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Abstract

The purpose of this pilot study was to explore how best to prepare and support nursing undergraduate students learning in a community/primary care setting through a Student Managed Initiatives in Lifestyle Education (SMILE) project. Further to this our intention was to evaluate the ways in which students were able to apply nursing theory to the practice of identifying and responding to the health needs of vulnerable people through health promotion and creative arts activities. Using a collaborative approach and a qualitative method, this pilot study used focus group discussions to explore both the experiences of community participants and undergraduate nursing students. This project found that students were able to draw on theoretical understandings and their simulated learning experiences to support their learning in a complex, non-clinical practice setting. It also illustrates the way in which community centres and other naturalistic environments where individuals and groups meet, can provide spontaneous and rewarding opportunities for nursing students to develop and apply health promoting knowledge and skills. Shaping nursing curricula with this in mind, creates the potential for nurses to make a significant contribution to improved health outcomes for vulnerable and/or marginalised people.

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Research Data Related to this Submission

There are no linked research data sets for this submission. The following reason is given:
Data will be made available on request

Introduction

The physical health and wellbeing and life expectancy of individuals living with long-term mental illness is a cause of concern in most countries. The incidence of heart disease, cancer, diabetes along with many other long-term health conditions is documented as being well above the average and as such represents a significant challenge (Bahorik et al 2017, WHO 2016, 2017; Hardy et al, 2011). Moreover, it is being recognised that the personal and financial costs of this situation is unsustainable (Lawrence et al 2001, Jones et al 2004, Crotty et al 2015). It has been established that people living within communities of disadvantage, experience increased levels of mental illness, are stigmatised, have poorer physical health, and receive less health care than the rest of the population (Collins et al, 2012; Ohrnberger et al 2017; Crotty 2015, Bradshaw et al 2017). The range of care provision in many deprived communities is said to be limited and clinical evidence confirms that vulnerable populations have a lower life expectancy (Stanley and Laugharne 2011). The current approach to this challenge, in terms of increasing access to health services of marginalised populations and vulnerable individuals, and providing the comprehensive health care interventions and appropriate health advice needed, necessitates a radical approach by the health care service and its workforce. This approach needs to address both the continuing pervading stigma of people with mental illness and the structures that shape service delivery. These persistent health inequalities have been recognised in many countries including Australia and the United Kingdom. Nursing regulatory bodies have introduced Standards for Higher Education Institutions to equip graduates to be able to respond to the pressing health priorities including the needs of marginalised and disadvantaged groups (NMC 2018, ANMC 2012). The NMC's recently published standards for proficiency for example, has devoted a platform for 'Promoting health and preventing ill

health' but there is a real challenge in nurse education to translate this into meaningful practice learning experiences that both challenge and change the practice of the future nurse. Therefore in this paper we argue that the future nursing workforce has a significant role to play in this, given the scale of unmet need.

Higher Education Institutions (HEIs) and their health and social care partner organisations providing nurse education, need to recognise the way in which theory and practice needs to develop in order to equip graduates with the skills to be instrumental in bringing about change. This includes addressing the personal and institutional stigma and schema that act as barriers to engagement and accessing services, becoming knowledgeable about and skilled in advising on appropriate lifestyle education interventions and non-medical interventions. Above all, graduates need to be able to recognise presenting opportunities for appropriate interventions that will help vulnerable and isolated people who have mental illness both to maintain better physical health and to access health services and advice early when they become physically unwell.

Background

To this end this project Student Managed Initiatives in Lifestyle Education (SMILE), was piloted within a Primary Health Care clinical placement for a group of final year Undergraduate Students in a University in Australia. Elements of this model for student learning had been developed and evaluated in previous placements in an ANMAC approved Bachelor of nursing programme (Ward and Barry, 2016) with a strong focus on enhancing communication and consumer health and wellbeing through the creative arts. Building on this model, this new project was designed to prepare and enable students to a greater initiative with opening discussions with consumers about their health and lifestyle factors.

Students had been prepared for the placement through theoretical and clinical nursing studies including learning about mental health and illness, national and local health inequalities and the social determinants of health and orientated to the contemporary context of primary health care provision. We had introduced students to the 'Peace and Power' approach to building communities in order to provide them with a 'tool kit' to use when opening and engaging conversations with vulnerable people (Chinn and Falk-Rafael 2015). The aim of this approach to professional and peer collaboration, allows the individual to lead discussions in identifying and exploring health needs and priorities in a way that encourages them to recognise and set aside personal prejudices, schema, priorities and intentions and by understanding the way in which power between client and professionals operate. This model also prepared students to understand the importance of critical reflection for example in building awareness of self and others through a collaborative approach to practice.

We argue that theoretical grounding is important for students. Research evidence and policy literature can orientate students to the significance of mental health and wellbeing and how lifestyle factors, alcohol and/or drug misuse, medication and psychosocial factors can impact quality of life. Further to this, students need to develop an understanding of how, in the broader scheme of things, nurses, and other health care professionals are already engaged in activities that make improvements in the general community, through education, health promotion, early intervention and prevention.

Students studying at this University are provided with extensive resources to support the theoretical component of their learning. However, working effectively in practice with this level of complexity is a daunting prospect for the student and achieving a level of

independence to make a difference requires an educational model that will optimise the learning experience, challenge the student and ensure appropriate levels of supervision and demonstrate the potential of Primary and Community Care for nursing careers. What is less well understood is the best way to prepare for the challenges of working with consumers closer to their homes and the power dynamics that operate within the professional/client relationships when health education or lifestyle change is required.

We are aware that future health care practice in Australia and the UK needs to be focussed on prevention and to be offered increasingly within the primary health care setting. The UK government for example is in the process of developing a national approach to 'Social Prescribing' (SP) as a means to address unmet health need in primary care, through non-pharmacological approaches (Department of Health and Social Care 2018, The Kings Fund 2017). Although this is a non-traditional health care setting it is one where there is a highly visible level of health care need and a large participating number of consumers, and we have found this to be an excellent environment for learning for final year students.

Through this project and its evaluation, we argue that:

1. Allowing students time to develop knowledge in primary health, mental health and wellbeing, therapeutic communication, and leadership skills in a community setting is invaluable to their learning and professional development.
2. Allowing students to engage in experiential learning in this way provides the community with a unique resource and provides the basis for partnerships and multidisciplinary working, we have found that the student contribution is important, even if on a small scale.

3. The approach illustrated in this project would sit well within newly developing approaches for the Social Prescribing model and other community development activities that seek to address ongoing mental health and other isolating long-term health conditions.

Research Design

Setting

This study took place in a non-clinical community setting where people were meeting to participate in adult educational activities within a local council neighbourhood house. The Neighbourhood House, funded by the local Council offers a meeting place for various groups, a community kitchen/restaurant and a rolling programme of adult learning activities.

