measures. The primary measure of problem severity in the suite is the clinician-rated Health of the Nation Outcome Scales (Wing et al. 1998), a broad measure of problem severity. It comprises 12 items covering overactive, aggressive, disruptive or agitated behavior; non-accidental self-injury; problem drinking or drug taking; cognitive problems; physical illness or disability problems; problems associated with hallucinations and delusions; problems with depressed mood; other mental and behavioural problems; problems with relationships; problems with activities of daily living; problems with living conditions; and problems with occupation and activities. Each item is rated on a five-point scale (0 = *no problem*; 1 = *minor problem*; 2 = *mild problem*; 3 = *moderately severe problem*; 4 = *very severe problem*) (Wing et al. 1998). While across Australia a number of consumer-rated measures have been introduced, in New South Wales the Kessler-10 or K-10 (Kessler et al. 2003) has been introduced. The K-10 was originally developed as a brief screening tool designed to identify psychological distress. It consists of 10 items, and for each item the consumer indicates the amount of time during the previous four-week period that he or she has experienced the particular problem. There is a five-level response scale that ranges from *none of the time* (1) to *all of the time* (5) (Andrews and Slade 2001).

As part of the rollout of this documentation and standard measures across services, I was involved in training and supporting their implementation. During this process of implementation, I was faced with nurses raising concerns that the content of the documentation and the standard measures did not fit their practice and that important aspects of the consumer's presentation were not being captured or that some information was superfluous to the assessment process. Still others argued that the documentation and the use of standard measures got in the way of their established assessment processes, that it stopped them engaging with the consumer.

There was a significant amount of resistance to MH-OAT, to the extent that there was industrial action taken by nurses, and the standard documentation was subsequently modified (Graham 2003). This is not to say that the beliefs of mental health nurses were all negative. Cleary, Walter, and Hunt (2005) found that the majority of nurses disagreed that this standard documentation would deskill nurses and remove nursing's identity. So, there was some support for the introduction of this documentation. The introduction of the standard measures did have some support from consumers and carers (Black et al. 2009). Some nurses found value in the standard measures, particularly the self-report measures (Callaly et al. 2006), but there were concerns raised about clinical usefulness of the measures (Lakeman 2004), and staff did have negative attitudes (Willis et al. 2009).

However, a review of the literature found that there was little written in the scholarly literature to identify the content and process of a comprehensive mental health nursing assessment (Coombs et al. 2011a). This gap in the literature makes it hard to reconcile the different views of the place of standard clinical documentation and standard measures of health status in undertaking a comprehensive mental health nursing assessment.

Statement of the problem

There were generally negative reactions from nurses to the introduction of a suite of standard clinical documentation and standard measures of outcomes and casemix. These documents aimed to enable the documentation of a comprehensive mental health assessment and the standard measures aimed to collect information on problems commonly experienced by consumers of mental health services. This negative reaction made me reflect on why this documentation and standard measures would “get in the way” of nurses’ assessment practice, exactly what was the content and process of a comprehensive mental health nursing assessment?

Study design

It is here that I would like to point out that the majority of my previous research has adopted a quantitative approach to generating knowledge. My Master of Nursing thesis used a quantitative approach to “Understanding facilitative and coercive practices by mental health nurses on crisis extended hours teams” (Coombs 1994). My Honours thesis in psychology used standard measures of insight, symptomatology and the Wisconsin Card Sorting Test to understand the relationship between insight and executive functioning in individuals with schizophrenia (Coombs 1999). Any of my work that has been published in the scholarly literature had adopted a quantitative approach either to understanding nurses’ approaches to medication adherence (Coombs et al. 2003), the results of training staff in standard measures (Coombs et al. 2002) or understanding variation in mental health services (Coombs et al. 2011c). So, with this work, I was ready to adopt a similar approach. However, my supervisors encouraged me to consider a qualitative approach to explore my area of interest and after some reading, further study and careful consideration I concluded that a qualitative approach would be the best approach to enable me to answer my research question.

The study started with a literature review because my basic assumption was that the assessment practice of nurses had probably been studied extensively and that the answer to my question would already be documented in the literature. However, the literature review revealed little. This reinforced the need to adopt a qualitative approach informed by grounded theory to

collecting and analysing data. Ethics approval for the study was obtained and more detail is provided in Chapter 3. Eighteen nurses were interviewed for between 20 and 70 minutes and I asked each of them to describe the content and process of a comprehensive mental health nursing assessment. These interviews were transcribed, and the transcribed interviews were used as data to identify in nurses' own words the content and process of a comprehensive mental health nursing assessment.

Results

The results of this thesis are presented as a series of six articles. The first article is a review of the literature on mental health nursing assessment. Articles two, three and four are the results of the qualitative descriptive study informed by grounded theory. Article two focuses on how a group of nurses described the content of a comprehensive mental health nursing assessment, and how the nurses in their own words described what information they are looking for when undertaking a comprehensive mental health assessment. Article three examines how the nurses described the process of that assessment, while article four describes the use of formal models by these nurses to inform their assessment practice. Article five explores the implications of the findings of the current study and their impact on nurses' ability to deliver recovery orientated mental health care. The final article (Article six) describes how standard measures might be used to support consistency in mental health nursing assessment practice as well as the delivery of nursing care in a recovery orientated manner. In this thesis each of these articles is preceded by an introduction and is followed by a commentary that provides additional information or augmentation of the article's arguments or implications.

Structure of thesis

For the purpose of formatting this thesis the numbering of tables and figures within articles is as they appeared in the published articles or articles under review. The numbering of tables and figures in the list of tables and figures in the table of contents of this thesis is the order in which they appear in the methodology and where to from here chapters, along with the commentary sections of this thesis. Figure 1 provides a brief overview of the 6 articles and shows that this thesis reports on the results of a qualitative study, explores the implications for mental health nursing practice and identifies an approach to supporting contemporary practice through the use of standard measures.

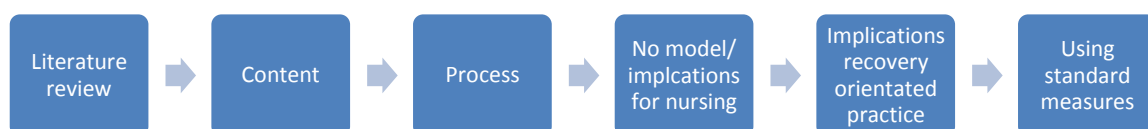


Figure 1. Overview of thesis articles

This thesis concludes with a potential future research programme aimed at confirming and perhaps expanding upon the results of the current study, as well as opportunities for research into improving the quality of comprehensive mental health nursing assessments.

Significance of the thesis

Assessment is essential for mental health nursing practice. It is the foundation upon which the needs of the consumer are identified and plans for mental health nursing interventions are based. The current study aims to give a better understanding of the content and process of a comprehensive mental health nursing assessment.

A better understanding of the practice of a comprehensive mental health nursing assessment may give reassurance to mental health nurses and others that mental health nursing practice is robust and that the foundation of practice adequately identifies the needs of consumers in a consistent manner. It may provide reassurance that these comprehensive and consistent mental health nursing assessments are the foundation upon which nursing interventions are offered and the outcomes of mental health nursing care are assessed.

Alternatively, it may raise concerns for mental health nurses about the adequacy and consistency of mental health nursing assessment practice. If comprehensive mental health nursing assessments are not taking place, then there are significant implications for mental health nursing. It raises questions about the adequacy of mental health nursing education, the ability of mental health nurse managers to ensure a standard of practice, as well as the role of clinical supervision in establishing and maintaining clinical practice. It has implications for research into mental health nursing including how comprehensive mental health nursing assessments are being undertaken and how, if necessary, these assessments can be improved.

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Wing, JK, Beevor, AS, Curtis, RH, Park, SB, Hadden, S & Burns, A 1998, 'Health of the Nation Outcome Scales (HoNOS). Research and development', *British Journal of Psychiatry*, vol. 172, no. 11-8.

Chapter 2 What is a comprehensive mental health nursing assessment? A review of the literature.

In this chapter I describe a review of the literature on the content and process of a comprehensive mental health nursing assessment. There is considerable debate in the literature around undertaking a review of the literature before undertaking a grounded theory, qualitative study because of concerns that the reviewed literature may bias the researcher during the data analysis process. I felt it was important to be aware of what was already known about the subject area. I am a mental health nurse and I have and do undertake what I think are comprehensive mental health nursing assessments. So, I already have an experience of the area under study. I assumed that there would be a rich literature on such an important aspect of practice and this literature would enable me to refine my research question. I describe the review of the literature in the article titled, What is a comprehensive mental health nursing assessment? A review of the literature. *International Journal of Mental Health Nursing*, 20, 364-370 (Coombs, T., Curtis, J. & Crookes, P. 2011).

What is a comprehensive mental health nursing assessment? A review of the literature.

Abstract

Assessment is the foundation on which nursing care is delivered. The aim of this paper is to better understand the content (what information nurses seek about consumers) and the process (how they go about gathering that information) of a comprehensive mental health nursing assessment in practice. Using terms like “nursing”, “mental health” and “assessment” the CINAHL, Medline and PsycINFO databases were searched for studies that describe the content and process of a comprehensive mental health nursing assessment. Although studies of aspects of mental health nursing assessment such as the assessment of risk or carer burden were found, no single study described *both* the content and process of a comprehensive mental health nursing assessment in practice. In Australia a comprehensive assessment is codified as a competency to practice nursing; however the standards of practice set for mental health nurses are less clear on what constitutes a comprehensive assessment or how this should be undertaken. The peer-reviewed literature describes assessment as both an independent and interdependent activity. It is described as informal and there is evidence that comprehensive mental health nursing assessments are not well documented. The credibility of training and research into mental health nursing requires that the content and the process of a comprehensive mental health nursing assessment needs to be clearly defined.

Introduction

Assessment is central to mental health nursing and is the foundation on which nursing care is delivered. It is a decision-making process based on the collection of information that gives an overall estimation of the consumer and their circumstances (Barker 2004). Mental health nurses are required to undertake assessments in a wide variety of contexts including inpatient units (Bobier et al. 2009) and community settings (Ryan et al. 2006), and with specific groups in defined roles (Collinson and Benbow 1998).

In a survey of the skills required to work in mental health in the UK, Bugge et al. (1999) found that community mental health nurses identified assessment as one of the top five core skills. In Australia, Cleary et al. (2005) mailed a questionnaire to 250 mental health nurses working in

inpatient units in an area health service seeking their views on nursing care delivery. Responses were received from 118 (47%) of the mental health nurses. Of these mental health nurses 93% indicated that assessment was moderately to very important as a nursing activity, and 92% indicated that they were moderately to very confident in undertaking an assessment.

The competency standards (competencies) for a registered nurse produced by the Australian Nursing and Midwifery Council (2006) highlight the importance of assessment. Competencies reflect the knowledge, skills and attitudes required for a registered nurse to deliver safe and competent care. Standard 5 requires that a registered nurse should be able to conduct a “comprehensive and systematic nursing assessment” (Australian Nursing and Midwifery Council 2006, p.5).

There are no established competencies for specialist mental health nurses. Practice standards were produced by the former Australian and New Zealand College of Mental Health Nurses (1995). These published standards provided clear guidance as to what was required to reach a minimum standard of mental health nursing practice. Standard 3 stated that the mental health nurse provide “systematic nursing care that reflects contemporary nursing practice and the client’s health-care/treatment plan” (Australian and New Zealand College of Mental Health Nurses 1995, p.11). The skills required to achieve this standard included the ability to undertake a physical and social assessment, a mental status examination and the ability to identify recurrent patterns of behaviour and contextual factors that impact on the consumer.

These standards were recently updated (Australian College of Mental Health Nurses Inc 2010). The word “assessment” appears only twice in this document, both times in relation to the need to consider culture during the “assessment” process. To determine what a comprehensive mental health nursing assessment entails in terms of content and process, the reader is required to seek guidance from a number of different standards. Standard 3 requires that the mental health nurse develops a therapeutic relationship, establishing trust and developing a rapport. This would appear to be a process standard. Standard 4 requires that care plans are developed collaboratively and identify the mental, physical, spiritual, emotional, social and cultural needs of the consumer. This needs assessment would appear to be a content standard. In combination, these standards give some indication of the process and content of a comprehensive mental health nursing assessment. Exactly what is assessed in these domains is not made clear.

In Australia, the basic nursing competencies indicate that nursing assessment should be systematic and comprehensive. The standards of mental health nursing practice however are less

explicit and guidance as to the how and what constitutes a comprehensive mental health nursing assessment is less clear.

In New South Wales, Australia, the Mental Health Outcomes Assessment Tools (MH-OAT) initiative developed out of a large multisite study of acute inpatient units (Carr et al. 2008a). A suite of modules was developed to enable the documentation of a comprehensive mental health assessment. These modules included an assessment module that included the documentation of an assessment of the consumer's physical, social and psychological status. These modules were subsequently introduced into routine clinical practice as a quality improvement activity (Chipps et al. 2002) and modified as a result of feedback (Graham 2003). Nurses expressed concern that the modules took time away from patient care (Cleary et al. 2005) and were little more than a bureaucratic activity (Patterson et al. 2006).

The first author in this article was responsible for the coordination and delivery of initial training in the modules and supporting their introduction into clinical practice through site visits to all mental health units in New South Wales from 2000 to 2004 (Coombs 2001). During conversations with mental health nurses, the author found that they were often concerned that much of the material to be documented was not relevant to their practice, did not reflect their assessment practice and seeking this information in fact "got in the way" of the assessment process.

These comments did not reflect the quality of mental health nursing assessments but given that the assessment module enabled the documentation of a comprehensive mental health assessment, the question is raised: why did the nurses respond this way? What are the content and process of a comprehensive mental health nursing assessment? Clearly, before nurses can be trained in a comprehensive mental health nursing assessment and meet a required level of competence, mental health nurses must be able to describe the practice expected of them. This article details how a comprehensive mental health nursing assessment is described in the peer-reviewed literature. The implications for education and research activities are will be discussed.

Much has been written in textbooks about what information should be collected as part of a comprehensive mental health nursing assessment and how this information should be collected (Stuart and Sundeen 1987, Beck et al. 1988, Barker 2004, Barker 2009). Similarly, the grey literature also contains descriptions of a comprehensive mental health nursing assessment - from sources such as Wikipedia to the training materials from professional nursing bodies (The College of Nursing 2005). However, these sources of information provide an *opinion* of how a comprehensive mental health nursing assessment should be undertaken. By contrast, this paper focuses on a search of the

peer-reviewed literature and how the content (what information mental health nurses collect) and process (how they go about collecting the information) of a comprehensive mental health nursing assessment have been described in practice.

Method

The selection of articles for this review was a three-step process. First, three computer databases, CINAHL (from 1982 to June 2010), MEDLINE (published 1966 to June 2010) and PsycINFO (1985 to June 2010), were searched for potentially relevant articles. The same keyword search terms were used across all databases and included “mental health”, “psychiatry”, “assessment”, “interview”, “content”, “process”, “scope”, “nurse” and “nursing”. Relevant articles (judged on the basis of the title and abstract) were retrieved for a more detailed evaluation. These search terms did not yield any articles that detailed the content and process of a comprehensive mental health nursing assessment. The second stage therefore involved the use of additional search terms, including “psychiatric”, “skills”, “diagnosis”, “decision-making” and “education”. Articles were then selected for more detailed evaluation based on their potential to describe the content and process of a comprehensive mental health nursing assessment. Third, the references of retrieved articles were manually searched for additional references. The 21 papers included in this review focus on the study of mental health nurses’ assessment activities and provide insight into the content and process of a comprehensive mental health nursing assessment in practice as it is described in the peer-reviewed literature.

Results

Opening Pandora’s box: The discourse on mental health nursing assessment revealed

Not a single article that described the information that mental health nurses collect as part of a comprehensive mental health nursing assessment or how they go about collecting that information could be located. That is not to say that there were no articles on mental health nursing that included reference to assessment. In fact, there was quite a rich discourse on mental health nursing and assessment; however, these articles focused on aspects of assessment, for example, descriptions of the need for the assessment of specific behaviours such as aggression (Mackay et al. 2005) or suicide (Duffy 1995, Temkin and Crotty 2004), the assessment of the potential for risk of violence (Murphy 2004) or risk in general (Hawley et al. 2006). Descriptions of practice were found that focused on activities like special observation in mental health intensive care units (Neilson and Brennan 2001) or the assessment of specific populations such as caregivers of clients with dementia (Carradice et al. 2002). Others meanwhile described assessment practices in different service

delivery contexts like triage (Sands 2007), or consultation liaison in general hospitals (Sharrock and Happell 2002). The peer-reviewed literature provides guidance on specific aspects of assessment but the nature of a comprehensive mental health nursing assessment in practice is not clear. The paper now focuses on those studies found during the search of the literature that provide some insight into the content and process of a comprehensive mental health nursing assessment.

What information do nurses seek in a comprehensive mental health nursing assessment?

Barratt (1989), in a qualitative study of the self-perceived role of community psychiatric nurses in the UK, undertook in-depth interviews with 16 community psychiatric nurses. These nurses identified assessment as the most common role of mental health nurses; however, the author identified that assessment meant different things to different nurses. In the study, four different kinds of assessments were identified. The first type aimed at identifying what problems the consumer was having and how these problems may be solved. The second type aimed at identifying how the consumer was coping at home. The third type aimed at supporting the development of a rapport with the consumer. The fourth type aimed at collecting information that would enable the nurse to provide advice to doctors on appropriate treatment. Street and Walsh (1998) studied the role of a duly authorised officer, a role primarily undertaken by nurses, who are tasked with responding to people with mental illness in crisis in the community. Using individual interviews and focus groups involving over 50 nurses in total, they identified that nurses, as part of the assessment process, gleaned information on a wide variety of aspects of the consumer, including medication, side effects, mental status, the consumer's environment, if the consumer had children, how they cared for these children and cultural information.

In Australia, Hamilton et al. (2004) used in-depth interviews to better understand what informs and organises the assessment practice of nurses, social workers and psychiatrists in acute inpatient settings. A nurse, a social worker and a psychiatrist were purposively sampled to participate in in-depth interviews, focusing on their ability to describe their practice and recent (within days) assessment practice. These interviews revealed that the timing of the assessment was not within the control of any discipline, and for the nurse, was influenced by such factors as the time available and ward policy. Participants felt that the perspectives of each of the disciplines were different. The distinctive aspects of the nurse's assessment were its sense of immediacy, the assessment of the immediate behaviour and interaction of the consumer on the ward. However, the authors concluded that the assessments undertaken by the nurse and social worker were heavily influenced by the medical model with a focus on the 'cure' of the clients' expressed feelings or needs and potentially discounted their experiences.

Mental health nursing assessment an independent or interdependent activity?

In a study aimed at understanding the role and function of mental health nurses, Cowman et al. (2001) used non-participant observation of the practice of 17 nurses and 57 nurses who kept activity logs of practice across 13 inpatient and community psychiatric sites in Ireland. They found that nurses undertook both independent and interdependent assessment activities across settings. Independent assessment involved the collection of information through observation (e.g. sleep patterns), interviews (asking clients about themselves) and the review of written material. They identified that nurses considered the strengths and needs of clients and inferred that the collection of information from a variety of sources and the identification of both difficulties and strengths produced a holistic assessment that provided the basis for care. The interdependent nature of nurses' assessments came about both formally, by participating in multidisciplinary team meetings and informally, through contact during the process of care. Nurses contributed information about consumers they had gained through their constant contact with clients to the multidisciplinary team (Cowman et al. 2001). Street and Walsh (1998) observed from their study that the knowledge and assessment skills of nurses were not recognised by other disciplines. If this is the case, they concluded that the independent nature of mental health nursing assessment may not be recognised.

How do mental health nurses collect information as part of a comprehensive mental health assessment?

In 1999 O'Brien used focus groups of community nurses (n = 5) and inpatient nurses (n = 4) in New Zealand and found that nurses described their assessment practice as "an unobtrusive process that occurred in the context of ordinary interactions" (O'Brien 1999 p. 158). In a review of nursing activities undertaken during close observation in acute inpatient units in the UK, Mackay et al. (2005) used in-depth interviews of a purposive sample of six mental health nurses responsible for decisions regarding close observation. They found that nurses took the opportunity of close observation to assess the mental state of consumers, how the consumer interacted with staff and others, the risk of violence posed by the consumer, their needs and if any intervention was necessary. Fourie et al. (2005) in New Zealand, used non-participant observation and focus group interviews of inpatient nurses (n = 10) and identified that nurses assigned to a non-nursing task like kitchen duty took the opportunity to observe the appropriateness of interactions between consumers. Delaney et al. (2001) studied nurses' management of aggression using a mixture of survey (n = 59 respondents), focus groups (n = 6 groups) and file audit (n = 60 files). They found from the focus groups that risk assessments were undertaken informally, and that nurses did not use checklists or other objective measures, but instead relied on their own knowledge and experience.

MacNeela et al (2010) in an analysis of ten focus groups comprising a total of 59 registered mental health nurses from inpatient and community settings in Ireland, observed that informal sources of information were privileged over formal sources like handover and case notes. This informal process of information collection is seen as important to supporting the development of a positive therapeutic relationship with the consumer (O'Brien 1999), which is central to the assessment process.

Documentation of mental health nursing assessment: Absence of evidence, or evidence of absence

In Australia, O'Brien et al. (1999) pointed out that the assessment skills of nurses have been developed in inpatient settings where the mental health status of the consumer had already been identified by the psychiatrist and most nurses had no formal training in assessing clinical psychopathology. In a study that aimed to develop a file audit tool to determine the effectiveness of a specific psychiatric assessment educational package, the authors found that prior to receiving training, 50% of 20 randomly selected records reviewed lacked information regarding the history of the consumer, their present mental health status or indications of treatment planning. Following training using a structured tool that provided a framework for assessment, nurses' documentation did improve. Using an independent t - test a statistically significant 19% improvement ($t = 3.5$; $df = 38$; $p < 0.001$) in the overall quality of documentation was found.

In the UK, Richards et al. (2005) used file audits ($n = 85$ baseline, $n = 135$ follow-up) to study the effects of a specialist inpatient education program across three mental health inpatient units on the quality of nursing care and the views of service users. They initially found poor quality documentation of assessment. Although 78% of initial assessments contained detailed assessment of mental health, less than half of these records contained information on social or physical health. Prior to the educational intervention, the authors described the detail of documentation as "cursory" (Richards et al. 2005, p. 640). Following the intervention there was comprehensive details on mental, social and physical health. Overall, a Mann-Whitney U test showed a statistically significant improvement moving from around 30% having a documented detailed assessment to just over 60% ($U = 3518.0$, $z = -5.36$, $p < 0.001$). It seems that nurses may be undertaking comprehensive mental health assessments but are simply not documenting them.

In Australia, Harris and Happell (1999) undertook in-depth interviews with six community mental health nurses on the skills needed for assessment. They highlighted the difference between assessments undertaken by inpatient and community mental health nurses and identified four major areas necessary to support assessment including interpersonal skills, a sound knowledge base, an

ability to work with a number of theoretical frameworks and documentation skills. They concluded that these skills are not being met by either hospital- based practice or through tertiary education. They go on to point out that:

“an ad hoc approach to health care of the mentally ill is both against government policy and against the humanitarian ideology linked with the nursing profession. To allow community psychiatric nursing to continue without formalized structures as a guide to the assessment of people living in the community can only be to our own disadvantage.” (Harris and Happell 1999 p.13).

Delaney (2006) warns that an ad hoc approach to assessment, without a structured framework may simply produce a stream of anecdotes not suitable for providing systematic care.

Conclusions

Assessment is central to mental health nursing practice and competencies and skills have been codified in a number of standards. The assessments undertaken by nurses in mental health should therefore be comprehensive and systematic. These assessments should include an understanding of the client’s physical health, their social situation, mental status, behaviour and contextual factors that may impact on these.

A search of the literature found a rich discourse on various aspects of mental health nursing assessment but failed to find any papers that describe the content or process of a comprehensive mental health nursing assessment in practice. However, the literature did provide some insight into comprehensive mental health nursing assessment in practice. Barratt (1989) found that mental health nursing assessment in practice can mean different things to different nurses. It can involve the collection of information on a wide variety of aspects of the consumer and is heavily influenced by the medical model. It has been described as both an independent and interdependent mental health nursing activity. The importance of a good therapeutic relationship with the consumer is central to the assessment process. Mental health nursing assessment has been described as informal with the collection of information about the consumer’s circumstances being incorporated into routine social interactions. It has been argued that the informal nature of mental health nursing assessment supports the development of a good therapeutic relationship (O'Brien 1999). The literature contains evidence that there are gaps in the documentation of mental health nursing assessment, particularly in the areas of social and physical health.

If mental health nursing assessment practice is informal then the response of nurses to the introduction of MH-OAT and a standard suite of clinical assessment documentation becomes understandable. Although some nurses may agree that the clinical assessment documentation covers areas that are important in a comprehensive mental health nursing assessment, others may not hold this view. Differences in the way that mental health nursing is practised across regions, given different management styles, resources and policies within organizations, may affect practice (Street and Walsh 1998) but an informal, ad hoc approach is not only detrimental to consumers but the very profession of mental health nursing (Harris and Happell 1999).

This paper has limitations as its focus is on peer-reviewed literature; but the lack of literature in this area is clear evidence of the need for more research into mental health nursing assessment. The need to describe the content and process of a comprehensive mental health nursing assessment in practice and to identify any discrepancy between theory and practice is paramount. Through the identification of these gaps we can determine essential areas for training and development. Research should aim to clearly identify those factors that impact on the scope and the process of assessment. The development of a clear consensus of what the content or process of a comprehensive mental health nursing assessment is essential to identifying appropriate training activities and more importantly the impact of training on the outcomes for consumers of mental health nursing care.

As mental health nursing develops into the 21st century the need for ongoing research into the assessment practice of mental health nurses seems fundamental to the very credibility of the discipline.

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Commentary

The review of the literature did not find one example of a study of a comprehensive mental health nursing assessment. In this commentary I explain why I thought it was important to undertake a review of the literature. I also add to the discussion a brief exploration of how nursing text books describe a comprehensive mental health nursing assessment and if these texts provide any greater clarity about the content and process of a comprehensive mental health nursing assessment.

As I have said, there is some debate within the qualitative literature about the merits of undertaking a review of the literature prior to the study (Dunne 2010). Glaser and Strauss (1967), indeed, specifically argue against a review of the literature: “an effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study” (Glaser and Strauss 1967p, 37). In contrast, Cutcliffe (2000) argues that no potential researcher is a person with no history or background in a particular subject area. It is unrealistic therefore to avoid reviewing the literature for fear of contaminating the researcher or imposing assumptions or preconceptions. McGhee et al (2007) observes that a researcher who is close to the field may already be aware of the literature associated with that particular field. However, the use of the literature and any other pre-knowledge should not prevent the researcher from using an approach informed by grounded theory when undertaking data analysis. Using a grounded theory approach, however, requires that the researcher prevents prior knowledge from distorting the researcher’s perception of the data. As a researcher using a grounded theory approach, I had to balance enhancing my understanding of the concepts that may be in play in the field with forcing data to fit predetermined categories or existing theories that I have gathered from the literature (Hoare et al. 2012).

As the study aimed to better understand the content and process of a comprehensive mental health nursing assessment, I concluded that how such an assessment is described in the literature would be an important foundation upon which to understand how that assessment may be undertaken in practice. This way I would not be undertaking a study of something that was already well known.

The review of the literature I undertook prior to the actual study enhanced my theoretical sensitivity to the subject area. Theoretical sensitivity in this case refers to my ability to be open to possibilities in the data (Heath 2006). My theoretical sensitivity was therefore enhanced by my review of the literature because I found no published work on what a comprehensive mental health

nursing assessment entailed. I knew I was researching a new area where little was known about the subject.

An early draft of the review of the literature article included a discussion about the way textbooks describe a comprehensive mental health nursing assessment. However, given space limitation and for clarity this discussion was removed from the article. There have been however, many textbooks written about mental health nursing, and most include chapters or discussion on assessment.

Much has been written in textbooks about what information should be collected as part of a comprehensive mental health nursing assessment and how this information should be collected (Stuart and Sundeen 1987, Beck et al. 1988, Barker 2004, Barker 2009). Similarly, the grey literature also contains descriptions of a comprehensive mental health nursing assessment, from Wikipedia to training materials from professional nursing bodies (The College of Nursing 2005).

A search of the University of Wollongong, library catalogue using the search term “Mental Health Nursing Assessment” and limited to items in the library catalogue alone (mostly printed or physical material) identified 26,682 items. A search of Amazon.com in Australia using the same search terms and limited to books identified 349 texts available for purchase, and of course, in 0.35 of a second Google identified 23 million possible sources of information. Mental health nurses do not therefore lack access to information on mental health nursing assessment. However, what knowledge do mental health nurses gain from access to all this information? I looked at five textbooks available to nursing students at the University of Wollongong. The first two were texts that I looked at were those that I was exposed to as an undergraduate. The next two texts are those currently being used as part of the current undergraduate nursing programmes at Wollongong University Australia and the final text is an often-referenced mental health nursing text specifically on assessment. I also searched the library catalogues of the University of Melbourne, Flinders University, Queensland University and Edith Cowan University and found that all of these texts (or newer editions) were also available to nurses at these universities. For the interested reader I have created a Table, which can be found in Appendix 1 that identifies how the authors of these texts describe the content of assessment and if the text advocates the use of standard measures as part of the assessment process.

Frustratingly, these basic mental health nursing texts vary greatly in their use of terminology to describe the content of a comprehensive mental health nursing assessment. While this may reflect particular philosophical or therapeutic approaches to practice, it engenders some confusion

around which aspect of content across the different texts takes precedence. Having said that, some core domains are discernible, including assessing the reason for current presentation, history, relationships and mental status. These domains are not dissimilar to the assessment domains included in the MH-OAT documentation. Four of the five textbooks identify that the assessment process involves the use of standard measures, the other one does not advocate their use but acknowledges that they are used in practice.

