



Trialling of the Partnership in Coping system

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The paper describes the results of a preliminary trial of a system of mental health nursing, the Partnership in Coping system, based on the subjective experiences of the participating mental health nurses and service users. The community mental health study involved action research, with data being collected through individual interviews and focus groups. Data analysis, using thematic content analysis, resulted in the emergence of two main dimensions. These dimensions are centred around a shift in responsibility from the service to the service user, and the authentication and clarification of the roles of the nurse and the service user.

Keywords: action research, consumer focused, mental health nursing, Partnership in Coping, psychiatric nursing, recovery-oriented service

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Introduction

The Partnership in Coping (PinC) system converts the philosophy and principles of the recovery model (Anthony 1993) into a practical workable system of mental health nursing. It was designed as a move away from the ‘one size fits all’ approach of the traditional medical philosophy in giving precedence to service users’ understanding of their concerns, their cognitive strategies in problem solving and their motivation. According to Glover (2005), the recovery-based service delivery is a shift away from services purely based on the objective decisions made by experts, to those services that also incorporate ‘the subjective personal and internal knowledge of individuals as a central tenet within service delivery’ (p. 3).

A definition of recovery is difficult to find. It has been described as a model, approach, philosophy and a process (Townsend & Glasser 2003). However, the overarching principle of recovery is that, unlike the medical model, the focus is on the restoration of the individual’s self-esteem, identity and gaining relevant and worthwhile roles in the community (Deegan 1996).

The PinC system, like the recovery approach, focuses on ensuring that the individual is able to take responsibility for his/her own life. This includes times in recovery when the person may become unwell. At these times, in particular, the role of the mental health nurse, using the PinC system, involves taking this opportunity to assist the individual to understand what is happening. The nurse is interested in getting clients to describe in their own words their experiences and what they could do better next time to avoid this occurring again. Townsend & Glasser (2003), in their article, describe this process, stating that ‘relapse can be a part of the overall recovery process’.

The PinC system, like the recovery approach, highlights and focuses on the importance of the service user–nurse relationship. As Deegan (1996) states, there is a need, using the recovery approach, for a level of intimate conversation between the service user and the nurse, in order to establish a trusting relationship.

Curtis (2000) discusses the concept of people’s humanity. He talks about the ‘me’ and ‘it’. ‘Me’ being the person and ‘it’ being the illness. When an individual sees the illness/diagnosis as ‘me’ the person, then there is little chance

that the individual can look beyond the illness. This is supported by Deegan (1993, p. 10), 'To me it is important to say that I have a disability but that I am not a disabled person'.

The PinC system is designed in such a fashion that the illness perspective, as Curtis calls it, (the 'it') is relegated to a position of lesser importance with the focus on the strengths of the individual. The reduction of the illness perspective is related to the person's unique coping abilities – which, according to the PinC system, everybody possesses.

Central to the PinC philosophy are the views that mental health service users have the responsibility for their own well-being, with each person possessing a repertoire of effective coping strategies. The role of the mental health nurse is to help service users use these strategies to deal with their concerns and, where appropriate, to help them develop new strategies.

Investigations into the treatment of people with mental illness have shown that they have been frequently devalued, dehumanized and their views ignored (Human Rights and Equal Opportunity Commission 1993). Service users have reported that they have not been listened to. They felt that nurses lacked empathy, have little regard for their concerns and act in a controlling manner towards them (Horsfall 1997). In a more recent report (Human Rights and Equal Opportunity Commission 2005), a lack of respect for individuals with mental illness and their families was frequently reported, and pleas for the provision of basic care with dignity were almost universal.

As identified by Townsend & Glasser (2003), the mental health services and the clinicians do not often assist individuals to live at their optimal levels. The system does not instil hope. Rather, it allows the individual to remain hopeless. Hope is recognized as one of the most important determinants of recovery and exists even in the face of serious mental illness (Deegan 1993). When clinicians instil hope, they are giving the message to clients that they can recover.