Participants

The participants were Undergraduate nursing students of the bachelor program of study and local people who were engaged in the SMILE project in the Neighbourhood House. All the participants were recruited once the project had received ethical approval from the University and the partner institution, and informed consent to participate had been given. The key ethical concerns arose from the vulnerability of some of the participants. Our consent process was based on open discussion and written information explaining the purpose and design of the study, assuring anonymity for participants and ensuring those

who participated could withdraw at any time without question. Students were invited to participate in the SMILE placement program via an Expression of Interest. There were no exclusion criteria for consumer participants as we hoped to include as many individuals as possible reflecting the diversity of the local community. The program was facilitated for 8 x 2-week blocks, 4 student cohorts (32 students in total) and (65 community members) participated.

The SMILE Program

The SMILE placement program facilitated student participation in the Neighbourhood House activities, such as conversational English, basic cooking class and a women's health and wellbeing group. A key element for the students was the development and leading of health promotion education sessions through a 'Kiosk' for Health Checks, student led community forums and health education delivery at what was known as the StARTalking creative arts workshop 1 day each week. The program of activities enabled an interprofessional approach to learning as provided an opportunity for the nursing students to learn alongside other undergraduate health care students about health and wellbeing in a number of ways and through the StARTalking activity, explore health topics and art-making in a relaxing, safe and informal environment (Ward and Barry, 2016). The key aims of StARTalking are to assist participants to develop social networks, build new skills and knowledge about maintaining their health, increase self-efficacy around creative activities and health literacy. The creative arts activities, ranged from traditional painting and drawing activities to, collage making, ceramics and mixed media (Ward and Barry, 2016).

The SMILE Clinical placement evaluation

The students

In all, thirty-two students, 2 nurse academics and sixty-five community members were invited to participate in the SMILE activities held during the student placement weeks. A qualitative method of enquiry was applied to the evaluation of the SMILE placement program. Focus groups were undertaken with student participants before the placement with four questions to prompt /provoke discussion with participants. The aim of the evaluation was to better understand to what extent students had been able to draw upon the theoretical learning that they had experienced to prepare them for this practice experience.

The following questions were used to prompt discussion and encourage reflective thought on student preparation:

1. Have you participated in a community arts/ mental health and wellbeing project or placement program before?
2. Have you practiced any art making before? What was your experience?
3. What do you understand by community mental health and wellbeing?
4. What do you do to manage your own mental health and wellbeing?

On completion of the placement, the student focus groups were reconvened, and the following questions were used again to encourage discussion about the experience:

1. Did you enjoy the mental health and wellbeing workshops and the SMILE placement program?
2. Did you learn anything new about yourself?
3. Did you learn anything about community mental health and wellbeing?
4. What did you learn from the SMILE placement program?
5. What do you think the community needs to support better mental health and wellbeing for community members?

The community members

The 65 community members who participated in the SMILE program activities participated in a focus Group evaluation at the end of the SMILE program. All participants who had attended the focus group had attended the 'kiosk for Health Checks' 'StARTalking' and participated in a student led health care assessment. All participants (n=65) expressed benefit of the SMILE program and the SMILE Clinical placement. We have deidentified the participants here but have provided alternative names and included genuine biography to humanise the accounts. We used the following broad and open-ended questions to trigger discussion:

- Have you practiced any art making before? What was your experience?
- What do you know about your health / mental health and wellbeing?
- What do you think your community needs, to support better mental health and wellbeing?

Analysis

The focus group data was audio recorded and transcribed verbatim. The data was deidentified and alternate names used to represent participants. The pre and post focus

group transcripts were analysed using a thematic approach (Hsieh and Shannon 2005). The transcripts were read and then re-read to identify any common themes, and or patterns. And a comprehensive immersion in the participant responses. To ensure an accurate representation of the themes the researchers analysed the data individually to identify key repetitions and subtext and then together to decide on emergent themes (Ward & Barry, 2016).

The student evaluation findings

Students expressed feelings about the extent to which they felt prepared for the placement and drew upon theory and practice in their recognition of the significance of the social determinates of health to individual and population consumer health outcomes. The students identified the challenges associated with working across disciplines and organisations; the importance of cultural safety practices working with vulnerable people and students could articulate concerns related to the power and inequalities that exist in society. Three key themes emerged: **Ditching nursing routine, Insight and outcomes, Different strokes for different folks.**

Ditching nursing routine

The perceived lack of routine, specific tasks to complete and the structure in the environment were highlighted as follows. Jenny (student) made a comment about their preparedness for the placement:

.... I feel that I only was only moderately prepared coming in because we have (experienced) such different nursing, there's a lot more independence here, and talking to the health care team, you know, there's not someone right there letting

you know exactly what you should say. So, it's a bit different, because you are giving health advice and you have to sort of draw a little on the education which isn't clinical, non-clinical which is not something we have done before.

And Meg (student) responded saying:

.... I would have to agree, I didn't feel overly prepared coming into this placement I felt like most of the other placements were hospital based and very regimented on a ward routine, with a strong focus on the current primary diagnosis. Of course, in ward nursing you do have that discharge planning but it's not the same intensity as community based (practice).

This theme was reflected in many of the student's comments during the focus group discussion. The theme highlights the students common understanding of the nursing role as experienced on previous clinical placements. The hospital, acute ward perspective was referred to several times in relation the nursing tasks they were familiar with. The nursing tasks required on the SMILE placement however were noticeably different. The reference to working autonomously at SMILE was raised and there was acknowledgement that however daunting that was at first it represented great learning. This variance between what they were used to doing and what opportunities SMILE offered them was significant to the development of leadership skills and nursing competence.

Insight and outcomes

Student participants were able to articulate their insight into the nursing approach necessary to work with communities of disadvantage.

(applying) knowledge of how to access healthcare and stuff and knowing what's available to them and even simple things like language barriers... they come to this facility but they may not be able to actually benefit from all the programmes because they don't fully understand what else there is here, they can't just read the brochures or things like that.

The students discussed the way in which they adopted a different nursing approach when working with people of disadvantage. They spoke about how they actively engaged in conversation to develop rapport however how they were mindful that the people they were caring for were not patients. Elle said:

you have to approach the person and be led by them, I felt I was following their lead, responding to their need'

They reported that because of the various approaches they adopted in this community setting their learning was significantly different. They considered their learning was 'in action' 'happening in the moment' and this was in contrast with how they had learnt in the hospital environment. The students articulated that in the hospital environment they were working off theory, step by step skills and a very structured time management plan. Rosie said:

In the hospital you have a very clear order of things you need to do and usually not enough time to do everything. And your work relates to a group of patients and the care they need on any one day.

Lenny (student) said that learning was different because you the community environment required different knowledge therefore students were stretched to see health and illness from a different perspective:

...I think that it's the health promotion, not the illness focus, you can't just fall back onto the idea of helping them recover you can't just be task orientated because, well you can't become complacent as you are about health promotion and providing, well I don't really know what I'm saying....

Different stakes for different folks

This theme recognised the different health beliefs arising from different cultural perspectives and how students were required to learn this information 'on the run':

....if you have a patient from a different cultural background, the typical western/ Australian model of health , they just do what the doctors say, and someone may come in and their culture may not believe in a certain medication and a certain way of doing something they can say OK, can you explain to me why you are uncomfortable with this 'cos then that makes them feel respected and more comfortable and you can try and find out what their reasoning is and if there's a way you can work around that.