The literature review undertaken for the current study identified that although much has been written about mental health nursing assessment, very little has been written about how it is undertaken in practice. In this way, the literature review undertaken as part of the current study “may be considered the sine qua non of science in that gaps in existing knowledge are revealed and a direction for the next logical step in the extension of knowledge becomes evident” (Fawcett 2013 p, 285).

As I have said, in Australia, Cleary (2005) mailed a questionnaire to 250 mental health nurses working in inpatient units in an area health service seeking their views on nursing care delivery; 118 (47%) mental health nurses responded. Of these mental health nurses, 93% indicated that assessment was moderately to very important as a nursing activity, and 92% indicated that they were moderately to very confident in undertaking an assessment. So, mental health nurses think an assessment is an important part of nursing practice and are confident that they can undertake an assessment.

The next articles look at how a group of mental health nurses described their assessment practice: what they identified as the content and the process of a comprehensive mental health nursing assessment.

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Chapter 3 Methodology

Introduction

In this chapter, I outline the method of data collection and analysis adopted for the current study. However, before turning to a detailed description of the method used, I will describe the process of choosing the method and the factors that were considered in making these research choices.

Ellis and Crookes (2004) make clear that the philosophical standpoint of the researcher will impact not only on what is the focus of research but how any research is undertaken. This is because the philosophy of the researcher combines beliefs about ontology (what is the nature of reality), epistemology (what is the relationship between the researcher and the known) and methodology (how do we gain knowledge in the world) (Chopra et al. 2004).

There is a difference between method and methodology (King 1994, Welford et al. 2011, Houghton et al. 2012). Methods are the way we go about collecting data, listening to informants, observing behaviour, reviewing the historical record. Methodology is much more complex; it is based on theory and is about how the research should proceed. Methodology encompasses method, impacts on the choice of method and how those methods are used plus ethical considerations to be dealt with.

As part of her journey in the development of a research design for a doctoral thesis and to better understand labels like 'sloppy research' and 'method slurring', Beattie (2002) identified the need to review her own ontological, epistemological and methodological beliefs, her beliefs about the nature of reality and what can be known and by whom. To ensure the rigour of the research process and to make the study real to the reader, establishing the philosophical foundations of the study are essential (Chiovitti and Piran 2003). However, the philosophical basis for much reported research is often not reported (Wilson and McCormack 2006) or even considered (Sundet 2012).

I will now explore the ontological, epistemological and methodological beliefs that underpin the current study.

World Views and approaches to research

Research takes place within the context of different communities with their own paradigms or world views (Norton 1999), and there seem to be a frustrating and bewildering number of these views that are ambiguous, with many authors using different terms to mean broadly the same thing (Wainwright 1997). Three broad research methodologies have been identified and each comes with its own ontological and epistemological beliefs (see Table 1).

Table 1 Comparison between quantitative, qualitative and critical research methodologies

	Quantitative	Qualitative	Critical
Focus	Quantity, focusing on an object or subject	Essence, meaning or attributes	Mean and perspectives
Orientation	Reductionist and deductive	Open discovery and inductive	Inductive reflection on phenomena of interest
Data sought	Measureable, numerical	Emphasises subjects' personal interpretation of events	Context-specific, emphasizes subjects personal interpretation
Research goal	Hypothesis testing, cause and effect prediction	Development of understanding, access participants' experiences of their reality	Taking action to change practice
Reliability indicators	Repeated measures, generalisability to other cases, reproducibility	Recurrent themes, patterns, lifestyles and behaviours	Patterns of behaviour
Domains of analysis	Predetermined, prejudgments and <i>a priori</i> position taken, non-dynamic, fixed and planned research design	Can reformulate and expand focus of study as one proceeds, no predetermined <i>a priori</i> judgements	<i>A priori</i> position taken, dynamic and flexible

Modified from Ellis and Crookes (2004).

The quantitative approach is set firmly in the natural sciences. It is focused on testing hypotheses or theories of already established ideas, using deductive reasoning (Nicholls 2009b). Results are predictions based on the balance of probability. Knowledge is deduced from the results of the research. This approach is focused on numbers. Objects and subjects are measureable and the results of research are generalisable to other cases. Lincoln and Guba (2006) have identified that the positivist and post positivist community holds the ontological belief that there is a “real” or probabilistic “real” reality, epistemologically, that the researcher is objective and that findings are true and that methodologically quantification and experimental manipulation are appropriate research methods.

In contrast, qualitative research is set in the human sciences. It is focused on understanding the essence or meaning of personal events. It looks for recurrent themes or patterns. It follows a process of inductive reasoning, developing theories (Nicholls 2009b). This approach to research is open to discovery and change. At one pole are communities that embrace critical theory/constructionist approaches who ontologically view reality as shaped by social and political forces, that epistemologically the researcher is transactional/subjective, that the truth is created and methodologically dialectic/hermeneutic, and interpretive or qualitative approaches hold primacy (Lincoln and Guba 2006). Positivist approaches work well with the natural world; here quantification control and prediction have been shown to be particularly successful. Using the positivist methods of data collection and deductive reasoning we have been able to build aircraft that enable positivist scientists to fly thousands of kilometres to give papers at academic conferences (Rice 2013).

However, does this positivist position hold true in the human sciences? One of the key tenants of positivism is the acceptance of determinism. The relationship between cause and effect is invariable, neither chance nor choice have a part to play in the way things happen (Porter 2001). However, the social world is different from the natural world, social structures are the result of human actions. Human actions impact on the social world, while the social world impacts on human actions. To understand this interplay requires knowledge of the humans making the actions and those factors that may impact on human actions. However, purely constructivist approaches have been criticised because of their potential to slide into relativism, where no one interpretation of truth is privileged over another and anything goes (Hussey 2004). There have been calls for the need to bridge the gap between these two positions in nursing (Georges 2003).

Nursing is a social practice in which people are engaged in intentional actions and interactions (Hussey 2000). Because of their role in society, nurses are in a position to directly influence the behaviour of consumers and in so doing they can also act as powerful agents of the

state (Perron et al. 2005). As such nursing can be seen as a socially constructed activity always influenced and changed as a result of financial and socio-political forces (Clarke 2006b). So nurses can be seen to act but also be acted upon in social contexts and therefore may not be in a position to change their lives or social circumstances (Appleton and King 2002).

Given this tension, a critical realist paradigm or world view has been suggested as bridging the gap between these two positions (Wainwright 1997). A critical realist approach has been used to understand the role of consumers in mental health services (Stickley 2006), gatekeeping access to community mental health teams (McEvoy and Richards 2006), risk and child welfare (Houston 2001) and understanding psychiatric nursing (Littlejohn 2003), and as a philosophical foundation for approaches to practice development (Wilson and McCormack 2006).

A critical realist approach adopts the view that there is interplay between social structures and human agency. That is, individuals are embedded within social structures that have certain discursive practices through which power relationships are mediated, but human agency is not entirely mandated by social structures, and individual or groups or agents are able to creatively respond to these social structures (McEvoy and Richards 2003). Rationality makes humans unique in nature. Humans have a capacity for conceptual knowledge, can reason to new knowledge and through the knowledge of options humans can exercise free will, and choose what to do and how to act (Whelton 2002).

A critical realist's philosophy holds that there is a reality "out there" and it exists in three separate domains, 'empirical' or observable events or what we experience, the "actual" events, where things happen which may or may not be observed and the "real" structures and processes which may make reality and produce events (Proctor 1998). A further distinction is made between intransitive and transitive knowledge (Littlejohn 2003). Intransitive knowledge is that which would exist without human input, for example, sound, gravity or the sun. Transitive knowledge is the result of the work of human input, all the models, methods and theories of man. So as Littlejohn (2003) argues, mental distress may be intransitive and exist in its own right, but psychiatry and psychology and the various theories of causation and treatment of mental distress are transitive knowledge. Given this conclusion, he argues that mental health nursing can exist in its own right but interestingly doesn't argue that it does. So there is a real world 'out there' that is separate from our descriptions of it, with knowledge being a social and historical product of a specific time and place.

However, there are critics of critical realism who have pointed out that any ideas we may have about what constitutes reality are also relative to our language and conceptual schemes and

therefore any description of so called reality is in fact relative to the lens through which we are forced to observe the world (Hussey 2000). Therefore a distinctive feature of the critical realists' philosophical position is the adoption of a relativist epistemology (McEvoy and Richards 2003). While critical of radical forms of relativism that highlight the socially constructed nature of scientific discourse, they accept that scientific observation is fallible and shaped by the context within which researchers operate. This is increasingly being explored as the philosophical foundation for nursing research (Angus and Clark 2012).

These philosophical differences have been reflected in the ongoing debates in the nursing literature describing the differences between qualitative and quantitative approaches to research in nursing (Duffy 1985, Burnard and Hannigan 2000). Schwandt (2000) believes that the heart of the dispute, which remains unresolved, is the belief that the human sciences are fundamentally different in nature and purpose to the natural sciences. Carr (1994) concludes that neither approach is superior to the other but that a qualitative approach is invaluable in exploring the subjective experience of nurses. Indeed, a number of authors have argued that the actual difference between the two approaches is very limited (Crowe and Shaeppard 2010, Clark 1998, Carr-Hill 1997), while Hafkenschied (2001) asserts that qualitative research has aspects of quantitative methodology. Importantly, it is not that quantitative research is necessarily superior to qualitative research, only which approach is right for a particular research question (Nicholls 2009a). Cuttcliffe and Goward (2000) argue that mental health nurses are drawn to qualitative research because the process involves the purposeful use of the self; it involves the creation of an interpersonal relationship, something that mental health nurses are drawn to, and is an approach that can accept and even embrace ambiguity and uncertainty.

My philosophical approach to this work was informed by a critical realist philosophy (Bhaskar 2008). This philosophical approach leads me to conclude that there is a "real" world that is objective and measureable but that our ability to understand this "real" world is informed and influenced by the socially constructed nature of our experience. So my perspective as a mental health nurse is that mental illness exists, that objective "real" chemical reactions located primarily in the brain which follow fundamental laws (which may or may not be understood at this time) produce disturbances of information processing that are experienced or viewed as mental illness. However, it is how this mental illness is expressed, understood and named, and how the assessment for this mental illness is undertaken that is fundamentally a socially constructed activity.

Given this philosophical conviction, the adoption of a quantitative methodology would limit my ability to understand how these socially constructed assessment practices occur. So I decided to

adopt a qualitative methodology, accepting that the assessment practice of nurses is a socially constructed activity but that this assessment practice must look for the systematic expression of the “real” mental illness.

Approaches to Qualitative Research

Having chosen a qualitative approach, my next challenge was to identify what type of qualitative approach. Some authors have argued that there are as many as sixteen different types of qualitative research (Crowe and Sheppard 2012). Table 2 gives an overview of the main approaches to qualitative research.

Table 2 Types of qualitative research

Type of qualitative Study	Types of research questions	Philosophical assumptions	Audience
Narrative/ Discourse	What narratives or discourse is in play that shapes identities and activities of X	Knowledge and meaning are produced through interactions	Policy makers and interventionists who need to understand different discourses and craft messages
Phenomenological	What is the lived experience of X	There is a perceived reality with common features	Clinicians and practitioners who need to understand the lived experience
Grounded theory	How does social process x occur in context y	Theory is discovered by examining concepts grounded in the data	Researchers and practitioners who seek models to design interventions

Ethnography	How do people and their culture experience X	Knowledge and meaning are shaped by cultural context	Clinicians, practitioners who need to understand the effect of culture
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Adapted from Smythe (2012) and Starks and Brown Trinidad (2007)

Considering the types of research questions, the philosophical underpinning and the target audience, I chose a qualitative methodology, using the constant comparative method and informed by grounded theory. The choice of a grounded theory approach for the current study was based on a number of factors. These include that grounded theory is focused on the study of human interaction, including social processes and interactions, and particularly social situations where people must adapt (Cooney 2010). Grounded theory is a method that is useful when little is known about the subject (Sofaer 1999), it is also useful in understanding how the group works with, or solves, a problem (Donalek 2004) and is the foundation upon which models can be tested and interventions designed.

Grounded Theory

Grounded theory as a method of scientific inquiry was developed by Glaser and Strauss in the 1960s (Glaser and Strauss 1967). Although there are disagreements about the approaches, there is general agreement that the development of grounded theory represents the discovery of an enduring theory that is faithful to the reality of the research area, that makes sense to the person studied, fits the template of the social situation regardless of the varying contexts related to the study phenomena, adequately provides for relationships amongst concepts and may be used to guide actions (Boychuk-Duchscher and Morgan 2004).

Hunter et al (2011a, 2011b) describe three broad approaches to grounded theory. The classic grounded theory of Glaser and Strauss (1967), the modified grounded theory of Strauss and Corbin (1998) and the constructivist grounded theory of Charmaz (2004). Each of these approaches to grounded theory has its advantages and disadvantages. A comparison of these three approaches is presented in Table 3.

Table 3 Comparison of different approaches to grounded theory

	Classic	Straussian (modified)	Constructivist
Identify the problem area	Emergent	Experience	Sensitising concepts
	No prior literature review	Pragmatism and literature	Discipline specific
Conduct of research and developing theory	Laissez-faire theory generation	Paradigm model of theory verification	Co-construction and reconstruction of data into theory
Relationship to participants	Independent	Active	Co-construction
Evaluating theory	Fit, work, relevance, modifiability	Validity, reliability, efficiency and sensitivity	Situating theory in time place, culture and context
			Reflexive rendering of the researcher position
Coding	Open coding	Opening coding	Line by line conceptual coding and focused coding to synthesise
	Selective coding	Axial coding	large amounts of data
	Theoretical coding	Selective coding	

Modified from (Hunter et al. 2011a)

The current study adopted a modified approach to grounded theory, taking aspects of all the approaches outlined in Table 3. Heath and Cowley (2004) conclude that a researcher is best to choose a method that fits with their cognitive style and undertake research accordingly. Consequently, as will be seen, the method adopted for this work combines the structured pragmatism of a Straussian approach, with the laissez-faire approach to theory generation of classic grounded theory and a constructivist sensibility with the researcher understanding the subject area. In this way, the study adopted the data collection and analysis techniques of grounded theory, in particular theoretical or purposive sampling and the ongoing constant comparative methodology.

Method

Data Collection

I gained access to nurses for interviews in two ways. First I approached nursing colleagues who I knew undertook mental health assessments as part of their practice and second, I approached nurses working in two local inpatient units and a local community mental health team via an invitation distributed by their nurse managers to participate in the study. In both cases I also asked people to identify others they thought might be interested in the project, so they could contact me.

Purposive sampling

I used a purposive sampling approach aimed at getting nurses with different years of experience and roles in mental health nursing to describe what they thought the content and process of a comprehensive mental health nursing assessment is/was. I hoped that by gathering information from a wide variety of nurses I would expose the key aspects of the content and process of a comprehensive assessment that are consistent across a range of mental health nurses and intrinsic to the practice of mental health nursing. This approach to sampling would give access to data that would expose the components of the content and process of a comprehensive mental health nursing assessment. This purposive sampling was also theoretical in that the approach emerged during the process of data collection (Draucker et al. 2007). Would neophyte nurses describe the content and process of a comprehensive mental health nursing assessment in the same way? Would the interviews with these nurses produce data that would support or challenge my initial codes? In this way, mental health service managers were included in the collection because they have undertaken mental health assessments and are responsible for ensuring that other nurses undertake these types of assessments. If nurses did not or had not undertaken mental health nursing assessments then they would be excluded from the study.

This purposive sampling approach resulted in participants who were less and more experienced nurses, hospital trained and tertiary trained, and working in hospitals or in community settings (see Table 4).

Table 4 Participant Demographics

		Number	%
Gender	Male	8	44.44
	Female	10	55.56
Qualifications	Hospital Certificate	9	50.00
	Bachelors Degree	6	33.33
	Masters or Higher	3	16.67
Years of Experience	0-5	4	22.22
	6 – 14	4	22.22
	15 -24	7	38.89
	25+	3	16.67
Service Setting	Inpatient	8	44.44
	Ambulatory	10	55.56
Focus of work	Clinical	11	61.11
	Management	7	38.89

I undertook this purposive sampling not in an effort to generate a sample representative of mental health nurses but to be assured that I interviewed nurses with a range and mix of experiences which would enable me to explore if nurses with different experience and in different contexts, described the content and process of a comprehensive assessment in different ways. I could argue that I only needed one participant in each cell of my matrix; however, I was reminded that “an adequate sample size in qualitative research is one that permits—by virtue of not being too large— the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in—by virtue of not being too small—a new and richly textured understanding of experience” (Sandelowski 1995 p, 183).

Sampling continued until my matrix was populated, but more importantly until the data had reached saturation; that is, when no new information emerged during data analysis (Strauss and Corbin 1998).

Ethical issues

The ability of the researcher to reflect on their research and the possible ethical implications are considered essential to undertaking ethical research (Wilson 2011). Ethical issues when undertaking research in health care can fall into three broad categories informed consent, researcher participant relationships and privacy and confidentiality (Ignacio and Taylor 2013). The current study was undertaken mindful of these ethical issues.

Informed consent involves the person having enough information on which to decide to participate in the research. Informed consent is an acknowledgment of respect for the research participants autonomy (Orb et al. 2001). The participants in the current study were free from coercion; it was made clear that they could cease their participation without any penalty. Potential participants in this study were given an information sheet (see Appendix 2) describing the study and that the interview would be recorded. Interviews did not proceed unless participants signed a consent form agreeing to participate (see Appendix 2). The information sheet made it clear that participants were free to end the interviews at any time and that their identity and that of their employer would be de-identified in the data. The human research ethics committee of the University of Wollongong reviewed the study and gave approval to perform the research (Ethics approval code HE06/126).

Researcher participant relationships are also an important ethical consideration when undertaking research. When undertaking qualitative research, the researcher must be aware of the potential effect that the researcher may have on vulnerable groups (Clarke 2006a). While I believed that the likelihood of me causing distress to mental health nurses asking them about their comprehensive mental health nursing assessment practice was unlikely, it was still a possibility so I made it clear to participants that the interviews were not a test but a genuine attempt to get their views in their own words. Undertaking research in an area in which a researcher works adds another layer of complication. Although the researcher may get better results because they know the situation and have the trust of the participant, the participant may feel coerced to participate and limit the information that they give. (Orb et al. 2001). The principle of justice recognises that the research participant is treated fairly and as an equal partner in the research process (Orb et al. 2001) and is supported by recognising the vulnerability of the research participant and recognising their

contribution to the study. As the reader will see, checking my interpretation of data with research participants is one way I demonstrated the equality of the relationship between myself as a researcher and the research participants.

Another ethical issue that I was mindful of while undertaking this study was ensuring privacy and confidentiality. Here I am guided by the ethical principle of beneficence, ensuring that the research is about doing good for others and preventing harm (Orb et al. 2001). Ensuring the confidentiality of interview material and anonymity is a way of avoiding harm for the participant by avoiding the possible sanctions or stigma that can be associated with being identified (Hewitt 2007). Maintaining confidentiality can be challenging given the detailed descriptions used to illustrate and report findings in qualitative studies (Houghton et al. 2010). In this study, names were not associated with interviews. The administrative assistant would help transcribe some of the interviews, but did not know the names of participants. Pseudonyms are used in this thesis, as well as in all papers and presentations associated with the study so as to avoid causing harm that may come from exposing the views of individual, identifiable participants.

Interviews

Interviews have become the approach to data collection synonymous with qualitative research, including grounded theory (Wimpenny and Gass 2000). My interviews with nurses involved a face-to-face encounter and took a conversational, unstructured approach rather than an approach directed with the use of a questionnaire or interview schedule. An unstructured approach to the interviews was taken in the belief that it would ensure that I did not bring any preconceived ideas to the interviews (Fontana and Frey 2000). All interviews were undertaken in private and occurred either in offices within mental health services or the nurses own home. Each interview started with the same single question: “what is the content and process of a comprehensive mental health nursing assessment?” Starting with such a broad question in an unstructured manner has its advantages and disadvantages. An advantage is that it allows questions to be asked that are useful when there is little known about the subject, this enabled me to explore in-depth during the interviews, what nurses meant or what may have produced the kind of practice that they described. A disadvantage of such an approach is that it enables participants to talk about irrelevant issues, sometimes making it difficult to code and analyse data (Doody and Noonan 2013).

All the interviews were digitally recorded which allowed me to concentrate on the interview process and not be distracted by taking notes. Although recording interviews can have the disadvantage of making people feel uncomfortable or inhibited, I often put people at ease by making

a joke about the recording process. That being said, I was aware that some participants, particularly at the start of the interview process, did feel uncomfortable and were aware they were being recorded. I therefore adopted a flexible approach during the interviews, using open-ended rather than closed questions. I also used my experience as a mental health nurse to put people at ease, making them feel comfortable with sharing information. I used my active listening skills, paraphrasing, repeating and seeking clarification to reduce misunderstanding. During the interviews I encouraged participants to explore, reflect upon, interpret, and explain, their understanding and experience of mental health nursing assessment in practice. Interviews were conducted between October 2006 and June 2007 and lasted between 20 – 70 minutes.

These audio recordings were initially transcribed either by me or by an administrative assistant. Regardless of who transcribed the recordings, I listened to the recordings a number of times in the first instance both to check on the veracity of the transcription(s) made by myself and the administrative assistant. This process also helped to orientate me in great detail to the material available for analysis.

After each interview, I made notes on the experience and kept a record of any ideas or insights that the interview and its process generated for me. I also kept field notes on my discussions with other people regarding the progress of this work. I used these discussions with others to check my ideas or discuss the themes that I thought were emerging. These notes and discussions were an important part of my reflecting on the study and how it was progressing from data collection to analysis.

Researcher in relation to subject

As I have pointed out, this work is founded on a critical realist perspective, which means that as a researcher I cannot ignore the part I played as an actor in the research process. In researching contemporary mental health nursing practice, I bring an intimate knowledge of the practice of mental health nursing assessment, having undertaken assessments as part of my own clinical practice (Kaplan et al. 1999) and having being involved in the education and training of nurses not only around assessment practice (Chipps et al. 2002), but also the use of standard measures as part of clinical practice (Coombs and Hirini 2005, Coombs et al. 2002).

A researcher can be seen as occupying one of three positions in relation to the research subject: 'outsider', 'hybrid' or 'insider' (McGhee et al. 2007). The 'outsider' is a researcher who is simply visiting the research area. The 'hybrid' is one who is undertaking research into a familiar area of practice, while the 'insider' is an actual practitioner undertaking research into their own and

known practice colleagues. Clearly, I was an 'insider' in this study and this raises a number of important issues in relation to bias, both during the data collection and analysis processes (McCann and Clark 2003).

Achieving objectivity, validity and rigour

Rigour in qualitative research in part rests on the transparency of the research process, the ability for those following me as a researcher to replicate my method and to come up with similar results (Strauss and Corbin 1998). Glaser and Strauss (1967) talk about the need for qualitative research to demonstrate credibility, plausibility and trustworthiness. These attributes of credibility, plausibility and trustworthiness can be shown by ensuring that a number of criteria for the evaluation of qualitative research as described by Walsh and Downe (2006) are evident. These include ensuring that the scope and purpose is clearly articulated, the design is apparent, the sampling strategy described, the approach to analysis is documented, the process of data interpretation is clear, there is evidence that the researcher has reflected on the data, that an ethical approach has been taken and that the research is relevant and transferable.

In part these attributes of qualitative research are shown by demonstrating the independence of the qualitative researcher. This independence must be convincingly communicated to the reader or the researchers biases openly acknowledged to confront concerns that the researcher have unduly biased the conclusions (Hurley 1999). During the interviews I was acutely aware of my own assessment practice and that the way I asked follow-up questions could have focused on areas of assessment that were important to me rather than areas of assessment that were important to those responding to the interview questions. Guarding against this, I specifically worked at taking a neutral but inquisitive stance during the interviews. For example, during my interview with Jill, I sought clarification *"When you say family do you mean....like just mother and father or do you mean like a broader.....?"* or during my interview with Edward *"When you said sort of like putting it into context for them....Is that putting it into context for them or is that putting it into context for you?"*

The other potential for bias was the respondents telling the researcher what they thought the researcher wanted to hear. As a researcher having been involved in training in assessment practice and standard documentation, I was aware that some respondents exposed to this training might simply repeat previously presented material. This is why McGhee et al (2007) assert that the researcher must develop a self-awareness, self-questioning approach and be prepared to expose prejudices that they may bring to data analysis. It is important to be willing to modify or reject an

emerging explanation not supported by the data. Neill (2006) asserts that the researcher should reflect on the research process in such a way that the 'self' that is the researcher simply becomes part of the data.

I worked at reducing the potential for bias or prejudice during data analysis and ensuring that theory emerged from the data by being transparent about my analysis process and theory development. I knew that the study had credibility and plausibility after presenting a preliminary analysis at a conference (Coombs 2008). Judging from the response, the questions asked and the comments in support of the presentation, I felt confident that my initial observations resonated with the mental health nurses attending that conference. In part, this may be because the themes actually used the words of those being interviewed, which is one way of demonstrating the quality of qualitative research (Chiovitti and Piran 2003). Using quotes in this way is an important way of presenting the participant's voice (Sandelowski 1994).

I also undertook a process known as 'member checking', which is basically what the term implies; I went back to some of the people that I interviewed and checked my interpretation of what they had said and that it was congruent with their experiences (Carlson 2010). I did not return to all participants but only those who expressed a desire to understand and be informed of my findings. Four nurses from the sample indicated they would like to know what I found and it was with these nurses that I discussed my preliminary findings. I talked about the themes that were developing and discussed my interpretations of my observations and how this related to their own thinking about what they had said during their interviews. Checking with participants in this way ensured the analytic rigour of the process (Tobin and Begley 2004). Member checking is not without its disadvantages, it can be an additional burden for participants, the focus of the study may be distressing and checking information may increase that distress or participants may regret some of the information that they provided and want it removed as data. None of these disadvantages were encountered in my discussions with the participants I discussed my initial findings and interpretations. However, the threat remains that those nurses with who I checked my interpretations may simply be demonstrating the halo effect, telling me what they thought I wanted to hear (McConnell-Henry et al. 2011).

In addition, I also discussed my study with nurses who were not interviewed; I discussed my observations and interpretations and had these nurses reflect on their own experiences. I used these discussions to reflect on my codes, categories and the emerging themes. I also discussed my data, codes, categories and conclusions with my supervisors, using these discussions to further refine my

thinking during data analysis. These discussions and the notes I made of these discussions were an important part of my personal process of reflection on data collection and analysis.

Glaser and Strauss (1967) provide guidance for when the project is ready for closure. When the researcher is convinced that the results are a reasonably accurate statement of the matters studied, can be presented in a form that it is possible for others to use in a study of a similar area and can be published with confidence, then the research (or at least the data collection phase) is near its end. When did data saturation occur and how did I know that new categories would not emerge? In the current study, it was clear that saturation in relation to the content of assessment occurred relatively quickly; with a few exceptions, the initial responses of participants made it clear that they struggled to articulate the content of an assessment. However, sampling continued until interviewees were saying nothing new about the process of undertaking a comprehensive mental health nursing assessment.

Data Analysis

Given that a review of the literature failed to find a single example of work describing the content and process of a comprehensive mental health nursing assessment, I approached data analysis with the aim of understanding how mental health nurses described the content and process of a comprehensive mental health nursing assessment. I wanted to identify what information these nurses sought about consumers and identify the way they went about gathering that information. I was looking for the core attributes of both the content and process of a comprehensive assessment so that these could be described in the nurses' own words.

One way of exploring qualitative data is through the use of 'word clouds'. Word clouds are a way of visualising qualitative data. They summarise qualitative data by depicting the words that appear most often in larger type within the cloud (Cidell 2010). The cloud below (see Figure 2) was created using the responses of the first four interviews. The most frequently occurring responses were the words "people", "assessment", "know" and "think". A number of observations can be made from this cloud. First, given that the word, "think" is the most frequently occurring, then assessment can be seen as a cognitive process. It is focused on "people" and "knowing". Reassuringly, the interviews focused on "assessment".

clear nurses don't have a format for their assessments that they all use. Another pointed out it might be what nurses do with the information that is important and not what information they collect"

The constant comparative method had me returning to the data many times. I found myself reading and re-reading the interview transcripts and listening to the interviews again. I would read the transcript of the interview I had just undertaken and compare it to the previous interview. I would compare the latest interview to my first interview. I would compare the interviews of less experienced nurses, with more experienced nurses, or those nurses with tertiary qualifications and compare them to those nurses who were hospital trained. I compared the interviews with male nurses to those of female nurses. I looked at how nurses who were primarily managers described the content and process of a comprehensive assessment and compared it with nurses who were working in clinical practice. Returning to the data was a process that occurred even during the final writing of this thesis. This process of constant comparison was undertaken for interviews, codes, categories and themes, exploring relationships in the data or new interpretations of that data.

The interviews, the notes and memos all became data as part of the analysis process. All during the process of data analysis I was questioning the data, Was this new information? Did it group in some way with information I had already collected? How did it differ? How did one description of a comprehensive mental health nursing assessment compare to another? What information did one nurse seek and how did that compare to another? How did one nurse describe the process and how did that compare to another? Is my interpretation of the data correct or is there another way of looking at it?

Questioning the data in this way supported the development of codes. Coding involved the identification of key issues (Licqurish and Seibold 2011) that I thought gave an indication of the content and process of a comprehensive mental health nursing assessment. My coding process began with open coding, fragmenting and breaking down the data so that concepts could be identified. The interviews provided a rich source of information not only about the content and process of assessment but also how these nurses gained their assessment knowledge, contextual factors that may have influenced their assessment practice and what personal factors may impact on the content and process of their assessment practice. This initial set of codes for the 18 interviews is shown in Figure 3 below.