Mental health service users who are subjected to deprivation of the basic right to be treated in a humane way experience a low sense of control over their lives (Bandura 1989) as well as low self-worth (Festinger 1954). These experiences are associated with high levels of stress and depression (Bandura 1989), further exacerbating their original mental health concerns.

Approaches used in mental health nursing such as care plans have been criticised for their failure to guide intervention (Brimblecomb 1995, Robinson 1996). According to Repper (2000), mental health service users do not want to be pigeon-holed or made to accept plans that others have designed for them. Findings from the consultation process, recently carried out in Ireland for the Expert Group on Mental Health Policy (Department of Health and Children

2006), identified the 'need for service users to be viewed as active participants in their own recovery rather than passive recipients of "expert" care' (p. 13). This includes the ability of the individual to 'direct their own lives like their non-diagnosed brethren' (Anthony 2003, p. 1). This idea is not new and has been expressed by many individuals (Munetz & Frese 2001, Lapsley *et al.* 2002, Martyn 2002, Davidson 2005), with some naming this as 'self management' or 'agency'.

The UK mental health charity, Rethink, defined self-management as something we all do. It encompasses the things we do to make the most of our lives, and it includes things like the individual's unique ways of coping that will minimize and manage the aspects of the condition which limits an individual's life (Martyn 2002).

In a review by Jubb (2002), shortcomings were identified in existing approaches (Peplau 1952, Newman 1980, Roper *et al.* 1990, Barker 1998) that made their application as a generic approach to mental health nursing inappropriate. As identified by Davidson (2005, p. 25), 'models which are professionally led are not only less attractive to service users but also seem to "lend responsibility" rather than sharing it'. This idea also fosters a kind of dependency and learned helplessness (Lunt 2004). As a response to shortcomings in the existing system of mental health nursing, the PinC system was developed (Shanley *et al.* 2003).

Aim

The aims of the study were twofold, namely, to obtain knowledge of participants' perceptions of the PinC system, and to generate ideas for changes that might improve protocols and documentation for the system in preparation for a larger trial. This paper is concerned solely with the former aim of the study.

Method

The study involved the prior running of a 3-day workshop for nurses on the operation of the PinC system. The education programme was designed to assist nurse participants to operate the PinC system and to become competent in the use of the relevant paperwork and documentation protocol. The Users' Manual and the Practitioners' Guide to the PinC System were used to explain how practitioners and consumers could work together to achieve the consumers' self-defined goals. Twelve service users and four nurses participated in the trial. Informed consent was obtained from all participants. The nurses constituted 50% of the complement of nurses in the community mental health service in which the study was located. Typical case selection (Le

Compte *et al.* 1993) was used in this study (service users who were invited to participate had the most common diagnosis of mental health disorders on the nurses' caseload). An Advisory Group was established, consisting of two consumer representatives, the nurse manager of the clinical area, an allied health professional, a nurse participant and the developer of the system. The remit of the group was to consider and act on recommendations from the participants and to offer advice.

Data were collected over a 3-month period using individual interviews and focus groups in an action research process. Separate focus groups for nurses and service users were held to give participants the opportunity to voice their opinions without feeling inhibited because of the presence of their nurse or service user. Feedback was discussed by service users and nurses (within each group) and changes made through the Advisory Group. Within each cycle, interviewing continued until no new or relevant data emerged; that is, data were collected until saturation was reached (Strauss & Corbin 1990).

Thematic content analysis (Burnard 1991) was used to categorize and codify the audiotaped interview transcripts as a means of maximizing understanding of participants' perspectives on the PinC system.

Results and discussion

Two major dimensions arose from the analysis. Although both dimensions focused on the interface between the service and the service user, each reflected different perspectives.

First dimension – shift of responsibility from the mental health system to the service user

The first dimension related to service users' control over their well-being. This dimension encompasses four categories: (1) focus on service user strengths; (2) service users' increased sense of responsibility; (3) service users' problem-solving approaches; and (4) a holistic perspective.