Students shared their learning about the way that health care is organised and delivered and what that can mean for vulnerable people trying to access services. Amy said:

I have found that I am more able to identify barriers to health for people, the things we are expected to doproviding education and support and advocacy for our patients and think that part of that even we have patients

who are without healthcare we need to be effective in our job and identify ways toeven those who don't speak the same language as us, to often I feel that nurses will not give....health education or work with the patient for them to become a partner in their health care and I think this placement has helped me to identify those skills an help me also address those barriers.

Student expressed that they had to work with each individual and respond specifically to their needs. They had to acknowledge culture, age and respect a person's belief system and way of being in the world. The students referred to being non-judgemental and 'respecting everyone's differences' 'learning that 'people have had different life experience' and those experiences influence them when they interact with others.

The consumer participant evaluation findings

The consumer participants shared their experience in one or more of the SMILE activities: The Kiosk for Health Checks, StARTalking- creative arts activities, the relaxation sessions, and the health education information. The two themes to emerge included **One Stop Shop** and **Connecting**.

One stop shop

The Kiosk for Health Checks were considered a One stop shop. The participants referred to them as an opportunity to ask questions and reflect on their health and wellbeing.

Gwen (67-year-old woman) made comment on the positive impact of SMILE on her health and wellbeing:

I realised I didn't know much about my health and I have diabetes so I should know more. One thing I realised is that it's my mental state that I need to manage so I can

manage my health. I get stressed about things and going to the doctors because I worry about getting sicker or having cancer. Going to the kiosk was great because I talked to the students and they told me where I can go to for free and how I can manage my health better.

Gwen had attended the Kiosk for Health Checks several times and felt that she learnt something new at each visit. Gwen expressed feeling very comfortable to ask students questions about her health and to enquire about local service providers.

Troy (a 33-year-old homeless man) said he too felt comfortable with the students. Troy spoke about the way in which students communicated. He considered them non-judgmental and caring. He said:

I have been able to learn a lot about my health. The students presented it in a way I could really understand'.

Marion (73-year-old woman) said that attending the SMILE Kiosk for Health Checks and education session provided her with a greater sense of awareness about her health and with this knowledge she was able to formulate a plan to take care of herself. Marion spoke about attending the kiosk and StARTalking. She said the two activities complemented each other. She said:

I have trouble with weight, but I didn't understand how that might affect my other health issues.

Joy a 74-year-old woman with a diagnosis of type 1 diabetes shared with the focus group that SMILE had provided education that was having a direct impact on her physical wellbeing. She said:

The one thing I want in my life is good health, but I have never had it. SMILE has taught me more about how to get it.

Mary (53-year-old woman) shared the following experience.

I am on a lot of medication so when the students had the kiosk, I told one about them all. They got the teacher because they didn't know all of them. The teacher then talked to us all about what they do and why I take them and then I understood more about them too. I didn't know I could ask the doctor to maybe change them if they didn't work. I then went to my doctor and I am going back to what I was on before. So that was good and wouldn't have happened without SMILE.

Mary was convinced that without SMILE she may not have followed up with her doctor. SMILE had offered opportunity to reflect on her current medication regime. This small intervention may have been lifesaving.

Connected

The theme of being Connected emerged as participant data continually referred to 'making friends' 'connecting to others' 'being heard' and 'having purpose'.

In reflection of the StARTalking workshops participants spoke about connecting, being part of something and they were clear that this group was positive to their health and wellbeing.

Mark (47-year-old male) shared he had a long-term mental health problem that had a huge impact on his life. He expressed a great appreciation of the SMILE program and in particular the StARTalking program:

I always wish to be healthy. I have schizophrenia. You can't get rid of that. My general health suffers and all I want to be is loved with luck, safe and successful. The students have given me friendships I don't have.

Dianne (45-year-old woman) attended StARTalking. Dianne shared in the focus group that StARTalking and the education provided by students had a direct impact on her life choices and her health:

I need to quit smoking and need to lose weight and exercise more. SMILE taught me to look at what to eat and how to eat better.

Dianne said:

Learning about how my heart works and then doing relaxation makes me understand how to be in control. It makes me want to stop smoking now so my heart can be healthier.

The participants spoke about the relaxation sessions and the theme of Connected was again apparent as discussion involve comments such as May's comment:

I feel welcome to be a part of the SMILE program and that feels good

Dianne (45-year-old woman) told us:

I want to be a loving mother. I don't want to be stressed and uptight because I am worrying all the time. The stress management I learned in SMILE has taught me how to take time out and breath. Be more mindful. The kiosk with the students was good and my blood pressure was good so I felt like there was less to worry about with my health. They also told me about the health coaches we can go to for more help.

Dianne made mention that being able to access the SMILE resource, and most importantly the relaxation sessions and the student assessment made them feel connected to others, which in turn resulted in good health. The other participants used words such as 'I've made friends at SMILE' and 'I feel good that I know SMILE is around the corner'.

Cindy (32-year-old woman) shared with the group that she had trouble managing her emotions and in turn her behaviour. She said that being connected to the SMILE program and attending StARTalking has meant she had to reflect on how she interacted with others. She said she was aware she needed to take responsibility for her behavior. She said:

I feel anxious all the time. I feel like I stuff up all of the time and end up hurting people. I need to stop stressing and consider other people more.

Cindy spoke further to the group about the positive impact meditation in StARTalking had on her life and that it was a practice she would continue to use to manage her anxiety.

Connecting to the SMILE program had enriched her life:

I need to control my anxiety. The students taught me how to breath and be more mindful. I want to keep coming to SMILE so that I can learn more about my health.

Susana (29-year-old woman) talked about being connected to SMILE and the benefit that health information she received from students had on her wellbeing and outlook on life.

Susana had disclosed a long history with depression. Susana said:

I am on a lot of medication and I hate taking it. It makes me feel sad that I have to do it for the rest of my life because I am young but in SMILE, we talked about what people took and other people are on lots of pills too, so I don't feel as bad. The students talked about health and I understood what they said because they spoke slow, and we could ask questions. When I go to the doctors it is always so quick and sometimes, I forget why I went in the first place and then I get home and think I should have asked that question.

The theme **Connected** represents the participants appreciation of being 'apart of something', 'in relationship with others', 'feeling safe to speak' and knowing they are 'being listened to'.

Discussion

The students who participated in the study reported a positive but challenging experience in this placement overall. The students spoke about the challenges of working in this non-clinical environment, and how they had to take the initiative and opportunities as and when they presented. They also recognised the language and other cultural barriers to beginning conversations about health and well-being and that sufficient time was needed to listen as well as talk and to find new ways to explain or provided information to people with very different needs and expectations.

The Focus Group discussions illustrated the students struggles to express and articulate the scale of the challenge of assisting vulnerable individuals to both recognise poor health and take steps to make even small changes. There was reference to 'thinking on your feet', 'you have to problem solve and find solutions-pretty quick'.

