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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.

Keywords	nurse education; primary care, mental health recovery, creative arts, arts for health, collaborative practice
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Submission Files Included in this PDF

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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 heath 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 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 stokes 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 do ….providing 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 to …..even 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 Connect 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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Learning how to SMILE: improving physical and mental health through nurse education and creative practice

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.

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.

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 heath 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 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 stokes 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 do ….providing 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 to …..even 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 Connect 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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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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