Talking about mental health nursing: a qualitative analysis of nurses' and service users' accounts.

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Talking about mental health nursing: a qualitative analysis of nurses' and service users' accounts

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Summary

This study explores talk about mental health nursing, in a policy and practice climate that promotes service user involvement in nursing processes. The intention of this study was to gain multiple perspectives about mental health nursing and service user involvement through in-depth research interviews and focus groups with mental health nurses, nursing students and mental health service users. Analysis centred on the meaning making of participants' talk and how mental health nursing identities are accounted for and constructed.

The opportunities for authentic service user involvement in nursing processes within mental health systems that include detention and a focus on compliance are under-explored. Historically mental health services have been linked with power and control, as treatments and interventions have often been coercive and at times involve forced assessment and treatment under mental health legislation. Challenges to power, control and coercion can be found in practices that promote service user involvement. However, a power imbalance in relationships between mental health service users and mental health practitioners is evident, with service users having partial agency and often limited involvement regarding their care and treatment.

This study found that nurses and mental health service users talked about how nursing work was often task-focused, and made reference to nurses spending limited therapeutic time directly with service users, who then spoke of their dissatisfaction regarding engagements with nursing staff. Nursing students voiced limited knowledge and exposure to examples of how nurses engage in service user involvement activities in practice indicating they had little experience of this. Instead students said they felt compelled to go along with practices that appeared to work in opposition to involvement. Displays of understanding in participants' talk about mental health nursing work indicated the existence of powerful professional cultures that included distance and separateness from service users and perpetuated limited involvement. It is important that mental health nurses consider imbalanced power relationships that exist in mental health environments and challenge cultures that discourage nurses from working more collaboratively with service users.

Declarations

I confirm that this work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

…….. (candidate)

…….. (date)

This thesis is the result of my own investigations, except where otherwise stated and that other sources are acknowledged by footnotes giving explicit references and that a bibliography is appended.

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I give consent for the thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Acknowledgements

The PhD journey has involved many challenges, mostly relating to time and stamina. As I have been writing about roles and identities I have become increasingly aware of my own. As a novice researcher I have had to change fundamental aspects of my very self and, with a nod to Aesop's fable, I have stopped being the hare and become the tortoise. A part-time PhD is not about rushing around and getting it done, it is a committed expedition requiring much determination. Changing my tack from whizzing along to slowly taking in the scenery and appreciating the view has been more productive for my learning. There have certainly been times when I just could not go any faster, as frustrations with myself and the complexities of research reduced my speed. A PhD is not a race, but I have had a huge sense of being cheered on by a number of people along the journey, without whom I would never have made it to the finish line.

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It is hard to describe the impact of someone doing extended study in a family unit. My husband Chris has been magnificent throughout, providing me with time and space to focus on my studies. Our three children, Jack, Lizzie and Annie, have often asked "Mummy, haven't you finished that yet?", which reminds me of the patience required on their part.

Lastly, my lovely parents who have been interested and supportive throughout, who have listened patiently to my story about each stage of the journey; their love and kindness have, as always, been my cornerstone.

List of tables & figures

Transcribing conventions

Symbol	**Description**
(2.0)	Timed pause denoted in seconds
… but I think it…that recognises	An ellipsis indicates an omission, an utterance partially reported, a short pause, hesitation or faltering speech, unfinished thought trailing off into silence
- w-w-word	A cut-off from the previous word, or stuttering
<u>word underlined</u>	Emphasis/stress in talk
[	Open square brackets denote the start of overlapping talk
]	Closed square bracket denotes the finish of overlapping talk
(?word)	Reasonable guess at an inaudible word
Erm	Speech sounds recorded phonetically
(laughs)	Description of behaviour

Glossary

Care co-ordinator	A Care Coordinator is a mental health professional with appropriate skills and qualifications (such as a social worker, mental health nurse, occupational therapist, psychologist or doctor) and who is responsible for working with a person to agree a written Care and Treatment Plan
CMHN	Community Mental Health Nurse - current term for nurses working in the community with people with mental health problems. Role may include health promotion work, short term interventions, mental health assessment and treatment.
CMHT	Community Mental Health Team - a team which exists to meet the mental health needs of a locality, typically funded by health and social care agencies and staffed by a range of mental health occupational groups
CPA	Care Programme Approach - a system of care coordination introduced in 1991 in England, and in 2004 in Wales. CPA requires health and social care providers to liaise to assess, and plan to meet the identified needs of people in contact with specialist mental health services. Key components of this system include the provision of an identified key-worker, a plan of care and regular reviews by the mental health team.
CPN	Community Psychiatric Nurse - initial term used for nurses with a remit for working in the community with people with mental health problems. The term is still in use, although the word psychiatric is aligned with diagnosis and treatment, and some argue that is too closely aligned to the medical model

CTP	Care and Treatment Plan – users of secondary mental health services in Wales have a legal right to a holistic Care and Treatment Plan under the Mental Health (Wales) Measure. This gives people the opportunity to set goals in all areas of life, to create a plan and, in the process, to take more control of their own recovery. A Care and Treatment Plan which will consider at least eight areas of a person's life: – finance and money – accommodation – personal care and physical well-being – education and training – work and occupation – parenting or caring relationships – social, cultural or spiritual – medical and other forms of treatment including psychological interventions
GP	General practitioner – a qualified medical practitioner working in primary care
Involvement	The active participation of a person with lived experience of mental distress, in shaping their personal care plan, based on their knowledge of what works best for them. Involvement also refers to the active inclusion of the perspectives of service users collectively in the design, commissioning, delivery and evaluation of services, as well as in policy development locally and nationally, and/or professional education.
Mental Health (Wales) Measure (2010)	The Mental Health (Wales) Measure 2010 is a law passed by the then National Assembly for Wales. The Measure is focused on the support that should be available for people with mental health problems in Wales, and implementation of the law began in 2012.
NHS	National Health Service - refers to the Government-funded medical and health care services that everyone living in the UK can use.
Service user	A person who is or was a patient, client or other user of health and / or social services

Chapter 1: Introduction

1.1 An introduction to the thesis

This study is about mental health nursing and people's accounts of it from multiple perspectives. Mental health nursing roles and identities are wide and varied. In society people have expectations about certain roles, and how they might interact with individuals working in those roles. Rather than considering roles and identities as inner traits, I am viewing them from an ethnomethodological position. Identity is constructed in talk and is a subject to be explored, rather than a resource to explain behaviour (Taylor & White, 2000). Identities are personalised in the language that people use in how they describe, explain and account for who and what they are in the world in which they exist. By exploring the commonly taken-for-granted knowledge of nurses' identities, there is the opportunity to examine how mental health nursing gets done. Identity research is an important topic for nursing inquiry and serves as a voice for the profession and a way of identifying insights into this field of nursing. Equally, how mental health nursing gets done has an impact on service users, the very people with whom mental health nurses most commonly work.

Mental health nursing as a profession may benefit if its practice is distinguishable and visible, so that nurses' contributions to mental health services are recognised. For mental health service users, negotiating available resources and the myriad of professional staff may be daunting and confusing. Knowing what to expect from a mental health nurse therefore may be reassuring and encouraging. According to the most recent review of mental health nursing in England by Butterworth and Shaw (2017), it is part of the mental health nursing role to work in partnership with service users. This partnership working would usually involve discussions about service users' plans for recovery, evidence based interventions, and on-going conversations provided through the context of a therapeutic relationship with the service user. However, recent research indicates that service user partnerships in practice require much improvement (Grundy et al., 2016; Simpson et al., 2016a). Equally, a shift is required in the relationships that mental health nurses have with service users in order to incorporate

participation and involvement into people's care (Newman, O'Reilly, Lee, & Kennedy, 2015). Generally there has been an emphasis in policy and practice guidance that service user involvement in mental healthcare is not only good practice, but is to be sought at every opportunity with benefits of involvement laid out in Patient and public involvement in the new National Health Service (NHS) (Department of Health, 1999a). I refer therefore in this thesis to a climate of increasing expectations of service user involvement.

In this introductory chapter I will set out the aim of my study, and outline why I have studied talk about mental health nursing and service user involvement in nursing processes. To provide some background context I will consider the profession of mental health nursing and positivist and interpretivist approaches to research. Then I will discuss elements of the mental health nursing role, along with definitions of service user involvement. I will highlight my own position as the researcher in this study, including my own background, and discuss my perspectives regarding reflexivity. I will briefly describe the study undertaken, and introduce the content of the forthcoming chapters in this thesis.