It was clear however, from the student discussions, that they were beginning to understand the challenge and that one of the key steps they had to make themselves was improving their own ability to listen and communicate with individuals whose health literacy was poor and who had many other priorities.

Chinn's ideas are powerful in that they remind students that this environment is not a health professional's domain. The priorities and preoccupations of health care services and professionals have to give way to the issues that are foremost in the mind of the individuals who are seeking help. This requires a reflexive, responsive and highly adaptable approach as well as a skill set that can be transferred to complex and challenging situations and experiences. Exploring these ideas through the Peace and Power model has helped students to recognize the power dynamics in professional/client relationships. Moreover, it has allowed them to think more critically about what empowers and disempowers individuals, what builds community and how they can contribute. The theoretical learning that preceded the placement, applying the Peace and Power approach and the academic teacher support were important dimensions and reference points for teachers and students. This is important when learning or working in a non-institutional health setting where the framework, routines and model of care is otherwise fluid or undefined and the people using this local service are marginalised and otherwise vulnerable. An important dimension of the student feedback was the account they gave of their improved understanding of why those

who experience mental health issues or live in poverty may not seek out health care and in turn limit their social interactions due to negative attitudes toward mental illness and ongoing associated stigma.

From the consumer perspective, their contribution to this study confirms the potential of programmes like this in their recovery and in their coping. Having the students and academics bring such a rich programme of activities and health care skill to an accessible place is clearly valuable to them. Based on the findings from the student learning evaluation process and SMILE participant focus groups, a risk and resilience framework that identifies protective factors will be introduced in the next SMILE clinical placement program.

Limitations

As a pilot study with a small number of overall participants and the localised (single centre) approach do limit wider application of the findings but we consider with some modifications to the design this study might be repeated in other settings where students are learning about Primary Care and health improvement. Other methods including interviews may also be appropriate and enable us to look more closely at individual case studies and narratives of experience. We are aware of a burgeoning interest in collaborative approaches to improving health and in new methodological approaches that may be helpful including co-creative community-based health research (Daykin et al 2017, Greenhalgh et al 2016). The insights this study provides, should assist those engaged in similar work or exploring its potential, to consider applying elements of the SMILE model in preparing students, supporting them in practice and helping them to analyse and evaluate their learning through critical reflection on their practice experiences. It may also provide encouragement to create partnerships with stakeholders to generate new knowledge both about how students learn but also how professionals can support consumers to make the lifestyle changes that will improve their health and wellbeing.

Conclusion

The SMILE clinical placement aimed to provide nursing students with an opportunity to offer nursing care to diverse community populations and gain insight into the way in which social and economic factors can affect mental health and wellbeing. The findings of the pilot study encourage us to continue with this collaborative approach both in its value to learning in primary care but also because of the way it has strengthened our community health partnerships. We identified that the participating students were able to recognise the way in which nursing interventions can help to overcome issues of disadvantage by engaging

potentially vulnerable people in a program that can contribute directly and indirectly to their mental and physical health and wellbeing. Hearing from the users of SMILE added to our understanding of the student contribution's value to them. The students were able to both recognise and discuss the different ways in which they can apply their knowledge and skills to support consumers to access health services, helping them to understand the ways in which lifestyle and socioeconomic circumstances can worsen or improve health and, through wider knowledge and understanding of the organisation and delivery of health services, help to increase the community's health literacy overall.

We are aware that government health departments in many countries are looking to address rising medical costs and unmet need through restructuring services, for example through community (or socially) based schemes and consequently making a significant health impact. We would argue that these schemes should not just seek to occupy participants in creative and other recreational activities (which are important ends in themselves) but should also seek to widen access to appropriate health care support and advice through new community partnerships and this we suggest, is especially important for vulnerable individuals with mental health care needs if health outcomes are to be improved. Making changes to the way that health practitioners (including the large nursing workforce) learn how to contribute to these efforts through theory and practice, is an important way to begin to realise these goals.

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Title: Learning how to SMILE. improving physical and mental health through nurse education and creative practice.

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4 **Learning how to SMILE: improving physical and mental health through nurse education**
5 **and creative practice**
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9
10 **Abstract**

11
12 The purpose of this pilot study was to explore how best to prepare and support nursing
13 undergraduate students learning in a community/primary care setting through a Student
14 Managed Initiatives in Lifestyle Education (SMILE) project. Further to this our intention was
15 to evaluate the ways in which students were able to apply nursing theory to the practice of
16 identifying and responding to the health needs of vulnerable people.
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19
20 Using a collaborative approach and a qualitative method, this pilot study used focus group
21 discussions to explore both the experiences of community participants and undergraduate
22 nursing students.
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25
26 This project found that students were able to draw on theoretical understandings and their
27 simulated learning experiences to support their learning in a complex, non- clinical practice
28 setting. It also illustrates the way in which community centres and other naturalistic
29 environments where individuals and groups meet, can provide spontaneous and rewarding
30 opportunities for nursing students to develop and apply health promoting knowledge and
31 skills. Shaping nursing curricula with this in mind, creates the potential for nurses to make a
32 significant contribution to improved health outcomes for vulnerable and/or marginalised
33 people.
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62 Introduction
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64 The physical health and wellbeing and life expectancy of individuals living with long-term
65 mental illness is a cause of concern in most countries. The incidence of heart disease,
66 cancer, diabetes along with many other long-term health conditions is documented as being
67 well above the average and as such represents a significant challenge (Bahorik et al 2017,
68 WHO 2016, 2017; Hardy et al, 2011). Moreover, it is being recognised that the personal and
69 financial costs of this situation is unsustainable (Lawrence et al 2001, Jones et al 2004,
70 Crotty et al 2015). It has been established that people living within communities of
71 disadvantage, experience increased levels of mental illness, are stigmatised, have poorer
72 physical health, and receive less health care than the rest of the population (Collins et al,
73 2012; Ohrnberger et al 2017; Crotty 2015, Bradshaw et al 2017). The range of care provision
74 in many deprived communities is said to be limited and clinical evidence confirms that
75 vulnerable populations have a lower life expectancy (Stanley and Laugharne 2011). The
76 current approach to this challenge, in terms of increasing access to health services of
77 marginalised populations and vulnerable individuals, and providing the comprehensive
78 health care interventions and appropriate health advice needed, necessitates a radical
79 approach by the health care service and its workforce. This approach needs to address both
80 the continuing pervading stigma of people with mental illness and the structures that shape
81 service delivery. These persistent health inequalities have been recognised in many
82 countries including Australia and the United Kingdom. Nursing regulatory bodies have
83 introduced Standards for Higher Education Institutions to equip graduates to be able to
84 respond to the pressing health priorities including the needs of marginalised and
85 disadvantaged groups (NMC 2018, ANMC 2012). The NMC's recently published standards
86 for proficiency for example, has devoted a platform for 'Promoting health and preventing ill
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121 health' but there is a real challenge in nurse education to translate this into meaningful
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123 practice learning experiences that both challenge and change the practice of the future
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125 nurse. Therefore in this paper we argue that the future nursing workforce has a significant
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127 role to play in this, given the scale of unmet need.
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131 Higher Education Institutions (HEIs) and their health and social care partner organisations
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133 providing nurse education, need to recognise the way in which theory and practice needs to
134
135 develop in order to equip graduates with the skills to be instrumental in bringing about
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137 change. This includes addressing the personal and institutional stigma and schema that act
138
139 as barriers to engagement and accessing services, becoming knowledgeable about and
140
141 skilled in advising on appropriate lifestyle education interventions and non-medical
142
143 interventions. Above all, graduates need to be able to recognise presenting opportunities
144
145 for appropriate interventions that will help vulnerable and isolated people who have mental
146
147 illness both to maintain better physical health and to access health services and advice early
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149 when they become physically unwell.
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152

