Education as an Exit Strategy for Community Mental Health Nurses: A Thematic Analysis of Narratives

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Abstract

A study of the narratives of community mental health nurses, with an emphasis on education and training, identified education as offering a 'stepping stone' out of a profession that struggles for recognition and status. This paper describes those narratives and the challenges facing healthcare organisations seeking to assimilate and retain the talent of those who have achieved academic success. The authors suggest that encouraging an expertise that integrates academic and practice skills might be achieved through more widespread appointment of clinical professorships.

Key words

Community mental health nursing, professional identity, narratives, education

Community mental health nurses (CMHNs) face difficulties over balancing work and home life (Majomi *et al*, 2003) and struggles over professional identity in sometimes inhospitable organisational environments (Crawford *et al*, 2008). There have been a number of reports of similar grievances from professional bodies representing nurses. For example, the Royal College of Nursing (RCN), in a widely publicised report published in mid-2007, highlighted that one of the major characteristics of the mindset of nurses in the NHS is the desire to leave it (Ball & Pike, 2007). Nearly a third (29%) reported that they would leave nursing if they could.

Ball and Pike (2004; 2007) identify education as one of the stepping stones out of the profession, but the precise relationship between people entering mental health nursing, education and their subsequent drift to other careers has been under-explored. Much literature on education and training for nurses stresses the process involved or has examined the outcomes. There have been accounts of nurses' experience of training, analyses of the skills needed and discussions of the implications of the shift from predominantly practice-based to university-based education. Moreover, under initiatives such as evidence-based practice and clinical governance there are emphases on nurses both continuing their education and maintaining a familiarity and literacy with ongoing research developments (Crawford *et al*, 2002; Brown & Crawford, 2003). This paper aims to contribute to the ongoing debate about continuing education for mental health nurses and the relationship of this to the issue of people leaving the profession.

The future educational preparation of mental health professionals, per se, has remained firmly on the national agenda (Department of Health (DH), 2006; Sainsbury Centre for Mental Health, 1997). The debate about nurse training, which has focused on the difficulty of balancing sufficient work experience with the newer, more academic curriculum, has led to a recognition of the role of 'communities of practice' as

important vehicles for learning (Ranse & Grealish, 2007). Moreover, the disruption of these communities through reorganisation was seen as a reason to leave by participants in a study by Skytt *et al* (2007).

In the RCN survey reported by Ball and Pike (2007), around a quarter of respondents (24%) held a degree as their highest qualification while a further four per cent reported holding a higher degree. Once qualified, nurses are faced with a range of options for increasing their panoply of qualifications and skills. It is increasingly desirable for nurses to be capable of self-directed learning so as to be able to seek, analyse and utilise information effectively, and the work of nurse educators is increasingly seen as needing to facilitate nurses in acquiring these skills in self-directed learning (Lunyk-Child *et al*, 2001; O'Shea, 2003). A host of new nursing roles was developed, such as nurse practitioner (Read, 1999; Shewan & Read, 1999), and nurse consultant (DH, 1999; Coster *et al*, 2006). This led university nursing departments to develop masters level programmes orientated towards professional practice (Gibbon & Luker 1995; Pearson *et al*, 2006; McManus, 2000, Gerrish *et al*, 2003). Indeed, Gerrish *et al* (2003) see the proliferation of postgraduate education as part of a professionalising strategy and as a way for nurses to garner respect and status among medically trained colleagues. In fact, the characteristics attributed to masters level nursing education reflect the aspirations of many nurses and nurse educators for the future direction of nursing, and suggest that many believe that qualifications are closely allied to the professionalisation process (Gerrish *et al*, 2003).

The greatest volume of criticism of Project 2000, which shifted the training of nurses from hospitals into universities, has come from students and practitioners of mental health nursing. The longstanding grievance that nurse training in higher education institutions 'does not work' or is problematic now seems to have gained more acceptance (Haines, 1997; Eaton *et al*, 2000) and those educated under Project 2000 schemes report a lack of practical skills for practice (Gass *et al*, 2007). Maben *et al* (2006) argue that the theory-practice gap is alive and well and has not been closed by changes over the last couple of decades.