Focus on service user strengths

The participants, in their interviews, often used the previous system of mental health nursing as a base for comparison. For example, one service user, in describing the services received under the previous system, stated that

Often all I've got time to do is look at what is not going well.

According to nurses, the PinC system

Is more coping focused rather than symptoms [focused].

Helps clients to realize that they have a lot of strengths.

Can look at the more positive aspects of how the client is going or their strengths rather than focus on the negative side of things – if you work on positive things it helps to sort out negative things.

Increased responsibility for own well-being

The move in the onus of responsibility of the service user was seen as not only empowering but also more demanding on them. These factors are seen in the following statements made by both service users and nurses:

Service users:

Helps me to help myself.

Empowering, what I needed to do for myself, had to go away and I [had to] think about concerns and priorities and they were things I could do something about.

Helped me to be more assertive and confident in expressing my needs and also making judgments.

Nurses:

Helps clients to realize that they can manage their illnesses.

Sitting down to be writing out something with clients is good – you dictate to me what you want which is different because I usually make my own notes.

... more demands on clients– expectations that they dig deeper to explain their concerns, coping strategies, etc. be a part of the process.

... clients in charge of their own decision making.

Service users and nurses considered that the PinC system overcame problems inherent in the previous system of case management.

Service users:

Not listened to.

Focuses on things that often you can't do anything about.

Nurses:

Often clinicians direct what will happen without the client's participation.

Promotion of problem-solving approaches

The use of the PinC system resulted not only in service users adopting problem-solving techniques, but also in making attitudinal changes.

Service users:

Has changed my whole outlook to my disability looking more at managing my illness than just trying to get others to understand how bad it is for me.

Able to pinpoint things rather than go around all the concerns.

Nurses:

Not focussed on medication or illness rather how they manage and want to manage and look at strategies to manage within who they are.

Greater emphasis on holistic perspective

With greater emphasis on service users prioritizing their concerns within the PinC system, there is greater consideration given by service users to non-medical issues.

Service users:

[According to the previous system] no recognition given by clinicians to major concerns when ill such as the welfare of others for example my daughter.

Nurses:

More holistic in that other issues in client's life that affect mental health are discussed.

Concluding statements on the first dimension

Supporting personal responsibility through self-directed care as well as self-management is a basic tenet of the recovery-orientated approach. This tenet has been translated into practice via the PinC system.

Service users and nurses viewed the PinC system as being empowering, in that it facilitated the identification of concerns that the service user 'could do something about'. For example:

Service user: 'Empowering, what I needed to do for myself, had to go away and I [had to] think about concerns and priorities and they were things I could do something about'.

The focus on the service users' strengths concurs with the vision of recovery defined in the English document, the National Institute for Mental Health in England (2005) Guiding Statement on Recovery. The vision of recovery was described as a 'process of changing one's orientation and behaviour . . . to the positive restoration, rebuilding, reclaiming or taking control of one's life'.

Nurses: 'Helps service users to realize that they can manage their illnesses'.

'more demands on clients – expectations that they dig deeper to explain their concerns, coping strategies, etc. be a part of the process'.

'clients in charge of their own decision making'.

The PinC system also provided an opportunity for service users to engage in problem solving that focused on a commitment to self, that is, a sense of being active rather than passive in the management of their illness. This active sense highlights the difference in the orientation of the traditional medical model as opposed to the recovery philosophy. For example, when discussing the use of the PinC system, the service user stated:

Has changed my whole outlook to my disability looking more at managing my illness than just trying to get others to understand how bad it is for me.

With the nurse stating:

Not focussed on medication or illness rather how they manage and want to manage and look at strategies to manage within who they are.

Second dimension – authenticating and clarifying the roles of the nurse and the service user

The second dimension concerned the roles of the nurse and the service user within the PinC system. This dimension is made up of four categories: (1) service user focus; (2) provision of structure to mental health nursing; (3) minimization of mental health nurses' preconceptions; and (4) validation of mental health nursing practice.