153 **Background**

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155 To this end this project Student Managed Initiatives in Lifestyle Education (SMILE), was
156
157 piloted within a Primary Health Care clinical placement for a group of final year
158
159 Undergraduate Students in a University in Australia. Elements of this model for student
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161 learning had been developed and evaluated in previous placements in an ANMAC approved
162
163 Bachelor of nursing programme (Ward and Barry, 2016) with a strong focus on enhancing
164
165 communication and consumer health and wellbeing through the creative arts. Building on
166
167 this model, this new project was designed to prepare and enable students to a greater
168
169 initiative with opening discussions with consumers about their health and lifestyle factors.
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180 Students had been prepared for the placement through theoretical and clinical nursing
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182 studies including learning about mental health and illness, national and local health
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184 inequalities and the social determinants of health and orientated to the contemporary
185
186 context of primary health care provision. We had introduced students to the 'Peace and
187
188 Power' approach to building communities in order to provide them with a 'tool kit' to use
189
190 when opening and engaging conversations with vulnerable people (Chinn and Falk-Rafael
191
192 2015). The aim of this approach to professional and peer collaboration, allows the individual
193
194 to lead discussions in identifying and exploring health needs and priorities in a way that
195
196 encourages them to recognise and set aside personal prejudices, schema, priorities and
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198 intentions and by understanding the way in which power between client and professionals
199
200 operate. This model also prepared students to understand the importance of critical
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202 reflection for example in building awareness of self and others through a collaborative
203
204 approach to practice.
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209
210 We argue that theoretical grounding is important for students. Research evidence and
211
212 policy literature can orientate students to the significance of mental health and wellbeing
213
214 and how lifestyle factors, alcohol and/or drug misuse, medication and psychosocial factors
215
216 can impact quality of life. Further to this, students need to develop an understanding of
217
218 how, in the broader scheme of things, nurses, and other health care professionals are
219
220 already engaged in activities that make improvements in the general community, through
221
222 education, health promotion, early intervention and prevention.
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227 Students studying at this University are provided with extensive resources to support the
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229 theoretical component of their learning. However, working effectively in practice with this
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231 level of complexity is a daunting prospect for the student and achieving a level of
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239 independence to make a difference requires an educational model that will optimise the
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241 learning experience, challenge the student and ensure appropriate levels of supervision and
242
243 demonstrate the potential of Primary and Community Care for nursing careers. What is less
244
245 well understood is the best way to prepare for the challenges of working with consumers
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247 closer to their homes and the power dynamics that operate within the professional/client
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249 relationships when health education or lifestyle change is required.
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253 We are aware that future health care practice in Australia and the UK needs to be focussed
254
255 on prevention and to be offered increasingly within the primary health care setting. The UK
256
257 government for example is in the process of developing a national approach to 'Social
258
259 Prescribing' (SP) as a means to address unmet health need in primary care, through non-
260
261 pharmacological approaches (Department of Health and Social Care 2018, The Kings Fund
262
263 2017). Although this is a non-traditional health care setting it is one where there is a highly
264
265 visible level of health care need and a large participating number of consumers, and we
266
267 have found this to be an excellent environment for learning for final year students.
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272 Through this project and its evaluation, we argue that:
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278 1. Allowing students time to develop knowledge in primary health, mental health and
279
280 wellbeing, therapeutic communication, and leadership skills in a community setting
281
282 is invaluable to their learning and professional development.
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- 284
285 2. Allowing students to engage in experiential learning in this way provides the
286
287 community with a unique resource and provides the basis for partnerships and
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289 multidisciplinary working, we have found that the student contribution is important,
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291 even if on a small scale.
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3. The approach illustrated in this project would sit well within newly developing approaches for the Social Prescribing model and other community development activities that seek to address ongoing mental health and other isolating long-term health conditions.

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Research Design

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Setting

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This study took place in a non-clinical community setting where people were meeting to participate in adult educational activities within a local council neighbourhood house. The Neighbourhood House, funded by the local Council offers a meeting place for various groups, a community kitchen/restaurant and a rolling programme of adult learning activities.

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Participants

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The participants were Undergraduate nursing students of the bachelor program of study and local people who were engaged in the SMILE project in the Neighbourhood House. All the participants were recruited once the project had received ethical approval from the University and the partner institution, and informed consent to participate had been given. The key ethical concerns arose from the vulnerability of some of the participants. Our consent process was based on open discussion and written information explaining the purpose and design of the study, assuring anonymity for participants and ensuring those

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356
357 who participated could withdraw at any time without question. Students were invited to
358
359 participate in the SMILE placement program via an Expression of Interest. There were no
360
361 exclusion criteria for consumer participants as we hoped to include as many individuals as
362
363 possible reflecting the diversity of the local community. The program was facilitated for 8 x
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365 2-week blocks, 4 student cohorts (32 students in total) and (65 community members)
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367 participated.
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370 371 **The SMILE Program** 372

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376 The SMILE placement program facilitated student participation in the Neighbourhood House
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378 activities, such as conversational English, basic cooking class and a women's health and
379
380 wellbeing group. A key element for the students was the development and leading of
381
382 health promotion education sessions through a 'Kiosk' for Health Checks, student led
383
384 community forums and health education delivery at what was known as the StARTalking
385
386 creative arts workshop 1 day each week. The program of activities enabled an
387
388 interprofessional approach to learning as provided an opportunity for the nursing students
389
390 to learn alongside other undergraduate health care students about health and wellbeing in a
391
392 number of ways and through the StARTalking activity, explore health topics and art-making
393
394 in a relaxing, safe and informal environment (Ward and Barry, 2016). The key aims of
395
396 StARTalking are to assist participants to develop social networks, build new skills and
397
398 knowledge about maintaining their health, increase self-efficacy around creative activities
399
400 and health literacy. The creative arts activities, ranged from traditional painting and drawing
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402 activities to, collage making, ceramics and mixed media (Ward and Barry, 2016).
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416 **The SMILE Clinical placement evaluation**
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421 **The students**
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424 In all, thirty-two students, 2 nurse academics and sixty-five community members were
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426 invited to participate in the SMILE activities held during the student placement weeks. A
427
428 qualitative method of enquiry was applied to the evaluation of the SMILE placement
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430 program. Focus groups were undertaken with student participants before the placement
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432 with four questions to prompt /provoke discussion with participants. The aim of the
433
434 evaluation was to better understand to what extent students had been able to draw upon
435
436 the theoretical learning that they had experienced to prepare them for this practice
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438 experience.
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442 The following questions were used to prompt discussion and encourage reflective thought
443
444 on student preparation:
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- 446
447 1. Have you participated in a community arts/ mental health and wellbeing project or
448
449 placement program before?
450
451 2. Have you practiced any art making before? What was your experience?
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453 3. What do you understand by community mental health and wellbeing?
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455 4. What do you do to manage your own mental health and wellbeing?
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461 On completion of the placement, the student focus groups were reconvened, and the
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463 following questions were used again to encourage discussion about the experience:
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490
1. Did you enjoy the mental health and wellbeing workshops and the SMILE placement program?
 2. Did you learn anything new about yourself?
 3. Did you learn anything about community mental health and wellbeing?
 4. What did you learn from the SMILE placement program?
 5. What do you think the community needs to support better mental health and wellbeing for community members?