Nevertheless, there are strong encouragements towards education and academic pursuits in many policy initiatives in UK healthcare. For example, the drives towards evidence-based practice and clinical governance exhort practitioners towards learning and the pursuit of qualifications. Ongoing education, developing scientific awareness and continuing professional development are all important parts of this strategy. To implement the new evidence-based culture of health care, a new kind of practitioner is needed. In a sense, this demands new entrepreneurial professional identities and new entrepreneurial patients, all working together to solve problems in a high-modernist demonstration of professional efficiency and therapeutic excellence.

This, then, is the background within the health service at the time the fieldwork was undertaken in the UK Midlands. It was begun at a time when the debates about the usefulness of Project 2000-style degree-level education were ongoing and when government policy was attempting to shift the culture of health care itself so as to enhance its reliance on fresh evidence, and to ensure it was responsive and capable of learning. It was in this context that the empirical work reported here was undertaken.

The study

In this study we aimed to explore the narratives of CMHNs in an urban NHS trust in the Midlands, looking at how they described their perceptions of their working lives, with a particular emphasis on the role of education and training in their professional development.

Design and methodology

The empirical work for this paper was informed by an approach based in thematic analysis (Braun & Clarke, 2006) and, to a lesser extent, grounded theory. In-depth, semi-structured interviews were conducted with a view to capturing narratives of professional identity (Charmaz, 2002). Explorations based on participants' own understanding and the themes to which they allude is believed to be particularly valuable for nursing research (McCann & Clarke, 2003) especially under conditions of uncertainty such as are unfolding in the UK. We examined:

- the fine grain or detail of what CMHNs think of their jobs, both in terms of their understandings of what the job involved and the extent to which they and their colleagues felt equipped for it
- how they identify the central tasks of their occupation
- the steps that CMHNs have taken to professionalise themselves and acquire educational credentials.

With the analytic strategy of thematic analysis, data exploration and theory-construction are combined. In addition, theoretical developments are made in a 'bottom-up' manner so as to be anchored to the data (Braun & Clarke, 2006; Glaser & Strauss 1967; Strauss & Corbin, 1998).

The strength of this approach is illustrated by the way that existing theoretical presuppositions about

the role of education as a professionalising process were challenged by the data, in that there appear to be broader issues at stake. For example, as we shall see, the idea of education representing an exit strategy or allowing the CMHNs to acquire 'escape velocity' from nursing to become a different kind of worker was unanticipated at the outset.

Sample/participants

Practising CMHNs were recruited from community mental health teams in two contiguous areas. Initial contact was made with the trust to determine the appropriate points of contact to gain entry to the organisation. Following approval from the relevant ethics committees and research committees with responsibility for the area under study, team leaders and managers were contacted and they and their colleagues were invited to participate. Although participants were willing and interested in the study, pressures of work meant that sometimes several contacts and follow-ups were required before a mutually feasible interview date was achieved. Thirty interviews were successfully completed, comprising 12 males and 18 females, ranging in age from 28 to 54 years.

Data collection

Interview data were collected over a period commensurate with the third author's PhD and represent a recursive revisiting of the issues with interested personnel from 2004 to 2007. After consent had been agreed and participants had been informed of their rights, semi-structured interviews were allowed to evolve as a dialogue between the CMHN and the researcher in which jointly they focused on and explored the meaning of being a CMHN. Although not a nurse herself, the researcher worked for several years with nurses at a number of sites in the UK conducting fieldwork concerned with occupational identity and stress, and was conversant with many of the issues they faced. As the fieldwork progressed, ideas and topics suggested by earlier participants, particularly those relating to continuing education were prominent, and these were used as a basis for further prompts in subsequent interviews to open fresh insights about professional and career development.

Ethical considerations

Participants were briefed about the study and informed of their right to withdraw participation or data at any time. Also, in line with the conditions necessary for local research ethics committee (in this case the relevant NHS LREC) approval, they were advised of the confidentiality and anonymity of their responses and availability of support if the interview were to prove stressful. While the details of participants' lives are reported as they were given, every effort was made to exclude information that would enable them to be identified.