1.2 The aim of the study

The aim of the study is to explore participants' talk about mental health nursing, and experiences of service user involvement in nursing processes. Perspectives of mental health nursing students, qualified mental health nurses and mental health service users were sought, in order to explore this phenomenon from a variety of perspectives.

The study aims and objectives appear in full in section 2.12 at the end of Chapter 2, the Literature review chapter.

A chronology of the research process from registration to completion of this thesis is provided in Appendix 1 (p.328-331).

1.3 Why study talk about mental health nursing and service user involvement in nursing processes

In this section I begin to build a conceptual framework through which mental health nursing and service user involvmement in nursing processes might be better understood. A conceptual framework is the system of assumptions, expectations and beliefs that inform research (Maxwell, 2013; Robson, 2011), and for myself as the researcher it helps to identify what might be going on in the context of this study.

Mental health nursing as an occupation has existed since the late eighteenth century when Victorian asylums first housed people with mental illness. First described as keepers, then attendants, and later asylum nurses, then psychiatric nurses, the history of mental health nursing includes much change in relation to practice and nursing work (Arton, 1998; Nolan, 1993). The forming and maintaining of a therapeutic relationship with service users has been the main rhetorical claim of the profession since the 1950s (Peplau, 1952). Through the years there have been shifts in the focus of nursing work with service users. Over time, mental health nurses' work has centred on those with severe and enduring mental illness (Gournay, 2005), a range of talking treatments (Couldwell & Stickley, 2007; Smith & Macduff, 2017) and physical health issues (Nash, 2014; Robson & Haddad, 2012). Since the advent of recovery oriented approaches, which focuses workers' attention on service users' priorities, the value of service user involvement has been increasingly recognised as good practice (Beresford, 2008; Borg, Karlssen & Kim, 2009). However, whilst this may be heralded as a practice imperative, it is suggested that nurses may struggle to carry out such work (Patton, 2013; Stenhouse, 2011).

Whilst individual nurses themselves may be motivated and enthusiastic about their roles, the system within which they work with large caseloads and inadequate resources may defeat their aspirations as service workers (Lipsky, 1980). Environments may crush initiative, service improvement ideas and result in burnout.

When considering the profession of mental health nursing it is worth taking into account the influence of positivist and interpretivist approaches to research, as both methods have influenced the history and development of the profession. Positivism and interpretivism are two important but different approaches to sociological research. Positivist styles favour scientific quantitative methods, whilst interpretivist methods prefer humanistic qualitative approaches. Positivism focuses on science and can be considered to be objective. In comparison, interpretisvism is more interested in how the world is constructed and its supporters view knowledge not objectively, but see it as transmitted through discourse and experiences, with a focus on how people interpret the world. When studying mental health nursing, it is important to consider its ontology, which means considering what exists in relation to the profession to better understand its status and position in the world. Crotty (1998, p.10) describes ontology as 'a meaningful reality'. Therefore the world views that exist in relation to the nature of mental health nursing include both positivist and interpretivist approaches. Norman and Ryrie suggest that:

"The origins of the profession are defined by two main traditions: the evidence-based healthcare tradition (the science) and the interpersonal relations tradition (the art of mental health nursing)"

(Norman & Ryrie, 2013, p.33)

Mental health nursing encompasses subjective and objective orientations, and interpersonal and evidence based traditions. According to Cleary, Horsfall and Jackson, 2013, p. 136) mental health nursing is an on-going and developing craft, a personal and experiential art, that draws on a range of relevant bodies of knowledge (science). Describing the mental health nursing profession as a 'discipline of nursing with a distinct character' (Wrycraft, 2009, p.19), goes some way in highlighting its complexity and uniqueness.

Evidence-based healthcare is said to focus on best research evidence, clinical expertise and patient values (Sackett, Straus, Richardson, Rosenberg & Haynes, 2000), with critics suggesting the focus is on the first two of these three principles. Practices named in guidelines (National Institute for Health and Clinical Excellence, 2009), such as

Cognitive Behavioural Therapy, frequently have a large body of evidence to support them. Dryden (2010) suggests that these types of interventions are accorded high value when compared with mental health nurses' informal experiential practices, which may lack apparent worth. For example, Gournay (1996, 2005) has been rejecting of discrete nursing activities, instead favouring multi-disciplinary approaches to care and treatment. This could be interpreted as focussing less on relationships with service users and more on advancing evidence based contributions by nurses. In the past Gournay (1996) suggested that the mental health nursing research workforce are poorly trained, with further research reporting a poor knowledge and skill base for a majority of nurses (Gray, 2001).

There is a contrast in positions adopted by Gournay as a positivist evidence based researcher advocating that mental health nursing should focus on particular types of evidence for practice. Gournay's view seems to emphasise 'doing to', whereas opposite views, like that of Barker, recognise the relational and therefore interpretivist stance on working with and alongside people. Norman and Ryrie (2013) suggest a middle road, and appear to embrace the two stances.

Mental health is a complex phenomenon that arises from the integration of everything that is within the human experience and therefore fluctuates as all things relative to that experience change over time. According to Dryden (2010) the forms of knowledge comprised within mental health nursing practice are different from those dominant in Evidence Based Medicine, but nevertheless are an essential element of practice needed to maintain the quality of care given to service users. Norman and Ryrie (2013) suggest there is a fusion of positivist and interpretivist traditions in contemporary nursing practice, which is discussed in more depth in Chapter 2.

Since the economic recession began in 2008, mental health services have experienced disinvestment (Docherty & Thornicroft, 2015), with mental health nurses working in environments that have been under-funded. Government strategy has recognised the need for improvements in mental health provision that include improvements in safety,

patient-centeredness, recovery and physical health (Department of Health, 2011). Yet service improvement is limited without sufficient funding of staff. Staffing levels have been debated for many years, particularly due to recession, rising costs and healthcare scandals (Baker & Pryjmachuk, 2016). Sufficient numbers of appropriately qualified mental health nurses are needed to offer evidence based interventions in environments that are supportive and safe for people in mental distress. Therefore mental health nurses are working in a climate of austerity with cuts in investment and reduced resources. Expectations are that nurses are compassionate and understanding of people's distress, even though they may be struggling to provide care with diminished resources.

For mental health nurses, compassion can mean empathising with people's life experiences and showing understanding of how these experiences can cause psychological distress (Stickley and Spandler, 2014). Service users' expressions of distress can be unpredictable, meaning that nursing work often includes a focus on safety and containment. The cultures that mental health nurses work in are largely powered by the medical model, based on a scientific approach, so working interpersonally with service users can be neglected and may be a continuing challenge.

With changes to services almost constant, increased clarity in mental health services may enable nurses to develop a better understanding of key elements of their role. It has been highlighted both inside and outside the profession that mental health nurses have had difficulty articulating their roles and subsequent identities (Happell, Hoey & Gaskin, 2012; Rungapadiachy, Madill & Gough, 2004; Sheppard, 1991) Reproaches from other professions, disciplines, regulators and the general public serve to make a case for identity research being an important topic for mental health nursing research inquiry.

Professional identity refers to identity defined by one's role at work and may be akin to assertions of a person's sense of distinctiveness, agency, dignity, special skills, and morality in line with colleagues who share the same occupational role (Van Manan, 2010). Stevenson (1996) suggested the practice of mental health nursing may lie in its

invisible skills which are recognised by mental health nurses, but are not detected by those unfamiliar with the discipline. The study of talk can serve as a voice for mental health nurses by acting as a vehicle through which roles and identities in this complex field of nursing can be made clearer (Leishman, 2004). Most studies in this area focus on expectations of mental health nursing roles (Hopkins, Loeb & Fick, 2009; Stenhouse, 2009). As enlightening as these studies are, there is no attempt to include a picture from multiple perspectives. For example, we know little about how mental health nurses, nursing students and service users view mental health nursing roles, nor how these social actors relate to people working in nursing roles.

The mental health nursing role involves working closely with mental health service users, with expectations that this will include assessing people's mental health and well-being needs, building relationships and collaborating through shared decision-making (Jones & Young, 2016). The intention of nurses engaging with service users is also to shape the helping process be participative rather than directive (Watkins, 2001), as the very reason that people have come to the attention of services and are needing help places power more firmly with the professional than the service user. Participative approaches are intended to go some way to adjusting the power balance, so people do not have care dictated to them, but have choices about their care and treatment as much as possible. This is of particular importance in mental health settings where an individual's capacity for rational reasoning can be called into question and result in their wishes being over-ridden in favour of system needs. Therefore collaborating with service users to promote a service user-centred philosophy is said to be part of the mental health nursing role (Stacey, Felton & Bonham, 2012). My view is that working together with service users in this manner is 'good' mental health nursing practice. As participatory approaches include skills of collaborating and working in partnership, these methods can also be termed service user involvement because the approach is about involving service users in their care and treatment as one way of addressing the potential democratic deficit in this area of healthcare practice.