Client focus

The service users' concerns, perceptions and actions are seen as a central aspect of the PinC system.

Service users:

I am asked what I think is bothering me.

It forces an attitudinal change which is not obvious to start with. It puts clients' needs as central rather than on the periphery.

Nurses:

Because I'm starting with a blank sheet and the way the PinC system is set out I have a better chance of identifying what is actually concerning the client not what is concerning me.

[It is] problem solving and using the client's strengths, something I try with clients – paperwork backs this up. Puts it into a frame.

It is an opportunity to learn from the client – clients appreciated clinicians asking for the client's perspective – sets up more of an equal relationship.

[You can] clearly see evaluation of what you are doing with people and clients in the centre of the service.

Provision of structure

The PinC system is considered systematic and structured by both service users and nurses.

Service users:

[It is] systematic. You know what you are doing.

I had to think about what my concerns were and organise them rather than talk about feelings.

Offers a structure and formal way of coping so things are less muddled in your head.

Nurses:

Found it good because the system allowed for the client to take up the work he was doing with the nurse where they left off – no repetition.

Gives a structure to my own practice.

References to the previous system did not compare favourably with the PinC system.

Nurses:

Existing system is crisis orientated – works well like that but not helpful when crisis is over.

Fragmented, no clear system, evaluation is piecemeal and ad hoc, crisis centred and reactive.

Minimizing preconceptions

Because of the absence of a predetermined method of classifying mental illness based on symptomatology (International Classification Diseases – 10), nurses using the PinC system depended on service users to identify their own concerns in their own language and to prioritize them. Thus, nurses based their intervention on how service users interpreted their situation and what they wanted to do to resolve it.

Nurses:

Existing system fails to identify the clients' concerns. Instead it makes assumptions about what their problem is.

I go to see the client without any assumptions because the way the system is structured. It doesn't allow me to make any assumptions.

Validation of mental health nursing practice

Nurses expressed positive views on the use of the PinC system.

Nurses:

Empowering for nurses and well as clients. Validates what you do with clients.

This system shows others that what we are doing is serious.

Gives some focus to what I am doing.

The new system [PinC] validates and formulates what I already do.

Concluding statements on the second dimension

The categories identified in the second dimension reveal some of the main principles underlying the PinC system. The system demands certain criteria be met; for example, the service user becomes the main decision maker and the nurse takes direction from the main decision maker, for example:

Service user: 'I am asked what I think is bothering me'.

Nurse: 'It is an opportunity to learn from the client – client appreciated clinicians asking for the client's perspective – sets up more of an equal relationship'.

In addition to creating a more influential role for the service user, the PinC system provides a structure that assists in clarifying and authenticating the roles of both the nurse and the service user, for example:

Service user: [It is] 'systematic. You know what you are doing'.

'I had to think about what my concerns were and organise them rather than talk about feelings'.

Nurse: 'Gives a structure to my own practice'.

'Empowering for nurses and well as service users. Validates what you do with service users'.

'This system shows others that what we are doing is serious'.

Conclusions

As indicated above, two dimensions emerged from the analysis. The first dimension reflected the perspective that the PinC system constitutes a radical change in mental health services delivery from the experiences of both the service users and nurses. It constituted a shift in the onus of responsibility away from the mental health system towards the service user, and offered a partnership with the service user as the major decision maker. As highlighted in the category 'Increased responsibility of own well-being', it can be seen that the service user participant began to direct her own care and management by focusing on things that she could do something about herself. This approach is in keeping with the view that the 'recovery orientated philosophy involves a shift in service delivery from a managed care and maintenance orientation to an orientation that embraces self-directed care and self management' (Glover 2005, p. 3).