Data analysis

The analytic strategy was to examine the interviews for common themes and ideas that occurred in more than one participant's account and to piece together a narrative from the various accounts to discern the logic of their thinking and recounted experience. Initial readings of the data disclosed that a good deal of material was concerned with educational and training issues, and the ensuing themes to which the participants' accounts were condensed signal the importance attached to these matters by the participants. Moreover, we have sought to order the presentation of these to reflect the succession of dilemmas from those identified concerning new entrants to the profession and those encountered by participants contemplating the exit process and subsequent careers. Using the insights from narrative methods that the events, experiences and interpretations are sometimes linked into a life story, the approach taken here involves identifying a sequence in the material, telling the story of education in the lives of the participants. The narratives themselves may present a confused and contradictory picture but these ambiguities and tensions themselves bear careful consideration. Chiefly, as we shall see, education was desired and pursued, yet at the same time it appeared to facilitate the movement of the participants away from nursing itself and into other spheres.

Validity, reliability and rigour

Whittemore *et al* (2001) and Jorgensen (2006) advocate credibility, authenticity, criticality and integrity as primary criteria for evaluating qualitative research. Credibility (Lincoln & Guba, 1985) relates to whether the results of the research reflect the experience of the participants in a believable way. Themes extracted were discussed subsequently with selected participants who had previously indicated a willingness to be involved in further inquiry. This enabled us to refine them in the light of feedback, thus addressing the challenge 'of preserving participants' definitions of reality' (Daly, 1997) through a process of participant validation. Authenticity was addressed by retaining a reflective awareness of our preconceptions and retaining also the possibility of being surprised by findings. The criteria of criticality and integrity relate to the potential for many different interpretations that can be made, dependent

on the assumptions and knowledge background of the investigators. To address this, two groups of nurse researchers were convened at the authors' host institutions to review the emerging themes and to establish their credibility, plausibility and their resonance with experiences beyond the confines of the original study (Horsburgh, 2003). Thus the resulting organisation of data is both plausible and rigorously defensible in terms not only of the authors' interpretation but that of participants and fellow researchers.

Results and discussion

Thirty interviews were completed successfully, comprising 12 males and 18 females. In terms of the jobs performed by the participants, they tended to identify themselves in line with the UK's so-called Whitley council grades, which were then in force and which ranged from A to I depending on qualifications and experience. There was one each of grades D, E (recently qualified) and F; 17 at grade G (of whom two were Fs acting as G-grade nurses); six at grade H; and four at grade I. All grade I were team leaders. The CMHNs worked in various sites comprising eight functional community teams, two each of primary care liaison, home treatment, rehabilitation and recovery, and assertive outreach.

The key themes derived from the data were as follows:

- entering nursing: Project 2000 and the theory practice gap.
- degree mania, professional advancement and exit from nursing.

Entering nursing

The first theme identified concerns the process of becoming a nurse working in mental health care in the community. This is characterised as a problematic process for trainees and novice nurses as well as for their colleagues, highlighting the idea that there are aspects of the role that can only be learned in practice:

NB017: *'I think experience counts for so much and I do think that it's good for these nurses on Project 2000 when they come through to have their time working on the wards, that they're on supervision and they've got a lot of support before they come out in the community because it's very different, you're on your own out there.'*

In this formulation, there may be a period of confusion in which the student finds it difficult to marry the two poles of supervised work in the hospital with the sense of being 'on your own' in the

community. Indeed, decision-making in community settings has been identified as problematic by other nurses (Danielson & Berntsson, 2007). The concerns expressed here intersected with the contrast between what some described as the 'old brigade' and new entrants coming through the Project 2000 route. Nurses trained in the pre-Project 2000 era were not convinced of the preparedness of their new colleagues:

NB012: *'One of the things with nurses as a group of people is that its academic base is not that strong. If you look at doctors they have a very strong academic medical base, very powerful people, social workers they're trained likewise, there's a theoretical base to it all, OTs [occupational therapists], when you get to nursing, well what's the theoretical base for nursing? And I know the training now has gone academic and a lot of people have been criticising that kind of training because it's not the hands-on aspect.'*