Although there are multiple definitions of service user involvement, it has been argued that no agreed definition of involvement exists, and that the concept is insufficiently

articulated and understood (Rise et al., 2011). The patient's role is reported to have changed over time from being a passive recipient of healthcare to a more active participant, who has a right to be involved in decisions that affect them. Furthermore, by drawing on their experiences, patients are encouraged to have an inclusive dialogue about their care with stakeholders (Rise et al., 2011). Service user involvement has been defined as service users participating in the decision making process (Hickey & Kipping, 1998). Yet this does not capture the more action-oriented potential of the concept. Storm and Davidson suggest service user involvement is more about people 'being involved, participating and influencing the planning and implementation of their treatment and service' (2010, p. 113). Lathlean et al's (2006, p.733) definition goes further still suggesting service user involvement is "an active and equitable collaboration between professionals and service users concerning the planning, implementation and evaluation of services and education". The emphasis highlighted in these definitions has been on involvement in a person's own healthcare and treatment; however involvement can be much wider than that. Omeni et al. (2014) highlights that involvement can relate to service improvement in residential and day services, inpatient services, appointing and training staff, managing and evaluating services, as well as researching services and commissioning services too.

Millar, Chambers and Giles (2015, p.209) undertook a concept analysis of service user involvement within the field of mental healthcare, and identified it included five key attributes: 'a person-centred approach, informed decision-making, advocacy, obtaining service users' views and feedback and working in partnership'. Millar et al. (2015) suggest service user involvement in mental health is still an emerging concept that is growing in use, and that the lack of exemplars suggests the concept is not currently well clarified. The definition provided by Millar et al. in their concept analysis paper goes further than Lathlean et al's in my previous paragraph and states service user involvement in mental healthcare is:

> "An active partnership between service users and mental health professionals in decision making regarding the planning, implementation and evaluation of mental health policy, services, education, training and research. This partnership employs a person-centred approach, with bidirectional information flow, power sharing and access to advocacy at a personal, service and/or societal level"

(Millar et al., 2015, p.216)

Castro, Van Regenmortel, Vanhaecht, Sermeus and Van Hecke (2016) noted the difference between terms relating to service user involvement and found a range of definitions exist for patient empowerment, patient participation and patient-centerednes with proposed definitions reported below:

> Patient empowerment (individual): a process that enables patients to exert more influence over their individual health by increasing their capacities to gain more control over issues they themselves define as important
>
> Patient participation (individual): focuses on a person's rights and opportunities to influence and engage in the decision-making about their care through a dialogue of their experiential, and the profession's expert knowledge.
>
> Patient centeredness (individual): a bio psychosocial approach that aims to deliver care that is respectful, individualised and empowering and implies the individual participation of the patient is built on a relationship of trust, sensitivity, empathy and shared knowledge.
>
> (Castro et al., 2016, p.1927, 1929, 1930))

Collective definitions about patient empowerment, patient participation and patient centredness included statements about groups having power to express needs and take action to shape health and care services by being actively involved at an organisational and policy level (Castro et al., 2016). Considering meanings of the term service user involvement can help to provide clarity, and to contemplate the aim of involvement activities. The purpose of service user involvement may vary. For example, public involvement may improve the quality of services, by clarifying what patients want. This clarification has often been the motive emphasised by UK policy directives (Department of Health, 2000, 2001, 2012). Additionally, service user involvement in the planning of health services paid for by taxation is a sound democratic principle (Milewa, 1999). However, Rutter, Manley, Weaver, Crawford and Fulop (2004) suggest public involvement may be seen as a strategy that legitimates unpalatable change (such as rationing and/or increased charges), allowing politicians to deflect criticism by suggesting a broader consensus.

Beresford (2003) indicates the multiplicity of involvement with two main approaches, one that is based upon a managerialist/consumerist model and the other he calls a democratic approach. The managerialist/consumerist model is concerned with 'getting the product right' and has its roots in market forces that have shaped health services in the past decade or so. The democratic notion is more concerned with the subjects of particular services having more say in those services, and gaining more control over their lives generally. Stickley (2006) suggests there are broader political and social factors that drive involvement which include civil rights, social inclusion, personal autonomy and collective social action. So whilst service user involvement appears to have a number of purposes, it is interesting to note that the impact of actual involvement and people's experiences of it has rarely been examined.

Aware of the increasing focus on involvement to ensure active participation in treatment decision-making for all NHS organisations, Omeni, Barnes, MacDonald, Crawford and Rose (2014) studied service user and staff perspectives about service user involvement focusing on impact and participation and found that around half of respondents had been involved in some form of service user involvement activity, with both groups reporting involvement had had a positive impact. Equally Laitila, Nummelin, Kortteisto and Pitkänen (2018) studied mental health service users' views on involvement and found that participants described service user involvement as being related to their own care and treatment, and stressed a wish to be more involved in decision-making and care planning about their individual care. However, despite notions that involvement is something positive that focuses on inclusivity and democracy, service user involvement is also a contested concept, and involvement activities can be in danger of being tokenistic.

Organisational and professional cultures may determine the extent to which service users can become involved in decision making (Omeni et al., 2014), which indicates that professionals frequently dictate the amount, type and approach to service user involvement. According to Foucault (1972) institutional power is wielded though language used, usually through those employed in knowledgeable roles, such as doctors and other health and social care professionals. The professional language of these

professionals who are at the top of the institutional hierarchy does little to include those who have not had such educational opportunities (Stickley, 2006), for example patients for whom the services exist. Stickley (2006) therefore suggests that service user involvement can be viewed through a Foucauldian lens, in that service users have learned the language of the dominant discourse in order to become more involved in decision-making. This suggests to me that involvement activities are very much on professionals' terms.

When considering service user involvement in service development at committee level, this has been described as a mechanism that serves to add legitimacy to stakeholders' plans (Repper, Hanson, Felton, Stickley & Shaw, 2001), rather than being authentic democratic involvement. This lends weight to Bramwell and Williams (1993) suggestion that service providers are simply searching for service users who fit into their structures. There is also a danger of the evolution of the 'lay professional', who might become socialized away from a genuinely lay perspective (Boote, Telford & Cooper, 2002). Consequently, these complex, and at times irreconcilable, issues of service user roles are considered by some as excuses so that service user involvement remains non-existent, or solely at a tokenistic level (Crepaz-Keay et al, 1997). Allott & Holmes (1993) suggest that while tokenism is unacceptable, it may be interpreted in a positive way, in that the concept of service user involvement is at least recognized. In terms of power, the process of service user ascendancy has made a great number of people feel uncomfortable (Stickley, 2006), as professionals have had to change their language and use of jargon to 'accommodate' or 'allow' involvement. The process of allowing involvement is very different from services being delivered in a user-friendly manner for the very people for whom they exist.

It is therefore argued by Stickley (2006) that service user involvement is a concept created by the dominant discourse (therefore a professional one), that reinforces the power and knowledge position of such discourse and only by applying theories of emancipation may genuine change be wrought for mental health service users. Rutter, Manley, Weaver, Crawford and Fulop (2004) reported that only 6 out of 25 service user representatives were satisfied with the outcomes of their participation in involvement

activities. Despite policy drivers that have promoted involvement (DoH, 2000, 2001, 2012), practitioners have struggled to overcome significant challenges associated with translating the rhetoric of empowerment and participation into practice (Cowan, Banks, Crawshaw & Clifton, 2011). The most frequently mentioned negative impact of service user involvement was that involvement can be tokenistic and fail to influence change as it was seen as having a low status (Omeni et al., 2014). Conversely, Omeni et al. (2014) report that service users being involved in decision-making was the most frequently highlighted benefit in terms of service user involvement being empowering, which service user participants termed 'exercising choice and control'.

The Nursing and Midwifery Council's (NMC, 2015) Code for professional standards of practice and behaviour for nurses and midwives states the need for nurses to:

> "Recognise and respect the contribution that people can make to their own health and wellbeing, that nurses need to encourage and empower people to share decisions about their treatment and care and need to respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care"
>
> (NMC, 2015, p.5)

However, the NMC were not pioneers of this approach, and have only come to this position more recently. Partnership approaches were suggested in early reviews of mental health nursing (DoH, 1994).