In addition to increasing the service users' responsibility for their own well-being, the PinC system was acknowledged by the participants in the study as promoting service users' own problem solving and coping strategies in a holistic way. Glover (2005) stated that, within recovery-orientated services, clinicians use 'their expertise to help people discover meaning and understanding of what works for them' (p. 3).

The second dimension reflected the perspective that the roles of both the nurse and service user were made clearer with the use of the PinC system. The PinC system also provided a structure which gave a greater focus on helping service users cope with their concerns; it validated nursing practice for nurses, as they were able to relate to the service user without making assumptions about their concerns and, most importantly, it required nurses to depend on the service user to give them the service users' understanding of their concerns. As illustrated in the category 'Client focus', a nurse participant acknowledged that the PinC system assisted him in clarifying his own role, which included what it was that concerned the client and not himself. These findings indicate a client-centred approach and are in accord with the recommendations of the Expert Group on Mental Health Policy 'A Vision for Change' (Department of Health and Children 2006), which state that 'care plans should reflect the service user's particular needs, goals and

potential' (p. 9), and they also concur with Principle 1 of the National Institute for Mental Health (2005) Guiding Statement on Recovery, 'the user of services decides if and when to begin the recovery process and directs it'.

In conclusion, it has been shown that the PinC system offers a systematic way of implementing the philosophy and principles of the recovery model. These philosophies and principles reflect the belief that it is possible for clients to achieve control over their lives to recover their self-esteem and to regain a sense of belonging and participation in their families and communities. As evidence of clients exercising their influence over their treatment, the PinC system, with the support of management, continued to be used after the trial had been completed.

Limitations and recommendations

Potential limitations of the study exist in the areas of generalizability, methodology and ethical considerations.

Generalizability

While the modifications to the paperwork and documentation protocol were recommended by the participants and approved by managers in the community mental health setting, extrapolation beyond this setting to inpatient locations may not be justified. Additional research is necessary to ensure that the paperwork and documentation protocol is considered satisfactory by clients and clinicians involved in inpatient treatment.

Methodology

Sampling

Convenience sampling was used for this study, because the 10 mental health clients identified as participants were case managed by the four mental health nurses who elected to participate in the project. Convenience sampling is seen as the weakest form of sampling, because of the danger that the participants may be atypical of the population (Polit & Hungler 1991). In order to reduce extraneous factors and attempt to gain a more representative sample of the population, only those clients with a diagnosis of schizophrenia, mood disorders, psychosis and anxiety states were asked to participate. It has also been noted that the four mental health nurses who have elected to participate in the study represent 50% of the community mental health nurses employed at the mental health service involved in the study.

Design

The failure of all participants to attend all the focus group meetings may be seen as a shortcoming in the administra-

tion of the methodology of the study. However, the design of the study allowed for inconsistencies in attendances. Because of the distances involved in travelling to the meeting venues and the nature of the disabilities that some of the participants experienced, it was decided to build into the design two major methods of data collection, namely focus group meetings and one-to-one interviews with the participants. Despite these inconsistencies in attendance, the conclusion is drawn that, having obtained saturation, the inconsistencies in attendance did not detract in any major way from the findings.

Ethical considerations

As highlighted by Williams (1995), when using action research, informed consent may not be fully possible if the anticipated changes that take place as a result of the study are unknown and only established by a growing reality. However, as much information as possible was given to the potential participants prior to consent being sought. This included the fact that the action research process involved changes that were unknown to both the participants and the researcher and, therefore, informed consent was viewed as a continuous process.

The major recommendation based on the findings of the study is that the PinC system could be used as an effective and acceptable way of applying a recovery-oriented system to mental health services. As stated earlier, because this study was carried out in a community setting, only inferences can be made about its applicability to inpatient settings. Therefore, a large-scale replication of the study across mental health services including an inpatient setting would be the next step in testing the comprehensive use of the PinC system.