491 **The community members**

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The 65 community members who participated in the SMILE program activities participated in a focus Group evaluation at the end of the SMILE program. All participants who had attended the focus group had attended the 'kiosk for Health Checks' 'StARTalking' and participated in a student led health care assessment. All participants (n=65) expressed benefit of the SMILE program and the SMILE Clinical placement. We have deidentified the participants here but have provided alternative names and included genuine biography to humanise the accounts. We used the following broad and open-ended questions to trigger discussion:

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- Have you practiced any art making before? What was your experience?
 - What do you know about your health / mental health and wellbeing?
 - What do you think your community needs, to support better mental health and wellbeing?

522 **Analysis**

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The focus group data was audio recorded and transcribed verbatim. The data was deidentified and alternate names used to represent participants. The pre and post focus

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533
534 group transcripts were analysed using a thematic approach (Hsieh and Shannon 2005). The
535
536 transcripts were read and then re-read to identify any common themes, and or patterns.
537
538
539 And a comprehensive immersion in the participant responses. To ensure an accurate
540
541 representation of the themes the researchers analysed the data individually to identify key
542
543 repetitions and subtext and then together to decide on emergent themes (Ward & Barry,
544
545 2016).
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548 **The student evaluation findings**

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551 Students expressed feelings about the extent to which they felt prepared for the placement
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553 and drew upon theory and practice in their recognition of the significance of the social
554
555 determinates of health to individual and population consumer health outcomes. The
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557 students identified the challenges associated with working across disciplines and
558
559 organisations; the importance of cultural safety practices working with vulnerable people
560
561 and students could articulate concerns related to the power and inequalities that exist in
562
563 society. Three key themes emerged: **Ditching nursing routine, Insight and outcomes,**
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566

567 **Different strokes for different folks.**

568 569 **Ditching nursing routine**

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572 The perceived lack of routine, specific tasks to complete and the structure in the
573
574 environment were highlighted as follows. Jenny (student) made a comment about their
575
576 preparedness for the placement:
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580 *.... I feel that I only was only moderately prepared coming in because we have*
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582 *(experienced) such different nursing, there's a lot more independence here, and*
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584 *talking to the health care team, you know, there's not someone right there letting*
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593 *you know exactly what you should say. So, it's a bit different, because you are giving*
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595 *health advice and you have to sort of draw a little on the education which isn't*
596
597 *clinical, non-clinical which is not something we have done before.*
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601 And Meg (student) responded saying:

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603 *.... I would have to agree, I didn't feel overly prepared coming into this placement I*
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605 *felt like most of the other placements were hospital based and very regimented on a*
606
607 *ward routine, with a strong focus on the current primary diagnosis. Of course, in*
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609 *ward nursing you do have that discharge planning but it's not the same intensity as*
610
611 *community based (practice).*
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614

615 This theme was reflected in many of the student's comments during the focus group
616
617 discussion. The theme highlights the students common understanding of the nursing role as
618
619 experienced on previous clinical placements. The hospital, acute ward perspective was
620
621 referred to several times in relation the nursing tasks they were familiar with. The nursing
622
623 tasks required on the SMILE placement however were noticeably different. The reference to
624
625 working autonomously at SMILE was raised and there was acknowledgement that however
626
627 daunting that was at first it represented great learning. This variance between what they
628
629 were used to doing and what opportunities SMILE offered them was significant to the
630
631 development of leadership skills and nursing competence.
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635 **Insight and outcomes**

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638 Student participants were able to articulate their insight into the nursing approach
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641 necessary to work with communities of disadvantage.
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652 *(applying) knowledge of how to access healthcare and stuff and knowing what's*
653 *available to them and even simple things like language barriers... they come to this*
654 *facility but they may not able to actually benefit from all the programmes because*
655 *they don't fully understand what else there is here, they can't just read the brochures*
656 *or things like that.*
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663
664 The students discussed the way in which they adopted a different nursing approach when
665 working with people of disadvantage. They spoke about how they actively engaged in
666 conversation to develop rapport however how they were mindful that the people they were
667 caring for were not patients. Elle said:
668

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674 *you have to approach the person and be led by them, I felt I was following their lead,*
675 *responding to their need'*
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678

679 They reported that because of the various approaches they adopted in this community
680 setting their learning was significantly different. They considered their learning was 'in
681 action' 'happening in the moment' and this was in contrast with how they had learnt in the
682 hospital environment. The students articulated that in the hospital environment they were
683 working off theory, step by step skills and a very structured time management plan. Rosie
684 said:
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693 *In the hospital you have a very clear order of things you need to do and usually not*
694 *enough time to do everything. And your work relates to a group of patients and the*
695 *care they need on any one day.*
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711 Lenny (student) said that learning was different because you the community environment
712 required different knowledge therefore students were stretched to see health and illness
713
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715
716 from a different perspective:
717

718 *...I think that it's the health promotion, not the illness focus, you can't just fall back*
719 *onto the idea of helping them recover you can't just be task orientated because, well*
720 *you can't become complacent as you are about health promotion and providing, well*
721 *I don't really know what I'm saying....*
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728 **Different stakes for different folks**

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730
731 This theme recognised the different health beliefs arising from different cultural
732 perspectives and how students were required to learn this information 'on the run':
733

734 *....if you have a patient from a different cultural background, the typical*
735 *western/ Australian model of health , they just do what the doctors say, and*
736 *someone may come in and their culture may not believe in a certain*
737 *medication and a certain way of doing something they can say OK, can you*
738 *explain to me why you are uncomfortable with this 'cos then that makes them*
739 *feel respected and more comfortable and you can try and find out what their*
740 *reasoning is and if there's a way you can work around that.*
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752
753 Students shared their learning about the way that health care is organised and delivered
754 and what that can mean for vulnerable people trying to access services. Amy said:
755

756 *I have found that I am more able to identify barriers to health for people, the*
757 *things we are expected to doproviding education and support and*
758 *advocacy for our patients and think that part of that even we have patients*
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770 *who are without healthcare we need to be effective in our job and identify*
771
772 *ways toeven those who don't speak the same language as us, to often I*
773
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775 *feel that nurses will not give....health education or work with the patient for*
776
777 *them to become a partner in their health care and I think this placement has*
778
779 *helped me to identify those skills an help me also address those barriers.*
780