It is perhaps surprising then that Omeni et al's (2014) study, which focused on the levels of service user participation in mental health services in three mental health trusts in the UK, found that in terms of professional background it was social workers who were more likely to participate in service user involvement activities than community psychiatric nurses. Stickley states that:

> "Mental health nurses are often the workers who have the most contact with service users. It is they who may be expected to implement strategies for involvement. It is essential that mental health nurses therefore give some consideration to the philosophies and approaches that underpin these models"
>
> (Stickley, 2006, p. 576)

Therefore working in partnership with service users to discuss their choices, plans and treatment goals may not always be labelled as 'service user involvement', but is very much the ethos of good mental health nursing.

For the purposes of this thesis I am using the term service user involvement to mean ways and approaches that mental health nurses use in practice to work collaboratively with service users. This refers to how service user involvement might be part of mental health nursing processes.

My interest is in both the profession of mental health nursing and service user involvement. I have come to question why mental health nurses have such difficulty in defining their roles and their professional identities, and am interested in what this says or implies about the work they do. Equally I am aware that service user involvement is considered of prime importance, not only in policy and guidance documents, but as a moral and professional obligation to ensure services are delivered in ways that are both democratic and just. How nurses then incorporate involvement into their developing professional identities, and how do they do 'being a mental health nurse' in contemporary services is where my interest lies. There is limited literature on how mental health nursing roles and professional identities are viewed by stakeholders, and no current literature examining how service user involvement in nursing processes is incorporated into mental health nursing identities. This study is an attempt to address this gap in the research literature.

1.4 An introduction to the researcher

A PhD is a personal learning journey for each individual. From my own perspective, I equate the term research with finding out, and was keen to discover more about both my own profession of mental health nursing and service user involvement in nursing

processes during my doctoral experience. I was interested to identify future actions in terms of progressing and influencing nursing practice and education; and most importantly improving the experience of people who use mental health services. Before looking forwards, I shall briefly glance backwards, because as a PhD student my background is important to me, as this reminds me how I have arrived at this point.

> "A researcher's biography and past experiences can provide motivation and curiosity that become a starting point for meaningful naturalistic enquiry"
>
> (Lofland, Snow, Anderson & Lofland, 2006, p.10)

In 1990 I began to volunteer on a Tuesday evening with a group at my local sports centre. The group was run by local mental health nurses for people experiencing a range of mental health problems. Much time was spent getting to know people, engaging in social activities and enjoying seeing people's confidence and quality of life improve. Before long I was facilitating the group and listening to suggestions that I start my training to become a mental health nurse. This starting point for me has always been important, as it was the relationships with people in that group, the discussions, the promotion of choice, the involvement of people, the creative possibilities and occasional risk-taking that began to form my own professional identity as a mental health nurse.

There is a suggestion that professionals' views about service user involvement in nursing processes are linked to people's past experiences, and those with backgrounds in voluntary work have a greater moral and political commitment to involvement than those who see it just as a National Health Service (NHS) requirement (Fudge, Wolfe & McKevitt, 2008). Robens (2012) suggests there are both professional and personal components to an individual's understanding of service user involvement, which need to be considered in the analysis of user involvement in practice. It may be that individual workers do not spend sufficient time reflecting on their own understandings of involvement when they enter a profession or during their career, which may limit their awareness and understanding about such practices. I think for me involving people, whether in relation to care, education or service development always seems like the most natural path to take. It is inclusive, respectful and logical. Without

involvement, we risk not hearing people's voices and could lose the privilege of working together.

I began my Registered Mental Nurse training in 1991, mostly based at Goodmayes Hospital in Essex and enjoyed a variety of placements, very much influenced by role models who put service users first. As I began my career as a qualified nurse at Bexley Hospital in Kent on an acute admission ward it was always service users who taught me most about how to be a mental health nurse, how to effectively engage people and how to explore ways that promote empowerment and recovery. When I began my first degree, a BSc in Community Mental Health Nursing, at Anglia University, I became more aware of both service user involvement models as well as criticisms aimed at mental health nurses. My memory of reading Sheppard (1991) has stayed with me, and the uncomfortable feeling that mental health nurses have difficulty describing their roles. I agree that biographic experiences can be a springboard (Riemer, 1977) to further research. At the time my degree required the production of a research proposal and I chose to focus on asking service users 'what they wanted in a mental health nurse'. For me, the answers to such questions potentially help shape future mental health nursing education and practice.

After a career working as a Community Mental Health Nurse with Community Mental Health Teams in both Kent and Essex, I moved into Child and Adolescent Mental Health and developed services in primary care and health promotion. Working closely with students and providing training to healthcare staff ignited my passion for education. My love of learning and development prompted me to start work as a lecturer in mental health nursing at Swansea University in 2007. I began to consider how our pre-registration nursing students were developing their own mental health nursing identities, as I continued to witness frequent changes to mental health service provision with the establishment of an ever-increasing range of teams and roles. I questioned how nursing students were managing service user involvement when they suggested they saw little occurring in everyday practice settings. I successfully applied to commence a part-time PhD in 2011 to explore people's stories about mental health nursing roles and

professional identities, in the context of a climate promoting increasing service user involvement in nursing processes.

My growing interest in service user involvement prompted an application for a Florence Nightingale travel scholarship to visit 15 centres of excellence in the UK and Ireland in 2011 who were conducting service user involvement in their nurse education programmes to a high standard. This travel scholarship was undertaken as a benchmarking exercise to explore good practice, with the intention that findings be disseminated through presentation and publication, and taken back to my own organisation for discussion and implementation. My travel scholarship had the following objectives:

- To visit Higher Education Institutions who provide pre and post-registration nursing programmes, to discover best practice methods that support and prepare individuals for service user involvement activities
- To meet with service users, students and staff to discover how this is working in education settings
- To identify support systems that enable and support service user involvement in nurse education programmes (including training, mentoring, policies, and evaluation processes)
- To explore experiences of support and preparation from service users' perspectives
- To identify best practice and how this may be incorporated into nurse education programmes to increase the effectiveness and quality of service user partnerships
- To disseminate the project's findings through reports, publications and presentation

This benchmarking exercise enabled me to learn about recruitment and engagement processes, to aim for small achievements, and that relationships were the heart of service user involvement. I began to share and implement my findings with the small group of service users and carers I had begun to facilitate in the College of Human and Health Sciences (Terry, 2013). This travel scholarship acted as a pre-research backdrop

to my PhD as I increased my knowledge and awareness of factors that relate to service user involvement in a broad sense.

My enthusiasm to see service user involvement gain momentum was further realised in April 2015, when I became the first mental health nurse in the UK to become a Fellow with the National Institute for Health and Care Excellence (NICE). One of the strands of my fellowship being to bring together the universities in Wales to form a network to support and grow service user involvement in health education programmes.

During my PhD journey I have been privileged to lead the College of Human and Health Sciences' Service user and carer involvement group for health professional programmes at Swansea University. I have witnessed first-hand the increasing amount of activities individuals are involved in to better shape and influence both mental health nursing students as well as other health professional learners. Equally I have been interested in the developing mental health nursing identities of pre-registration mental health nursing students, and how as an educator I can influence and develop students' awareness about mental health nursing identities.

1.5 The study

The approach I have chosen for this study has been to explore accounts about mental health nursing from multiple perspectives. The roles and professional identities of mental health nurses are reported to be not sufficiently understood or valued, and those in the role can experience a certain amount of role ambiguity (Chang & Hancock, 2003; Hercelinskyj, 2010; Rungapadiachy et al., 2004). Misunderstandings may be due to the low visibility nature of skills that mental health nurses employ, such as communicating and engaging with mental health service users. People unfamiliar with this field of nursing are unlikely to fully understand what it is that mental health nurses do. Whilst mental health nurses strive to hold named, valued skills that are useful for service users, and although service users may value nurses; this worth is not always verified by those

who shape mental health service provision (Dryden, 2010). Nurses frequently struggle to comprehend the definitiveness of their role boundaries, and if the mental health nursing profession cannot articulate their contribution, the profession may be under threat. Perils have been apparent at each review of standards for nurse education in recent years (Nursing and Midwifery Council, 2010; Nursing and Midwifery Council, 2017a), with nurses concerned whether or not the profession would maintain its specialist field status in the UK, or lose it like other countries (Happell & McAllister, 2014).