References

- Anthony W.A. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 16, 11–22.
- Anthony W.A. (2003) Expanding the evidence base in an era of recovery. *Psychiatric Rehabilitation Journal* 27, 1–2.
- Bandura A. (1989) Perceive self efficacy in the exercise agency: the psychologist. *Bulletin of the British Psychological Society* 10, 411–424.
- Brimblecombe N. (1995) The use of brief therapy as part of the nursing care plan. *Nursing Times* 91, 34–35.
- Burnard P. (1991) A method of analysing interview transcripts in qualitative research. *Nursing Education Today* 11, 461–466.
- Curtis L.C. (2000) *Moving Beyond Disability: Recovery from Psychiatric Disorders. One Person's Perspective*. The Council on Quality and Leadership in Support for People with Disabilities, The Capstone, Towson, MD. 17 (2), Summer 2000.

- Davidson L. (2005) Recovery, self management and the expert patient – challenging the culture of mental health from a UK perspective. *Journal of Mental Health* 14, 25–35.
- Deegan P.E. (1993) Recovering our sense of value after being labelled mentally ill. *Journal of Psychosocial Nursing* 31, 7–11.
- Deegan P.E. (1996) Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal* 19, 91–97.
- Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Stationery Office, Dublin.
- Festinger L. (1954) A theory of social comparison processes. *Human Relations* 7, 117–140.
- Glover H. (2005) Recovery based service delivery: are we ready to transform the words into a paradigm shift? *Advancement of Mental Health* 4, 1–4. [Online].
- Horsfall J. (1997) Psychiatric nursing: epistemological contradictions. *Advances in Nursing Science* 20, 56–65.
- Human Rights and Equal Opportunity Commission (1993) *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*. Australian Government Publishing Service, Canberra.
- Human Rights and Equal Opportunity Commission (2005) *Not for Service*. Australian Government Publishing Service, Canberra.
- Jubb M. (2002) Partnership in coping changes at the grass roots level: an action research project in a regional area in Western Australia. MN Thesis. Edith Cowan University. (unpublished).
- Lapsley H., Nikora L. & Black R. (2002) *'Kia Mauri Tau!' Narratives of Recovery from Disabling Mental Health Problems*. New Zealand Mental Health Commission, Wellington.
- Le Compte L.S., Preissle J. & Tesch R. (1993) *Ethnography and Qualitative Design in Educational Research*, 2nd edn. Academic Press, Chicago, IL.
- Lunt A. (2004) The implications for the clinician of adopting a recovery model: the role of choice in assertive treatment. *Psychiatric Rehabilitation Journal* 28, 93–97.
- Martyn D. (2002) *The Experience and Views of Self Management of People with Schizophrenic Diagnosis*. Rethink, London.
- Munetz M. & Frese F. (2001) Getting ready for recovery: reconciling mandatory treatment with the recovery vision. *Psychiatric Rehabilitation Journal* 25, 35–42.
- National Institute for Mental Health (2005) *Emerging Best Practices in Mental Health Recovery*. National Institute for Mental Health, London.
- Polit D.F. & Hungler B.P. (1991) *Nursing Research: Principles and Methods*, 4th edn. J.B. Lippincott Co., Philadelphia, PA.
- Repper J. (2000) Adjusting the focus of mental health nursing: incorporating service users' experience of recovery. *Journal of Mental Health* 9, 575–587.
- Robinson D.K. (1996) Are nurses fulfilling their proper role? Measuring culture trends in mental health nursing. *Psychiatric Care* 2, 27–31.
- Shanley E., Jubb M. & Latter P. (2003) Partnership in Coping: an Australian system of mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 10, 431–441.
- Strauss A. & Corbin J. (1990) *Basics of Qualitative Research; Grounded Theory Procedures and Techniques*. Sage, Newbury Park, CA.
- Townsend W. & Glasser N. (2003) Recovery: the heart and soul of treatment. *Psychiatric Rehabilitation Journal* 27, 83–86.
- Williams A. (1995) Ethics and action research. *Nurse Researcher* 2, 49–59.