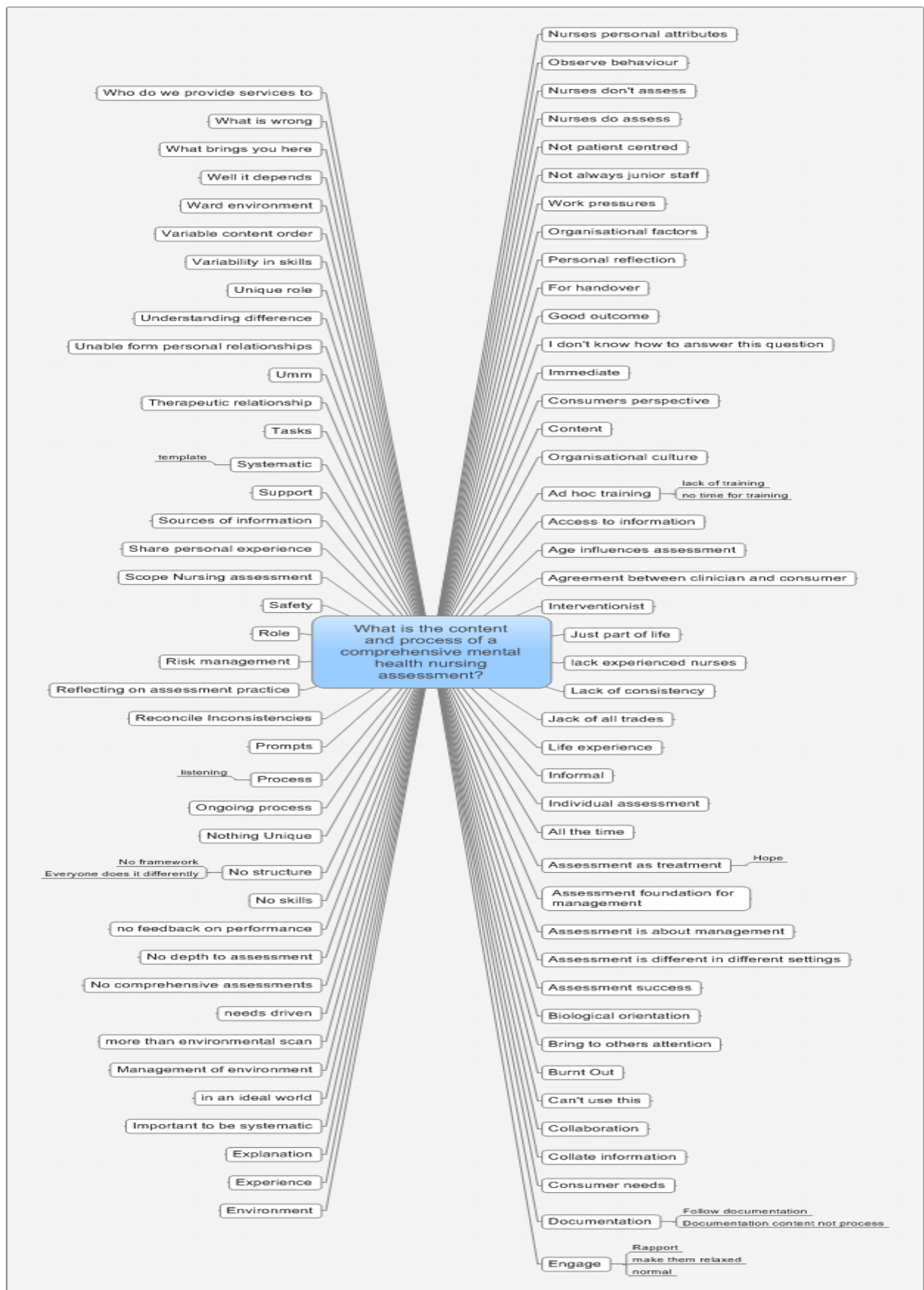


Figure 3. Initial code set

Initially I used Nvivo 7 (QSR International Pty Ltd 2006) to support the generation of codes. Nvivo is a commonly used piece of qualitative analysis software that enables the user to collate, organise and analyse interview data. As interviews were transcribed they were entered into this software, reviewed and the process of coding began. This was a progressive process with new material being added and additional codes generated or additional material being added to existing codes. This coded data was categorised into themes, and these codes, categories and themes were constantly reviewed as new data became available (Elliott and Jordan 2010).

My own cognitive style sits much more on the 'visualiser' side of the bipolar cognitive visualiser-verbaliser divide (Kollöffel 2012), that is, I find it easier to understand pictures than words. However, I wasn't comfortable with the visualisation component of Nvivo. I was familiar with MindMap 8 (Mindjet 2009). This software is designed to enable the creation of mindmaps. Mind mapping has proven useful in organising complex areas to provide coherence (Heinrich 2001). Codes and categories can also be diagrams that can help the researcher make links between data, concepts and categories (Chen and Boore 2009). I transferred my initial codes created in Nvivo to MindMap 8 to "see" what I had and how these codes and related data fitted together. Showing the reader a mind map of the coding process for them to verify is one way of demonstrating the trustworthiness of the process (Whiting and Sines 2012).

The figures that follow show the evolving nature of the analysis process, how I moved from open coding to more specific categorisations of data. This involved my moving between MindMap 8 to Nvivo and returning to original recordings all the time, constantly comparing data, codes, themes and interpretations to better understand what was being said or not said by the data. This initial set of open codes (Figure 3) became the focus of analysis and the codes were collapsed, disentangled, reorganised and reordered to better describe the content and process of a comprehensive mental health nursing assessment. For example, in the bottom right hand corner of Figure 3 the reader will see that as I moved between reviewing the codes in Nvivo and MindMap 8 there were three codes: 'rapport'; 'make them relaxed'; and 'normal'. I thought these codes and underlying data probably sat together under a code that I titled 'engage'.

It became clear as part of this process unfolded that there was some overlap between codes and their associated content. These themes were reviewed and more general groupings were uncovered. This consolidation, similar to axial coding (Strauss and Corbin 1998), is where data is linked creating categories and subcategories, locating codes and data items that are conceptually similar. These categories and subcategories were not fixed, however, and changed almost every time I analysed the data, these codes and categories were constantly reviewed as they became themes.

Themes are abstract constructs that can be identified before, during and after data collection (Ryan and Bernard 2005). So, in the case of the code 'engage' above, I linked this code to a higher order category that I called 'process' which can be seen in Figure 4. (Enlarged Mindmaps found in appendix 5)

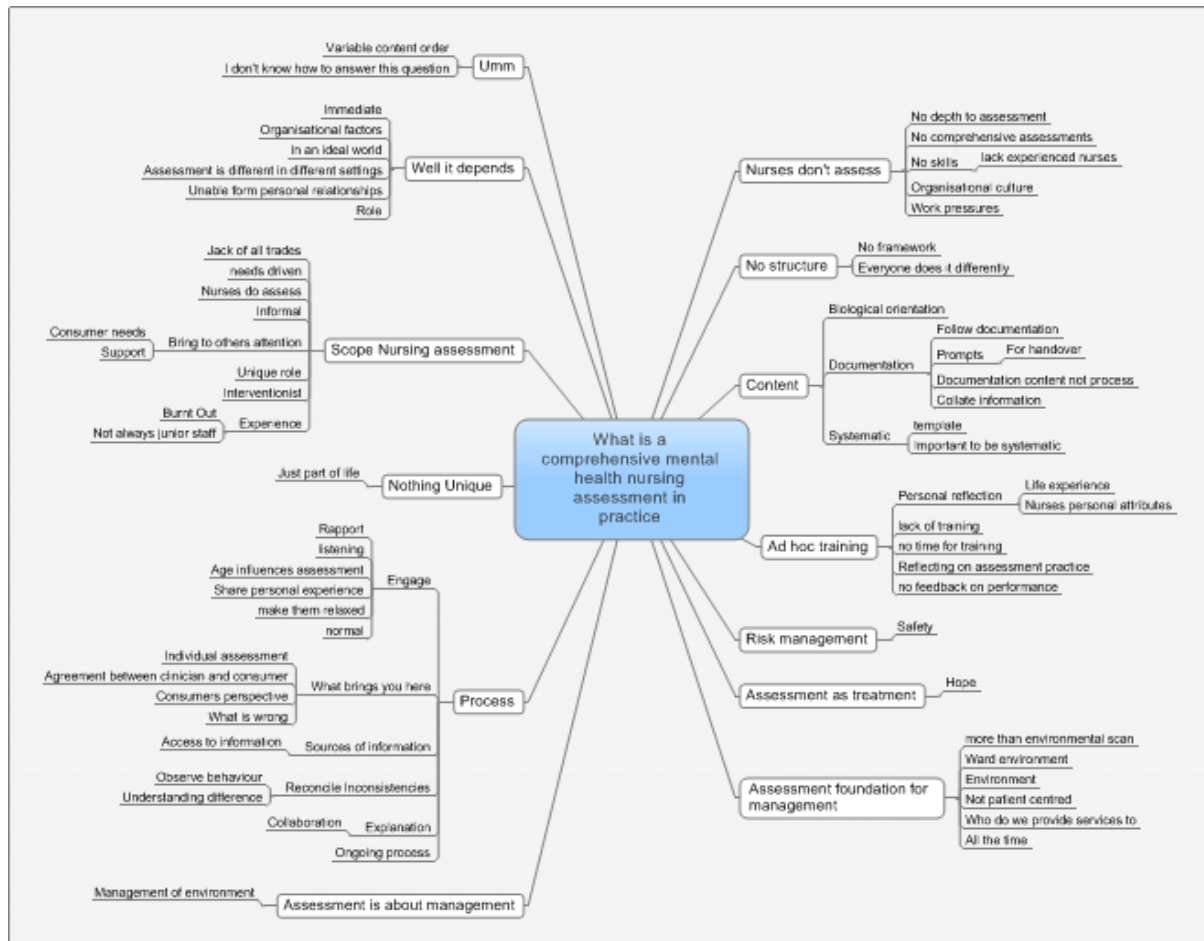


Figure 4. Codes grouped into themes

The refinement of these codes into categories and themes was an ongoing process that required returning to the original codes and the data attributed to those codes. It also involved going back to the audio recording to ensure that the transcription was correct or to elicit the emotional content or context of the transcribed interviews. This ongoing refinement process was focused on understanding the key aspects of the content and process of a comprehensive mental health nursing assessment. In part, this involved not exploring some aspects of the data collected, such as the training experiences of the participants. Figure 5 (Enlarged Mindmaps found in appendix 5) shows an example of the further refining of codes, categories and themes. Here, overarching categories began to be identified in an attempt to identify links between categories and sub-categories with the aim of organising the data into a meaningful whole.

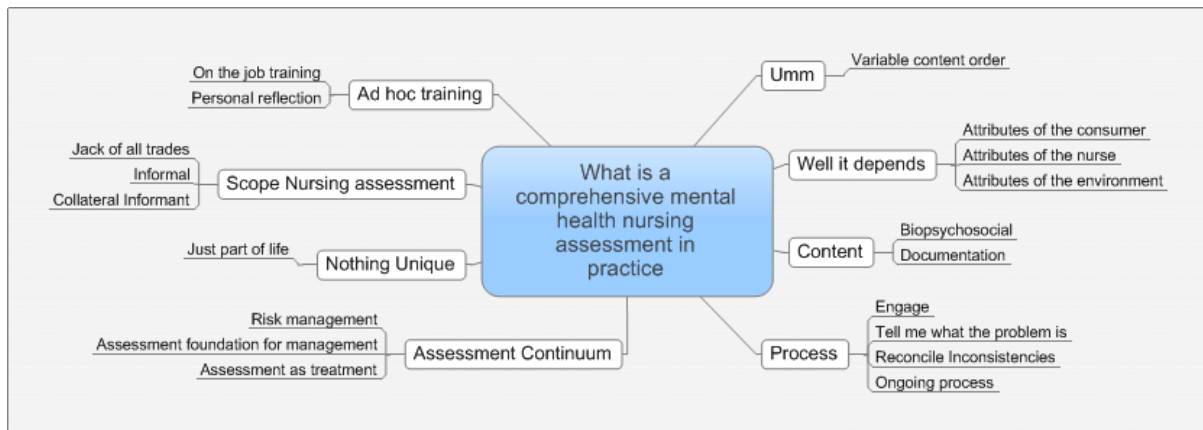


Figure 5. Ongoing refinement

Example code, associated data and more detailed analysis

I will now give two examples of how the data from interviews was coded, analysed and related to specific themes that emerged. First, Table 5 gives an example of the data that was coded as “variable content order” that at this stage of analysis sat under the theme “Umm” (see Figure 5). As I was reviewing this data, I wrote a memo to myself that said “they never say it the same way twice”. Meaning that each interview indicated that these nurses looked for different things and the order was never the same twice. As you can see in Table 5, Jennifer starts describing the content of a comprehensive mental health nursing assessment as the assessment of appearance, behaviour and orientation. In contrast Wayne starts by looking at biological causes, then psychological and finally social aspects of the consumer. Allen starts with mental status particularly focusing on psychotic phenomena and mood disturbance. While, Alison describes the content starts with general wellbeing, sleeping and eating, then medication and risk. This variability in the order of content became a theme and as new data was gathered it was compared to either confirm or challenge this theme.

Table 5 Code: Variable Content Order

Interview	Interview Text
Jennifer	It would take in their appearance, behaviour, orientation and demeanour. It would include things like risk assessment, past behaviours, vulnerability, suicide, aggressiveness, physical state and domestic violence issues.
Wayne	We look for biological causes first, so that's the first thing we look at, if we have no joy with obvious biological aberrations, then we look for the psychological. So if we can explain something biologically from a mental health point of view, very quickly we ship it out to some other specialist, say neurology, some other field of medicine. Send them off to a physician, do something about it. So if we can't make sense of what's going on with the person biologically we then look to the psychological and if we have no real joy there, it's a bit of a mixed picture, we don't really understand the picture, we then look at the social explanations. Look at their social system. There are fewer people that look at that, and then it would be as rare as hen's teeth in this country to really look at or accept any sort of spiritual explanation.
Allen	O.k. what I seek to do is to reveal... ahhh... umm... the person's mental state. I seek to find evidence of, in particular psychosis, certainly mood disturbance, umm... and I... umm... pretty well suck it and see. I... umm... I listen carefully, I watch carefully, I look at behaviour, I listen for what people are talking about and the way they are talking about it. That way you can usually pretty easily pick up, you know, any evidence of in particular of psychosis, or thought disorder, which are probably really the first rank stuff for me, if you like, the umm...
Alison	Oh well, you want to know about general well being, have they been sleeping and eating, do they have money, do we need to do social work referrals and do they need psychology referrals and stuff like that even though it's a bit later on. But you also want to know have they been taking their medication, how well are we going to be able to get them to be compliant are we going to have an aggressive incident with this person if we push it too much, do we want to have two people with them at all times because they are aggressive.

What is also shown in Table 5 is an example of the hesitancy of respondents to the question, “what is the content and process of a comprehensive mental health nursing assessment”. As you can see in Table 5, Allen hesitates before providing an indication of the content of a comprehensive mental health nursing assessment. In order to better understand the scope of this hesitancy I undertook a componential analysis (Ryan and Bernard 2005) of the interviews. This analysis is based on the principle that data has distinctive features that either occur or do not occur. One distinctive feature of the interviews was the presence or absence of “umm” as part of the response. The use of the “um” can be seen as the speaker searching for a word, deciding what to say next, wanting to keep the floor or wanting to cede the floor during conversation (Clark and Fox Tree 2002). So the use of the “um” during the interview can be interpreted as the respondent searching for the right word or way of expressing his or her thoughts. A second distinctive feature of the interviews was if respondents either directly repeated the question back to me, sought to have the question repeated during the interview or talked around the question as they gathered their thoughts and formulated their response before the actual content of their response was expressed. A third distinctive feature was the time in seconds from when the respondent seemed to understand the question and when they began to deliver an answer to any aspect of the question (either content or process). All three components of the interviews were analysed producing the results in Table 6 (which also appears in the published article, A comprehensive mental health nursing assessment: variability of content in practice). This information became coded as ‘Umm’.

Table 6 Distinctive features of audio recordings of interviews

	Number of participants	Proportion (%)
Used “Um”	10	62.5
Repeated the question	8	50
	Range in seconds	Mean/Standard deviation
Pause before reply all respondents	12.5 to 0.5	5.87/3.90

Both of these codes are important aspects of the way that these nurses described the content of a comprehensive mental health nursing assessment. The hesitancy and variability giving in these interviews gives an indication that these nurses did not have a consistent approach to the content of a comprehensives mental health nursing assessment and struggling for words perhaps indicates that they had not given the area that much thought.

The second example is a code that emerged as an important aspect of the process of a comprehensive mental health nursing assessment. This code was “tell me what the problem is”. This code was created early in the analysis, following interview 2. It also prompted a memo in which I considered “what does that mean for recovery?” This was important because it led to work exploring the personal recovery movement in mental health and the requirements necessary to practice in that way. In Table 7 the interview text was coded “tell me what the problem is”. As can be seen in the table, the majority of nurses (13 of 18) indicated that part of the process of undertaking comprehensive mental health nursing assessment is the identification of the consumers’ problems in some way.

Table 7 Code: "tell me what the problem is"

Interview	Interview text
Edward	I usually start with, ‘tell me what the problem is’, ... get them to elaborate and then to go back and put that into some sort of context for that patient.
Jill	you have to really pinpoint the problems, make a decision ...
Wayne	you simply ask the person to outline in their own words what the problems are
Marco	their mental health is the primary problem but accommodation might be a problem, their social needs might be a problem
Lauren	...just a problem solving exercise where you actually....sit down with a person and help them define what the problem is?
Nicole	...why they think they have got a problem and why do they need help.
James	...looked at activities of daily living, um, problem-solving approaches, practical issues of how the illness is actually affecting their life
Allen	... umm recognizing the problems that are within my range to deal with, recognizing the ones that are outside my range and umm dealing with the ones I can
Sue	Then you would start asking them all the usual questions-‘What’s your problem?’ ‘What’s going on?’ ‘How long it been going on for?’
Kelly	How did you get here? I want to know everything about why they are here now, who brought them and who has got the problem

Rosemary	I look for problems, their affect, at how the patient responds to you when you're talking to them
David	I'm assessing that they are orientated to where they are and what has happened to them and why it's happened to them, what the problem is
Terri	And is it a problem? Does it matter if he walks around telling everybody that he is God? Is that a problem and did you intervene? Why didn't you intervene?

This very early initial code became a theme "tell me what the problem is" with "reconcile inconsistencies" identified as a sub-theme of the process of a comprehensive mental health nursing assessment.

Results

This process of constant comparison continued until I had the smallest number of categories that emerged from the data that described the content and the process of a comprehensive mental health nursing assessment. The final themes (see Figure 6) that emerged from this process focused specifically on the question, "what is the content and what is the process of a comprehensive mental health nursing assessment in practice?" In terms of the content, the main themes were 'hesitancy', 'variability' and 'no model'. The process involved engaging with the consumer, putting them at ease, then getting the identification of the problem, in some ways reconciling inconsistencies in the consumer narrative. These nurses identified that the process of assessment was ongoing.

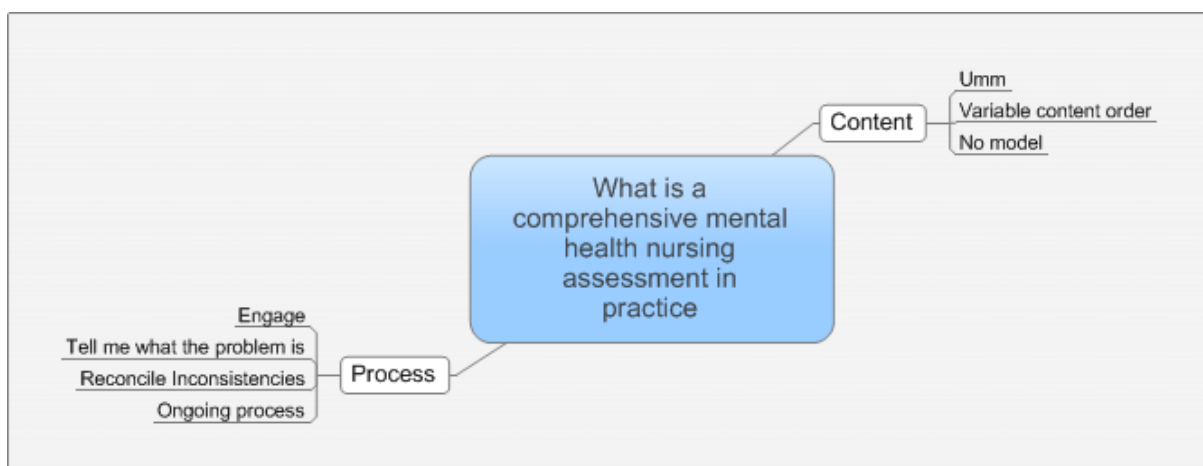


Figure 6. Final themes

Conclusion

In many ways, the themes that emerged came from not only what respondents said but also from what they didn't say. Having a broad, open-ended question resulted in a rich data set. The process of analysis involved understanding this data set in a way that exposed the content and process of a comprehensive mental health nursing assessment. This understanding was developed through the process of coding words, sentences and paragraphs as data. I constantly compared data within and between respondents, across codes and categories, searching for themes to understand the content and process of a comprehensive mental health nursing assessment.

Having undertaken this data analysis the focus of this thesis now turns to reporting the results. This is undertaken across three articles, one looks at how the content of a comprehensive mental health nursing assessment is described by the nurses who participated in the current study, another focuses on the description of the process of a comprehensive mental health nursing assessment and the third reports on finding that the nurses who participated in the current study, did not identify a formal model that informed their undertaking of a comprehensive mental health nursing assessment.

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Chapter 4 A comprehensive mental health nursing assessment: variability of content in practice.

Chapter 4 begins the reporting of the results of the qualitative study. The chapter focuses on the content of a comprehensive mental health nursing assessment, while Chapter 5 looks at the process of that assessment. The content and the process of a comprehensive mental health nursing assessment were split into two articles for a number of reasons. First, because of the limitation on the number of words that can be used in journal articles, the amount of material to cover would not fit into one article. Second, it was felt that there was enough material to do justice to the results by separating them into two articles. Third, reporting them separately gave the content greater clarity. The 'content of a comprehensive mental health nursing assessment' is explored in the following article: A comprehensive mental health nursing assessment: variability of content in practice. *Journal of Psychiatric and Mental Health Nursing*. Coombs, T., Crookes, P. & Curtis, J. 2013. vol 20, no (2): pp. 150-155.

A comprehensive mental health nursing assessment: variability of content in practice

Abstract

Background

Assessment is the foundation of mental health nursing practice, but little is known of how it is undertaken.

Objectives

This paper explores how mental health nurses describe the content of a comprehensive mental health nursing assessment.

Method

18 nurses who worked in inpatient and community settings either as clinicians or managers, ranging from new graduates to nurses with greater than 20 years of experience, were interviewed and asked to describe the content of a comprehensive mental health nursing assessment. Transcribed interviews were analysed using a grounded theory methodology.

Results

The primary theme to emerge was one of variability. Most respondents hesitated and then identified different content areas that needed to be assessed as part of a comprehensive mental health nursing assessment.

Discussion

If the areas that are being assessed vary between nurses, then logically the types of interventions being offered will also vary. These results have implications for the education of nurses, their clinical practice, ongoing supervision, and research into contemporary mental health nursing practice.

Keywords: Content Comprehensive Mental Health Nursing Assessment

Accessible summary

- Little is known of how a comprehensive mental health nursing assessment is undertaken in practice
- Nurses describe the content of a comprehensive mental health nursing assessment in different ways
- Different content may lead to different interventions
- More work is required to ensure comprehensive mental health nursing assessments are undertaken in practice.

Introduction

Assessment is central to mental health nursing practice and provides the foundation for nursing interventions. In Australia the need for nurses to be able to undertake a comprehensive assessment has been codified as an essential competency for a new practitioner in nursing (Australian Nursing and Midwifery Council 2006). In mental health nursing the Australian College of Mental Health Nurses standards of practice (Australian College of Mental Health Nurses Inc 2010) indicate that the mental, physical, spiritual, emotional, social and cultural needs of the individual should be the basis for the delivery of care and clearly should be included in a comprehensive assessment. Regardless of the philosophy, model or school of thought that informs mental health nursing practice or the setting within which a comprehensive mental health *nursing* assessment takes place, that comprehensive assessment should contain similar themes and questions, it should include a key set of content that is essential to the practice of mental health nursing.

The nursing literature contains a rich discourse on mental health indicating it can include the assessment of aggression (Mackay et al. 2005), suicide (Duffy 1995, Temkin and Crotty 2004), risk of violence (Murphy 2004) or general risk (Hawley et al. 2006), the assessment of carers (Carradice et al. 2002) and detailed assessments on entry to mental health services (Wand and White 2007). Although often described in textbooks or the grey literature, Coombs et al. (2011a) failed to find any journal articles that described the content and process of a comprehensive mental health nursing assessment.

The current paper describes some of the results of a qualitative study that aimed to understand the content and process of a comprehensive mental health nursing assessment. This paper focuses on the way nurses described the content of a comprehensive mental health nursing assessment. This description provides an insight into contemporary practice and provides guidance

for research and training activities which could usefully be aimed to support understanding and improvements in this important area of mental health nursing practice.

Method

The study adopted a qualitative modified grounded theory approach because this approach is a useful research method when little is known about a subject (Chiovitti and Piran 2003). The approach is referred to as modified in that the process did not strictly adhere to methodological approaches described by either Strauss and Corbin (1998) or Glaser (Cutcliffe 2005) but it did adopt central features of grounded theory methodology as originally described (Glaser and Strauss 1967). These include the coding and categorisation of data and the adoption of the constant comparative methodology. Here the researcher is constantly asking what does this data mean in this context? The challenge of describing the method of such a study is the non-linear manner in which the process occurs. It is non-linear in that coding, supports data analysis which leads to additional data collection, additional coding and more analysis and. It is often difficult to describe this process without undertaking a discussion of the results (Bringer et al. 2004). In this way the study methodology can be seen as an iterative process with data collection and analysis revealing categories that are descriptions of key concepts that emerge from the process of data collection and analysis. The advantage of this method is that it enables nurses to provide a description of their actual practice from their perspective.

To avoid concerns that coding may be biased by this experience, hypotheses, codes and categories were checked with study participants. This process is known as “member checking” (Murdoch et al. 2010). Member checking involves sharing draft study findings with participants and enquiring if their views or ideas have been accurately recorded; if there are errors of fact; and if the account makes sense to them. Coding and identification of concepts was reviewed by all authors. Preliminary analysis, codes and concepts were presented at a conference, where the nurses present indicated that they recognised the plausibility of the results and the interpretation of the data. This exposure of the hypotheses and codes should generate confidence in the rigor of the analysis process (Rolfé 2006) and the suitability of this work for dissemination.

Participants

Interviews were conducted with 18 mental health nurses, ranging from new graduates (less than 12 months’ experience) to experienced nurses (greater than 20 years’ experience), clinicians and managers working in either inpatient or community settings. The majority of participants came from New South Wales in Australia. These interviews were digitally recorded and then transcribed.

Table 1 shows the gender, qualifications, years of experience, service setting and primary focus of work undertaken by each participant.

Table 1 Participant demographics

		Number	%
Gender	Male	8	44.44
	Female	10	55.56
Qualifications	Hospital Certificate	9	50.00
	Bachelors Degree	6	33.33
	Masters or Higher	3	16.67
Years of Experience	0-5	4	22.22
	6 – 14	4	22.22
	15 -24	7	38.89
	25+	3	16.67
Service Setting	Inpatient	8	44.44
	Ambulatory	10	55.56
Focus of work	Clinical	11	61.11
	Management	7	38.89

Data collection

Ethics approval for the study was granted by Wollongong University. Participants were approached on a convenience basis and through their nurse managers, with an explanation of the study and initial information. As the study was exploratory, each interview began with the same question: “What is the content and process of a comprehensive mental health nursing assessment.”

Data analysis

NVivo 7 software was used to support analysis with the initial coding and identification of themes. This coding process resulted in the development of a large number of codes which were, during the process of analysis, collapsed, disentangled, reorganised and reordered to better describe the content of a comprehensive mental health nursing assessment. This process was supported with the use of “mind maps” to support memo recording (Chen and Boore 2009) and organising large number of codes to provide coherence (Heinrich 2001).

Results

One primary theme of ‘variability’ emerged from the interviews on the content of a comprehensive mental health nursing assessment. In part this theme was based on two observations. First, the hesitancy and difficulty that these nurses had in answering the question and second, the variability in the way the nurses described the content of a comprehensive mental health nursing assessment.

Variability

“Um”... hesitancy

The first observation was that the majority of respondents hesitated prior to describing the content of a comprehensive assessment. They, “Um’d” and “Arr’d”, repeated the question, moved in their chair and were visibly uncomfortable with the question. It was not as if the nurses participating were not prepared for the question. The ethics committee required informed consent. The majority of participants had initial information on the project from their nurse manager. Participants then had to read information on the scope of the study and the study question. This also involved a detailed discussion with them as to why this information was being sought and what that information was. This all took place prior to signing a consent to participate document. The recording of the interview would commence and the following is an example of the hesitancy in answering the question.

“I will just have to think about it because it will come to my mind.”

Kelly, Manager, 15–24 years experience

This hesitancy occurred in most interviews. It resulted in the question being repeated or broken down so that participants were only being asked about the content of a comprehensive mental health nursing assessment. Indeed, one participant was provided with an example of a

domain that may form part of a comprehensive mental health nursing assessment, mental status examination. To demonstrate this hesitancy, Table 2 identifies the proportion of respondents who used “Um”; the proportion who required additional prompting by having the question repeated; and the range, average and standard deviation of the length of the pause before receiving a response. This was done after all interviews were completed and during the process of data analysis as a way of using numbers to create meaning from the data and to identify patterns (Sandelowski 2001).