It has been identified that the relationship between mental health nurses and service users is an essential foundation when providing interaction and support. A relationship needs to be flexible enough to accommodate a fundamental shift in the provider–service user relationship in order to fully engage a service user in their care (Newman et al., 2015; Rutter, Manley, Weaver, Crawford & Fulop, 2004). In the main this shift refers to a change in the power differential between service user and professional worker. Rather than the nurse prescribing the direction of care, the service user is in a more empowered position to take a lead in discussions about their own care.

The approach I have adopted in this study has been to seek first-hand narrative accounts from people who are mental health nurses, mental health nursing students and from people who have met mental health nurses as part of their experience of using mental health services.

My research sample was drawn from a range of contacts, predominantly from third sector mental health organisations, and from mental health nurses and nursing students in South Wales. I commenced data collection in 2011 following ethical approval from the university Research and Ethics committee. Data collection continued until 2013. I undertook individual interviews with 13 mental health service users and 17 mental health nurses; and 3 focus groups with nursing students. In total 30 interviews and the 3 focus group transcripts constitute the main data for this study. All research interviews were audio recorded and transcribed. Analysis of the transcripts focussed on accounts

about mental health nursing identities and how nurses 'do' being a mental health nurse. It is through talk that people reveal their displays of understanding about particular topics, in this case the work their talk is doing about mental health nursing processes and service user involvement. Accounts were also analysed in relation to participants' perceptions of mental health nursing roles and service user involvement. Data were analysed in relation to ways in which talk about user involvement were supported or challenged in the accounts of participants from multiple perspectives.

My purpose in completing this research is to make an analytically informed contribution to understandings about mental health nursing roles and professional identities in relation to service user involvement. My work in this area has started (see Appendix 2), with publications about service user involvement in nurse education (Terry, 2012; Terry, 2013; Terry, Raithby, Cutter & Murphy, 2015; Terry & Warner, 2011) and mental health nursing practice (Terry et al., 2018).

1.6 Influences and suppositions about my position as researcher

My choice of area for PhD study grew out of my own experiences as a mental health nurse, and an interest in service user involvement in mental health care as well as in health professional education. Given that my own professional identity has been that of a mental health nurse for over twenty-five years, and as a mental health nurse academic for the past ten years; being reflexive and reflective was extremely important. Aware that I was occupying the roles of both researcher and mental health nurse, such duality requires rigorous reflexive examination (Kamler, 2001). Additionally I was aware of starting my research journey as a mental health nurse academic, who would be a familiar face to both nursing students and local mental health nurses. However, I was not expecting to distance myself from the research process in a way that denied my position of having a variety of roles.

During my PhD journey I began to learn that subjecting my own knowledge claims and thoughts to critical analysis was essential, so that I could examine dominant

professional ideologies, and challenge my own thoughts. I employed strategies to minimise the risk of researcher bias. I engaged in regular supervision, and routinely wrote in a reflective research log. This writing enabled the development of an audit trail about my research decisions, and enabled me to capture the interactions between myself and research participants (Brunero, Jeon & Foster, 2015). My research log writing helped clarify my thinking, and record decisions to demonstrate dependability. Engaging in this process enabled me to consider how I positioned myself as both a mental health nurse, a mental health nurse educator and as a qualitative researcher.

Being a mental health nurse enabled me to understand the special vocabulary of 'doing' being a mental health nurse. Rawls (2001) and Morriss (2014) describe such a position as a unique adequacy in understanding practices that have specialised populations. My position goes some way in explaining why I chose to use an ethnomethodological lens in order to explore the meaning making in people's talk. People who are members of specialised groups often do not see what is taken for granted. As a researcher I needed to make the familiar strange (Wright Mills, 1959), in order to explore the taken for granted positions about mental health nursing, particularly in relation to service user involvement in nursing processes. Reflexive research opportunities would help me consider everyday experiences as parts of larger social structures.

I was intrigued by scholars who focused their doctoral studies on trying to capture what it is that mental health nurses do, and the difficulty articulating mental health nursing work that does not fit into clean categories (Dryden, 2010; Hercelinskyj, 2010). I have heard colleagues question what it is that mental health nurses do that is different and better than other professional workers. I have noted how often colleagues argue that mental health nurses bring something that is different and unique, but with little evidence to support such claims. Leishman (2003) suggested that a social constructionist approach can allow researchers to explore the uniqueness of mental health nursing.

> "In order for mental health nurses to be able to command a valued position within the field, the elements that define their practice must be distinguished and made visible to themselves and their disciplinary counterparts. However, this is

> by no means straightforward. Somehow, core aspects of mental health nursing practice appear to be quite intangible, barely visible and consequently undervalued. Yet they are fundamental to their daily work"
>
> (Dryden, 2010, p.9)

The notion of an ethnomethods approach interested me and was appropriate to my method of inquiry and my research questions.

It has been suggested that people become mental health nurses because they 'wish to help others recover from distress and ill-health, and to regain valued relationships with family, friends, colleagues and communities' (Evans & Hannigan, 2016, p.3). The journey to accomplishing a mental health nursing identity was of interest to me. I was aware that accomplishing a particular identity requires work, through interactional talk, in order for that identity to be generated and sustained.

Equally I was interested in how mental health nurses and nursing students saw service user involvement as part of their professional nursing identities. I was curious about how the notion of involvement might influence their approach or daily work. I was interested in how mental health nurses might talk about 'doing involvement' in practice and what helped or hindered this. Essentially I questioned whether user involvement was indeed adopted as part of mental health nurses' professional identities.

I have set out to explore mental health nursing roles, and the context of service user involvement within those roles. I have been challenged to focus on issues of professional identity which are fundamental to mental health nursing work. My intention is that this thesis makes an informed contribution to understanding mental health nursing identities in a climate of increasing service user involvement. The study's findings will be made more widely known through the production of journal and book chapter publications, and presentations at local and international conferences (see Appendix 2).

Being a mental health nurse myself it has been important to remain reflexive throughout this research study and the writing of this thesis. Reflexivity is the capacity to reflect upon one's own actions and values during research, focusing analytic attention on the researcher's role (Gouldner, 1972; Seale, 1998). It is good practice for novice researchers to make explicit their own position as a researcher, as this encourages self-awareness. Reflexivity assumes that the researcher will engage in continuous self-critique and self-appraisal, considering how their experience may or may not have influenced the research process (Koch & Harrington, 1998). I kept a research log during the entirety of the study in order to record my reflections, concerns and decisions. This type of audit trail provides a transparent description of the research steps taken from the start of a research project to the development and reporting of findings, and provides a description of the research path. This includes research design, data collection decisions and the steps taken to manage, analyse and report data. I used my research log to constantly reflect on my journey and interactions during the research process.

Audit trails have been heralded as a transparent description of the research steps, which may be useful in establishing the confirmability of qualitative findings (Lincoln & Guba, 1985). Although the practice of an audit trail is debated in terms of its value (Cutcliffe & McKenna, 2004); I found it essential. I saw my research log as meeting the function of an audit trail, as it provided me with a chronological record of research activities, and helped me to reflect on all aspects of the study and my developing research knowledge.

I reflected critically on my rationale for the study, and whilst I admit I was keen to pursue PhD study, I was also extremely passionate about my topic. Throughout my twenty-five year mental health nursing career, I have always had a sense of pride in being a nurse, and am intrigued by this sense of professional identity and role. Equally, in various mental health teams I have observed mental health nurses struggling with professional identity about their roles and nursing work. Taking into account my own experiences from practice and the literature regarding mental health nurses' roles and professional identities, I considered the study's aims to be of value to mental health nurse educators, service users, nursing students, and mental health nurses themselves. I

am aware I have much invested in the notion of professional mental health nursing identities, and am aware that steps are needed to guard against my too readily assuming understanding of the role, or that I could potentially present it in an overly positive light. This further reinforces the importance of reflexivity in the researcher.

I perceived the study's aims could advance mental health nursing knowledge regarding role development and professional identity in a changing mental health landscape, and that they were therefore worthy of study. My motivation sought to generate new evidence to inform and improve how mental health nursing students are educated about their roles, in order to understand more about professional identity development. This increased understanding might assist them to better perform their roles and functions, and to collaborate more effectively with mental health service users, resulting in improved care delivery.