781
782 Student expressed that they had to work with each individual and respond specifically to
783
784 their needs. They had to acknowledge culture, age and respect a person's belief system and
785
786 way of being in the world. The students referred to being non-judgemental and 'respecting
787
788 everyone's differences' 'learning that 'people have had different life experience' and those
789
790 experiences influence them when they interact with others.
791
792

793 794 **The consumer participant evaluation findings**

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796
797 The consumer participants shared their experience in one or more of the SMILE activities:
798
799 The Kiosk for Health Checks, StARTalking- creative arts activities, the relaxation sessions,
800
801 and the health education information. The two themes to emerge included **One Stop Shop**
802
803 and **Connecting**.
804

805 806 **One stop shop**

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808
809 The Kiosk for Health Checks were considered a One stop shop. The participants referred to
810
811 them as an opportunity to ask questions and reflect on their health and wellbeing.
812
813

814
815 Gwen (67-year-old woman) made comment on the positive impact of SMILE on her health
816
817 and wellbeing:
818

819
820 *I realised I didn't know much about my health and I have diabetes so I should know*
821
822 *more. One thing I realised is that it's my mental state that I need to manage so I can*
823
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827
828
829 *manage my health. I get stressed about things and going to the doctors because I*
830
831 *worry about getting sicker or having cancer. Going to the kiosk was great because I*
832
833 *talked to the students and they told me where I can go to for free and how I can*
834
835 *manage my health better.*
836
837

838
839 Gwen had attended the Kiosk for Health Checks several times and felt that she learnt
840
841 something new at each visit. Gwen expressed feeling very comfortable to ask students
842
843 questions about her health and to enquire about local service providers.
844
845

846 Troy (a 33-year-old homeless man) said he too felt comfortable with the students. Troy
847
848 spoke about the way in which students communicated. He considered them non-judgmental
849
850 and caring. He said:
851

852
853 *I have been able to learn a lot about my health. The students presented it in a way I*
854
855 *could really understand’.*
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858
859 Marion (73-year-old woman) said that attending the SMILE Kiosk for Health Checks and
860
861 education session provided her with a greater sense of awareness about her health and with
862
863 this knowledge she was able to formulate a plan to take care of herself. Marion spoke about
864
865 attending the kiosk and StARTalking. She said the two activities complemented each other.
866
867

868 She said:

869
870 *I have trouble with weight, but I didn’t understand how that might affect my other*
871
872 *health issues.*
873
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875
876 Joy a 74-year-old woman with a diagnosis of type 1 diabetes shared with the focus group
877
878 that SMILE had provided education that was having a direct impact on her physical
879
880 wellbeing. She said:
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887
888 *The one thing I want in my life is good health, but I have never had it. SMILE has*
889
890 *taught me more about how to get it.*
891
892

893 Mary (53-year-old woman) shared the following experience.
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897
898 *I am on a lot of medication so when the students had the kiosk, I told one about them*
899
900 *all. They got the teacher because they didn't know all of them. The teacher then*
901
902 *talked to us all about what they do and why I take them and then I understood more*
903
904 *about them too. I didn't know I could ask the doctor to maybe change them if they*
905
906 *didn't work. I then went to my doctor and I am going back to what I was on before.*
907
908
909 *So that was good and wouldn't have happened without SMILE.*
910
911

912
913
914 Mary was convinced that without SMILE she may not have followed up with her doctor.
915
916 SMILE had offered opportunity to reflect on her current medication regime. This small
917
918 intervention may have been lifesaving.
919
920

921 922 923 **Connected** 924

925
926 The theme of being Connect emerged as participant data continually referred to 'making
927
928 friends' 'connecting to others' 'being heard' and 'having purpose'.
929

930
931 In reflection of the StARTalking workshops participants spoke about connecting, being part
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933 of something and they were clear that this group was positive to their health and wellbeing.
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947 Mark (47-year-old male) shared he had a long-term mental health problem that had a huge
948 impact on his life. He expressed a great appreciation of the SMILE program and in particular
949 the StARTalking program:
950
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953

954
955 *I always wish to be healthy. I have schizophrenia. You can't get rid of that. My*
956
957 *general health suffers and all I want to be is loved with luck, safe and successful. The*
958
959 *students have given me friendships I don't have.*
960
961
962

963 Dianne (45-year-old woman) attended StARTalking. Dianne shared in the focus group that
964 StARTalking and the education provided by students had a direct impact on her life choices
965 and her health:
966
967
968
969

970
971 *I need to quit smoking and need to lose weight and exercise more. SMILE taught me*
972
973 *to look at what to eat and how to eat better.*
974
975
976

977 Dianne said:
978
979
980
981

982 *Learning about how my heart works and then doing relaxation makes me understand*
983
984 *how to be in control. It makes me want to stop smoking now so my heart can be*
985
986 *healthier.*
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991 The participants spoke about the relaxation sessions and the theme of Connected was again
992 apparent as discussion involve comments such as May's comment:
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995

996 *I feel welcome to be a part of the SMILE program and that feels good*
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999 Dianne (45-year-old woman) told us:
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1003

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1005
1006 *I want to be a loving mother. I don't want to be stressed and uptight because I am*
1007
1008 *worrying all the time. The stress management I learned in SMILE has taught me how*
1009
1010 *to take time out and breath. Be more mindful. The kiosk with the students was good*
1011
1012 *and my blood pressure was good so I felt like there was less to worry about with my*
1013
1014 *health. They also told me about the health coaches we can go to for more help.*
1015
1016

1017
1018 Dianne made mention that being able to access the SMILE resource, and most importantly
1019
1020 the relaxation sessions and the student assessment made them feel connected to others,
1021
1022 which in turn resulted in good health. The other participants used words such as 'I've made
1023
1024 friends at SMILE' and 'I feel good that I know SMILE is around the corner'.
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1028
1029 Cindy (32-year-old woman) shared with the group that she had trouble managing her
1030
1031 emotions and in turn her behaviour. She said that being connected to the SMILE program
1032
1033 and attending StARTalking has meant she had to reflect on how she interacted with others.
1034
1035 She said she was aware she needed to take responsibility for her behavior. She said:
1036
1037

1038
1039
1040 *I feel anxious all the time. I feel like I stuff up all of the time and end up hurting*
1041
1042 *people. I need to stop stressing and consider other people more.*
1043
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1046
1047 Cindy spoke further to the group about the positive impact meditation in StARTalking had
1048
1049 on her life and that it was a practice she would continue to use to manage her anxiety.
1050

1051 Connecting to the SMILE program had enriched her life:
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1053

1054
1055
1056 *I need to control my anxiety. The students taught me how to breath and be more*
1057
1058 *mindful. I want to keep coming to SMILE so that I can learn more about my health.*
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1068 Susana (29-year-old woman) talked about being connected to SMILE and the benefit that
1069
1070 health information she received from students had on her wellbeing and outlook on life.
1071