Table 2 Distinctive features of audio recordings of interviews

	Number	Proportion of respondents
Used “Um”	10	62.5%
Repeated the question	8	50%
	Range in seconds	Mean/Standard deviation
Pause before reply all respondents	12.5 to 0.5	5.87/3.90

Analysis of the audio recordings revealed that half the respondents hesitated before responding, repeated the question, or had the question repeated; one respondent took 12.5 seconds to respond to the question. There was one exception — one respondent did not repeat the question and had the shortest pause (0.5 seconds) before replying. This respondent identified a comprehensive mental health assessment involved a biopsychosocial approach, a commonly adopted model of assessment in mental health. In this context this hesitancy is an indication that these nurses did not have a readily available model of the content of a comprehensive mental health nursing assessment that they readily express. When a model was available the nurse was able to articulate the content of an assessment as involving the biological, psychological and social aspects of the service users presentation.

Variability in order of content

When respondents began to answer the question, the second observation was the variability of the content described. The following three responses were typical of the variability in the description of the content of a comprehensive mental health nursing assessment. The first respondent describes an approach that looks at general wellbeing and then focuses on medication adherence or previous incidents of aggression.

“Oh well, you want to know about general wellbeing, have they been sleeping and eating, do they have money, do we need to do social work referrals and do they need psychology referrals and stuff like that even though it’s a bit later on. But you also want to know have they been taking their medication, how well are we going to be able to get them to be compliant are we going to have an aggressive incident with this person if we push it too much. Do we want to have two people with them at all times because they are aggressive.”

Alison, Clinician, 0–5 years experience

In contrast the second respondent identifies mental state assessment (but doesn’t elaborate what this entails) then focuses on drug and alcohol use, they do not mention aggression or medication, they focus on drug and alcohol use and developmental history.

“Include a mental state, it would include their social situation, any drug and alcohol issues, any physical issues like drug and alcohol including tobacco. I would include some social issues and include family history and if possible look at developmental history, educational background.”

James, Clinician, 6–14 years experience

The third respondent starts with classic aspects of the mental status examination appearance and behaviour, but then talks of risk, past behaviours, suicide and physical state; neither mentioned by the previous two respondents. They don’t mention medication or drug use.

“It would take in their appearance, behaviour, orientation, and demeanour. It would include things like risk assessment, past behaviours, vulnerability, suicide, aggressiveness, physical state and domestic violence issues.”

Jennifer, Manager, 25+ years experience

Again to demonstrate this variability in the content areas described, the content areas were identified and the proportion of respondents who identified these content domains is provided in Table 2. A review of Table 3, shows that a large number of domains were identified but all domains were not identified by all respondents.

Table 3 Content areas of mental health nursing assessment

Area of assessment	Mention by respondents (%) n=18	Number of respondents
Mental status	33.33	6
• Appearance (body language)	27.78	5
• Speech	11.11	2
• Behaviour	22.22	4
• Cognitive status	5.56	1
• Orientation	16.67	3
• Hallucination/delusions (psychotic phenomena)	38.89	7
• Symptoms (includes anxiety, mood)	38.89	7
• Distress	16.67	3
Interactions with others	5.56	1
Sleeping and eating	11.11	2
Behavioural triggers/ antecedents	11.11	2
Financial situation	16.67	3
Activities of daily living	5.56	1
Presenting problem	16.67	3
Accommodation	5.56	1
Social situation	33.33	6
Family relationships	16.67	3
Physical health	33.33	6
Risk	5.56	1
• Aggression	33.33	6
• Suicide	38.89	7
• Domestic violence	5.56	1
Drug and alcohol (including history)	16.67	3
Medication	16.67	3
History		

• Past behaviour	5.56	1
• Family history	22.22	4
• Developmental history	11.11	2
• Social history	5.56	1
• Previous treatment	27.78	5
• Education	5.56	1
Service user opinion	5.56	1

The most commonly mentioned areas of assessment were suicide and aggression risk assessment, symptoms and hallucinations/delusions, general mental status, physical health, social situation and previous treatment. Other categories were only mentioned by one or two respondents, for example the opinions of the service user. There was no pattern to these categories across participants, for example, suicide risk assessment was not only mentioned by nurses working in the community, the nurse who identified accommodation as an area to be assessed did not mention social situation, analysis failed to identify any systematic variability across respondents.

While the theme of variability came through most strongly, it should be noted that the assessment of risk and aggression were the most often mentioned content areas of assessment. This is consistent with the literature that identifies the focus of contemporary mental health care as the assessment and management of risk (Buchanan-Barker and Barker 2005), increasingly resulting in defensive practice that determines the type of questions being asked of service users (Mullen et al. 2008). While risk assessment may be a feature of contemporary mental health practice, the lack of consistency and the variability in the content of assessment, as described by these nurses, was the most noteworthy result from this study.

Discussion

The most significant observation from this study is that there was no consistency in the content of a comprehensive mental health nursing assessment as described by these nurses. One of the hallmarks of a discipline is the systematic application of a body of knowledge. The respondents in this study did not articulate a systematic body of knowledge in relation to the content of a comprehensive mental health nursing assessment. Over 20 years ago, Coler and Vincent (1987) identified variability in the way mental health nursing assessment was described in nursing textbooks. Likewise Duffy (1995) found variability in the suicide assessment practice of nurses. Similarly, Goossens et al. (2008), in a study of nursing care of people with bipolar disorder in the

Netherlands, came to the conclusion that there was a general lack of systematic activity in the assessment practice of community psychiatric nurses. This variability in assessment practice has significant implications for mental health nursing. Variability in assessment will no doubt lead to variation in the focus of care, the type of interventions offered by nurses and the way in which that the success or failure of those interventions will be determined. This need for systematic assessment is seen as a cardinal element of competency required by professional bodies (Australian Nursing and Midwifery Council 2006) but there is clearly a tension between this requirement and the way the practice of assessment is described by these nurses.

MacNeela et al. (2010), in a study of mental health nursing assessment using focus groups and questions designed to identify nurses contributions to care, concluded that typically mental health nursing assessment was informal, implicit and contextual. Mental health nursing assessment was seen as an invisible activity. It was seen as being embedded in patient care rather than as a discrete activity or intervention. Like much of nursing practice, the type of assessment that a mental health nurse undertakes is influenced by the context within which it takes place, the unit in which the nurses work, the workflows of the units and particular aspects of the service user's presentation (Tanner 2006). Perhaps a concept from anthropology may be useful here. Boyer (1986) uses the term "empty category" to describe a notion that is complex, abstract, defies definition, and which is at the core of a particular discourse. An 'empty' category does not describe something which is devoid of meaning; rather it has many meanings, allowing for meaning to shift and change between people and contexts without challenge. It also has limits and boundaries on its interpretations that are situationally specific. Knowledge and practical understanding of the meaning of an empty category is acquired over time, and through experience of its use in specific contexts. In this way a comprehensive mental health nursing assessment can be seen as an empty category, a complex activity, driven by a variety of external factors with a negotiated agreed meaning.

This study goes some way to emphasising the invisible nature of mental health nursing assessment practice. If the profession is to be able to adequately train new members of the profession, deal with its information management needs or be involved collaboratively with service users, then a clear understanding of what the content of mental health nursing assessment is in practice, compared to what it should be, is essential.

The assessment of risk of self-harm or aggression were identified as important content areas of contemporary practice. However, with regards to contemporary practice, what was not said is even more illuminating. The concept of recovery and the assessment of the service user's strengths are well documented and nurses are expected to practice with this in mind (Lakeman 2010,

Australian College of Mental Health Nurses Inc 2010). Service users are being actively encouraged to be active participants in care (Lammers and Happell 2003), that is, be involved in every aspect of their care (Simpson 1999). While in other studies it has been found that nurses consider service user strengths and work within a recovery orientated framework (Cowman et al. 2001, Gaskin et al. 2003), only one respondent in this study mentioned the need to gather information about the service user's opinion as part of the content of a comprehensive mental health nursing assessment. The data was again reviewed to identify more recovery orientated language for respondents to indicate that they asked, "what would you like?" of the service user, or "what are the positives?" there was no evidence of this type of language, indeed 16 of the 18 respondents used talked of "problems". Hopton (1997) believed that the apparent lack of service user-centred assessment is probably because nurses do not really practice in this way. The results of this study give some support to the notion that nurses do not practice in a strengths-based or recovery-orientated manner (Slade et al. 2008).

This current study has obvious limitations. The interviews were reports of nursing practice, the use of a participant (nurse) observation approach may have produced different insights into contemporary mental health nursing practice. Nurses may actually regularly carry out comprehensive recovery orientated mental health nursing assessments but not say that they do. The identified hesitancy and the need to pause at the start of the interview and recording process may be a the result of the stress caused by the interview and recording process., thus impacting on the ease with which respondents expressed their ideas. The need to prompt one participant may have been the result of the stress of interview, and their responses potentially biased through prompting. Given the implications for contemporary practice of these finding, the need for further research with a larger sample is warranted.

However, these issues aside, the results raise some important challenges for mental health nurses and those that prepare them for practice. The inability to discern any consistent systematic content of a comprehensive mental health nursing assessment is clearly significant. As Barker (2004) pointed out nurses "cannot offer valid and reliable forms of nursing care without valid and effective assessment". The results of this study identify the need for a better understanding of those factors that govern the completion of a comprehensive mental health nursing assessment and how this type of practice can be developed, supported and evaluated given the pressures of contemporary care.

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Commentary

In this commentary, three additional issues are acknowledged. First, finding variability in mental health nursing assessment practice is nothing new. Second, the assessment practice of mental health nurses may be influenced by external factors like attributes of the environment (inpatient or community service provision) or attributes of the consumer (psychotic phenomena, lack insight, are violence) and it is these factors that produce variability in the content of a comprehensive mental health assessment. Third, variability in assessment content may be a deliberate strategy on the part of nurses to better engage with the consumer and actually get the type of information they want.

This paper focuses on how the nurses that participated in the current study described the content of a comprehensive mental health nursing assessment. The primary finding was one of variability: every nurse described the content in a different way.

This finding of variability is nothing new in mental health nursing, for example Happell, Scott, Platania-Phung and Nankivell (2012) found differing views about the level of involvement of mental health nurses in managing the consumer's physical health, with some mental health nurses seeing it as their role while others saw it as outside their scope of practice. Variation has also been found in the documentation of practice with Chung, Chiang, Chou, Chu and Chang (2010) finding a lack of inter-rater reliability in nursing documentation.

In Australia, Harris and Happell (1999) undertook in-depth interviews with six community mental health nurses on the skills needed for assessment. They highlighted the difference between assessments undertaken by inpatient and community mental health nurses and identified four major areas necessary to support assessment, including interpersonal skills, a sound knowledge base, and an ability to work with a number of theoretical frameworks and documentation skills. They concluded that these skills are not being met by either hospital-based training or through tertiary education.

Indeed, variability in assessment can have significant impacts on consumers. Molinari et al (2012) in a pilot study comparing the impact on nursing home residents who did and did not have a structured mental health assessment found that ensuring nurses undertook a brief structured mental health assessment decreased the use of psychoactive substances to manage behaviours. Without a structure, nurses may not always elicit important information. Duxbury, Wright, Hart, Bradley, Roach and Harris (2010) in a study of behaviour during medication administration found

that nurses asked as infrequently as 10% of the time if the consumer thought the medication they were being administered was effective.

Reasons for this variation

Beck, Rawlings and Williams (1988) argue that the format of the assessment depends on a number of factors, including the type of consumer being assessed (individual, family or community), the scope of the assessment (limited or comprehensive) and the nurse's level of autonomy (agency or private practice). Hazelton (1999) identifies a variety of factors that may impact on the type of assessments that are undertaken by nurses; these include organisational, political, legal and economic factors. Clinical skills are also used differently in different settings; for example, routine services compared with services delivered as part of a specific research project (Slade et al. 2003).

As discussed previously, during the interviews in the current study, discussion took place on how nurses received their training in mental health assessment. Most of the nurses who participated in this study spoke about "learning on the job". While it is tempting to attribute variation in content to variation in preparation, this was not consistent. Nurses who had apprenticeship-type hospital training expressed just as much variability in the content of their assessments as those prepared at university. The constant comparative method of analysis involved comparing the variability in content across qualifications.

Alternatively, this variability may be a deliberate strategy on the part of mental health nurses. Spiers and Woods (2010) found that nurses weighed the importance of gathering assessment data systematically to complete bureaucratic needs: "to fill all the boxes", with following the client's needs or cues. Nurses in this study expressed that assessment was most effective when the nurses turned the lead over to the client and used their own clinical experience to extract information. The variability in content found in the current study may be an indication of the nurses involved adopting this type of process as part of their assessment practice. However, if this were true it would be reasonable to assume that there ultimately would be a core set of information that mental health nurses would want to gather as part of their comprehensive mental health nursing assessments. The next article in this thesis focuses on an exploration of the process of a comprehensive mental health nursing assessment.

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Chapter 5. What is the process of a comprehensive mental health nursing assessment? Results from a qualitative study.

Chapter 5 explores the way the nurses who participated in the current study described the process of a comprehensive mental health nursing assessment: how they go about gathering information from consumers. This is done in the article titled, 'What is the process of a comprehensive mental health nursing assessment? Results from a qualitative study'. *International Nursing Review*. Coombs, T., Curtis, J. & Crookes, P. 2012. vol 60 no (1): pp. 96-102.

What is the process of a comprehensive mental health nursing assessment? Results from a qualitative Australian study

Abstract

Background

It is a truism that nursing care must be informed by assessment, otherwise how can one know what care is required or that it has been successfully delivered? Yet, little is known about the process of comprehensive mental health nursing assessment in practice. If the education of mental health nurses is to be effective, it is essential that the key content of, and the processes involved in, carrying out a mental health nursing assessment in practice are able to be articulated to learners.

Aim

To identify the processes of assessment that occur in mental health nursing practice, based on interviews with mental health nurses working in clinical and management roles in clinical areas.

Method

Interviews were undertaken with eighteen nurses who worked in inpatient and community mental health settings either as clinicians or managers. The nurses ranged from new graduates to those with more than 20 years of experience.

Findings and Discussion

Clear processes were reported to be involved in undertaking a comprehensive mental health nursing assessment in practice, with three main themes emerging during analysis. The first is the importance of *engaging the patient*; the second is *tell me what the problem is?* with one subtheme *reconcile inconsistencies*; and finally, the *ongoing* nature of the assessment process.

Conclusion

Common processes emerged when the nurses described their individual approaches to undertaking comprehensive mental health assessment. The results have important implications for the

educational preparation of mental health nurses, their ongoing supervision and further research into contemporary mental health nursing practice.

Keywords: Nursing Assessment, Psychiatric Nursing

Background

In Australia, assessment is integral to mental health nursing practice. To be recognised as competent to practice nursing in Australia, the Australian Nursing and Midwifery Council requires that nurses should be able to conduct a “comprehensive and systematic nursing assessment” (Australian Nursing and Midwifery Council 2006). Whilst there are no specific mental health nursing competencies for accreditation as a practising nurse and there is no separate register for Mental Health Nurses in Australia, the Australian College of Mental Health Nurses has articulated standards of practice that require mental health nurses to consider the mental, physical, spiritual, emotional, social and cultural needs of the individual in the delivery of care (Australian College of Mental Health Nurses Inc 2010 p, 273).

Latimer (1998), looking at the assessment practices of aged care nurses, identified two broad conceptualisations of nursing assessment. In the first, a positivist epistemology is adopted. Assessment can be seen as a cognitive activity undertaken at discrete moments throughout the different stages of nursing practice and involves problem identification and decision-making. The nurse is the skilled and educated observer and the patient’s illness, which is a fact to be detected. In the second, a constructivist stance is taken; where assessment can be seen as a situated and interpretative activity, the interactions between the nurse, the patient and other actors resulting in the creation of meaning. These different views have significant implications for understanding the process of a mental health nursing assessment. In the former, reality is objective and observable, the nurse is value free; while in the latter, reality is socially constructed, and the identification of a patient’s illness is both the product of the nurse’s interpretation of that reality and of socially produced knowledge (Bergin et al. 2008, Littlejohn 2003). Understanding these differences has important implications in understanding reflective practice, ie. Is it reflection on the technical rationality of a positivist epistemology of practice, or reflection on the contextual and negotiated constructivist stance? (Kinsella 2010)

Therefore, while competency standards for nurses stipulate the need for the ability to carry out a comprehensive and systematic mental health assessment, at present it is unclear as to what this may involve in practice. To best educate and support mental health nurses to carry out best

practice in mental health nursing assessment, it is essential that the content and processes involved in a mental health nursing assessment in practice be able to be clearly articulated to neophytes.

This paper is the third that reports on the results of a larger study aimed at better understanding the content and process of comprehensive mental health nursing assessment in practice. The first paper, was a review of the literature which identified a variety of different types of assessments (in terms of focus) in mental health nursing (Coombs et al. 2011a). These included risk assessment (Godin 2004), assessment of aggression (Mackay et al. 2005), assessment of need +/- physical assessment (Fowler et al. 2005), mental state assessment (O'Brien et al. 1999), assessment of different symptoms such as depression (Fisher and Shumaker 2004) and outcomes assessment (Cranley and Doran 2004). However, the search undertaken for that review yielded no articles that had researched the content or process of a comprehensive mental health nursing assessment in practice. A second paper (Coombs et al. 2012) focused on the content of a comprehensive mental health nursing assessment and found that there was significant variability in the areas that mental health nurses reported that they assessed as part of a comprehensive mental health nursing assessment.

Aim

The aim of this paper is to describe the attributes of the process of a comprehensive mental health nursing assessment as it is described by mental health nurses.

Method

Eighteen interviews were conducted with mental health nurses who ranged in experience from new graduate nurses working clinically in inpatient units to nurses with over 20 years of experience, working in management; in either inpatient or community mental health settings. Supporting information Table S1¹ provides biographical data describing the nurses who participated in the study. Most worked in clinical practice and were female but there was an even distribution of hospital certificate prepared and bachelor or higher degree prepared nurses with equal numbers working in inpatient and ambulatory services.

Participants were approached not in an effort to produce a representative sample but to provide analytically useful information (Higginbottom 2004). Sampling was purposive in that nurses who undertook or had undertaken mental health nursing assessments and who were currently working in clinical practice or managing mental health services were approached. Two main

¹ Additional Supporting Information may be found in the online version of this article

approaches were adopted in seeking participants. Initially the first author approached colleagues who were undertaking assessments as part of practice, these participants then suggested other potential participants and a snowballing technique was adopted (Streeton et al. 2004), this process resulted in the identification of nurse unit managers of community mental health teams and inpatient units who provided access to nurses working in these teams by talking about the study and identifying nurses willing to participate. This process resulted in participants coming primarily from New South Wales, however there were participants drawn from other states in Australia. Interviews lasted from between 19.5 minutes to 69 minutes with a mean length of 32.5.

Approval for the research was granted by the University of Wollongong Human Ethics committee. Participants were given written information on the project prior to the interviews commencing and informed consent was demonstrated through written consent to participate. All responses are kept private and confidential; pseudonyms are used in this paper to identify individual comments.

The study used a qualitative research approach with the aim of generating exploratory and descriptive knowledge (Draper 2004). Central features of grounded theory methodology as originally described by Glaser and Strauss (Glaser and Strauss 1967) were used to support analysis. These include the coding and categorisation of data and the adoption of the constant comparative methodology. This methodology requires the researcher to constantly review data and seek to understand its meaning within the participant's context. The starting point for each interview was the question, *"What is the content and process of a comprehensive mental health nursing assessment"*? Interviews were transcribed and these transcripts were treated as data. Words, sentences and passages in the transcripts of interviews were identified that described aspects of the process used by nurses during a comprehensive mental health nursing assessment. Conceptually-related pieces of information were coded together and this coded information was then categorized into themes and these codes, categories and themes were constantly reviewed as new data became available (Elliott and Jordan 2010). While it is often difficult to describe this type of qualitative methodology (Bringer et al. 2004), its advantage is that it enables people (in this case, mental health nurses) to provide a description of their actual practice from their perspective. Themes and associated data were reviewed by the authors and conclusions regarding conceptual relationships were checked with participants to ensure analytic rigour (Tobin and Begley 2004). A preliminary analysis of the data and its interpretation was presented at a conference, where the results were seen by those nurses present as plausible. According to Rolfe (2006) the exposure of data coding and

analysis in this way should generate confidence in the rigor of analysis and the suitability of the work for dissemination.

Findings

Three main themes emerged during analysis regarding the process that is followed during a comprehensive mental health assessment. The first was the importance of *engaging the patient*; the second was *tell me what the problem is?* with the sub-theme of *reconciling inconsistencies*; and the third, the *ongoing* nature of the assessment process.

Engaging the patient

Seven of the eighteen respondents interviewed specifically mentioned the need to engage the patient as part of the assessment process. Others used phrases like *“putting people at ease”* or building a *“bit of a rapport”*. Nurses therefore felt it was important to treat the mental health patient in *“a very normal way”*. This could be achieved by simple social activities like making the patient a cup of tea or being polite:

“A cup of tea is important. I am always making cups of tea. You can get the HASA’s

[Health and Security Assistant] to make them but I think it is more important that I do it”.

Nicole, Clinician, 6 – 14 years experience

Although this nurse identifies that another member of staff could bring this cup of tea for the patient, it is the act of making and giving the tea to the patient that is the important part of the engagement process. The simple social act of sharing a beverage—a typical social activity that is often associated with sharing information and establishing a relationship—is consistent with the social experience of people. As Barker et al. (1999) have noted, tea-making can afford a layer of symbolism, anchoring the patient in distress to established cultural traditions, normalising their experience. Making tea for the patient also establishes the equality of the participants during the interaction. From the patient perspective, being treated like anyone else is an important aspect of quality care (Schroder et al. 2006). This approach has its advantages; Carlsson et al. (2006) have found that there is less risk of violence if patients are approached in an undisguised, straightforward and open way; that is, treated the way other people are treated.

However, the act of making the cup of tea shows more than simply equality; it also makes clear that the nurse is there to serve the needs of the patient. It establishes that the nurse is here to

help—not superior to the patient or ‘doing things’ to the patient—but there with the patient. Of course, there is an alternative interpretation. The act of making tea establishes reciprocity in the relationship. In this act of giving (the tea), it is clear that the patient is expected to give something in return: information on their present situation and an understanding for the nurse as to why the patient is there having a mental health assessment. Here the subtle power-relations at work in the assessment process become a little clearer: the nurse is in a position of power over the patient. Making a cup of tea either knowingly or unknowingly hides the power in the relationship but does open the door to asking the central question.

‘Tell me what the problem is’

Thirteen of the eighteen respondents talked of problem identification as a component of a comprehensive mental health nursing assessment. What is the problem that brings the mental health patient here? In which part of their life is there a problem? For example, a male arrives at the accident and emergency department, seeking admission to the acute psychiatric unit

“How did you get here? I want to know everything about why they are here now, who brought them and who has got the problem.”

Kelly, Manager, 15 - 24 years experience

The following example highlights the use of the problem from the patient’s perspective as the basis for the assessment process. It is not simply identifying a problem; it is placing the problem within the context of the patient’s whole life.

“I usually start with, ‘tell me what the problem is’, ... get them to elaborate and then to go back and put that into some sort of context for that Patient.”

Edward, Clinician, 15 – 24 years

Nursing in general has been seen as problem-orientated rather than solution-focused (McAllister 2003). The process of determining the mental status of the patient involves the elicitation of symptoms that are often deficits or problems (Jacob 2003), so it is not surprising that problem identification is part of the practice of mental health nursing assessment. However, the need for mental health to be delivered in a way that is strengths-based, recovery orientated and in a collaborative manner is being called for by patients (Piat et al. 2009) and clinicians alike (Lester et al. 2006, Castle and Gilbert 2006). While there have been efforts in psychiatry to adopt a collaborative, recovery orientated, strengths-based approach to assessment (Chopra et al. 2009), which patients

find more satisfying (Bjorkman et al. 2002), this has proven challenging in mental health (Deane et al. 2006).

Reconciling Inconsistencies

This process of problem identification is then augmented by the reconciliation of inconsistencies within the patient narrative or with other information the nurse has access to. Reconciling inconsistencies can be seen as important components of problem identification, with inconsistencies being problems that the patient may be unaware even exist. Six respondents identified that their assessment process involved the identification of inconsistencies in the information being provided by the patient. It starts with problem identification but involves a return to the mental health patient with additional questions in order to understand the issue and its relationship to other aspects of the patient's life.

"If the picture isn't coherent or if there appear to be any inconsistencies then I try and reconcile them."

Allen, Clinician 6 – 14 years experience

Reconciling inconsistencies involves a process of checking and re-checking facts with the patient. For example, the patient says that there are no conflicts in the family, but they had previously talked of arguments with their mother.

"It is in my head and I remember, ...but I'll add the things up in my head, so I have got these markers... just want to check on this, just want to check on that".

Kelly, Manager, 15 - 24 years experience

This process of reconciling inconsistencies can be seen from two perspectives. First, Foucault a French historian philosopher, who wrote extensively on the power-relations within psychiatry, made the observation that the psychiatric interview has a number of different functions. These include absolving the patient of any moral or legal responsibility for their actions, feelings or experiences if they describe these actions, feelings or experiences as psychiatric symptoms. He also identifies the psychiatric interview as functioning to enable the "organisation of the central confession"(Foucault 2006 p, 273). Here the interview functions to actualise 'madness' in two ways: either to force an acknowledgement by the patient of the existence of symptoms with statements like 'yes I hear voices', 'yes I am omnipotent', or else actualised so that the hallucinations or delusional ideas are exposed in the interview. Reconciling inconsistencies can be seen as part of the

process of eliciting these symptoms: that a story lays waiting to be revealed, unearthed or hatched, upon which the professional may impose a layer of meaning (Barker and Buchanan-Barker 2007). In this case, the process of a mental health assessment can be seen as fundamentally a negotiated activity between patient and nurse, with one side clearly more powerful than the other.

The alternative perspective is to view the process of reconciling inconsistencies as a component of the clinical decision-making process. This can be a hypothetico-deductive approach where the nurse recognising cues, forms hypotheses and tests them (Banning 2008) or uses intuition or a set of heuristics or “fast and frugal reasoning” (Dowding 2009 p, 310) to support decision making (Simmons et al. 2003). Being able to reconcile inconsistencies is a skill required by graduate nurses who should be competent in recognizing the “congruence between the patient’s speech and actions”(Patterson et al. 2008 p, 413). Observing for inconsistencies is essential to the accurate identification and description of psychiatric symptoms. For example, clinicians have identified the coherence of narratives as an important indicator of the level of insight into illness (Lysaker et al. 2002). Nurses need to be able to differentiate between the flatness of affect displayed by a patient with an affective psychosis and the slowed thinking of severe depression, in contrast to the flatness of affect associated with a patient with schizophrenia who has an inappropriate affect and poverty of thought (Pini et al. 2004). It is not unreasonable to conclude then, that mental health assessment practice of nurses may involve clinical judgement *and* the expression of power-relations.

Ongoing process

Finally, eight respondents spoke of the ongoing nature of the assessment process. The process of a comprehensive mental health nursing assessment is seen to continue for as long as the nurse and patient interact, with new pieces of information becoming evident with ongoing contact.

“The other thing about good assessments is that they will elucidate patterns over time ...It’s a work in progress. It’s an ideal we aspire to and we might approximate the ideals but...so much will not be discovered”.

Luke, Manager, 15 - 24 years

The desire for ongoing contact is expressed by patients as the desire for a close relationship with the nurse, they want consistency in the relationship to ensure that there is a depth of understanding (Barry 2007). This depth of understanding can only develop over time with continuity of contact between the nurse and the patient.

Discussion

The findings from this study indicate that the process of a comprehensive mental health nursing assessment consistently involves a number of activities. It involves engaging with the patient and putting them at ease. This can be seen as the nurse normalising the process of assessment to demonstrate empathy and to relax the patient so that they feel comfortable discussing often-difficult issues. Alternatively, it can be seen as indication of the subtle use of power-relationships to have the patient divulge symptomatology.

The majority of nurses in this study indicated that the process of a comprehensive mental health nursing assessment involved the identification of the patient's problem(s). This process of problem identification is augmented by the reconciliation of inconsistencies, where the nurse explores the internal consistency of the patient narrative with their own observations or information from other sources. Finally, the process is ongoing, as long as the patient has contact with the nurse, the process of assessment continues. The results of this study are important as a review of the literature failed to find any research into the process of a comprehensive mental health nursing assessment Coombs et al. (2011a) and thus, this study takes the first steps in better understanding contemporary mental health nursing assessment practice.

The findings of this study point to the process of a comprehensive mental health nursing assessment as a situated and negotiated social activity as well as a discrete stage in the process of nursing that requires information processing, problem identification and diagnostic reasoning (Latimer 1998).

Limitations

The study relied on interviews to elicit descriptions of nurses' assessment practice. This self-report approach is prone to influence from a number of factors including a desire to provide a description of the 'correct' rather than the true approach to mental health assessment and the influence of the nurses' recall of their most recent assessment experiences. An observational approach may have produced different insights into the process of mental health nursing assessment. A further limitation of the study is the process of recruitment of participants. Initial participants were known to the first author. While those recruited using an alternative method reinforced existing themes, the possibility of the introduction bias in the results cannot be discounted.

Policy implications

These findings along with the results of the larger study on the content and process of a comprehensive mental health nursing assessment (Coombs et al. 2011a, Coombs et al. 2012) have implications for practice, education, research and management in mental health nursing. Engaging with the patient is clearly a necessary step in building an empathic therapeutic relationship. However, building this relationship in a manner that illustrates an understanding of the impact of power on that relationship is an important component of reflective practice. Preparing aspiring mental health nurses to engage more effectively in the core process aspects of undertaking a comprehensive mental health nursing assessment will be a key challenge for mental health nursing educators, who have to provide educational experiences that expose the subtle power relationships at play in practice.