The identity of the researcher is of key importance, as this will impact on the construction of research questions, data collection and analysis (Hewitt, 2007). In terms of transparency and seeking to develop trust with respondents, I considered how I should present myself, and how people would view me in relation to the study. Nursing students and qualified mental health nurses (who had been former students), may know me as a nurse educator, therefore it was important that this information was present on the participant information sheets. Particularly as I was asking participants about nurse education, and worked in that environment. I viewed myself as having multiple professional identities, not only was I a nurse educator and had worked as a mental health nurse; I was also a researcher. These multiple identities provide challenges for the researcher, and reflexive practice may enhance the researcher's credibility (Arber, 2006). It is suggested fieldwork often capitalises on researchers' biographies, and starting 'where you are' can provide meaningful linkages (Lofland et al., 2006). The concept of insider/outsider status means the degree to which a researcher is located within or outside a group being researched (Gair, 2011). In a sense I was neither one nor the other, but became aware during data collection and analysis when moments of potential role-overlap were revealed to me, and identified with the position from Dwyer and Buckle below:

> "Whether the researcher is an insider, sharing the characteristic, role, or experience under study with the participants, or an outsider to the commonality shared by participants, the personhood of the researcher, including her or his membership status in relation to those participating in the research, is an essential and ever-present aspect of the investigation."
>
> (Dwyer and Buckle, 2009, p.55)

Allen (2004) states that situations are frequently neither wholly familiar nor wholly strange, and that the researcher's status fluctuates at different points during a study, and may vary with different groups and individuals. Potentially different aspects of my role might have had a meaning or implication for different participants, and the ethical aspects of these needed to be explored. I was aware that I would potentially come into contact with a number of participants in the future through my work roles. This could be nursing students in my role as nurse educator, service users in my role as user and carer involvement co-ordinator, or mental health nurses who may be working in clinical settings where I have the role of link lecturer. I was aware of this particularly during the data collection stage, which prompted further reading about small communities and related ethical dilemmas, such as challenges related to ensuring anonymity.

Role conflict can arise for nurse researchers who are researching their own field of nursing. Self-disclosure by the researcher can have a beneficial impact on information exchange, resulting in more meaningful sharing by informants (Wilde, 1992). Whilst a researcher should engage in a position of 'standing back', a kind of balance of detachment and involvement, it may be that this marginal positioning is not always possible (Darra, 2008). It can be an unavoidable fact that we are part of the world that we study (Ochieng, 2010), being aware of the ethical dilemmas as a researcher with several roles has remained an important part of my research.

Anecdotally, mental health nursing is sometimes viewed as a small world, which can be interpreted as people may know, or know of each other. This particularly applies to the geographical area of South Wales. The risk of breaching confidentiality increases when engaging with small networks where individuals may know one another, for example through education or work. It is essential that researchers recognise a dual mandate, whereby they need to implement strategies to protect participants' identity; but also

fulfil their remit to generate new knowledge (Damianakis & Woodford, 2012). I was mindful of these risks at all stages of the study.

Potentially, unintentional identity disclosure is heightened when studying small communities, and strategies including not collecting identifying information, removing identifying information and anonymising transcripts can reduce the likelihood of confidentiality being breached (Daminakis & Woodford, 2012). Equally, there was the possibility of participants knowing others who had participated in this study in these small, connected communities. I recognised the need to protect participant's anonymity, in case they highlighted they knew of other participants involved in the study. Anonymsing locations, workplaces and healthcare environments in participants' talk was also important. I recognised that knowledgeable observers may be able to identify camouflaged communities or locations. One example of this occurred in Vidich and Bensman's (1968) Small town in Mass Society study, where pseudonyms did not prevent residents identifying locations and key participants. I therefore sought to ensure that contents of participants' talk omitted identifying features.

Critically examining my own actions as a researcher has been one way of acknowledging my subjectivity, and position as a co-constructor of the data (Scerri et al., 2012; Shaw, 2010). The proactive management of myself during interactions with participants, and actively exploring how these encounters impacted upon my own beliefs, has been an essential part of the reflexive process.

1.7 Organisation of the thesis

In this first chapter I have introduced my study, set out my research objectives and rationale; and the conceptual framework that applies to my topic. In Chapter 2 I present a discussion of historical, policy and practice-related issues which serves as a background about the context of mental health nursing roles and professional identities, along with service user involvement. Chapter 2, the literature review section, begins

with the historical context of mental health nursing. This is followed by discussion of both biomedical and inter-professional relations approaches, and perceived divisions within the profession in relation to such approaches. I move on to highlight reviews of the mental health nursing profession, along with relevant policy change. I then discuss the notion of professional identity work and elements of mental health nursing practice. This is followed by a section on service users' views of mental health nurses which I use to frame a discussion about the development of the growth of the service user movement and service user involvement more generally.

Chapter 3 details my methodological approach to this study and the exploration of people's talk about mental health nursing and service user involvement in nursing processes. I explain my approach of examining participants' accounts by exploring the work their talk is doing. I provide a rationale for my use of research interviews and focus groups as means of data collection, and acknowledge limitations in connection with my approach. I highlight the early involvement of stakeholder groups, and how I negotiated access and secured ethical approval. I report on my approach to recruitment and sampling, and my approach to data collection, as well as the audio recording and transcription of participants' accounts. I discuss reflexivity and the importance of this for both this study, and myself as the researcher. This is followed by an explanation of my approach to the data analysis.

In Chapter 4 I begin to discuss my analysis of the research data. This analysis begins with an examination of talk about mental health nursing in terms of time, busyness and tasks. Participants were asked to tell their stories about mental health nursing work, or in the case of service user participants, when they had encountered mental health nurses. I include discussion about mental health nurses' work in different settings. In this chapter I argue that mental health nursing work appears task-focused, and because of this service users experience limited direct contact with nursing staff. Chapter 4 finishes with a discussion of participants' narratives that focused on debating whether the nursing role is considered specialist, generalist or a Jack of all Trades.

I move on in Chapter 5 to present findings about the context of service user involvement in nursing processes and discuss involvement from multiple perspectives. First, I explore talk from nursing students and their knowledge and understanding about involvement. I include a discussion about talk from a nurse regarding the practices and challenges of user involvement in a practice setting. Finally I present analysis of stories from two service users who describe their experiences of involvement and their perceptions about mental health nurses in relation to their involvement experiences. In this chapter I advance my argument that service user involvement in practice is limited, with students having little understanding of it, and service users' experiences of involvement being inadequate.

My analysis in Chapter 6 centres on expectations present in the talk of participants. I start with nursing students' expectations about mental health nursing work and how they spoke of feeling a need to comply with established nursing behaviours in practice settings. I then present a story from a mental health nurse participant about role blurring and role ambiguities in mental health nursing and different expectations that stakeholders have about professional roles. I conclude this chapter with analysis of a narrative from a service user who had what I perceive as mismatched expectations about her treatment approach from a mental health nurse. I have used this story to acknowledge power differentials between service users and nurses. Through discussion of this service user's narrative I stress perceived differences experienced when a nurse promoted a more collaborative partnership, although this particular service user had expected the nurse to retain a more autocratic approach, in line with her previous experiences.

In Chapter 7 I draw together the different threads of my analysis to explore mental health nurses' professional identity work and service user involvement in nursing processes. I suggest that much of professional identity work is concerned with busyness and task-oriented activities, and the challenges of working within complex systems. I highlight that frequently outsiders have limited knowledge about the mental health nursing profession, and this limited knowledge may result in service users and their families not knowing what to expect regarding interventions and partnerships with

mental health nurses. Service user involvement does not appear to be a convincing part of nurses' professional identity, and does not feature as part of everyday talk about established nursing processes and practices.

I present conclusions of my thesis in Chapter 8, which begins with a summary of the main findings, then contributions of this study. I then discuss the limitations of this study and follow this with implications for education, practice, and further research. Finally I reflect on the benefits and challenges experienced during my doctoral student journey before concluding.

A note to the reader: I have included a Glossary of terms on page 10. Throughout this thesis I use the terms service user, consumer, client and patient. My decision to use these terms is based on the language from participants' talk in my study, as people used the terms interchangeably.

Chapter 2: Literature review

2.1 Introduction

The purpose of this chapter is to create the rationale for my study and to set the study in a wider context by considering relevant literature associated with mental health nursing and service user involvement in nursing processes. Mental health nurses have worked with people experiencing mental distress in a range of settings for centuries. It is with both groups in mind that I address historical, social and practice developments for the provision of mental healthcare, and how this relates to the profession of nursing. Mental health provision has been linked with issues of power. Those employed in nursing roles engage in work that is both caring and controlling, as they seek to protect people with mental illness from harm. Many aspects of nursing work will involve power dynamics, whether this relates to health promotion, treatment or restriction of liberties. However, the growth of consumer involvement in healthcare generally since the 1990s is potentially changing these power balances. These changes impact on the relationships service users have with those working in professional roles. Mental health nursing roles and professional identities, and how they are perceived, can impact on nurses themselves as well as mental health service users. How mental health nurses and service users talk about nursing work and the meaning communicated by talk are the phenomena under study.