There is a pervasive sense that despite the new approach to training nurses, with its stress on university-based courses, there are still fundamental differences between what is taught academically and what is learned through experience. Participants, however, were not opposed to classroom-based learning. Many emphasised what they saw to be a need for theory and practice to go hand in hand in such a way that neither one should be subservient to the other:

NB20: *'I think the theory is rather important ... I think it's very easy for us old timers ... you see, I was trained on the wards and it's very easy to say "oh, that's the way it should be ... get the experience" ... but also there is so much bad practice ... and if you don't have the proper theory behind it and understand why you're doing it, then you can go on to the wards and only pick up what other people are doing, and then you're picking up the old ways which often can be very uncaring. And if you don't have the real understanding of depression and anxiety you can't work with it.'*

Nevertheless, this value placed on knowledge gained through education was often tempered by scepticism about just how much could be achieved through formal training courses. Some practitioners are concerned that students are not getting enough experience with clinical practice in mental health nursing. There appear to be high expectations on the part of those who describe themselves as the 'old brigade' – those who qualified before degrees in nursing were commonplace – regarding raising the training to degree level. They believed that if nursing is going to be a degree course then the least that staff

can expect of students is that they will have the competencies to function when beginning as practitioners in community mental health. This was sometimes seen to be lacking:

> NB003: *'Yeah, we've had students ... if they're going to go on to the mental health branch they need to do more time ... they're all over the place these students ... they don't have skills when they qualify that we used to have ... and they jump in very quickly from a D [grade] to an E to an F and they're managers before they're 24! And it's crazy ... I mean, alright, it's nice to know that you're a diploma or a degree staff ... but what's not there is that background, many years of experience to get you to where you know ... but I think they're pushing people too quickly now ... I mean some people are struggling, they're floundering in their training, they're not doing depots until their final year; well, they're not doing injections till their final year, that's so sad.'*

There are a few interesting issues here. Note the centrality of 'injections' to practice in this practitioner's account – which a number of people mentioned as one of the defining features of the job – and the emphasis on the curative medical aspects of the work rather than on the ideas of wellness and health, or concerns with social inequality that have found their way into nursing ideology more recently (Rice & Wicks, 2007). In a sense then, the conflict about work experience and academic learning is mirrored by this conflict about what nursing is and what it should be about.

There were other occasions when the apparent conflict between academic learning and experience became prominent. For example, there was sometimes a sense of nostalgia:

> NB007: *'You, with the experience, I think you should be looked at more. Nursing is more about what you can do than this degree. Years ago we didn't have all these degrees and yet still you couldn't wish for better nurses.'*

The emphasis on craft skills learned on the job was expressed pervasively, even by those who thought learning the theory was a good idea. This reflects findings elsewhere (Clark & Holmes, 2007) suggesting that degree-level education is not seen as inculcating a well-developed fluency with practical nursing skills. Rather, these are usually seen to be developed through working experience and through relationships with more experienced colleagues. This phenomenon also corresponds to the way that education is often seen as separate from the skills of practice, where the latter is seen as a somewhat

numinous, difficult-to-measure emergent gestalt (Billay *et al*, 2007; Griffiths, 2008).

Degree mania

The issues highlighted in the first theme presented participants with a dilemma. Having a degree is believed not to equip a person with the practical skills needed in nursing, but having a degree might become increasingly important in the struggle for recognition and promotion:

> NB018: *'I think in the long term there's going to be so much competition and if you don't have a degree you're going to be the odd man out ... give it, say, another 10 years and if you haven't got a degree then you're at the back of the professional queue. But I think the theory and the practice do go hand in hand so you have people coming out with the theory base knowledge and they haven't got a clue or very limited experience in terms of their practical experiences, and you find that's going to be detrimental to the client.'*

Some participants highlighted the feeling of marginalisation of people who are non-graduates. Yet despite this expressed scepticism of education, a good many of the nurses had undertaken further study, and often they expressed how they felt it had impacted negatively on personal and family well-being:

> NB30: *'The degree has added even more pressure. I felt I've been juggling everything. I mean, they're good here, they give me one day a week. But I spend most evenings on the computer. I can't enjoy holidays. If my husband and my daughter say in the summer they want to go the botanical gardens, swimming – I mean, I'll go but I'll be feeling very anxious, I shouldn't be doing this, I should be at home studying. Then I don't enjoy the time I've got with them.'*

Here the pressure involved in completing a degree is keenly felt and represents a manifestation of the home-work conflict described in Majomi *et al* (2003). Despite difficulties like this marking the experience of doing an undergraduate degree, many participants had gone on to postgraduate courses. However, why they had done so and even what they intended to do with this newfound knowledge after acquiring it was less clear. Those who had acquired new skills through education and training were not necessarily able to deploy this knowledge advantageously because of time constraints:

> NB027: *'Some of us have caseloads of up to 40 people, to manage... You end up fire-fighting a lot of the time whereas other disciplines get time to actually do their specialist work and they have the time allocated to do that, whereas me, though I'm*

technically qualified to do CBT [cognitive behaviour therapy] I don't really get the time to do that because I'm so busy doing everything else.'

This means that the actual practice of being a nurse is further obscured, and being condensed, for example, into phrases like 'fire-fighting'. Hence, when CMHNs undertake a course they often have only a hazy idea about what it will lead to within their nursing careers. They seemed to be undertaking further study on the basis of what courses are available, what they were interested in and which universities will admit them, rather than on the basis of any precisely formulated career plan. The infrastructure in the teams to identify training needs and roles for postgraduate-educated staff once they have obtained their qualifications was also described as lacking. This leads to a paradoxical situation. There is, in a sense, nowhere for the trained and postgraduate-educated nurse to go except out of nursing:

NB021: 'I'm finishing my masters this year so I'm not sure what's going to happen. I do hope to carve some career path out for myself but I'm not sure how I can do that. My only option might be in the future to leave nursing.'

Even among those who had undertaken undergraduate degrees there was a sense that the degree itself was not related to the everyday craft of nursing and that it would lead to a drift away from the profession itself. This sense of what to do with the education that had often been so painfully achieved was also rendered more acute by the sense that there was nothing for them to do in nursing once an undergraduate degree or masters qualification had been obtained:

NB026: 'When you get to a G grade, that's it. I mean, where do you go from there? There's nowhere to go. H grades are few and far between and not only that but most of the progression in nursing is managerial so if you want to stay clinical it's not an option for you so you remain G grade. I mean, I know G grades who have been G grades most of their working lives. It bothers me that that might be me one day.'

Practitioners would like the skill and knowledge gained through post-qualification education to be paralleled by some sort of recognition and promotion within the organisation. However, in the likely event of this not happening, practitioners are actively making escape plans from nursing, plans that are facilitated by taking courses that lead them away from nursing. This, as we have seen, is made even more difficult by the fact that

other constraints, such as loss of earnings, may make it difficult to change direction. This sense of being trapped can be depressing and lead to low morale:

NB024: 'I've often thought "What am I doing in this job" and I've thought a lot of the time "How can I get out? What would be an alternative for me?" That's one of the reasons I started doing the course that I'm doing – it's part of a long-term plan. Now that I'm nearing the end I'm not sure where it's going to take me. So really you can get a bit despondent because the desire to break free and on the other you've got the security of a very comfortable position at a high grade.'

Education was thus a way out of nursing just as much as a form of advancement within the profession. The apparently haphazard additional education undertaken by participants does not necessarily fit into their nursing careers, nor does it correspond in any simple way with what is perceived to be needed in the work situation. Indeed, the experience-related clinical skills identified as valuable by those who had served several years in the job do not seem to be involved in this additional learning. A corollary, then, of much of the education sought and undertaken by nurses is that they use it to escape. It means that if they do get to do a job that matches their newly achieved qualifications they will very likely have accelerated out of nursing.

This notion was reinforced by a sense expressed by some participants that their education and expanding skill base placed them at odds with colleagues from other disciplines. Undertaking education transforms the relationship between the participant and his or her colleagues in the multidisciplinary team. Professional cultures that might otherwise form a source of identity and support for the mental health practitioner may also be a source of difficulty.