There is clearly a need for more research in this area. A first step would be the empirical verification of the core elements of the process of assessment identified by this study. Further work may focus on how nurses turn the problems that they have identified into goals that support patient recovery. While the accurate identification of patient problems and the ability to recognise symptoms is a necessary part of the mental status examination, this should not be to the detriment of attending to other aspects of the patient's presentation. Both patients and clinicians are calling for a more strengths-based recovery orientation to service provision (Anthony 1993, Slade et al. 2008). However the findings of this study indicate that in Australia, nurses focus on the identification of patient problems. Simply focusing on problems will increasingly not fit with contemporary practice expectations. Clearly, there is a need to understand if this focus on problem identification is central to the practice of nurses in countries like New Zealand, the United States of America or the United Kingdom, where the recovery orientation of service provision is more advanced (Stickley and Wright 2011).

Regardless of the country in which mental health nursing is being delivered, If there is significant variability in the content of the assessments being undertaken by mental health nurses (Coombs et al. 2012) and the process does not meet the expectations of contemporary practice, then nurse clinicians, researchers, educators and managers have a significant problem. It is a problem that requires a coherent policy response that includes agreement on the content and process of a comprehensive mental health nursing assessment and a response that ensures that research, education and management activity is focused on ensuring the delivery of that kind of assessment in practice. A failure to do so would call into question the very legitimacy of mental health nursing and its contribution to mental health care.

Conclusion

While assessment is the foundation of mental health nursing, no previous research has identified what is actually involved in contemporary mental health nursing assessment in practice. This study identified common processes undertaken during comprehensive mental health assessments by nurses with a range of experience. A better understanding of the process of a mental health nursing assessment and its part in producing a comprehensive mental health nursing assessment will support education, research and improvements in the quality of that assessment and ultimately the delivery of nursing care.

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Commentary

This commentary will discuss the use of standard measures as part of mental health nursing assessment practice. This is important because not one nurse in the current study mentioned the use of a standard measure as part of the assessment process (even though standard measures had been introduced into their clinical practice some ten years previously).

Using standard measures to support practice

None of the nurses in the current study mentioned using any standard measures as part of the assessment process. Savage (1991) argues that for the assessment process in nursing to claim scientific legitimacy then the methods of collecting data should be those that are used in science. The three principal methods available to conduct a standard assessment are: (1) interview; (2) observational techniques; and (3) rating scales and inventories. There is considerable overlap between the three different methods, with an interview including both observation and the use of rating scales; however, there is little nursing literature on how these principal methods are applied within nursing. As part of the assessment process, Othmer and Othmer (2002) advocate the use of quantitative standard measures for two purposes. First, it allows the nurse to examine a suspected impairment in a standardised way. Second, it provides the nurse with quantified information about impairment at a certain point and can serve as a baseline and allow the measurement of change.

The use of structured assessment tools has been advocated by a number of authors, not only as part of a comprehensive assessment (Barker 2004) but also the assessment of specific aspects of the consumers presentation ; for example, the assessment of mental health consumers' nutrition status (Abayomi and Hackett 2004) or the assessment of risk (Faay et al. 2013). Indeed, mental health nurses have been active in creating standard measures to evaluate or observe change in phenomena that are important to nurses. Including, the attitudes of nurses working in acute mental health units towards consumers (Baker et al. 2005); the quality of the nurse/consumer therapeutic relationship (Kim et al. 2001); the intensity of community mental health nurses workloads (Willis et al. 2012) and the assessment of nursing students confidence in performing psychiatric mental health nursing skills following training (Fiedler et al. 2012).

While standard measures are advocated as an important part of the practice of assessment for mental health nurses and are being developed to understand nurses and nursing practice, no nurse in this study indicated that they were used as part of the assessment process.

There may be a number of reasons why standard measures were not mentioned. Sometimes, the context within which an assessment is taking place also impacts on the ability of nurses to use standard measures as part of the assessment process; for example, Mathers (2012) found that nurses in acute inpatient units found it difficult to use structured assessment tools because of the frenetic pace of units. Meanwhile attitudes towards standard measures may play a part in their use in practice, with nurses seeing standard measures as lacking clinical utility (Callaly et al. 2006).

None of the nurses in the current study identified the use of standard measures as contributing to the process of a comprehensive assessment. This is an important observation because the current study also identified variability in the types of information these nurses collected as part of their comprehensive mental health nursing assessments. How standard measures might contribute to a reduction in variability in the information collected as part of a comprehensive mental health nursing assessment, will be explored later in this work.

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Chapter 6 No model of a comprehensive mental health nursing assessment?

Chapter 6 reports on the formal model used by the nurses who participated in the current study to guide their comprehensive mental health nursing assessments. In particular it explores the implications of not having a model that guides a comprehensive mental health nursing assessment. I do this in the article titled, No model of a comprehensive mental health nursing assessment?

Coombs, T. Crookes, P. & Curtis, J. (2013) Under review. Collegian

No model of a comprehensive mental health nursing assessment?

Abstract

During data analysis in a study of the content and process of a comprehensive mental health nursing assessment, one of the findings to emerge was that 15 of 18 mental health nurses did not describe using a formal model as part of their assessment practice. While not mentioning a model does not necessarily mean that they did use one, it would be reasonable to expect that if a model guided practice then it would be mentioned. As was the case with the remaining 3 nurses in the study, they indicated that they used the biopsychosocial model; however, they described this model in very different ways. This results in the conclusion that no model guided the assessment practice of the mental health nurses in this study. This paper explores the implications for mental health nursing if there is no model that guides comprehensive mental health nursing assessment practice. If no model guides practice then this seriously limits the profession's ability to educate for, research on, and improve the performance of, comprehensive mental health nursing assessments in practice. Further research is required to understand what model guides the assessment practice of mental health nurses, and if no model is used, how consistency in assessment practice can be assured.

Keywords: Models, Nursing, Assessment, Mental Health

Introduction

Assessment is a foundation of mental health nursing practice. However, a review of the literature revealed that while much has been written about what constitutes a comprehensive mental health nursing assessment, not a single paper could be found that describes how it is undertaken (Coombs et al. 2011a). A qualitative descriptive study using interviews with 18 mental health nurses found that there was significant variability in the way these nurses described the content of a comprehensive mental health nursing assessment, with different aspects of the patient's presentation being the focus of nurses' attention during assessment (Coombs et al. 2013a). It also found that the process of a comprehensive mental health nursing assessment involved engaging with the consumer to enable problem identification and to identify and reconcile inconsistencies in the consumer's narrative (Coombs et al. 2013c). This paper reports on one of the themes to emerge during data analysis in this study, which was that the majority of these nurses did not mention using a formal model to guide their assessment practice, and when they did indicate they used a model, they described the model in very different ways.

Models are useful in that they provide a common language for nurses describing concepts that are important to the profession, like caring, therapeutic alliance and assessment. Models guide practice, research and education and enable the demonstration of nursing's unique contribution to the delivery of health care (Jacob et al. 2008). If a model is not being used to guide the assessment practice of mental health nurses, then this could have serious implications for the practice, research and education of mental health nurses. This paper will describe the serendipitous finding of no model seeming to guide the assessment practice of a group of mental health nurses, and the implications for mental health nursing if this finding is true for mental health nurses in general.

Method

Following ethics approval from the University of Wollongong, interviews were conducted with 18 mental health nurses, ranging from new graduates (less than 12 months' experience) to experienced nurses (more than 20 years' experience), clinicians and managers working in either inpatient or community settings. The majority of participants came from New South Wales, Australia. The focus of the interviews was the content and process of comprehensive mental health nursing assessment, and all interviews began with the same open-ended question. "What is the content and process of a comprehensive mental health nursing assessment?"

Sampling was purposive in that potential participants had to be nurses who were currently working in clinical practice or service management and who were, or had undertaken mental health

nursing assessments in practice. The interviews lasted between 20 and 70 minutes. In this paper, all responses are de-identified to ensure all responses are anonymous and no participant can be individually identified.

The interviews were digitally recorded and then transcribed. These transcripts became data to be analyzed. Data was coded, then categorized using the constant comparative methodology (Glaser and Strauss 1967), and these codes and categories were reviewed to identify themes (Elliott and Jordan 2010).

Findings

One of the themes to emerge during data analysis was that there appeared to be no model that guided the assessment practice of these nurses.

No Model

It is significant that during interviews ranging from 20-70 minutes in length, 15 of 18 nurses interviewed for the project did not mention or allude to any formal or conceptual model(s) (nursing or non-nursing) in relation to guiding, or informing, their comprehensive mental health nursing assessment practice.

The biopsychosocial model

Three nurses did, however, indicate that a model was used as the basis for their comprehensive mental health nursing assessment. These three nurses referred to using the 'biopsychosocial' model and did so early in their interviews (between five seconds and three minutes from the start of their interview) of between 28 and 70 minutes. However, all three described the model in different ways. The first nurse described the biopsychosocial model in this way:

"we look for biological causes first, so that's the first thing we look at, if we have no joy with obvious biological aberrations, then we look for the psychological... So if we can't make sense of what's going on with the person biologically we then look to the psychological and if we have no real joy there, it's a bit of a mixed picture, we don't really understand the picture, we then look at the social explanations. Look at their social system".

(Clinician 15- 24 years of experience)

For this nurse the biopsychosocial model not only provides the basis for the areas that should be assessed as part of a comprehensive mental health nursing assessment, but also provides

a hierarchy that informs clinical decision making. For this nurse, the biological cause of mental illness is excluded before seeking a psychological cause or subsequently a social cause. Once the cause of the patient's problem is identified at the specific level of the hierarchy, then the appropriate intervention may be offered.

The second respondent also identified the biopsychosocial model but described it differently:

"The content... is that sort of total holistic approach to a person - so you want their immediate, what their immediate problem is, so the way I usually start is - "tell me what the problem is"... Umm, so you are looking at mental state, you are looking at their function - the level of functioning, their social situation... you're looking at symptoms, you're looking at things that they have described, at appearance... any sort of physical problems they have, their medical history"."

(Clinician 15 – 24 years of experience)

While this nurse identified the biopsychosocial model, the explanation of the components of this model is different to the first respondent. Initially it is described as a "holistic" assessment, but one that focuses on problem identification, a mental status examination and then social functioning, symptoms and finally physical health problems.

The third nurse to identify the biopsychosocial model provided a different description of the model.

"you look at Orem's theories and that sort of stuff, then basically you're covering your whole biopsychosocial sort of sub-theories down to your religious... I mean to your social needs to economic needs, your housing needs and so forth, so you're... incorporating your whole sort of sphere of what life is about."

(Manager 25+ years of experience)

Here, although the term *biopsychosocial* model is used, the components of that model are not immediately clear but it is holistic and includes economic and housing needs.

15 of the 18 nurses interviewed did not mention a model that informed their comprehensive mental health nursing assessment practice. The remaining 3 nurses indicated that their comprehensive mental health nursing assessments were guided by the "biopsychosocial model". However, although they reported using a model, their description of that model varied significantly

and does not appear to indicate the systematic use of the same “biopsychosocial” model. This data leads one to the conclusion that for all practical purposes these 18 mental health nurses did not offer or were unable to consistently articulate a model that guided their comprehensive mental health nursing assessment practice.

Discussion

When eighteen mental health nurses were asked to describe the content and process of a comprehensive mental health nursing assessment, if a formal model was being used to guide assessment practice then it would be reasonable to expect that a formal model would be mentioned, although they described it in different ways, three nurses did indeed mention using the biopsychosocial model to guide their assessment practice. However, the remaining fifteen mental health nurses made no mention of any kind of model.

The majority of nurses in this study may have made no mention using a formal model because in practice a formal model may get in the way of their assessment practice. Much of mental health nursing knowledge is tacit, hidden and the intuitive use of experience (Welsh and Lyons 2001), with an intuitive experiential approach preferred by nurses as part of their assessment practice (MacNeela et al. 2010). While nurses during their training are exposed to a variety of formal models (Kalofissudis 2007), nursing models have been criticized for using unworldly language and lacking practical benefit for those seeking recovery (Clarke 2011). That the majority of nurses in this study did not mention using a formal model may be an expression of their lack of practical benefit. Not mentioning a formal model may be a reaction to the standardisation of clinical practice through the use of models or practice guidelines and be an expression of these nurses autonomy and the importance they place on their individual clinical judgment (Timmermans 2005). Indeed, there may be advantages to not using a model to guide assessment practice; the nurse is not forced into one way of interacting with the consumer with the nurse able to use their experience, skill and creativity to undertake the individualised assessment of each consumer.

A model is a set of relatively general and abstract concepts that are central to a discipline and, provides a framework within which the attributes of mental health nursing can be described (Fawcett 2005). Binnie (1984) argues that without an explicit model of (mental health) nursing our beliefs about human beings, the goals of care and the knowledge base necessary to achieve these goals cannot be articulated. She argues that from the perspective of the medical model, human beings are seen as biological creatures whose integrity is altered by disease. The goal of care is seen as the treatment of disease, through the use of knowledge of physiology and pathology. While many

nurses would agree that this is not a model that underpins their approach to nursing care, most of the participants in this study failed to even reference a model that they used to answer the same questions. Those that did profess to using a model thus (presumably) believed that human beings are biopsychosocial creatures, but clarity regarding the goal(s) of practice and the knowledge necessary to achieve said goal(s) was not evident. In order to carry out consistent, comprehensive mental health nursing assessment in a meaningful and rational manner, which allows for meaningful sharing of assessment findings and evaluation of the efficacy of care, a model is essential.

Implications of no model for mental health nursing

Not using a model to guide mental health nursing assessment practice impacts on every aspect of mental health nursing, from mental health nursings' claim to professional status, to clinical practice, clinical supervision, education, management and research. In addition, not having a model has the potential to lead to widely differing assessment practices and different outcomes for those assessments.

There are a number of agreed hallmarks to a profession (Welie 2004). These hallmarks include the possession of a specific set of skills based on theoretical knowledge, these skills having been developed through extended and standardized education, and that the practitioner can demonstrate competence in these organized and codified behaviours. Mental health nurses claim professional status. It would be expected that with this status, mental health nurses should be able to articulate, without prompting, the model that guides such a fundamental part of their practice - their assessments. However, the respondents in this study failed to articulate a coherent systematic model that guided their personal comprehensive mental health nursing assessment practice, let alone a shared one. If this lack of a model is found more broadly then mental health nurses' claim to this professional status may be in question.

McAllister and Moyle (2008) argue that if nurses lack an explicit model of care, they are unable to explain their contribution to care and the outcomes of care. This results in their contribution being disregarded by other disciplines, management, the public and even themselves. As assessment is (or should be) the foundation of mental health nursing practice, the lack of a model means that assessment cannot be systematically undertaken, nor can the results of assessment and subsequent care be easily shared with colleagues.

In clinical practice, mental health nurses purport to undertake holistic assessments and work in a holistic manner (Happell et al. 2010). However, without a model guiding practice, or a model that is used consistently, any claim to holism cannot be demonstrated or ensured. This variation in

assessment can lead to variation in the type of interventions being offered. For example, nurses who don't include the assessment of drug and alcohol use would not identify the impact of drug use on a person's mental state. Without a model guiding assessment, practice consistency cannot be assured.

So, although nurses may think they are providing appropriate care, different approaches to assessment may result in consumers and carers experiencing inconsistency and confusion (Ondrejka and Barnard 2011) when receiving nursing care. One way of ensuring consistency in clinical practice is through clinical supervision which is, in part, meant to form and ensure normative practice, in that it enables the development of a consistent approach to care following norms or standards of practice (Brunero and Stein-Parbury 2008). However, if there is no model of a comprehensive mental health nursing assessment then clinical supervision cannot shape normative practice in relation to that assessment practice. Without a model, one nurse offering clinical supervision may focus on mental status examination, while another focuses on developmental history. We cannot be clear about the scope of clinical supervision or understand its success or failure in influencing normative practice if there is no model of practice.

Having no model will also impact upon what is taught to nursing students about mental health nursing assessment. If there is no model of a comprehensive mental health nursing assessment, then educational institutions and their staff will inevitably preference some knowledge or assessment practices over others, basically because there is no guide to content, other than curriculum recommendations and the 'academic freedom' of individual educators. Assessment practices and capabilities of graduates will therefore vary at the level of the course or even at the level of the individual educator(s) who taught them.

Similarly, without a model of a comprehensive mental health nursing assessment, nurse managers are unable to fulfil their clinical governance responsibilities. They are unable to manage the risk of mental health nursing assessments if, for example, mental health nurses' assessments do not include the consumer's potential for aggression and the risk this can pose for others, or the consumer's potential vulnerability from sexual assault and the risk this can pose for the consumer. Failure to assess these aspects of a consumer's presentation often results in a sentinel or significant events that can result in harm for the consumer. Nurse managers are unable to provide leadership, resource and enable good assessment practice if it is unclear what that assessment practice should involve.

Without a model for comprehensive mental health nursing assessment then researchers are also affected. They are unable, for example, to determine the efficacy of mental health nursing. If

each nurse has their own unique model of mental health nursing assessment, with its own unique goals and knowledge required to achieve those goals, then the nursing interventions offered may be equally idiosyncratic. Any difference in the outcomes of care may be a function of variation in assessment practice rather than the delivery of mental health nursing care per se.

Limitations

The study reported here is not without its limitations in terms of the generalisability of the data to the wider profession. There were only a small number of interviews, and a different set of nurses may have been able to articulate a consistent model that guided their comprehensive mental health nursing assessment practice. Indeed, a different approach to data collection through file audit or participant observation may have yielded a different result. The nurses in this study were not asked if they use, or prompted about their use of, a particular model to inform their assessment practice; if they were, the results may have been different. However, when asked to describe the content and process of that assessment, if any structured approach was used, then it seems reasonable to expect that these nurses would identify it or at least mention this approach (indeed 3 participants did). Finally, the recruitment process could have introduced a potential source of bias to the study, with some participants approached directly by one of the authors.

The fact remains that if this lack of the use of a model found in the interviews of these 18 mental health nurses is found more broadly, then the implications for the profession of mental health nursing are profound.

Conclusion

During the study of the content and process of a comprehensive mental health nursing assessment a theme to emerge was that no model appeared to guide the assessment practice of a group of mental health nurses. There is a need for more research into assessment, one of the foundations of mental health nursing practice. If other mental health nurses do not have a model that guides their mental health assessment practice then there are significant implications for mental health nursing's claims for professional status, clinical practice, clinical supervision, education, management and research.

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Commentary

The finding that the nurses in the current study did not use formal models as part of their assessment practice was deliberately reported as a separate article for a number of reasons. First, the lack of use of a model of mental health nursing assessment could be seen as explaining why the content of the assessments varied so considerably. Second, the lack of a model may explain why the process of assessment is impacted by factors outside the nurse's control, such as organisational, political, legal and economic factors. And finally Third, the lack of a model of mental health nursing assessment may explain the lack of research in the area.

This commentary briefly looks at the impact of models on nursing practice and argues that any model that is introduced into mental health nursing practice has to be simple and of direct relevance to clinical practice.

Models have been found difficult to introduce into both nursing in general and mental health nursing. O'Donovan (2007), in a study using in-depth interviews of nurses (N = 8) on two inpatient units in Ireland where the Tidal Model (a model of recovery orientated mental health care designed for nurses) had been adopted found that the model was used inconsistently, with staff just taking up the underlying philosophy and not the detail of the model. Similarly, Simpson and Taylor (2002) mailed a 22-item questionnaire that asked about the use and impact of conceptual models of nursing to sample health care agencies across Canadian provinces and territories. Of the 87 nurses from 47 agencies who responded to the survey, only 25% indicated any use of a conceptual model within their agency. Wimpenny (2002) explored the meaning of nursing models to practicing nurses and found after interviewing 14 nurses prior to, immediately after, and some one to two years after an educational activity around nursing models, that ultimately models were seen as "incidental" to practice. It is not surprising that nursing models have been "seen as unrealistic dogma from ivory towers and a diversion from intuitive care"(McCrae 2012 p, 224). So, any model introduced to practice must have immediate practical benefit for nurses if it is to have any chance of being adopted.

A pause to reflect

Each mental health nurse in the current study described collecting different information, with different priorities as part of a comprehensive assessment. As we have seen, there are significant implications for nurses, consumers and nursing in general if this variability is found more

broadly amongst mental health nurses. The mental health nurses in this study also described a mental health assessment process that focused on problem identification, and as we have seen, simply focusing on problem identification does not fit with contemporary recovery orientated practice. The mental health nurses also did not mention the use of standard measures as part of their assessment process, and they had no model that guided their assessment practice. Finally, models of practice face challenges in implementation if they do not have a direct practical benefit for nurses.

If the findings of this study are found more generally among mental health nurses, then mental health nurses in Australia face the challenge of being required to use standard measures as part of their routine clinical practice. The focus of this thesis now shifts from reporting on the findings of the qualitative descriptive study to exploring the implications of the results before offering a model of practice that supports consistency in assessment and recovery orientated practice. The next article explores the implications of the current study's findings on the adoption of recovery orientated practice.

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Chapter 7. The content and process of a comprehensive mental health nursing assessment: Is it recovery orientated practice?

Over the course of the qualitative study and the publication of results, Australian mental health services like other across the world were increasingly being driven to adopt a more recovery orientated approach to practice. Chapter seven looks at the implications for mental health nurses if the results of the current study are found more broadly. In particular, it focuses on the impact of problem identification as it relates to the delivery of recovery orientated mental health care delivery. This is done in an article titled, The content and process of a comprehensive mental health nursing assessment: Is it recovery orientated practice? *International Journal of Mental Health Nursing*. Accepted for publication. Coombs, T. Crookes, P & Curtis, J. (2013)

The content and process of a comprehensive mental health nursing assessment: Is it recovery orientated practice?

Abstract

A comprehensive mental health assessment is essential to understanding the needs of consumers and informs the mental health nursing care delivered; however, little is known of how assessment is undertaken in contemporary practice. This paper describes the content and process of a comprehensive mental health nursing assessment and then goes on to postulate implications for the provision of recovery orientated mental health practice. A qualitative descriptive approach was used with mental health nurses being asked open-ended questions regarding the content and process of their comprehensive mental health nursing assessment(s). How nurses described the content of a comprehensive mental health nursing assessment varied significantly. There was no evidence that they used a model to guide their assessment practice. The process of the assessment typically involved engaging with the consumer in an effort to identify their problems, in relatively unstructured ways. The finding of the study indicates that the assessment practices of mental health nurses are arguably not systematic or recovery orientated. If these findings are replicated then changes to the educational preparation and ongoing development and supervision of mental health nurses will need to be made, if services are to become recovery orientated.

Keywords:

Mental Health Nursing, Mental Health Nursing Assessment, Recovery

Introduction

Assessment is fundamental to mental health nursing practice and provides the basis for mental health nursing interventions (Barker 2004). To be seen as competent to practice in Australia, nurses should be able to conduct a “comprehensive and systematic nursing assessment” (Australian Nursing and Midwifery Council, 2006, p.8) and mental health nurses need to consider the “mental, physical, spiritual, emotional, social and cultural needs of the individual in the delivery of care” (Australian College of Mental Health Nurses Inc 2010 p, 273). These comprehensive mental health nursing assessments occur within the context of a service system that calls for a recovery orientation to practice (Resnick et al. 2005). This is a profound shift away from the traditional medical model paradigm and a move towards the consumer empowered organisation and delivery of mental health care that aims to promote recovery (Delaney 2010). But, without direct research into contemporary mental health nursing assessment practice there is no way of understanding the contribution that mental health nurses are making towards recovery orientated mental health care; nor is there any way of changing practice, where necessary, through education (Stacey and Stickley 2012) and management practice (Boardman and Shepherd 2011) to enable nurses to deliver recovery orientated mental health care.

Recovery

Across the world there have been demands for mental health services to adopt a greater recovery orientation to the way services are provided. (Hebert 2008, Australian Health Ministers 2009a, Andresen et al. 2000). The concept of recovery has been evolving, with a gradual shift in emphasis from ‘clinical’ or ‘service-based’ definitions of recovery to ‘personal’ or ‘user-based’ definitions (Slade et al. 2008, Schrank and Slade 2007). ‘Clinical’ recovery is more associated with the medical model, which considers remission as evidenced by a reduction of symptoms and/or improvements in functioning. The notion of ‘personal’ recovery has emerged from the consumer movement in mental health. The documented ‘life journeys’ of people experiencing mental illness form the basis of this alternative definition of recovery, which sees recovery as being less about the absence of symptoms and functional impairment and more about a change in outlook, and about leading a meaningful, purposeful life, with or without episodes of mental illness. Leamy, Bird *et al.* (2011) state that recovery is an individual, unique and gradual process that includes developing a sense of connectedness, hope and optimism about the future, an identity independent of illness, meaning in life, and empowerment. Recovery is also a process that occurs in stages from moratorium to growth (Andresen et al. 2003). Although a variety of factors outside mental health services can impact on the personal recovery process, such as community attitudes and access to

employment, education and housing, the role of a recovery orientation in the way mental health nursing is undertaken is seen as crucial to the way an individual's goals, as they relate to recovery, can be realised (Caldwell et al. 2010). Crucial to enabling recovery orientated practice would be an approach to assessment that does not simply focus on clinical recovery but also on important aspects of personal recovery.

In a review of the literature, (Coombs et al. 2011a) identified a myriad of different assessments in mental health nursing, including risk assessment, assessment of aggression, assessment of need, physical assessment, mental state assessment, assessment of specific symptoms such as depression, and outcomes assessment. However, despite the obvious centrality of assessment to mental health nursing practice, the review identified no study that described the content and process of a comprehensive mental health nursing assessment in practice.

This paper reports on a study aimed at providing a better understanding of the content and process of comprehensive mental health nursing assessment in practice. For the purpose of effectively communicating the findings of this study, the results were initially reported in three papers focusing on the content of a comprehensive assessment, the use of a model to guide mental health nursing assessment practice, and a description of the process of such an assessment. This paper specifically draws these findings together to provide the foundation for a discussion regarding the implications for recovery orientated comprehensive mental health nursing assessment practice.

By the end of this paper, the reader will have a better understanding of how a group of nurses described the content and process of undertaking a contemporary comprehensive mental health nursing assessment and how this description relates to the provision of care that is focused on supporting consumer recovery.

Method

Approval for the study was granted by the University of Wollongong Human Ethics committee. Potential participants were given written information on the study and consent was demonstrated through written consent to participate.

Sampling was purposive in that potential participants had to be nurses who were undertaking, or had recently undertaken, comprehensive mental health nursing assessments. This approach to sampling aimed to provide analytically useful information, not a representative sample (Higginbottom 2004). Participants were approached using two methods. The first was a snowballing method (Streeton et al. 2004) where the first author approached colleagues who were known to be

undertaking assessments in clinical practice. Some of these became participants and/or suggested other potential participants. This approach resulted in the identification of nurse unit managers of community mental health teams and inpatient units who then became the foundation for the second method of approaching potential participants. These managers talked about the study with their staff, and individual nurses identified themselves as willing to participate.

This sampling approach resulted in interviews being conducted with 18 mental health nurses. Primarily these nurses came from New South Wales; however, there were participants drawn from a number of Australian states. Interviews lasted between 20 and 70 minutes, with an average duration of around 30 minutes. Participants ranged from new graduates (less than 12 months since initial registration) to experienced nurses (greater than 20 years since registration). They were a mix of clinicians and managers working in either inpatient or community settings. The focus of the interviews was on the content and process of a comprehensive mental health nursing assessment. All interviews began with the same question: "What is the content and process of a comprehensive mental health nursing assessment?" These interviews were transcribed verbatim and the transcripts then treated as data. Words, sentences and passages in the transcripts of interviews were reviewed for themes that provided a description of the content and process of a comprehensive mental health nursing assessment. These themes were constantly reviewed by the authors as new data emerged (Elliott and Jordan 2010) and then the themes were subsequently checked with participants to ensure analytical and interpretational rigour (Tobin and Begley 2004).

The Content of a Comprehensive Assessment

There was no discernible consistency in the ways in which nurses in the current study described the content of a comprehensive mental health nursing assessment (Coombs et al. 2013a). All 18 nurses hesitated before they began to describe the content of a comprehensive mental health nursing assessment. When they began to describe the content of this assessment, they did so in quite different ways. The order varied, one nurse would start with drug and alcohol use, another would ask about family relationships, while another nurse would not even mention these as content areas to be covered by a comprehensive assessment. The nurses in this study consistently described the content of a mental health nursing assessment in very different ways.

In terms of recovery orientated assessment practice, only one nurse in the current study mentioned the need to gather information about the consumer's opinion as a component of the content of a comprehensive mental health nursing assessment. None of the nurses identified

aspects of personal recovery such as a sense of hope, feelings of empowerment, or personal goals as content components of a comprehensive assessment.

The non-use of formal models in undertaking a comprehensive mental health nursing assessment

Another element of the variability in the way that nurses in the current study described the content of a comprehensive mental health nursing assessment was their inability to identify a formal model of nursing assessment that they used to guide their practice (Coombs et al. 2014). No nurse identified a recovery orientated model or indeed a recovery orientation to their practice. With no model guiding practice, and variability in the content of what is being assessed, nurses cannot be sure that they are accurately monitoring the progress of a person's journey of recovery.

The process of a comprehensive mental health nursing assessment

In terms of the process of a comprehensive mental health nursing assessment, three primary themes emerged in the current study. The first was *engaging with the person*; the second, *'tell me what the problem is'* was augmented by the subtheme of *reconcile inconsistencies*; and finally, *ongoing process* (Coombs et al. 2013c).

Most nurses in the current study saw engaging the consumer as an essential part of the process of a comprehensive mental health nursing assessment. Phrases such as "putting people at ease", building a "bit of a rapport" or treating the person in a "normal way" were commonly used with respect to facilitating engagement. But once the person was at ease, the process of a comprehensive mental health nursing assessment became about problem identification (Coombs et al. 2013c).