I begin this chapter by acknowledging the historical context of the profession, and then critically analysing enduring tensions, namely divisions between supporters of the medical model and those who favour a more humanistic approach. This will be followed by discussions about the influence of professional reviews of mental health nursing, as well as mental health policy in relation to the profession in the United Kingdom.

I then discuss the development of professional identity, including division of labour and role jurisdictions, along with key points from the stress and burnout literature relating to mental health nursing. This is followed by literature regarding elements of mental health nursing roles, and then service users' views of those roles. Social reform and political change have impacted on mental health nurses' practice, as has the growth of the service user movement, with mental health service users increasingly more involved in their care choices (Network for Mental Health, 2014; Sainsbury Centre for Mental Health, 2006). In this chapter I will explore what is known about these topics, in order to develop a rationale for this research study.

2.2 Researching mental health nursing and service user involvement in nursing processes

In preparing for this review I examined peer-reviewed articles and grey literature including studies and opinions about mental health nursing as a profession, nurse education, practice settings and nursing treatments. I also included service user involvement literature which included material about the development of user movements, service user voices, and experiences of mental healthcare. Whilst this chapter includes critical analysis about a number of these issues to provide background context, the focus of my study is on mental health nursing in practice and service user involvement in nursing processes as a joint entity, and people's experiences of these phenomena. I conducted a review of the literature in this field exploring the quality of the research. I reviewed empirically based peer-reviewed papers on mental health nursing in practice and service user involvement in nursing processes with the aim of:

- identifying and critiquing the range of methodological approaches to the topic
- Critiquing approaches utilised to gain participant views
- Establishing the existing knowledge base or what is known about these topics

I searched the following databases for material published in English between 1995 and 2017: Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, PsycINFO, British Nursing

Index, Medline and Web of Science. My search terms included 'mental health nursing' and 'psychiatric nursing', combined with the terms 'identity', and/or 'role'. I combined results with 'service user involvement', and included a range of terms including 'patient', 'consumer', 'patient experience', and 'user experience'. I sought empirical studies that had a focus on mental health nursing in practice and service user involvement in nursing processes. I did not include papers if they referred to service user involvement in education, or student assessment, service user involvement in research, in systems or any other aspect of involvement without a link to mental health nursing processes.

My search strategy produced 12 research papers which focused on mental health nursing combined with service user involvement in nursing processes (papers from UK – 5, Norway – 3, Ireland – 2, Sweden – 1 and Australia – 1), and I have summarised them in Appendix 3. Papers were considered for quality using the Critical Appraisal Skills Programme (CASP, 2018) tool for qualitative research. My main findings of this review were as follows; the volume and breadth of studies exploring mental health nursing in practice and service user involvement in nursing processes are limited both in numbers and in respect of the range of approaches to data collection and analysis. Equally I did not locate studies about how mental health nurses incorporate service user involvement into their professional identities. Published research regarding how mental health nurses talk about service user involvement in the context of their nursing work is currently under-reported.

2.3 Background

In this section of the literature review I set out the contextual background regarding mental health nursing, in order to accomplish two aims: to highlight conflicting debates about what mental health nursing claims to be, and to explore the tensions that exist between bio-medical models versus humanistic perspectives. A brief historical context

of mental health nursing will be provided, along with information regarding the development of the profession.

The history of mental health care in the United Kingdom (UK) is well documented with reports of how people with mental illness were initially cared for by monks in the Middle Ages, then in bridewells, (which were prisons) in the 16th and 17th centuries; and later in Victorian asylums in the 18th and 19th centuries (Leiba, 2001). The early psychiatric system in the UK confined mentally ill people to institutions, and segregated them from communities. The main staff group who cared for patients in mental hospitals were initially termed lunatic attendants, and would later be called nurses. Care during the 18th and 19th centuries was referred to in places as moral treatment, based on humane psychosocial approaches, as nurses provided comfort, kindness and support regarding hygiene and nutrition (Porter, 1992; Sheehan, 1998), but this was not the case everywhere. Later in the mid-20th century, mental illness became viewed as treatable with new drugs, with less need for custodial containment (Busfield, 1986). It is reported that large asylums were under the control of hospital superintendents, and these psychiatrists delegated work to nurses, who in turn were described as doctors' handmaidens (Nolan, 1993). Mental health care and treatment has a history of being strongly influenced by the medical model, with nursing staff frequently working to orders from medical staff.

There is much debate about the variety of mental health nursing roles, and one of the aims of this chapter is to explore those roles and the focus of work for the profession. One could assume that mental health nurses' roles have greatly changed; however, in her thesis Hercelinskyj (2010) compared both the historical 19th century role and contemporary roles that mental health nurses occupy in many Western countries today. Hercelinskyj observed similarities and commented that in some respects she saw the role as unchanged, focusing on housekeeping and custodial care; but highlights any similarities are likely superficial as the role is now broader, occurring in a wider range of settings. Suggestions of a focus on housekeeping and custodial care rather downplay

mental health nursing roles and work, with little notion that time might be spent with people in mental distress using skilled and purposeful interactions.

Historically it was suggested that mental health nurses have been informed by two specific and competing traditions; one focusing on a scientific approach which prioritises evidence based interventions, the other centring on the therapeutic relationship (with a values-driven humanistic approach) (Nolan, 1993), and these approaches will be explored in the next two sections.

2.4 The biomedical approach to mental distress

The origins of bio-medical approaches to mental distress, and their links with mental health nursing appear to date back to the late 19th and early 20th century, when psychiatrists were actively trying out new treatments on hospital patients (Braslow, 1997). Although it is now debated whether staff were attempting to cure what they viewed as illness, or actively trying to suppress socially unacceptable behaviour (Read, Mosher & Bentall, 2004). In 1949, the sixth edition of the International Statistical Classification of Diseases, Injuries and Causes of Death (World Health Organisation, 1949) was published, and included a section on mental disorder, medical and nursing treatments (Dickinson, Cook, Playle & Hallett, 2012). The focus of mental health care at that time was on the biological and physiological aspects of illness, with psychiatrists interested in the science of diagnosis and treatment. During the 1930s-1950s treatment included physical interventions such as electroconvulsive therapy, insulin therapy and psychosurgery. As psychiatrists held the greatest hierarchical power in asylums, nursing duties were often dictated by medics, resulting in nurses' involvement with bio-medical approaches to care. Whilst not all methods at this time were biomedical, this was certainly the dominant approach.

It appears that the medical model has a focus on clarity and precision, informed by the best available evidence; with doctors co-ordinating or delivering health interventions using a 'does it work?' approach (Shah & Mountain, 2007). Supporters of the biomedical approach consider mental disorders as 'nothing more than brain diseases' (Kielsler, 1999). Eisenberg (1986) suggested that one peril of the biomedical model is that if the focus centres on the brain, then the experiences of the person may be overlooked. Although psychiatrists claim to understand and practice a holistic bio-psychosocial approach (Shah and Mountain, 2007), there appears an over-reliance on the biological element.

Forchuk (2001) observed that both the humanistic and biomedical camps have used evidence based arguments to reinforce their position, with differing views on what constitutes evidence. In 1996, Gournay's article, Schizophrenia: a review of the contemporary literature, prompted heated debate after he presented what was viewed as a purely biological perspective. It seems that Gournay berated nurses for utilising interpersonal nursing theory (Forchuk, 2001). Gournay was accused of proclaiming that biological approaches provided an undisputable model for mental disorder, but Gournay's presented evidence was seen as unconvincing (Dawson, 1997). Caution was urged by Dawson that in the light of questionable evidence, and on-going debates in opposing camps, that it may be premature to advocate blanket concurrence with an entirely biological model. There are many more biomedical treatment trials studies published than there are studies about non-medical approaches, and to a degree randomized, controlled trials (RCTs) have been considered to have reshaped medical knowledge and practice (Bothwell, Greene, Podolsky & Jones, 2016; Priebe & Slade, 2002), with non-medical research under-reported.