1072 Susana had disclosed a long history with depression. Susana said:

1073
1074 *I am on a lot of medication and I hate taking it. It makes me feel sad that I have to do*
1075
1076 *it for the rest of my life because I am young but in SMILE, we talked about what*
1077
1078 *people took and other people are on lots of pills too, so I don't feel as bad. The*
1079
1080 *students talked about health and I understood what they said because they spoke*
1081
1082 *slow, and we could ask questions. When I go to the doctors it is always so quick and*
1083
1084 *sometimes, I forget why I went in the first place and then I get home and think I*
1085
1086 *should have asked that question.*
1087
1088
1089

1090 The theme **Connected** represents the participants appreciation of being 'apart of
1091
1092 something', 'in relationship with others', 'feeling safe to speak' and knowing they are 'being
1093
1094 listened to'.
1095
1096

1097 **Discussion**

1098
1099 The students who participated in the study reported a positive but challenging experience in
1100
1101 this placement overall. The students spoke about the challenges of working in this non-
1102
1103 clinical environment, and how they had to take the initiative and opportunities as and when
1104
1105 they presented. They also recognised the language and other cultural barriers to beginning
1106
1107 conversations about health and well-being and that sufficient time was needed to listen as
1108
1109 well as talk and to find new ways to explain or provided information to people with very
1110
1111 different needs and expectations.
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1124 The Focus Group discussions illustrated the students struggles to express and articulate the
1125
1126 scale of the challenge of assisting vulnerable individuals to both recognise poor health and
1127
1128 take steps to make even small changes. There was reference to 'thinking on your feet', 'you
1129
1130 have to problem solve and find solutions-pretty quick'.
1131
1132

1133
1134 It was clear however, from the student discussions, that they were beginning to understand
1135
1136 the challenge and that one of the key steps they had to make themselves was improving
1137
1138 their own ability to listen and communicate with individuals whose health literacy was poor
1139
1140 and who had many other priorities.
1141
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1143
1144 Chinn's ideas are powerful in that they remind students that this environment is not a
1145
1146 health professional's domain. The priorities and preoccupations of health care services and
1147
1148 professionals have to give way to the issues that are foremost in the mind of the individuals
1149
1150 who are seeking help. This requires a reflexive, responsive and highly adaptable approach as
1151
1152 well as a skill set that can be transferred to complex and challenging situations and
1153
1154 experiences. Exploring these ideas through the Peace and Power model has helped
1155
1156 students to recognize the power dynamics in professional/client relationships. Moreover, it
1157
1158 has allowed them to think more critically about what empowers and disempowers
1159
1160 individuals, what builds community and how they can contribute. The theoretical learning
1161
1162 that preceded the placement, applying the Peace and Power approach and the academic
1163
1164 teacher support were important dimensions and reference points for teachers and students.
1165
1166 This is important when learning or working in a non-institutional health setting where the
1167
1168 framework, routines and model of care is otherwise fluid or undefined and the people using
1169
1170 this local service are marginalised and otherwise vulnerable. An important dimension of the
1171
1172 student feedback was the account they gave of their improved understanding of why those
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1182
1183 who experience mental health issues or live in poverty may not seek out health care and in
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1185
1186 turn limit their social interactions due to negative attitudes toward mental illness and
1187
1188 ongoing associated stigma.
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1190
1191 From the consumer perspective, their contribution to this study confirms the potential of
1192
1193 programmes like this in their recovery and in their coping. Having the students and
1194
1195 academics bring such a rich programme of activities and health care skill to an accessible
1196
1197 place is clearly valuable to them. Based on the findings from the student learning evaluation
1198
1199 process and SMILE participant focus groups, a risk and resilience framework that identifies
1200
1201 protective factors will be introduced in the next SMILE clinical placement program.
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1204 **Limitations**

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1242 As a pilot study with a small number of overall participants and the localised (single centre)
1243
1244 approach do limit wider application of the findings but we consider with some modifications
1245
1246 to the design this study might be repeated in other settings where students are learning
1247
1248 about Primary Care and health improvement. Other methods including interviews may also
1249
1250 be appropriate and enable us to look more closely at individual case studies and narratives
1251
1252 of experience. We are aware of a burgeoning interest in collaborative approaches to
1253
1254 improving health and in new methodological approaches that may be helpful including co-
1255
1256 creative community-based health research (Daykin et al 2017, Greenhalgh et al 2016). The
1257
1258 insights this study provides, should assist those engaged in similar work or exploring its
1259
1260 potential, to consider applying elements of the SMILE model in preparing students,
1261
1262 supporting them in practice and helping them to analyse and evaluate their learning
1263
1264 through critical reflection on their practice experiences. It may also provide encouragement
1265
1266 to create partnerships with stakeholders to generate new knowledge both about how
1267
1268 students learn but also how professionals can support consumers to make the lifestyle
1269
1270 changes that will improve their health and wellbeing.
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1279 **Conclusion**

1280
1281 The SMILE clinical placement aimed to provide nursing students with an opportunity to offer
1282
1283 nursing care to diverse community populations and gain insight into the way in which social
1284
1285 and economic factors can affect mental health and wellbeing. The findings of the pilot study
1286
1287 encourage us to continue with this collaborative approach both in its value to learning in
1288
1289 primary care but also because of the way it has strengthened our community health
1290
1291 partnerships. We identified that the participating students were able to recognise the way
1292
1293 in which nursing interventions can help to overcome issues of disadvantage by engaging
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1301 potentially vulnerable people in a program that can contribute directly and indirectly to
1302
1303 their mental and physical health and wellbeing. Hearing from the users of SMILE added to
1304
1305 our understanding of the student contribution's value to them. The students were able to
1306
1307 both recognise and discuss the different ways in which they can apply their knowledge and
1308
1309 skills to support consumers to access health services, helping them to understand the ways
1310
1311 in which lifestyle and socioeconomic circumstances can worsen or improve health and,
1312
1313 through wider knowledge and understanding of the organisation and delivery of health
1314
1315 services, help to increase the community's health literacy overall.
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1320 We are aware that government health departments in many countries are looking to
1321
1322 address rising medical costs and unmet need through restructuring services, for example
1323
1324 through community (or socially) based schemes and consequently making a significant
1325
1326 health impact. We would argue that these schemes should not just seek to occupy
1327
1328 participants in creative and other recreational activities (which are important ends in
1329
1330 themselves) but should also seek to widen access to appropriate health care support and
1331
1332 advice through new community partnerships and this we suggest, is especially important for
1333
1334 vulnerable individuals with mental health care needs if health outcomes are to be improved.
1335
1336 Making changes to the way that health practitioners (including the large nursing workforce)
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1338 learn how to contribute to these efforts through theory and practice, is an important way to
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1340 begin to realise these goals.
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1st February 2019

Dear Editor

Please find our research paper:

Learning how to SMILE: improving physical and mental health through nurse education and creative practice

which we submit for review. We declare as follows:

- 1) Conflict of Interest: none
- 2) Funding Sources: not applicable
- 3) Ethical approval details: La Trobe University Ethics Committee approval and written permissions from the local partner organisation)

Yours faithfully

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