Nursing in general has been seen as problem-orientated rather than solution-focused (McAllister 2003). Indeed, 16 of the 18 nurses in the current study talked about the identification of "problems" as part of a comprehensive assessment (Coombs et al. 2013c). However, recovery orientated practice requires a focus on more than just problem identification. It requires openness, a desire to collaborate as equals and a focus on the consumer's inner strengths (Borg and Kristiansen 2004). A recovery orientated approach to assessment would not simply focus on problem identification but would understand how the consumer successfully copes with symptoms, how they assert their goals and preferences and establish meaningful social connections (O'Connor and Delaney 2007).

Discussion

Coombs et al. (2011) were unable to identify any study that described the content and processes of comprehensive mental health nursing assessment, and therefore, this study appears to be the first of its kind.

One of the findings of the current study was the variability in the way that the nurses who participated described the content of a comprehensive mental health nursing assessment. The need for a comprehensive and systematic assessment is seen as a cardinal element of the competency required by professional bodies to practice as a nurse (Australian Nursing and Midwifery Council 2006). Indeed, one of the hallmarks of a discipline is the systematic application of a body of knowledge. However, the nurses who participated in the current study were unable to describe the content of a comprehensive mental health nursing assessment in a systematic manner.

One main limitation of this study was the small sample size, meaning the findings may not be generalisable. Also, the interviews were self-reports of nursing practice, so respondents may actually regularly carry out comprehensive and systematic mental health nursing assessments, but just did not describe them in this way. However, this possibility seems unlikely.

The finding of variability in mental health nursing assessment practice is not new. Over 20 years ago, Coler and Vincent (1987) identified variability in the way mental health nursing assessment was described in nursing textbooks. Duffy (1995) also found variability in the suicide assessment practice of nurses, and Goossens et al. (2008) came to the conclusion that there was a general lack of systematic activity in the assessment practices of community psychiatric nurses.

The nurses in the current study were also unable to describe the use of a model of assessment that informed their practice (Coombs et al. 2014). This finding reflects that of McAllister and Moyle (2008), who found that within a mental health service that espoused a recovery orientated model of practice, the nurses they interviewed ($n = 9$) were not able to state that they had a nursing model in mind when they set about working with consumers. If nurses have no model and the content of their assessment varies significantly, then consumers cannot be assured that they are receiving consistent, nor recovery orientated care.

In the current study, regardless of the content of the assessment or the use of a model, the process was said to involve a number of activities, starting with engaging with the consumer and attempting to put them at ease. This could be seen as the nurse normalising the process of assessment and an attempt to demonstrate empathy and to make the consumer feel comfortable

enough to discuss difficult issues, providing a foundation to collaborate and work with the consumer (Cleary and Dowling 2009). However, the majority of nurses in the current study also indicated that the process of a comprehensive mental health nursing assessment involves the identification of the consumer's problem(s). This focus on problem identification is evidence that a comprehensive mental *health* nursing assessment, which can be seen as positive, collaborative and health orientated, may in fact be merely a mental *illness* assessment, which is paternalistic, negative and illness orientated (Barker and Buchanan-Barker 2011b). If this focus on problem identification during assessment practice is found among the majority of nurses, then the adoption of recovery orientated practice will face significant challenges. Further work to support or challenge the results of this study therefore needs to be undertaken. But, if these results hold true then there are significant implications for mental health nursing assessment practice, education and research.

Mental health nurses report that they are knowledgeable (McLoughlin and Fitzpatrick 2008) and confident (Gale and Marshall-Lucette 2012) that they work in a recovery orientated manner. However, none of the nurses in the current study identified important aspects of personal recovery such as hope, empowerment and personal ownership as areas that they covered in a comprehensive mental health nursing assessment. If they are not assessing for these aspects of the person, then they cannot understand or support the individual's personal journey of recovery. This is not to say that psychological aspects of personal recovery should be the sole focus of a mental health nursing assessment; clearly, traditional areas of clinical recovery assessment, like risk, still need to be part of a comprehensive assessment.

If mental health nurses are to undertake comprehensive and systematic assessments in a recovery orientated manner, then the content and process of those assessments and the model that underpins those assessments need to be agreed. An agreed model would provide a foundation upon which the systematic planning, implementation and evaluation of recovery orientated mental health nursing care could rest. Without such an explicit model, beliefs about the person, the goals of care and the knowledge base necessary to achieve these goals are missing (Binnie 1984). Indeed, without explicit agreement on this model, recovery orientated mental health nursing assessment practice cannot be encouraged and supported by nursing leaders (Cleary et al. 2011).

Models of recovery orientated practice exist: the Tidal Model specifically articulates the importance of joining with individuals to gain a sense of meaning in life (Barker 2001), while the collaborative recovery model emphasizes the importance of hope, autonomy, self-determination and consumer participation (Oades et al. 2005). Frameworks for recovery orientated practice are being produced (Victorian Government Department of Health 2011) and a range of recovery

orientated mental health measures have been developed (Milton et al. 2005). However, models, frameworks and assessment tools in and of themselves do not support a consumer's personal journey of recovery or produce recovery orientated practice. While there have been efforts in psychiatry to adopt a collaborative, recovery orientated, strengths-based approach to assessment (Chopra et al. 2009), which consumers find more satisfying (Bjorkman et al. 2002), it has proved challenging (Deane et al. 2006). There is a need for guidance on how these models, frameworks and tools can be turned into recovery orientated practice.

There is a need for further research aimed at better understanding recovery orientated mental health nursing assessment practice. The results of the current study may have been different if a participant (nurse) observation approach had been adopted. Would recovery orientated assessment practice have been observed? How do nurses and consumers experience recovery orientated assessment? There is a need to understand the barriers to the completion of a comprehensive and systematic recovery orientated mental health nursing assessment and how these barriers can be overcome.

Conclusions

Given the limitations of the current study, there is clearly a need for more work in this area. The variability in the content of a comprehensive mental health nursing assessment as described by the nurses in the current study, if widespread, has significant implications for practice. Variability in assessment will no doubt lead to variation in the focus of care, the type of interventions offered by nurses and the way in which the success or failure of those interventions will be determined. Inaccurate assessment based on a lack of information in fact may have a detrimental effect on the consumer. As Barker (2004p 45) points out, nurses "cannot offer valid and reliable forms of nursing care without valid and effective assessment". The nurses in the current study focused on consumer problems, which, while no doubt important for understanding clinical recovery, is less important to the assessment and understanding of a person's personal journey of recovery. The content and process of a recovery orientated mental health nursing assessment urgently needs to be identified, agreed and implemented into routine practice.

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Commentary

This paper drew the results of the previous four papers together and asks, what are the implications of this study's findings for mental health nursing? The introduction of recovery orientated practice is one of the largest paradigm shifts in mental health, with a significant impact on the practice of nurses. Across the world, there have been demands for mental health services to adopt a greater recovery orientation to the way services are provided (Piat et al. 2010, Australian Health Ministers 2009a, Kaewprom et al. 2011). This commentary further explores the challenges of adopting a recovery orientation to practice with a view to how a recovery orientation to practice maybe supported.

The introduction of recovery orientated practice has proven a challenge. Aston and Coffey (2012), in a thematic analysis of a focus group with consumers and nurses, found ambiguity around the concept of recovery and confusion around the practicalities of the implementation of a recovery orientation to practice in acute mental health care. Cleary et al (2013) found that nurses on acute units viewed the concept of recovery with some scepticism; however, they also found that some of the ideas and practices associated with the recovery movement have been adopted to some degree by nurses working in the acute end of service provision. Training can thus have an effect on mental health providers' knowledge, attitudes, hopefulness and optimism regarding recovery (Glascoe 2003).

Moving towards a recovery orientated approach to care is a significant challenge to the traditional practice of mental health nurses—a practice that can be seen as relying on subtle power relationships, which gives nurses authority over consumers and focuses on a medical/ biological understanding of the consumer's experience that holds a pessimistic view of the continuation of symptoms (Walsh et al. 2008). Indeed, the paternalistic and stigmatising attitudes of student nurses result in them finding it a challenge to share decision making with consumers (Tee et al. 2007). A recovery orientation requires a focus on empowering the consumer, acknowledging their expertise and requiring the nurse to support, rather than direct, their (the consumer's) journey of recovery (Barker 2003). Encouraging more recovery orientated nursing practice is a perennial issue; Munjas, writing nearly 30 years ago, implored nurses to “use the power of their practice to empower clients, and not dominate, coerce, or control them” (Munjas 1986).

Moving away from a problem-focused assessment process to a recovery orientated practice may be a challenge for nurses, but there are ways that the assessment practice of nurses can become more focused on the positive aspects of the person, their strengths and abilities, rather than

their deficits. Wand (2013) identifies an approach to questioning that focuses on adaptive coping strategies, that is solution focused rather than focusing on reinforcing deficits, while others have argued that calling ourselves mental health nurses simply exposes the fact that nurses actually focus on deficits and difficulties (Barker and Buchanan-Barker 2011a).

One pragmatic solution to the challenge of the introduction of a recovery orientation to practice amongst nurses who vary in the way they undertake comprehensive mental health nursing assessments, potentially focus on problems and have no model which guides their assessment practice is to use what they are already required to do, nurses should use the measures that have been introduced as part of National Outcomes and Casemix Collection (NOCC).

The next article focuses on the use of the standard measures that make up the NOCC, as a model that supports consistency in assessment and encourages recovery orientated practice. It offers a solution for the issues that have been identified in the previous articles.

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Chapter 8 Using standard measures to support consistency and a recovery orientation to mental health nursing assessment and practice.

It is important to remember that while the content and process of a comprehensive mental health nursing assessment were reported as separate papers, they in practice occur at the same time. Chapter 8 suggests a solution to the challenges identified in the previous papers, in particular, variability in assessment content and a focus on problem identification; this is done by exploring the use of standard measures to support consistency and a recovery orientation to practice, in the article titled, Using standard measures to support consistency and a recovery orientation to mental health nursing assessment and practice. *Issues in Mental Health Nursing*. Under review. Coombs, T. Crookes, P. & Curtis, J. (2014)

Using standard measures to support consistency and a recovery orientation to mental health nursing assessment and practice.

Abstract

There is significant variability in the way that some mental health nurses describe the content of a comprehensive mental health nursing assessment. One way of reducing variability is through the use of standard measures that provide structure and consistency to mental health nursing assessment. In Australia, New Zealand and the United Kingdom standard measures such as the Health of the Nations Outcomes Scales have been mandated for use in mental health services; however, concerns have been raised that the use of such measures reduces the potential for individualised recovery orientated practice.

This paper argues that nurses can use standard measures to support consistency in the content of mental health nursing assessment as well as the individualised recovery orientated assessment of mental health consumers. Standard measures provide the opportunity to undertake ideographic (Individual) assessment while at the same time making use of nomothetic (group) data to contextualise the presentation of the individual consumer for both the consumer and nurse. Standard measures provide an opportunity for mental health nurses to have conversations with consumers that are open, honest and empowering. The challenge for mental health nurses is to explore these opportunities.

This paper argues that mental health nurses need to take a fresh look at standard measures in order to take advantage of the opportunities that the use of such measures provides which includes consistency in assessment and the potential for recovery orientated practice.

Keywords: Assessment, Psychiatric Nursing

Introduction

Assessment is fundamental to mental health nursing practice and provides the basis for mental health nursing interventions (Barker 2004). A recent study of the assessment practice of mental health nurses (Coombs et al. 2013c) found that the process involved engaging the consumer

and making them feel comfortable and then looking for problems they may be experiencing. That study also found that the nurses interviewed described the content areas of a comprehensive mental health nursing assessment in very different ways, with no two nurses covering the same domains (Coombs et al. 2013a). This variability in the content of these mental health nurses assessments may in part be the result of these nurses not consistently using a formal model to guide their assessment practice (Coombs et al. 2014). Within the larger contextual issue of there being no generally agreed model of care (and thus assessment) within nursing, here we focus on mental health nursing, the implications of this study's findings and a potential resolution are identified

If mental health nurses have no underlying model to guide their assessment practice and the content of that assessment varies between nurses then there is a significant problem in ensuring consistency in the delivery of care as differences in assessment. This will result in different interventions being offered and potentially different outcomes of care. If mental health nurses merely focus on client problems, then their ability to deliver recovery orientated practice, which is desired contemporary practice, must be called into question (Coombs et al. 2013b). This paper argues that the use of standard measures can play a part in overcoming variability in the assessment practice of nurses and support the delivery of recovery orientated nursing care.

Background

In Australia, the adoption of recovery orientated practice has been identified as a priority area for mental health service reform (Australian Health Ministers 2009b) and supported by the development of a National framework for recovery orientated mental health services (Commonwealth of Australia 2013). Each consumer's recovery is a uniquely personal process that includes participating in meaningful activities with the support of others, like nurses (Salzmann-Erikson 2013). This national framework recognises the need for consumer ownership of the process by taking responsibility for their own wellbeing, including developing a sense of hope and personal meaning (Oades and Anderson 2012). To achieve recovery orientated practice requires openness on the part of the nurse and collaboration with consumers as equals (Borg and Kristiansen 2004). Approaching practice in this way can be seen as an *idiographic* approach to practice, aiming to understand the individual's unique personal story and journey.

At the same time as adopting a recovery orientated approach to practice, Australia has introduced a National Outcomes and Casemix Collection (NOCC) (Department of Health and Ageing 2009). This has seen an agreed set of standard measures introduced into routine clinical practice. These standard measures include a consumer-completed measure: the Kessler-10 (K-10) (Kessler et

al. 2003) and a nurse-completed measure: the Health of the Nation Outcomes Scales (HoNOS) (Wing et al. 1998).

The K-10 is a consumer self-report measure and was originally developed as a brief screening tool designed to identify psychological distress. It consists of 10 items, and for each item the consumer indicates the amount of time during the previous four-week period that he or she has experienced the particular problem. There is a five-level response scale that ranges from *none of the time* (1) to *all of the time* (5). Brooks, Beard et al (2006) undertook a factor analysis of the Kessler-10 and identified four factors that make up this broad construct of distress: nervousness, agitation, fatigue and negative affect.

The HoNOS is completed by the nurse and comprises 12 items covering:- overactive, aggressive, disruptive or agitated behavior; non-accidental self-injury; problem drinking or drug taking; cognitive problems; physical illness or disability problems; problems associated with hallucinations and delusions; problems with depressed mood; other mental and behavioural problems; problems with relationships; problems with activities of daily living; problems with living conditions; and problems with occupation and activities(Wing et al. 1998) . Each item of the HoNOS is rated on a five-point scale (0 = no problem; 1 = minor problem; 2 = mild problem; 3 = moderately severe problem; 4 = very severe problem). Together, these measures seek to gather information from the individual to develop a *nomothetic* or general understanding of consumers of mental health service.

However, the introduction of recovery orientated practice has been seen as slow and patchy (Gilburt et al. 2013) with some nurses seeing it as more rhetoric than reality(Cleary et al. 2013). While there is some evidence that standard measures are being used in clinical practice (Coombs et al. 2011b), concerns have been raised that such standard measures lack clinical utility (Cheung et al. 2009) and there is a reluctance on the part of mental health nurses and other mental health service staff to use standard measures (Callaly et al. 2006, Trauer et al. 2009, Garland et al. 2003), even if it improves the outcomes of care (Walter et al. 1998).

This paper argues for the use of standard measures as a part of nursing practice to achieve two objectives. The first is to reduce variability in the content or types of information that mental health nurses seek as part of their assessment practice with the aim of achieving consistency in assessment. The second is to promote a recovery orientation to the practice of nurses that supports the active engagement of consumers in the process of assessment and monitoring their individual journey of recovery through the use of nomothetic standard measures in an idiographic way. By the

end of this paper the reader will have an understanding of how standard measures can achieve both objectives.

However, before these objectives can be achieved, there is a need to discuss the challenge of blending an idiographic (individual) recovery orientated approach to nursing practice with standard measures that are orientated to providing a nomothetic (general) understanding of the consumer.

Nomothetic and Idiographic approaches in mental health

Germany in the 19th Century saw the separation of science into two camps: *Naturwissenschaften* and *Geisteswissenschaften* (Salvatore and Valsiner 2010). In the former, natural laws or general (nomothetic) principles were to be identified, while the latter was concerned with unique (idiographic) instances. Generally speaking, the former approach became associated with the natural sciences such as physics, and the latter with the humanities such as history and literature; however, in mental health both approaches (understandably) were embraced.

Levine, Sandeen et al (1992) assert that nomothetic understanding provides mental health nurses with three broad opportunities. Firstly, nomothetic understanding can describe the general principles of complex constructs such as behaviour, cognition, physiology or relationships, so the general concept of classic conditioning can provide insight into what sustains or modifies a consumer's behaviour in relation to anorexia nervosa (Strober 2004). Secondly, nomothetic understanding can provide normative data and the opportunity to predict the probability that a particular mental health issue will exist or vary in some way with the existence of another issue. A consumer with drug and alcohol problems is in all probability more likely to have problems with depressed mood than someone who does not abuse alcohol or drugs (Pacek et al. 2013). Thirdly, a nomothetic understanding can provide information about the effects of certain treatments on certain groups of people by demonstrating, through research based on scientific principles, that the intervention works better than no intervention at all or an alternative intervention (Berry 2002). While this kind of knowledge can hold tremendous opportunities, it is based on probability theory which means that these general rules may not hold true for some consumers.

In contrast, practitioners who adopt an idiographic approach to practice identify people as unique individuals and are of the view that it is only through an in-depth analysis of the individual's situation that a true understanding of them develops. Indeed, some clinicians would argue that any kind of nomothetic or generalised knowledge is invalid when it comes to human beings (Salvatore and Valsiner 2010). This notion of individual experience is central to the adoption of a recovery

orientated approach to practice where the insights and lived experience of the person with a mental illness, guide practice. An idiographic approach requires the nurse to affirm the personal identity of the individual and move beyond the constraints of such broad and limiting categorisation such as diagnosis(Commonwealth of Australia 2013).

Barker (2004) asserts that professionals need to ask the consumer what has worked for them in the past and what they think will work right now. This represents an idiographic consumer-centred focus of care in place of the use of nomothetic standardised techniques. Barker's approach thus provides a contrast between the adoption of evidenced-based guidelines that are usually developed for a particular diagnostic category (group), with a deeper, consumer-centred idiographic understanding of the person. While the advantage of clinical guidelines is that treatment can be clearly specified and evaluated, in clinical practice it is often more complex than the simple categories used in nomothetic studies. One of the criticisms of randomised controlled trials, the gold standard of evidence based practice, is that participants involved in these trials often have a very clear set of similar characteristics, such as depressed mood; however, in routine clinical practice, consumers typically present with a range of different issues such as depression *and* anxiety, relationship problems and variability in functioning. In everyday clinical practice, consumers often present as a challenging set of inter-relationships, not a 'classic case'.

Concerns regarding standard measures

Valenstein et al (2009) cautions that the use of standard measures may not capture the unique characteristics of an individual consumer's presentation. Consumers with depression may experience this phenomenon in different ways, with some experiencing angry rather than sad moods. However, the Beck Depression Inventory (Beck et al. 1961), does not include items for angry mood but for irritability and agitation. Conversely, standardised measures may include items that are not important to individual consumers; for example, a loss of libido is a common item on depression scales, but individual patients may not be concerned about this symptom and so the item on the scale may not be selected because it isn't seen as important or of sufficient importance for a consumer completing the measure to select it, even though it may be a phenomena that they experience. These examples indicate that standard measures at an individual level may be meaningless to the consumer and produce similarly meaningless information for nurses who are assessing them. However, if constructed properly, these standard measures can provide the foundation upon which a nomothetic understanding of consumers can be based and the probability of the existence of a particular disorder, or the success or failure of a particular treatment, can rest,

in individuals. They can also provide information about an individual consumer's experience in relation to other consumers or the population in general.

De Matteo et al (2010) warn that both idiographic and nomothetic approaches have their advantages and disadvantages and neither alone is sufficient. If the nurse takes too much of an idiographic approach, the potential for a probabilistic understanding of the consumer's behaviour or the potential efficacy of an intervention is lost. Meanwhile, adopting a purely nomothetic approach means that the potential impact of individual difference may render the understanding of the consumer's condition, or the relevance of the intervention to the individual, meaningless. The challenge for nurses then, is to understand how they can work in an idiographic manner using standard measures whilst taking into consideration nomothetic science and the opportunities it provides (Westen and Weinberger 2004).

Using standard measures for idiographic practice

Haynes, Mumma and Pinson (2009) have identified a number of ways in which standard measures that produce nomothetic understanding can be also used in an idiographic manner. First, the standard measures selected for use and their method of application can be individualised; when working with a consumer whose primary issue is depression, the nurse could choose a standard measure of depression such as the Beck Depression Inventory (Beck et al. 1996), or a consumer whose primary issue is psychotic phenomena could be assessed using the Brief Psychiatric Rating Scales (BPRS) (Overall and Gorham 1962). Second, information from standard measures can be used to construct an idiographic case formulation, where the various issues facing the consumer and the strengths that they bring to situations are identified using a standard measure and these are then brought together as part of the formulation process prior to management or recovery planning (Mellsop and Banzato 2006). Third, elements from a nomothetically based standard measure can be selected for use with a particular consumer, in that they can be used to identify the most clinically significant issue facing the consumer, which is then used to monitor change on one issue that is important to both the consumer and the nurse (McKay and McDonald 2008).

The discussion that follows focuses on the exploration of the second use of standard measures for idiographic case formulation. It describes how standard measures support consistency in assessment practice and then explores how nurses can use standard measures and the nomothetic understanding they provide, in an idiographic, recovery orientated manner. It does this by exploring the use of two measures: the Kessler-10 and the Health of the Nation Outcome Scales (HoNOS).

Whilst this discussion uses measures that are part of the Australian NOCC , these are simply being used as examples; regardless of the standard measure, the focus is on how nurses can use standard measures can promote consistency in nursing assessment practice and practice that is recovery orientated.

By using these measures as part of clinical practice, nurses can ensure consistency in the content of their assessments because each assessment that includes the K-10 must include the consumer's perspective of their overall level of psychological distress, nervousness, agitation, fatigue and negative affect, and to rate the HoNOS, the nurse must seek information about each of the 12 domains that make up the HoNOS. Using these measures also ensures that nurses' assessments do not merely become narrow assessments of symptoms, but also include behavioral disturbance, symptomatology, the functional impact of physical impairments and social functioning. Such measures can also be used to support recovery orientated practice because they can represent clinically meaningful scenarios (McKay and Coombs 2012), promote discussion between the nurse and the consumer and empower the consumer to monitor their own recovery.

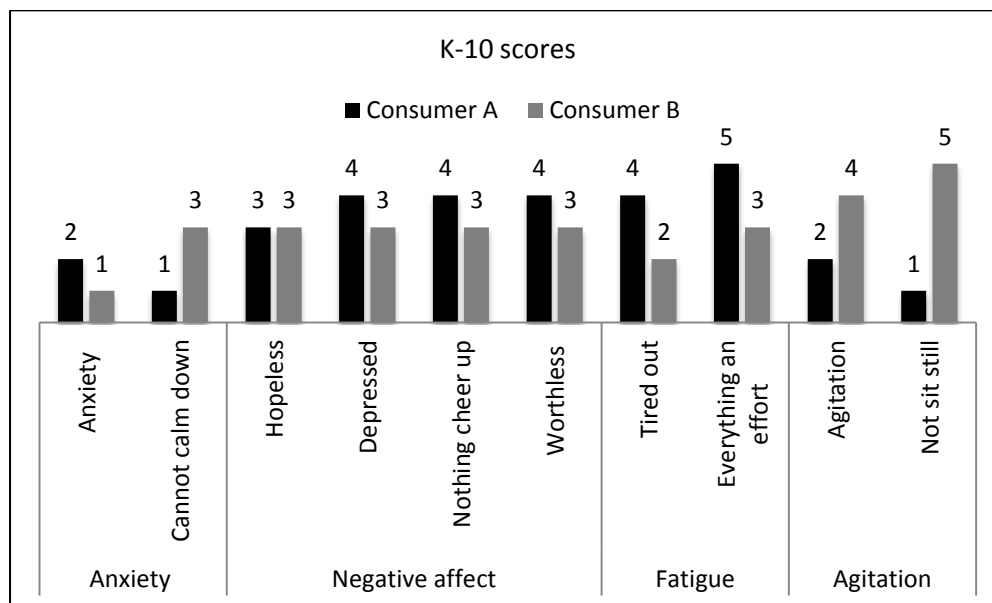
Recovery orientated practice includes fostering hope and empowering the consumer (Ruscinova et al. 2013) in part through the use of caring and respectful communication (Anthony 2008), which includes openness and collaboration as equals (Shepherd et al. 2008). Explicitly inviting the consumer to share their opinion of these ratings is one method of enabling shared decision-making, thus providing an important component of recovery orientated practice (Matthias et al. 2012). The examples that follow aim to provide insight into the presentations of consumers which can provide the nurse with the opportunity to have a conversation with them about how they are and how they want to be in the future. Consumers may wish to discuss the insights that standard measures provide to the triad of care: consumers; carers; and nurses. They also want to share their perspective via the consumer completed measures and gain an understanding of the nurses view, by discussing the measures completed by nurses. (Black et al. 2009). In New Zealand where the HoNOS has also been mandated for use, consumers are specifically encouraged to discuss HoNOS ratings with their service provider (Te Pou 2013).

The examples that follow first describe how nomothetic measures can be used to provide an idiographic understanding of the issues facing the consumer and secondly how comparing the individual with the group can provide empowering insights for the consumer and the nurse.

Nomothetic measures can provide an idiographic understanding

The K-10 as a standard measure of distress can be used to support idiographic practice through a focus on how the individual rates particular items or factors and in the discussion of these ratings with the consumer in a recovery orientated manner. Consider the following scenario: two consumers present; consumer A is a 20-year-old man and Consumer B is a 65-year-old woman. After completing the K-10 they both score 30, giving a similar indication of psychological distress. However, looking at individual factors that make up the K-10, the individual presentation of each consumer is very different (see Figure 1).

Figure 1. Differing item scores on the K-10 for two consumers with the same overall score.



Brooks and Beard (2006) provide a nomothetic understanding of how consumers generally complete the K-10 measure. They found that those with a diagnosis of depression scored higher on negative affect and lethargy, while those with a diagnosis of anxiety scored higher on nervous, agitation and lethargy factors. Meanwhile, those with an alcohol and other drug disorder (AOD) scored higher on negative affect and agitation factors. Figure 1 shows Consumer A and Consumer B self-reporting different patterns of concern using the K-10.

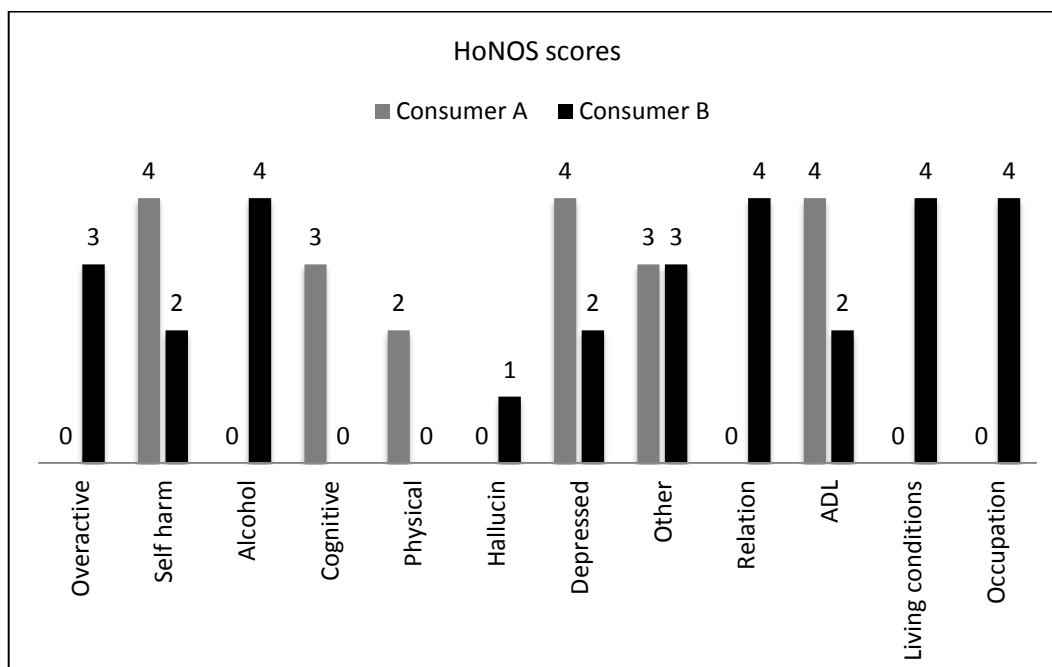
For Consumer A, who self-reports negative affect and lethargy (a pattern consistent with depressed mood) the focus of the conversation between the nurse and the consumer may be on strategies to manage the lethargy the consumer is experiencing. The nurse and the consumer can collaborate to identify behavioural activity goals to ameliorate the effects of this lethargy. In contrast, Consumer B self-reports negative affect and agitation, which is consistent with an alcohol

and other drug disorder. The conversation between the nurse and this consumer may focus on relaxation methods to deal with the agitation and setting goals for the performance of relaxation techniques on a regular basis. Independently, the nurse may also consider motivational interviewing to facilitate behavior change if the consumer does not recognise the need for change. If these same measures are used again as a part of an ongoing assessment process, then there is the obvious opportunity to identify any change that has taken place in the consumer's level of distress nervousness, agitation, fatigue or negative affect that may have taken place as a result of the consumer or nurse's activities.

Taking this nomothetic understanding, the nurse can work in an idiographic manner, individualising care for the consumer. Having a conversation with the consumer regarding the insights that the standard measure provides is one way of empowering the consumer to take personal ownership and responsibility for their recovery (Oades and Anderson 2012), particularly if this conversation is focused on how things can change for the consumer through different interventions.

A similar unique variation can be seen for the HoNOS ratings of these two consumers (see Figure 2).

Figure 2. Differing items scores on the HoNOS for two consumers with the same overall score.