General discussion

The themes presented here form a narrative that catalogues a number of salient features of the career of the community mental health nurse. This does not necessarily mean that everyone who enters mental health nursing and subsequently leaves will have experiences corresponding to the themes listed here; nor is it plausible to suppose that this geographically localised and relatively small-scale study will reflect entirely the experiences of nurses in other regions or nations. The key finding, however, is that experiences of additional education and training gained do not necessarily resolve issues around professional identity and role but create additional tensions that might lead to a desire and opportunity to escape into one of the fields opened up by the very education one has

undertaken. This sequence of experiences appears to be consolidated in participants' sense that a good deal of nursing work is not readily captured by education and training. Indeed, the scepticism expressed concerning education, the distress experienced and the effort and hardship that go into becoming educated are all difficult to identify or acknowledge within the institutional framework of the workplace. In addition, nurses who have struggled to become educated may find themselves frustrated by the lack of opportunity to practise their newfound skills, apply the newly acquired knowledge or be frustrated by the perceived lack of opportunities for promotion.

Thus, we can perhaps shed some light on the issue of nurses leaving or wishing to leave the profession (Ball & Pike, 2007), and why education and training might, paradoxically, accelerate this flight rather than lead to a more highly skilled, educated and fulfilled workforce.

In terms of the implications for policy and practice from this admittedly small vignette, it is clear that education, further training and the much vaunted 'continuing professional development' may not be a panacea for problems in nursing. From the point of view of managers and policymakers, it may well be that the interest in promoting education and continuing professional development needs to be balanced by a corresponding emphasis on ensuring that such development is valued and recognised in the work situation, and that personnel have the chance to derive fulfilment from exercising their new skills and applying their new knowledge. Jones (1996), in the United States, has suggested that turnover is likely to be higher among better-educated nurses simply because of the additional opportunities that flow from educational attainment and that view is echoed here. As Griffiths (2008) describes, there is a need to appreciate the value of 'education and not just training' as an important part of nurses' learning (McKenna et al, 2006). The dichotomy between academic learning and the practical craft of nursing can be bridged. Recently Gobet and Chassy (2008) offered an alternative approach to understanding the nature of 'intuition' underlying expert practice, emphasising the link between conscious, knowledge-based problem-solving and the kind of expertise that appears intuitive in work settings. Unless we can show the value of this, if learning is left to nurses, nurses will learn to leave nursing.

This project also underlines the point made by Sumner and Townsend-Rocchioccioli (2003) that the causes of nurses' exodus from the delivery of health care may lie more in intrinsic factors, as offered by the nurses' own narratives, that may contribute to a

nurse's unhappiness and dissatisfaction and cause him or her to leave. Education as a 'professionalising strategy' (Gerrish et al, 2003) might well, paradoxically, propel people out of the profession.

CMHNs in the trust in which the study took place have found that nursing does not have the appearance of a 'traditional' profession, neither has it a clear stance as a 'new profession'. Rather it appears to be especially responsive to the tide of public opinion manifest through government edicts. While nursing is employing rhetoric that espouses both positions, the direction of masters level education is anomalous.

The NHS must address the reasons why nurses, and CMHNs in particular, have left and continue to leave the workplace. Retention might be facilitated if nurses felt more valued for both their continuing education and their skilfully applied humanness. Nursing has to be made a more appealing choice to keep committed practitioners from exiting the NHS, and the NHS must pay attention to what nurses are saying. The implication from this study is that without a meaningful, non-managerial career pathway that rewards and adds status to academically informed clinical practice it might be difficult to counter 'escape velocity'. Although nurse consultant posts have gone some way towards rectifying status deficit, perhaps it is time to further bridge the gap between practice and higher education by more widespread appointment of prestigious clinical professorships.

Summary

What is already known about this topic?

- A major characteristic of the mindset of nurses generally in the NHS is the desire to leave the profession.
- Education is considered one of the stepping stones out of the profession.

What this paper adds

- Examines the precise relationship between people entering mental health nursing, education and their subsequent drift to other careers.
- Shows how additional education does not always translate into the practise of new skills or greater recognition or acknowledgement within the workplace.
- Extends our knowledge of the link between professional identity narratives, role and educational development among CMHNs.

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