The HoNOS represents a summary of the nurse's assessment, with any rating of two or higher being considered 'clinically significant' (Burgess et al. 2009). Reviewing the nurse's rating of these consumers, we see that the individuals vary in their presentation in such a way that would

require very different nursing interventions. Nurses can use standard measures and a simple mnemonic such as 'SIGO' to first identify the consumers **Strengths**, the **Issues** facing the consumer, their **Goals** and any **Obstacles** they may face in achieving their goals. For consumer A their strengths are supportive relationships; the issues may be their depressed mood and self-harm. In contrast, for consumer B their strength may be their physical wellbeing; while their issues are drug and alcohol use, relationships and their social conditions.

Sharing these observations with the consumer is one way of having an open and honest conversation that is aimed at developing trust. This is not to say that on occasions, differences in perspective may not involve challenging conversations, but challenging conversations are a part of clinical practice; indeed, conversations based around standard measures can be seen as the *radical genuineness* of dialectical behaviour therapy with the nurse treating the consumer as valid, recognising that they have capabilities, but also difficulties and incapacities (Neacsiu et al. 2012). In short, taking the approach of sharing their ratings, the nurse treats the consumer as an equal (Sneed et al. 2003). Conversations that include standard measures provide an opportunity for the nurse to clarify his or her own thinking based on feedback from the consumer, and vice versa and this is important given the evidence that nurses' and consumers' perspectives on standard measures can differ significantly (Trauer and Callaly 2002).

Comparing the individual with the group

Access to normative data—a type of nomothetic information—on the K-10 and HoNOS provides another insight into the presentation of these consumers and an opportunity for different kinds of conversations. Normative information for the K-10 is available, given its extensive use in epidemiological studies (Andrews and Slade 2001), so that the way the individual consumer completes the measure can be compared with the general population. Table 1 shows scores on the K-10 and what these generally reveal about consumers who score in a certain way when compared with the general population.

Table 1. Interpreting scores on the K-10.

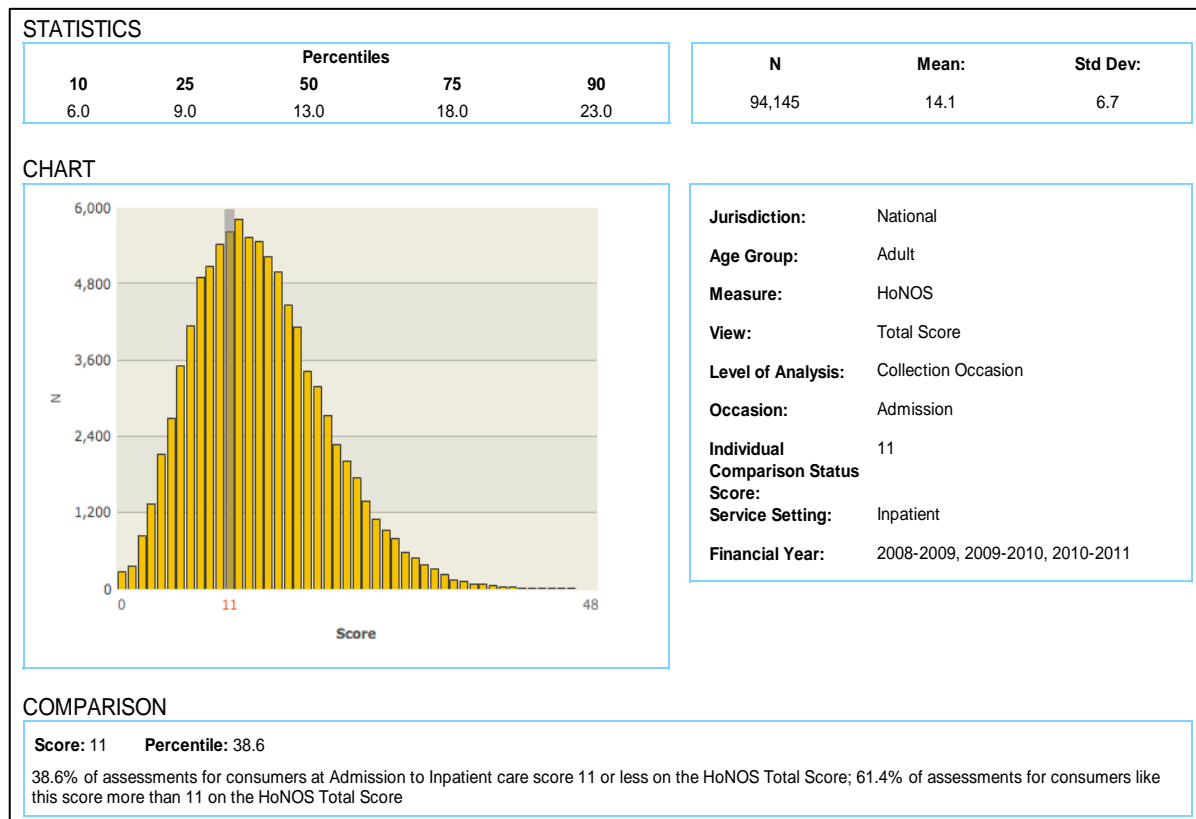
Score	Indication
10-19	This score indicate that the client or patient may currently not be experiencing significant feelings of distress.
20-24	The client or patient may be experiencing mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.
25-29	The client or patient may be experiencing moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder.
30-50	The client or patient may be experiencing severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.

Source: (Australian Bureau of Statistics 2012)

Consider Consumers C and D; both have completed the K-10. Consumer C scores 38, while consumer D scores 15. For Consumer D, this information may be very empowering, reassuring her that her experience is similar to other members of the community. Likewise for Consumer C, his score may be affirming for him because it reassures him that the level of distress he is experiencing is significant and in need of attention. This affirming of the consumers' level of distress may account for the relief that some consumers experience once they have been given a diagnosis. Making "the invisible visible" (Hayne 2003p, 725) for some consumers this means the start of the recovery process. Of course the delivery of any type of nomothetic feedback needs to be tailored to the individual (Gallagher et al. 2010).

Similarly, scores on the HoNOS can provide a reference point for consumers and nurses (see Figure 3). Take the consumer that scores 11 on admission to an inpatient unit in Australia. Accessing nomothetic knowledge via the internet (www.amhocn.org), the consumer can be compared with others under care. The consumer who scores 11 sits around the middle of the population under care on admission to inpatient units in Australia. This again can be an empowering piece of information for a consumer. The consumer could argue for or against continued care, for example. Indeed, a consumer has been able to use information from a standard measure to, in part, argue for the discontinuation of a community treatment order (Trauer and Jones 2002).

Figure 3. Inpatient HoNOS admission scores.



Discussion

Mental health nurses should be concerned that the focus of some nurses assessments are on problem identification (Coombs et al. 2013c) and that the content areas of some nurse's assessments vary greatly (Coombs et al. 2013a). This type of variability in assessment can lead to variability in the treatments being offered and variability in the outcomes of care. As Harris and Happell (1999) observed over 10 years ago, an ad hoc approach to assessment is to nursing's disadvantage and against its espoused humanitarian ideology.

The examples provided in this paper demonstrate, standard measures such as the K-10 and the HoNOS can provide a wealth of both idiographic and nomothetic understanding. They help ensure consistency in the types of information mental health nurses collect as part of their assessment practice. Importantly for recovery orientated practice, these standard measures can be used to support the involvement of consumers in the assessment and care planning processes, if they are used in this way. While this paper has focused on the use of the K-10 and HoNOS, there is no doubt that other measures may be more suitable in some circumstances. As Haynes, Mumma and Pinson (2009) point out, the first step may be identifying the appropriate standard measure for use with an individual consumer. While the measures used as examples here have the advantage

that they collect information from the consumer and nurse perspective, opening up the opportunity to explore differences of opinion, they are measures that focus on consumer deficits. Other measures may be more useful, such as recovery orientated measures (Oades and Anderson 2012), measures of consumer strengths (Bird et al. 2012) or measures of social inclusion (Coombs et al. 2013d). The point is that regardless of the measure, the use of standard measures ensures consistency in the content of a nurse's assessment, whatever that content may be. The fact that mental health nursing doesn't have an agreed model of assessment and that does not seem a concern to some nurses is outside the scope of the current paper. When used in a recovery orientated manner, standard measures can help to demonstrate the nurse's genuine interest in the consumer's perspective, by facilitating sharing of information in an open, honest and transparent manner. This information can then be used to empower the consumer to set their own goals in a way that can be monitored in a consistent manner. What this paper has outlined is how standard measures, which are nomothetic knowledge, can be used in an idiographic manner.

It is clear that to use standard measures in the way advocated in this paper requires clinical skill. Regardless of the measure, when to offer a consumer self-report measure, the timing of discussions around measures, the language used, and the translation of results into goals generated with the consumer are all skills to be developed. The preparation of mental health nurses needs to include the use of standard measures in practice, how to include consumer self-report measures in a clinically meaningful way, or orientate the consumer to a model of practice that makes use of standard measures that are completed by the nurse. Importantly, this preparation should not be limited to having measures completed but should include the skills necessary to ensure that meaningful, therapeutic discussions of the results or insights that are provided by standard measures are part of nursing practice.

Conclusion

Nurses should use standard measures both ideographically and nomothetically to support consistent assessment and recovery orientated practice. The examples provided here show how one set of standard measures can be used. There are many standard measures; the challenge for nurses is to use standard measures and their nomothetic knowledge in an idiographic manner.

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Commentary

The focus of this commentary is on the introduction of standard measures to practice and some of the challenges that have to be faced.

Standard measures in practice

Mental health nurses are encouraged to use standard measures as part of their practice. For example, as a screening tool for metabolic syndrome (Brunero et al. 2009) or to evaluate the outcomes of mental health nursing practice, or the provision of specialist mental health nurses to accident and emergency departments (Wand et al. 2012). If mental health nurses consistently used standard measures as part of their assessment practice, then these measures could generate evidence of the role that nurses play and the outcomes they achieve. For example the way in which Lakeman and Bradbury (2014) were able to demonstrate the outcomes of care in an evaluation of the mental health nurse incentive program in Australia.

Barker (2004) identifies a number of advantages of the use of standard measures. First, standard measures yield a quantifiable measure of a problem area with the minimum investment of time. Second, they generate a manageable body of information for care planning and evaluation. Third, these measures generate information that enables comparison; that is, how the consumers compares to other similar consumers or the general population. Finally, standard measures often break a problem down into its various components; 'deconstructing' a problem can be a useful activity for both the nurse and the consumer.

Bamber (2013) argues that having consumers monitor their symptoms through the completion of a standard measure is not only a vital part of mental health care, but can also aid the consumer's recovery. It can give them a voice in their health care and provide a record of progress for both consumers and clinicians alike. Indeed, consumers are enthusiastic about participating in such an approach, although often unaware that standard measures are or should be used. Once informed, consumers demand that standard measures be used as part of practice (Black et al. 2009).

There has been increasing use of standard measures for various purposes across Australia (Coombs et al. 2011b); to support clinical practice with specific age groups like children and adolescents (Wolpert et al. 2012), to provide structure during nurse education field placements

(Simpson et al. 2005), to provide a framework for clinical practice and service development activities (Leavy RL et al. 2005) and to describe clinically meaningful scenarios for team review purposes (McKay and Coombs 2012).

However, Webster, Bretherton, Goulter, and Fawcett (2013) found that nurses did not see the HoNOS as useful, instead, they viewed the HoNOS as primarily for bureaucratic use rather than for clinical purposes, and that the scores they assigned were of limited importance in the assessment of the consumer's condition because this assessment would be "undertaken by the medical team" (Webster et al. 2013 p, 325). For me, this last comment is telling and resonates with my personal experience. Nurses with whom I have recently worked in clinical practice in an acute mental health unit (after data analysis and publication of the findings articles) in acute care mental health units have told me that comprehensive assessment and its documentation is "someone else's job" — either the clinical nurse consultant in the accident and emergency department or the registrar. The series of articles I have presented here were prompted by my being told, over ten years ago, that a suite of standard documentation and standard measures did not reflect, and got in the way of, how mental health nurses undertook a comprehensive mental health nursing assessment. I fear that some mental health nurses do not undertake comprehensive assessments and that comments like those offered by Webster et al just reinforce my personal experience of a managerial risk adverse approach to care that is progressively deskilling the mental health nursing workforce. It is possible to bring about change, but it takes training, leadership and investment in sustaining it (Swain et al. 2010).

This final article (article 6) is an attempt to describe a way of using "bureaucratic" tools in a therapeutic, recovery orientated manner. This paper provides the foundation for a model of mental health nursing assessment as well as ongoing practice. Of course the model needs greater elaboration but the mustard seed of a model and an approach to nursing practice is there. This final article is a call for mental health nurses to ensure that their assessment practice is consistent through the use of standard measures and a recovery orientation in the way they use those measures. This is not to advocate that the measures that make up the NOCC are necessarily the basis of a comprehensive mental health nursing assessment, the point that is being made is that standard measures, regardless of what they are, can be a useful tool to support mental health nursing assessment and recovery orientated practice.

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Chapter 9 Where to from here?

This chapter provides a summary of the study, what prompted the study and how the research question was answered. It also outlines the main limitations of the study and suggests potential future research into a comprehensive mental health nursing assessment.

Summary

This work has been an opportunity to contribute to an area that has not been extensively researched in mental health nursing. The journey began with the introduction of MH-OAT in New South Wales in 2001 (Chipps et al. 2002). I was employed to support the MH-OAT implementation process, which involved training staff in the use of a suite of clinical documentation and standard measures and discussing, encouraging and troubleshooting the introduction of this suite into routine clinical practice. During these discussions I would hear concerns expressed by nurses that the standard clinical documentation and standard measures did not “flow” or “follow” the way that nurses currently undertook a comprehensive mental health nursing assessment. Some ten years after the introduction of MH-OAT one of the reviewers of an article published as part of this thesis provided the following comment:

“With the MH-OAT case workers are required to enter data at the end of a shift, or immediately after an event, or to designate a day during the week for data entry - it appears to this clinician that everyone uses shortcuts, favours some categories over others, or simply enters basic information without following up with mandatory measures. The system is cumbersome, unreliable and a waste of tax payers’ money; furthermore, it places all mental health professionals in the same basket and further blurs the boundaries between mental health nursing and other disciplines.”

These comments point to an acknowledged variability in the practice of nurses. They also reflect, I think, that the reviewer’s concerns are about clinical information systems and not assessment, documentation or measurement. However, the comments indicate the implied acceptance of variability that “everyone... favours some categories over others” and the reviewer does raise the issue of the blurring of boundaries between disciplines and with the introduction of standard clinical documentation and standard measures something unique to nursing is lost.

Although not the focus of the current study, as the interviews were unstructured, some interviews touched on what participants thought was unique about a comprehensive mental health

nursing assessment. Indeed during data analysis several comments were identified around the unique aspects of a comprehensive mental health nursing assessment and were coded as “nothing unique” (see Figure 4). These comments included:

“Here’s the radical part: I don’t think there is any such a thing as a nursing assessment”.

Wayne (Clinician 15- 24 years of experience)

“I don’t know, I have always found it hard to separate out the roles. I always felt that I was a mental health worker not a mental health nurse.”

Bea (15 – 24 years of experience)

While not central to the question posed in this thesis, these comments point to the need for further research into mental health nurses’ unique contribution to the multidisciplinary assessment process. Some of the nurses who participated in the current study indicated that there is nothing unique about a mental health nursing assessment.

The concerns raised by the reviewer were not uncommon during the implementation process of MH-OAT. These are concerns that standard documentation and standard measures force a generic type of practice that does not reflect the approach undertaken by mental health nurses. If what was being introduced was not what nurses did, then I had to ask myself, just what did they do? This prompted the original research question of this thesis: “what is the content and process of a comprehensive mental health nursing assessment?”

This thesis has described how I have gone about answering the question, what is the content and process of a comprehensive mental health nursing assessment? The findings of the current study have significant implications for contemporary mental health nurses. The current study started with a review of the literature that found no research into what constitutes the content and process of a comprehensive mental health nursing assessment. This prompted a qualitative grounded theory approach to the study of the subject area. This study produced three articles. The first article outlined the significant variability in the way that the nurses who participated in the study described the content of a comprehensive mental health nursing assessment. The second article illustrated that the process of a comprehensive mental health nursing assessment involves engaging with the consumer and focuses on problem identification. The third article suggested that these nurses did not use a model to guide their assessment practice. The findings reported in these three articles thus have significant implications for mental health nursing. The focus of the thesis then turned to the implications of the study finding. The next article in this thesis then explored the impact of these findings for clinical practice and the adoption of a recovery orientation to practice, as well as the

impact on education, clinical supervision, the management of mental health nurses, as well as research into mental health nursing practice. The final article of this thesis explored how standard measures might be used to support consistency in mental health nursing assessment practice, as well as being used in a way that supports a recovery orientation to practice. It hints at a model of nursing assessment and practice that warrants further research and development.

Strengths and limitations

One of the strengths of the current study was hearing from nurses themselves, including nurses with a wide variety of experience; however, the study does have its limitations. The sample size was relatively small, so the results cannot be broadly generalised. Although I took great care to be as neutral as possible during the interviews, I have experience in the area of practice, so the potential for my personal opinions to have influenced my interpretation does exist. However, I worked to protect the study from these influences by presenting my ideas at conferences, where my interpretations were typically reinforced; and I underwent the regular scrutiny of my research supervisors.

The method of data collection used in the current study, also may have influenced the results. Perhaps the description of the content and process of a comprehensive mental health nursing assessment is too hard a task for nurses being interviewed. If much of nursing knowledge is tacit and hidden, then asking nurses to express this may be something that they may find very difficult or even impossible to do.

A different approach to data collection might have produced different results. For example, an observational study might have observed less variability in the content of assessment or provided a better understanding of the process of these nurses' mental health assessment practice. Although, there is evidence to suggest that an observational approach may just confirm variability in practice. Bradley, Roach and Harris (2010), who used an observational approach to study medication administration, found variation in what nurses asked about the effects of the medication they were administering. Similarly, Rollans, Schmied, Kemp and Meade (2013), in an observational study of the way midwives used a psychosocial assessment screening tool, found variation in practice, with some nurses consistently using these tools as a way of engaging with the pregnant woman during antenatal visits and others using them in a cursory way, as a task to be completed before moving onto a physical assessment. Regardless of this evidence, an observational study may have had some merit in confirming variability or lack thereof in nursing assessment practice.

The ability for mental health nurses to deliver consistent care has to be questioned if all mental health nurses assess for different aspects of the consumer's condition in different ways. The variability in content as the nurses in the current study described their assessments will no doubt lead to a focus on different interventions for consumers. If nurse 1 assesses for drug and alcohol use while nurse 2 does not, then the chance that the consumer being cared for by nurse 1 will be offered specific drug and alcohol interventions is much greater than if they are assessed by nurse 2. Similarly, if nurse 1 routinely tries to understand intra-family relationships as part of his or her assessment practice and nurse 2 does not, then the likelihood of receiving family support from nurse 1 is greater than receiving such support from nurse 2.

There are a range of factors that can impact on undertaking a comprehensive mental health nursing assessment and the delivery of recovery orientated practice. Issues such as the nurses workload, the location and the ease with which collateral information is available can impact on how comprehensive the assessment may be. The type of education and training the nurse was exposed to can impact on the type of assessment they undertake or their ability to deliver recovery orientated practice. These additional factors were not systematically explored as part of the current study and this can be seen as a limitation.

While the current study did not look at the temporal stability of the descriptions of a comprehensive mental health nursing assessment provided by these nurses, the probability that these descriptions will vary between assessments is high, given that these nurses did not appear to have a model to guide their assessment practice. Given this variability in assessment their ability to consistently monitor the outcomes of care is also questionable.

Conclusion

The central question of this thesis has been "what is the content and process of a comprehensive mental health nursing assessment?" I have to conclude that, at least for the nurses interviewed, there is no such thing. While some have argued that mental health assessments are most effective when nurses turn over the lead of the assessment to the consumer and the nurse simply uses their own clinical experience to extract information (Spiers and Wood 2010), if this were true, it would be reasonable to assume that there ultimately would be a core set of information that mental health nurses would want to gather as part of their comprehensive mental health nursing assessments. I found no such pattern in the data.

My theory, grounded in the data, is that for these nurses at least, there is no such thing as a commonly undertaken comprehensive mental health nursing assessment; instead, there is problem

identification that involves engaging the consumer and collection of information with differing foci; with the difference being at the level of the individual nurse.

That is not to say that some nurses don't undertake comprehensive mental health assessments, as I am sure they do. However, mental health nursing does not appear to have an agreed model of a comprehensive assessment that is used for training, clinical supervision and for research purposes. If this model exists, the nurses in the current study certainly did not articulate it. Instead, the mental health nurses who participated in the current study described the content of their assessments in significantly different ways. If the content varies from nurse to nurse, then the chances are that all of these nurses' assessments will not be as comprehensive because of a lack of consistency. The process of a comprehensive assessment that the nurses in the current study described involved engaging with the consumers as a way of enabling the extraction of information regarding the consumer's problems, and that this was an ongoing process. Just focusing on problems does not make an assessment comprehensive. These nurses had no model that guided their comprehensive mental health assessment, which in part may explain why the content varied and why the focus of these nurses' assessments was problem orientated.

If these findings were confirmed more generally, and I suspect they would be, then I have come to the conclusion that mental health nurses identified that MH-OAT did not fit their current assessment practice and got in the way because it tried to impose a framework where none existed; it flagged consistency where no consistency existed.

Similarly, if variability in the content of assessment or the focus on problem identification is found more broadly amongst mental health nurses, then mental health nursing faces some serious questions. If each mental health nurse focuses on different aspects of the consumer as part of the assessment process, then consumers cannot be assured of getting the same care even if they have similar presentations. The variation in the nurse's assessment will lead to variation in care. Equally, if each nurse assesses for different aspects of the consumer's presentation, then their perception of the outcomes of nursing care will vary. Nurses' ability to link the interventions they offer with the success or failure of those interventions will be lost because variability in assessment practice will always confound the results.

The findings of this study challenge mental health nursing in a number of ways. They call into question the adequacy of mental health nursing education if nurses can't offer a model that guides assessment practice. They confront mental health nurse managers with the task of ensuring a standard of consistent assessment practice. They require a concerted effort from clinical supervision

to establish, ensure and maintain comprehensive mental health nursing assessments. The findings also have implications for research into mental health nursing including how comprehensive mental health nursing assessments are being undertaken and how, if necessary, these assessments can be improved

It is important to note that although this thesis is about the assessment practice of mental health nurses, I suspect the findings hold true for other disciplines currently working in Australian mental health services. Disciplines like occupational therapy, social work and psychology would probably find that they face similar issues. Although this is a conjecture that requires further research, it is an observation based on my experience that provided the initial impetus to undertake this work. In this thesis I have focused on nurses rather than other mental health workers. I suspect the same results for other disciplines. So, there is a challenge for other disciplines and nursing. If they find something different to what I found here, then nursing has something to learn from how these disciplines go about translating theory into practice. If, however, they find similar results to those I found, then we all face some significant challenges in ensuring comprehensive mental health assessment practice.

Recommendations for future research

There is the need for more research into such a fundamental activity as mental health nursing assessment. I have pointed out that contemporary mental health nursing faces a number of challenges. Mental health nurses are required to collect standard measures as part of their routine clinical practice (Department of Health and Ageing 2002b) and are encouraged to adopt a recovery orientated approach to their practice (Commonwealth of Australia 2013). With no model to guide their assessment practice, the challenge I have suggested is to use standard measures in a recovery orientated way as a model of practice. However, to achieve this further work is required.

A first step may be a review of nursing curriculum; what are nurses being taught about mental health assessment across Australia? Is the variation in practice found in the group of nurses studied here reflected in educational preparation? Are students being educated to collect the same content in a similar fashion? What exposure to nursing models are students receiving, and is it consistent across education providers? Do nursing curricula include an understanding of standard measures and the clinical skills necessary to apply them in practice? This is not to say that variation in the way students nurses are educated isn't acceptable, or that students should not be exposed to different types of educational preparation but the end product of that education, should be a nurse who can undertake a comprehensive mental health nursing assessment.

Work needs to be undertaken to identify if the findings from the group of mental health nurses studied here are generally true for all mental health nurses. As already stated, an observational study may, in part, help to confirm or disconfirm such a hypothesis. Alternatively, a survey seeking mental health nurses to endorse or not endorse certain content of processes as part of a comprehensive mental health nursing assessment may expose variability or lack of variability in comprehensive assessment practice. To undertake such a work, agreement on what constitutes a comprehensive mental health nursing assessment should be sought. This could involve the use of the Delphi technique, which has been found to be very useful in harnessing the opinions of often diverse groups of experts around practice-related problems (Hasson et al. 2000, Powell 2003). A Delphi study aims to develop a group consensus from individuals, usually experts in the particular area of interest. This consensus is developed through an iterative process of using structured questionnaires. The results from each round of questionnaires are feedback to these experts until consensus agreement is reached.

A Delphi study could bring together a group of expert nurses, the codes for the content and process of a mental health nursing assessment found in the current study could be used as the foundation for the first round in such a Delphi study. The technique does not preclude additional material, domains or process indicators being introduced as the process unfolds and is ideally suited to electronic format of information collection (Lakeman 2010). Given the importance of a recovery orientation to mental health service provision, the expertise of consumers should be included in a Delphi panel (Baird et al. 2012).

This Delphi study could also provide the foundation for a detailed model of mental health nursing assessment that identifies the content and process of a comprehensive mental health nursing assessment that includes the use of standard measures. I am not advocating the use of the measures that make up the Australian NOCC, although these could be candidates, but measures that specifically relate to the information that nurses agree is fundamental to a comprehensive mental health nursing assessment. There are plenty of standard measures available; a recent review of measures suitable for use in the non-government sector in Australia identified over 120 potential measures (Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia 2013). However, there is work required to identify those measures that would fit with the agreed content of a comprehensive mental health nursing assessment. Indeed, such a measure may actually need to be created. The model of mental health nursing assessment and practice as described in article six could be beginnings of a more detailed research agenda exploring the use of standard measures to support consistency in assessment and recovery orientated

practice. However before developing a new model, work needs to be undertaken to determine the model that currently guides comprehensive mental health nursing assessments.

Alternatively, research may not be about what is assessed but what is done with that assessment information by mental health nurses and how this compares to other disciplines. A productive area of research may be identifying what mental health nurses do with the information that they collect as part of a comprehensive mental health nursing assessment.

Clearly a fruitful area of research would be to compare nurses who use standard measures as advocated in article six with those nurses who do not. This type of work could explore potential differences in the quality of the therapeutic alliance, the outcomes of care (change in mental health status or functioning), or the consumer's satisfaction with nursing care.

A lack of understanding may be preventing nurses from taking on the use of standard measures as part of their assessment practice. Once there is an agreed model of mental health nursing assessment, then the way is open for consistency in educational preparation, clinical supervision and clinical governance of mental health nursing assessment practice. A model of a mental health nursing assessment would also provide the basis for further research into this foundational aspect of mental health nursing practice.

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Appendix 1 Table of textbook comparison

Textbook description of mental health nursing assessment

Text	Content	Process includes rating scales
Beck, C. K., Rawlins, R. P., & Williams, S. R. (1988). <i>Mental Health - Psychiatric Nursing. A holistic life-cycle approach</i> (Vol. 2nd). St Louis: C.V. Mosby Company.	<ul style="list-style-type: none"> • Physical • Emotional • Intellectual • Social • Spiritual 	Data gathering includes the use of psychological test.
Stuart, G. W., & Sundeen, S. J. (1987). <i>Principles and Practice of Psychiatric Nursing</i> (3rd ed.). St Louis: C.V. Mosby Company.	<ul style="list-style-type: none"> • Reasons for seeking help, including: <ul style="list-style-type: none"> ○ Suicide or self-harm ○ Assault or violence ○ Substance abuse withdrawal ○ Allergic reactions or adverse drug reactions ○ Seizure ○ Fall/ accidents ○ Absconding risk (if hospitalised) ○ Physiological instability • Biopsychosocial assessment • Patient and family appraisal of health and illness • Previous episodes of psychiatric care in self and family • Current medications • Physiological coping responses • Mental status • Coping responses 	Rating scales of behaviour are used as part of the assessment process.
Elder, R., K. Evans, and D. Nizette. (2012) <i>Psychiatric and mental health nursing</i> .	<ul style="list-style-type: none"> • Identifying information • Reason for referral • Presenting problem and/or precipitating 	Does not specifically advocate the use of standard measures as

Chatswood, NSW: Elsevier Australia.	<p>factors</p> <ul style="list-style-type: none"> • Previous mental health history/medical history/ drug history • Developmental/psychological/ relationship history • Assessment of strengths • Assessment of mental health status 	<p>part of the assessment process but explains that in Australia all mental health services have standard documentation and outcome measures are collected in services.</p>
Edward, K. (2011) <i>Mental health nursing: dimensions of praxis</i> . South Melbourne, Vic: Oxford University Press.	<ul style="list-style-type: none"> • Psychiatric history • Medical history • Family health history • Major life events (e.g. losses); and response, coping, recovery and resilience factors • Developmental history • Substance use behaviours • Risk potential • Mental status examination 	<p>Advocates the use of standard measures as part of the assessment process.</p>
Barker, P. (2004). <i>Assessment in Psychiatric Mental Health Nursing: In search of the whole person</i> (2nd ed.). Cheltenham: Nelson Thornes Ltd.	<ul style="list-style-type: none"> • Psychological and biological phenomena • Functional behavioural performance • Self-efficacy • Relationship with family • Relationship with wider social environment • Interpersonal communication • Social resources 	<p>Advocates the use of standard measures as part of the assessment process.</p>

Appendix 2 Study Information and Consent Form



University of Wollongong

The content and process of a comprehensive mental health nursing assessment

Researchers: Tim Coombs, Professor Patrick Crookes, A/Professor Janette Curtis

PARTICIPANT INFORMATION SHEET

Mental health nurses play an important part in the delivery of mental health care. Integral to mental health care is an assessment of the consumer's mental health. A research project is being undertaken by Tim Coombs as part of his study at the University of Wollongong. His project aims to collect information on the content and process of mental health nursing assessment. The project is not another word rather than aims to ask a range of different types of nurses; students, teachers, managers and academics *What does a mental health nursing assessment actually entail?* There is no right or wrong answer to this, just an opportunity to describe the content and process of a mental health nursing assessment from your perspective. Basically, nurses who participate in this project will spend some time with Tim and be interviewed about their thoughts on mental health nursing assessment. This interview will not take longer than one hour. This interview will be audiotaped so that an accurate record can be kept. It is important to keep an accurate record so that nothing is lost to subsequent analysis of the interviews. The interviews will be reviewed to identify any common themes that describe the content and process of mental health nursing assessment.

Your participation is totally voluntary and there will be no detrimental effects for you if you choose not to participate or withdraw from participation. At a time and at a location convenient to you, the project will again be explained to you. If you choose to participate you will be asked to complete a consent form.

The information collected by this project will be used for research and educational purposes. All responses will be deidentified and at no stage will your individual responses be made known to anyone other than the chief investigator Tim Coombs. Please note that your participation is totally voluntary and you are free to withdraw at any time including during the interview.

The results from these interviews will be included in a thesis that will be written by Tim Coombs, may form part of conference presentations and articles that will be written for submission to scholarly journal. No individual participant will be identified in any presentation of this material.

If you are interested in participating in this project or have any questions regarding this project please do not hesitate to contact Tim Coombs on 42257881 or 0408 601 326. If you have enquires regarding the way in which the research is or has been conducted, they should contact the Secretary of the University of Wollongong Human Research Ethics Committee on (02) 4221 4457.



CONSENT FORM

The content and process of a comprehensive mental health nursing assessment

Researchers: Tim Coombs, Professor Patrick Crookes, A/Professor Janette Curtis

This project aims to collect information on the content and process of a mental health nursing assessment. You will not be able to be identified from the data collected. This information gathered will be used for research and training purposes.

Your participation in this research is voluntary, you are free to refuse to participate and you are free to withdraw from the research at any time. Your refusal to participate or withdrawal of consent will not affect you in anyway.

If you would like to discuss this project further please contact Tim Coombs on (02) 42257881 or 0408601326. If you have any enquires regarding the conduct of the research please contact the Secretary of the University of Wollongong Human Research Ethics Committee on (02) 42214457.

.....

Research Title:... The content and process of mental health nursing assessment

I, consent to participate in the research conducted by Tim Coombs as it has been described to me in the information sheet. I understand that the data collected will be used for research and training purposes and I consent for the data to be used in that manner.

Signed

Date

.....

...../...../.....

Appendix 3 Ethics Approval

University of Wollongong



AMENDMENT APPROVAL SUBJECT TO LETTER

In reply please quote: HE06/126

Further Enquiries Phone: 4221 4457

12 October 2006

Mr Tim Coombs
5/100 Church Street
Wollongong NSW 2500

Dear Mr Coombs,

Thank you for your email dated 9 October 2006 containing amendment requests to the Human Research Ethics application referred to below. I am pleased to advise that the amendments listed below have been **approved**, subject to the following conditions:

- i. Please amend the following in the Participant Information Sheet (PIS);
 - a. Please include the job designation of the new participants in the list of the first paragraph.
 - b. Please broaden the references to the participants in other places to include them.
- ii. Please provide a copy of the revised PIS to the HREC for final approval.

Ethics Number:	HE06/126
Project Title:	The content and process of a comprehensive mental health nursing assessment
Name of Researchers:	Mr Tim Coombs, Professor Patrick Crookes, A/Professor Janette Curtis
Amendment/s:	Interview undertaken with a different component to the mental health workforce and carer consultants.
Amendment Approval Date:	12 October 2006
Expiry Date:	7 June 2007

Please remember that in addition to reporting proposed changes to your research protocol the HREC requires that researchers immediately report:

- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

You are also required to complete monitoring reports annually and at the end of your project. These reports are sent out approximately 6 weeks prior to the date your ethics approval expires. The reports must be completed, signed by the appropriate Head of School, and returned to the Research Services Office prior to the expiry date.

The University of Wollongong/SE Sydney and Illawarra Area Health Service Health and Medical HREC is constituted and functions in accordance with the NHMRC *National Statement on the Ethical Conduct in Research Involving Humans*.

Yours Sincerely,

A/Professor Arthur Jenkins
Chairperson
Human Research Ethics Committee

cc: Professor Patrick Crookes

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Appendix 4 Example Interview Transcript

Interviewer

O.k. what do you think our comprehensive mental health nursing assessment looks like, what's sort of like the content of that?

Respondent

O.k., I think that bio-psychosocial model of assessment is one that nurses feel reasonably comfortable with and the one that's been in vogue for a long time now. The content of it is that sort of total holistic approach to a person-so you want there immediate, what their immediate problem is, so the way I usually start is-"tell me what the problem is", get their sort of point of view of it and then ("I won't use the term drill down 'cause that's a horrible term") but then to get them to elaborate and then to go back and put that into some sort of context for that person.

Umm, so you are looking at mental state, you are looking at their function-the level of functioning, their social situation umm what changes have taken place in that situation, what their perception is regarding how they are traveling as opposed to how they're traveling when they're completely well or when they're feeling on top of things. Your looking at symptoms, your looking at things that they have described, at appearance, your looking at things that you can see and tell, and then from there, um umm, looking at their, you know their medical history, their physical history, any sort of physical problems they have, their medical history, their previous history of you know, treatment. Umm and then getting some collaborative history as well, from family, carers, friends, ah treating psychiatrists, treating doctors and things like that. Umm and then also looking at records, old records.

So the assessment really starts with what they perceive their problem is, digging down into that, putting that into context for them, then getting a collaborative look at it from carers and friends, other treating people, people involved in their care or in their life, and then a formal history taking, medical, surgical history taking and things like that.

Interviewer

When you said sort of like putting it into context for *them*...Is that putting it into context for *them* or is that putting it into context for *you*?

Respondent

Yeah it's a bit of both I think, I just find it interesting that when your talking to someone they usually have a completely different view of what's wrong with them than what we do and after we have assessed them or after what someone else has set them up with-for instance when I'm in the emergency department people send them up with *this* problem and when you ask them what their problem is and the reason why they're here, they give you a completely different picture of it, and may also have a different view of why they are the way they are at the moment...you know, if they didn't lick it off the road this morning, and they didn't wake up like this. It's come on. so the context is you know, if their presentation for me to do a nursing assessment on them is a snapshot or a slice of life or what's the bread like before they get to that slice then what's going to be like afterwards and then if I don't know them and if it's the first time I have seen them it gives me a sort of context for how I find them now across what they would ordinarily be like and that's where the history

gathering and the other carers and the family, the treating psychiatrists, or other treating professionals and the medical records add the context for me...not so much for them.

Interviewer

Right, right. So all that sort of collateral bits of information along with the record that gives you your context-what sort of context do you give to them? Are you explaining that or are you...

Respondent

I try to, I mean it's the same as that reflective listening process and open ended questions and things like that-the reflective listening process where I, you know, at different points in the assessment if I feel like I am getting some sort of conceptualisation of what's happening with them, then I will reflect that back to them i.e. "this is what your telling me, is this and this and is that right in what's happening?".

Interviewer

Square up with what your perspective is...

Respondent

Yeah or is it completely different, because often it is different and they say "well no that's not what I was sort of thinking, this is what I was thinking was the problem". And then I think o.k. well fair enough. And then trying to come to some sort of an agreement about what the problem is.

Interviewer

Do you always come to an agreement?

Respondent

No...and that's obvious...

Interviewer

"Laughter"

Respondent

Obviously people that are very psychotic and insight-less and have impaired judgment from alcohol for instance, you know clearly you don't, its' about risk and management. I'm not so worried about their longitudinal, holistic or psychosocial self; I'm more worried about their safety and their immediate survival and that of others. So often you don't come to an agreement.

Interviewer

Right o.k.

Respondent

Most people though, who are not heavily intoxicated or under the influence of drugs, you can come to some sort of agreement about, umm, why they're here and what we can do for them-and it may be that that takes some negotiation time, but that's fair enough, that sometimes you don't have that time, sometimes it's got to be about safety and things like that which is unpleasant but that's the easy part...that's simple.

Interviewer

Right, the management of the safety thing?

Respondent

That's a simple, almost like a structural process that's got to be gone through and then once that safety is established then you can go into the other parts of it...and once they, either calm down or once their environment is safe in which you are seeing them then the other parts of it can be gone into and maybe perhaps some further agreement can be reached.

Interviewer

So assessment, the assessment process...going over into the process side of things-it's a negotiated activity?

Respondent

I think so, I think it should be. I'm always clear when I go and talk to people and I know I've been out of the assessment game full time for a while-moving back into it recently-but I found that break a good thing, because I think that the development of a relationship between people, whether if its in a therapeutic context in an emergency department or in homes or whatever, and just the relationship with people you just meet for the first time, there are similarities between it, its about politeness and engaging them and making eye contact, making them feel comfortable, explain to them what you do and why you're there and depending on how they are, is how much information you give them. And that it is a negotiated thing, it works much better that way rather than me/people going in there and "this is what I'm going to do for you, and this is what you're going to do for me", and this doesn't work, and you can see that with an experienced people all the time. They go through these certain steps almost in a certain order and if I don't get through this checklist, but I've not done my assessment, where

Interviewer

It doesn't work like that....

Respondent

It doesn't work like that, you've gotta start at some place with some people and other people are very articulate or don't talk to you at all, you've just got to get a sense of, I've spent the first 5 to 10 minutes of just trying to get them to relax and feel comfortable and see that I'm not a threat and I'm not the person to come and give them a hard time, I'm not going to boss them around

Interviewer

Just a genuine sort of bloke

Respondent

Just a genuine “let’s have a talk about it”, “how are you going?” You’re in a y’know, people I see are in an unpleasant environment, for most of them reasonably noisy and non conducive to that sort of thing happening in the first place, so you’ve gotta do it reasonable quickly, but at the same time you’re aware that it’s a frightening experience for people, for most of them.

Interviewer

How do you do it quickly? You’ve got your little tricks of the trade?

Respondent

Umm...I always sit down, if they’re sitting on the floor, I’ll sit on the floor, if they standing up, I’ll stand up. If they’re...like you do in that mirroring posturing, if I’m carrying a notebook or whatever, and I do carry a notebook, I put it down and sit with them and talk quietly but I always explain who I am, why I’m here, what I do and what process is for people so that they understand what’s gonna happen

Interviewer

Right.

Respondent

Umm but yeah, use of humour, I think use of humour is good, you’ve gotta pick who that’s gonna be with, y’know, young people are engaged differently to older people. I always call older people by their last names, it’s about...its just life experience I think, it’s got nothing to do with being a nurse, I think it’s just you learn that as you...about life. About how to relate to different people, when you have your own kids or whatever, how to engage them and what works and what doesn’t work, sometimes you get it completely wrong...oops, that wasn’t the way to do that! Let’s add ice to the pack to the black eye there

Laughter

Interviewer

Can we backtrack a little bit, you used the word “functioning”, you had a person “functioning”, what does that mean?

Respondent

Well it means different things to different people. You or I might consider functioning to be at a reasonably high level, we’ve got our basic needs and wants met, but there are other things that we may require to be happy, other people for them to be considered functional is for them to get up in the morning at a reasonable time, and get through the day, and not set fire to the house. I mean, functioning is how they can get through their day, or how they behave or how they relate to the world around them in the way that they feel allows them to get through the next day.

Interviewer

So the assessment process is really about all of us is in some way trying to establish what it is that gets them through the day or the will to get them through the day...

Respondent

Yeah, and what's their baseline for it, what we might consider to be a dysfunctional life or dysfunctional level of behaviour for that person may not be considered dysfunctional - all my friends behave like this and this is completely normal for me, and what it looks like to you is another thing entirely. That's fine.

Interviewer

This is kind of off the track (*laughter*) because I'm not particularly organised....but ummm...did you get any training in this?

Respondent

Did I get any... that's a very good question. You know as well as I do that I didn't have any formal mental health training. In being a psychiatric nurse I went straight from my general nursing into mental health nursing. Since I've finished my training, and the training I had was what would be considered the old apprenticeship style on-the-job training. That is watching people who were good, and you recognise who are good – I watched others on Service Unit XXX and I thought, I can see what you're doing here that's working and picking that up. It was observational, I mean I read a lot of books obviously – not a lot of books...

Interviewer

A few books...

Laughter

Respondent

I mean I watch people, I worked with Dr XXX, who I thought was very good at doing assessments on people and calming people – not so much now, but when he first started when I met him, he was...I thought he was very good. I watched Dr YYYY interview, I watched some psychiatrists – mainly doctors how they assessed...Nurses didn't do a lot of assessments when I started nursing, I worked in a ward and all you did was...you know...you do basic ones but handholding and custodial and it was a social setting more than anything, it wasn't till I...

Interviewer

Say you were kind of managing that environment...

Respondent

Yeah, I think so. I didn't have any training. I went to some training, I went to the institute of psychiatry and did some training, some brief courses and things. And that was helpful but a lot of it

was observing people who I thought were, not just good at that, they were good human beings, who were good at engaging people because that's the sort of person they were. And watched them and learnt – I'll do that, and I won't do that (*Laughter*)...there's people but that's not working out...so no, I didn't have a lot of formal training. I had a few brief courses and when i did a degree in mental health but that wasn't any help whatsoever in doing my mental health nursing. It was more of a observational thing and a reading thing...and ask them questions.

Interviewer

Do you think nurses have developed...are now more involved in like the assessment process? Or is it just a function of your role?

Respondent

I think it's a function of my role. I know that watch/observing in-patient nurses for instance, people who've only worked in in-patient settings who go into a community setting are very poor at doing assessments, and it takes them some time to feel comfortable with it because they're...I don't think nurses in the ward and in a mental health unit in an acute environment are very good at doing assessments at all. My observation, even their notes reflect that. I think it's a peculiar to the role I've been in which is that community based care and now in E.D and whatever... that's what you would expect to do. And it wasn't a nursing thing in particular, it was a multi disciplinary thing

Interviewer

Right. So just by the fact that you were out in the community you're sort of autonomous...

Respondent

That's what you were told to do. So yeah, I think they're probably worse now than they were when I was first starting

Interviewer

In the in-patient...

Respondent

Absolutely. I think they're very disempowered...because they don't often, they don't get to do comprehensive assessments in the nursing, in the ward environment any more than they've done before they get there, often, in the comprehensive assessment. They repeated it in sporadic intervals by doctors mainly, and they do continuous low grade assessment of risk, that's all they're doing – in the ward. I don't think that they're...

Interviewer

Continuous low grade assessments of risk...

Respondent

Yeah, which is basically all they're doing, and that's what their natural reflect...that's what their conversations are about, patients reflect. Not really anything about their functional status or social relationships or how they're feeling about what's going on, what's happening to them in the ward environment. I've read a lot of notes and they just don't reflect that, and they don't even know how to talk about it, I don't think, a lot of them. The ones I've observed, I mean there are obviously others, but the ones I've observed, the new graduates and older people, older nurses who've been out of the workforce and come back into it don't seem to have that ability to do these comprehensive assessments and documented, articulate to their colleagues in a good way

Interviewer

Because that's the other thing about this thing between, I mean I might make an assessment but the documentation of that assessment does thatso in your experience that doesn't, like, occur?

Respondent

It doesn't necessarily...look I think the standard documentation we've got now is a good thing for junior nurses. I think it gives you cues, it gives you prompts to ask certain questions, and I don't mind the way its laid out, I think there's a couple of overlaps that's a bit tedious but I think that all the things in that A1 for instance, and the A2 and even the A3, all that is all fair enough. I think it's a good cue and prompt for inexperienced nurses

Interviewer

And they kind of need that?

Respondent

And they do need it. And you watch them when they write it, they're actually reading the little prompts and they're repeating it. That's ok, at least they're thinking about it, but I know before we had to send documentation, I use to have that little format in a card that I carry so it'll prompt me and after awhile it becomes automatic, so now I can do it, and I just know that I've gotta ask these questions

Interviewer

Where did you get the card from?

Respondent

I think I got it from a psychiatrist, I think Dr XXX gave it to me, now the governor of NSW, when I was doing the adolescent mental health course years and years ago

Interviewer

You name dropper you

Laughter

Respondent

She visited us on Monday....

Interviewer

Yeah?

Respondent

Yeah!

Interviewer

Oh really?

Respondent

Yeah, I got it off her when I did the adolescent mental health course. She said look this is not for everyone but you might find this is uh...it was a conversational approach to assessment and it was....it had a series of questions, and it had like the usual headings, the mental state blah blah appearance, all that sort of thing, but it had a few other things as well. And I collected bits and pieces from different places, backs of old textbooks or I'd seen them somewhere on websites and thought "that's good", or someone had send it to me and you know, I have a little card, and I've still got it and its umm... its good. And I've given it out to people as well.

Interviewer

Right. Cause that's another thing in terms of assessment, is there any processing/nursing for checking on the quality of the assessment that are being...

Respondent

I don't think so, I don't think there is any process for checking, there's file audits but that doesn't check for quality, what it checks for is quantity and information availability, I don't think it actually checks for quality. I think the check for quality that exists internally is supervision, I think that's a really good thing for nurses to.. and especially nurses who are in my position who are working by themselves a lot and I have to make....

Interviewer

Do you get that do you? Supervision?

Respondent

No I can, but Dr VVVV provides supervision to Nurse QQQ, and he's offered it to me as well, I'm not sure I'll go to him but I will seek supervision mainly to run things past people, and think "look, I wasn't quite sure, how would I describe this, and this is what's going on". I can access him and ring him up and ask him

Interviewer

But he's not a nurse you'll go to for supervision...

Respondent

Well I don't think he's the nurse who is more senior to me, who knows...not that I know everything about....where are those nurses in the system? I might talk to Nurse BBB for instance or I might talk to Nurse CCC or someone but they're not really in that assessment clinical mode anymore. I'm at that the senior clinical level.....who do I go to? Number one, do I think it's any good that I would think yeah, that would be useful, and also is it good as supervision? Cause it's not just me sitting down for a chat, and knows how that works. So I have to think about that up and it wasn't a nursing thing and now that I think of it I will access it somehow.

Interviewer

Better with a doctor...

Respondent

Possibly, only because I just don't think that there's a nursing person who I would feel comfortable talking to about these things, who I would think would be able to push me to think about that more. It probably would be a doctor, but that's not necessarily the case. I just can't...and I've thought about it...identify who would I go to talk about, who would I go for supervision from the nursing perspective down here....I just can't think of it. There would be someone at Service FFF I'll go to, but I'm not going up there to get supervision.

Interviewer

Yeah....does anyone come to you for supervision?

Respondent

They did up in Sydney, I've supervised three of the CNC's and two of the new graduates up there when I was working up there as the acute services manager, but I will make myself available for supervision. I think it's a good thing, I liked it, I enjoyed the...that was good for me. Cause it'll make you think about when people ask you questions...well I dunno, maybe I'll look that up...and I'll maybe think about that.

Interviewer

Sorry for jumping around, as I do, this whole idea of assessment being related to treatment, I mean, how much of that part of your thinking when you're doing a nursing assessment, a mental health nursing assessment, you know this content and this process, this conversational style, how much of your thinking is sort of "Uhhh ok...I've got that sort of like problem, this is what I'm gonna have to do about that". And if you do think that, what is it you do? Is there a uniquely nursing thing to do?

Respondent

Well there appears to not be a uniquely...I'm not sure if I think uniquely like a nurse. I know I have that nursing training, but it was a generalness in training and I'm aware that there are certain treatments that are available for certain things and I'm aware, and I'm keeping in my mind,

particularly if the person's is going home after I...if I do an assessment anywhere I am...and not going to be admitted to hospital which the treatment options are, let's face it, frankly limited. So basically medication, I don't see anything else going on there other than a very low grade, supportive therapy counseling type stuff and even that's variable. That I'm thinking of, not necessarily nursing interventions other than like a nurse counselor type role, supportive psychotherapy type role, nurses are de-skilled in for instance CBT techniques, they don't appear to have those skills, if they ever have. They haven't got them now, I haven't noticed. I'm more thinking about other service settings...psychological services, counseling services, addiction services, drug and alcohol services. But I'm also aware of brief interventions around, providing brief interventions at the time I'm seeing...people are panicking and anxious...I'm aware of certain brief interventions that I can do. Also motivational interfering techniques for drug and alcohol uses and things like that, all the stages of change and awareness of that, I've got that so I'm using that. But I'm not particularly thinking about nursing interventions because I'm not quite sure what nursing interventions are, that the use of therapeutic-ness itself in the nursing assessment and the nursing treatment....

Interviewer

And it's that whole ability....your experience enable you to relate to people you interact with...

Respondent

Yeah, and I don't think it's necessarily...a specific nursing...I don't think so. I found that it's more of a personal and life experience thing, and a general reflective approach to living that enables you to put yourself into that space with this person, I don't think that's necessarily a nursing thing. I just think that's a sort of....or maybe that's the sort of person I am anyway, and that's what I do, and that's why I find effective in any relationships with people is

Interviewer

That's an important part of the process being....when you surf into that?

Respondent

I think so, I think so, that's what gets me out of a lot of situations and trouble...when I'm getting myself into a hole or it's not going well, I'm not...you know the back of my mind calling out nursing processes or assessment tools. I'm thinking about...I'm not even thinking about it, I'm aware that this is what I need to do to back out of this and get out of this, and get this person to back down or whatever that is an unconscious half of it. You just know it's not going well, I said to you before that sometimes the hairs at the back of your neck stand up and you know you've gotta do certain things, and talk in a certain way, and behave in a certain way, and I say back out, and get out of the room and don't get punched.

Interviewer

Laughter

Respondent

But that's a lived/learned experience from watching people... as I said before... watch the people who do it well and watch the people who do it poorly, and I know what works, and I can see "ok delete that experience and take that one and use that"

Interviewer

Right, right. And that's sort of like...knowing where you're at...during this assessment process you're thinking about yourself as well?

Respondent

I think so, and how I feel and whether I'm tired, and whether I have a natural affinity with the person as well, and if I don't...in all the projection and that sort of thing, in all the transference and counter-transference...I'm trying to be aware of those as I possibly can. Just depends if you're tired, or it's the third assessment you've done that day, obviously if the police is standing then and there, making the situation worse and you're trying to take in a multitude of things...but yeah I'm aware of how it's going for me and how I feel – confidence, assessment confidence as well, and whether I feel like I've got this right but sometimes I'm thinking that I'm not sure, maybe I've got it wrong, and the person goes and maybe they come back three hours later and they're back again, well I got it wrong! How come, and I try to reflect on that, well how come... what didn't I get right or what did I do wrong.

Interviewer

The assessment process involves reflection, involves you stopping to consider what's worked in the past, what hasn't worked in the past...

Respondent

During the assessment and after it as well. But also during it, depending on how long it's taken and how long you've got.

Interviewer

Right, right cause some have to be done in like 10 minutes...

Respondent

Some have gotta be done in 10 minutes, while screening others you got two hours, it just depends, you've got three people turning up at the same time, you can't be spending that time...you just can't. What's the coaching point here, what's the point of this, what's needs to be done right now. To manage not just those people but the environment in which you're doing it...in the E.D environment for instance...the stress of the staff, I might consider this person to be the biggest priority, the E.D triage nurse consider this person to be....because they're causing them the most amount of anxiety. You've got to juggle that up as well...so pre-assessment...

Interviewer

(Laughter) Is that right?

Respondent

I think so...It's an environmental assessment, and it's a situational assessment when you...

Interviewer

When you're walking into the room...

Respondent

You do! You see what mood people are in and what/how much is going on...

Interviewer

And you're talking about the staff there?

Respondent

Absolutely, the staff. And it's not just E.D...when I worked in Service Unit XXX it's the same thing....who you're going in there with is going to be how you approach it differently. If I'm going in there with you, I'm relaxed. If I'm going with other individuals who would remain nameless, I know if I don't take control, I don't get through the door first; it's going to go bad. It could still go bad when I get in there cause this person is unpredictable and they might get upset – so I've got to manage that. And all the family who were there, it's not the 80 year old mother, it's the 40 stone gorilla, he's the problem. I'm not worried about him, I'm worried about her . And it's the same in E.D, I'm not worried about him, I'm worried about the two security guys cracking jokes about the footy show outside the room. And when you're trying to manage all that without upsetting people...

Interviewer

So even doing an assessment is all some way of managing the environment? Or understanding or managing the environment?

Respondent

Understanding the stressed environment is like a quiet room. You haven't been here but the quiet room is like an unpleasant, it's an unusual shape as well, it's like a wedge shape with these horrible vinyl soft chairs, and there's graffiti on the walls and there's bits gauged out of it with these two big cell like doors with great frames

Interviewer

Nice...

Respondent

Institutional lights...and its echoey. Managing that environment with people who are aware of it as well, who are "why am I here?"

Interviewer

(Laughter) Why did they put me in the freaky weird room when I'm already freaky and weird?!

Respondent

Trying to manage that as well...

Interviewer

Anything else you'll like to say about mental health assessment? Any mental health nursing assessment...you know...if you had to encapsulate it

Respondent

I think this. Mental health nursing assessment, because I'm a nurse and its considered to be a nursing assessment, and I think encapsulated this: it's a variable response to a person's presentation and environment context... it has to be adaptable, it has to be flexible enough to be able to be used in a variety of settings but it also has to be rigid enough that there's some sort of structure and skeleton to it to be able to withstand the different environments in which it takes place. So whether you have a format that you use, whether you just have a philosophical approach to it, it's gotta be able to withstand the multiple blows it's gonna take – to do a good one, a comprehensive one – in different settings. I'm not sure one model/one size fits all other than the one I said, try to make the person where they are, what they consider to be their problem is the best way to start with it I think. Trying to get to what that person thinks they need, what's gonna work for them, what's going to help them...what model you use is at the core of it I think.

Appendix 5 Enlarged Mindmaps

Figure 4

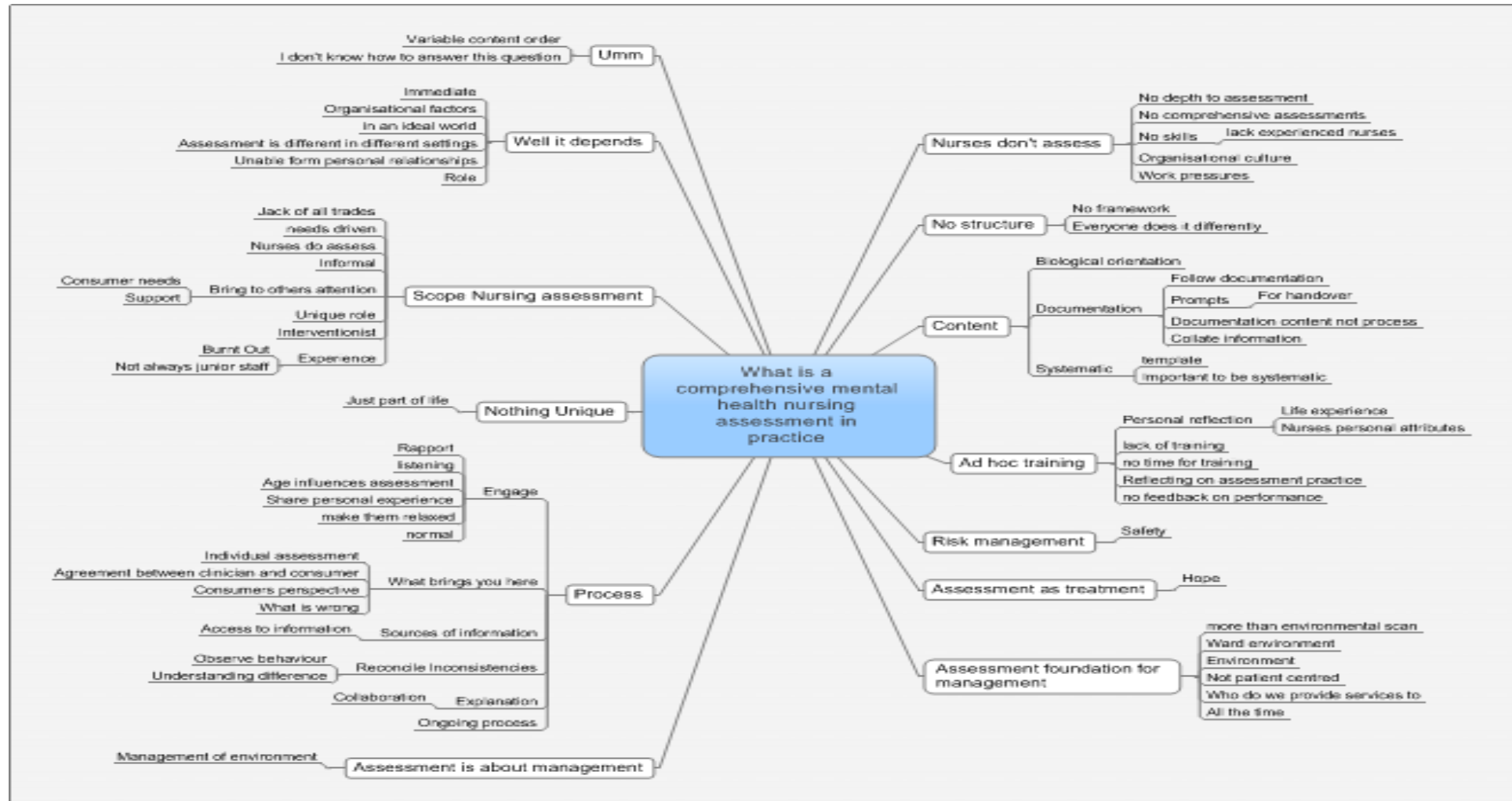


Figure 5