The most frequent biomedical treatment activity nurses are engaged in is the administration of prescription drugs to patients. This topic has been discussed in mental health nursing literature, one example being Mutsatsa and Rinomhota's (2002) debate with Clarke. It was suggested by Clarke (2000, p.468) that the 'human experience of taking medication' should be central to nursing discourse. Conversely, Mutsatsa and

Rinomhota (2002) argued why this should be the sole concern of nurses, as they suggested nurses were not the only personnel dealing with the human experience of patients. Mutsatsa and Rinomhota (2002) stressed that nurses were 'no more gifted to deal with the human experience than other health professionals' (p.223). This notion will be explored later, as mental health nurses have at times regarded themselves as different, with unique qualities in terms of developing therapeutic relationships with service users (Humble & Cross, 2010). Clarke emphasised that his intention was to highlight that 'drugs need not be the cornerstone of psychiatric care, but of psychiatric *nursing* care' (Clarke, 2002, p.227), and he also stressed there to be many other roles for mental health nurses.

Dissension in the literature is apparent as to what comprises mental health nursing work. There is disagreement as to which roles different mental health professionals might take for themselves, who possesses which skill sets, and where role blurring may occur; which will be explored later in this chapter. Different professionals will jostle for their own space in a system of work and will often defend or try to advance that space (Abbott, 1988). Jurisdiction refers to the control or claims professionals have, usually on the basis of their relevant knowledge base (Coffey & Hannigan, 2013). In the next section I set out to examine the interpersonal relations approach to mental distress suggesting how this differs from a medical slant.

2.5 The interpersonal relations approach to mental distress

A significant influence on mental health nursing has been described as the humanistic approach (Kogstad, Ekeland & Hummelvoll, 2011), which focuses on relationships and meeting human needs. Nolan (1993) suggests there is something unique about mental health nursing, and that this distinctiveness relates to the human factor. Distinctiveness stems from a focus on the interpersonal context of nursing (Barker, 1997; Peplau, 1952); and although not exclusive to mental health, it is the significance given to this activity and the nature of relationships formed, that mental health nurse researchers

suggest appears to be different to other types of nursing (Cutcliffe & Goward, 2000). Hildegard Peplau (1952) viewed nursing as both a healing art and an interpersonal process because it involves interaction between two or more individuals with a common aim. The aim or desired goal of nursing being engaging with the patient. Peplau's *Interpersonal relations theory in nursing* in 1952, suggested that her theory had the potential to define the significance of the mental health nurse's role as a therapeutic agent (Barker, 1998). Peplau (1994) stated nurses had queried whether medication was the only treatment, and saw nursing with its roots in nurture, with an appreciably different ethos from psychiatry and its focus on diagnosing illness.

Peplau proposed that whilst a role existed for untrained staff to support service users by providing companionship and containment; people expected mental health nurses to be therapeutically responsive, and aware of their own behaviour and skills, rather than busy with routine tasks (Peplau, 1994). The therapeutic relationship between the nurse and patient is an interpersonal, transactional process that aims to affect positive change (Cameron, Kapur & Campbell, 2005). Peplau (1952) encouraged nurses to look beyond the parameters of the patient label and to start to consider what it might mean to be the person (Barker, 1998). The focus of this model of nursing centres on the importance of therapeutic engagement with patients, involvement and social inclusion, which Winship, Bray, Repper and Henshelwood (2009) suggest remain intrinsic to the aspirations of modern mental health nursing.

Peplau's work marked an important juncture in the history of the profession, as it provided an alternative for nurses to the provision of medical treatments, and may have similarities to moral treatments active many decades previously, with humanistic approaches representing a return to previous ways of knowing and caring for people in mental distress. Peplau's work owes much to the approach of Rogers, who emphasised core conditions that must be communicated to patients in terms of empathy, congruence and unconditional positive regard.

Carl Rogers was an American psychologist who developed the person-centred approach to counselling and the student-centred approach to education, which was his unique way of understanding personality and human relationships, and has been widely applied to disciplines including nursing. Rogers' (1951) person-centred model promotes interpersonal relationships with patients that facilitate growth and development. Rogers suggested the worker must possess the following attributes: realness (authenticity, congruence, or compassion), prizing (trust or acceptance), and empathetic understanding (Bryan, Lindo, Anderson-Johnson & Weaver, 2015). Rogers (1957) defined empathy as a sensing of the patient's private world as if it were the therapist's/worker's own world, with the aim of identifying feelings and gaining understanding of the person's experience. This view of empathy was applied carte blanche to the nurse-patient relationship (Morse et al., 1992). Nurse educators have since focused much attention on the development on the cognitive and interpersonal processes related to empathy (Alligood & May, 2000), although nursing may have further developed theories of empathy, the roots eminate from Rogers' work.

It was important to Rogers what the patient made of their current position, in terms of them interpreting and making sense of their own situation. This very much places value on the patient's own expertise and experience, much as the philosophy of service user involvement values people as experts by experience. This may be rather at odds with how mental health nurses are taught about engaging with people. According to Burnard (1999. p.246), in nurse education the tendency has been for nurses to be taught how to look after patients, and to be given certain 'facts', which it is assumed will serve them well in looking after people. However, Burnard (1999) suggests that if supposed 'facts' are questioned so might the teaching of nursing be examined, and a more critical or problem-posing way be sought. Like Rogers, having nursing students encourage service users to find their own theories about the situation they find themselves in may encourage nurses to develop a more person-centred approach to mental healthcare.

Interpersonal relations theories of nursing are not without their critics, and Sullivan (1998, p.42) purported 'there is no well-developed concept of nurse–patient interactions

based on sound theory'. Furthermore it has been suggested that as interactions occur they are neither purposely therapeutic, nor theoretically informed (Whittington & McLaughlin, 2000). Critics of the humanistic approach imply its foundation is weak. However, Burnard (2003) in his paper 'Ordinary chat and therapeutic conversation' emphasised the importance of everyday talk, and that communicating through conversation is probably one of the core skills of mental health nursing.

Whilst Cameron et al. (2005) agree that mental health nursing is an interpersonal transaction, undertaken in order to better understand and empathise with service users, the authors emphasise routine problems. In practice settings a disproportionate amount of time is spent on administrative tasks, resulting in minimal time spent with patients (Cameron et al., 2005). Reports from acute inpatient units have highlighted dissatisfied patients and low staff morale (Royal College of Nursing, 2014), and it is then difficult to consider such spaces as therapeutic environments. It is apparent that from service user reports, that the delivery of mental health nursing care is in need of attention (Stenhouse, 2009). For nurses to ignore such views may result in increased criticism of both nurses and services, with potentially mental health service users left dissatisfied, and aspects of their health at risk.

2.6 Fields of contention in mental health nursing

Competing tensions of humanistic principles versus views from the biomedical camp have been apparent in the profession for decades, and were highlighted in Section 1.3, Chapter 1. Conflict often involves supporters of one approach being scathing of the other through a barrage of claims and counterclaims (Barker, 2003; Dawson, 1997), along with retorts and challenges to each other's evidence base (Huxley, Parikh & Baldessarini, 2000). Supporters of human relations theorists, such as Clarke (1999), suggest the ascendancy of biologicalism and behaviourism has shifted the emphasis away from the inter-relational dynamics of nursing to conflicting models which remain a source of tension. Neela, Scott, Treacy and Hyde (2007) explain these differences with one approach being a control-based, medically oriented model (psychiatric nursing) and

the other more akin to a psychosocially oriented perspective (mental health nursing). Over the years there has certainly been much debate about preferable names and descriptors for this field of nursing (Cutcliffe, Stevenson & Lakeman, 2013), and both the terms psychiatric and mental health nursing remain in current use. Although the term 'mental health nursing' is used more throughout Europe and other Anglophone countries; and the term 'psychiatric' used more in the United States of America.

Burnard (2002) proposes that the opposing tensions of these models do not have to exist at loggerheads, but can complement one another, at least by extending debate. Burnard also queries to what extent the division exists, and suspects that the schism is:

> "held up by those more sympathetic to one set of ideas than the other, as a sort of claim to the 'correct' position in the mental health debate. Fortunately, I suspect that reality is rarely so easily carved into two clear chunks in this way. I doubt, too, that many day-to-day practitioners align themselves only with one of these two ends of an apparent spectrum"
>
> (Burnard, 2002, p. 231)

However, Coffey and Hannigan (2013) suggest claims that mental health nurses are delivering biopsychosocial approaches themselves may not stand up to scrutiny because for the most part the profession is biomedically educated and socialised. This means that despite claims to the contrary, mental health nurses will struggle to deliver socially oriented approaches, for example like the Approved Mental Health Professional role. The long-standing debate between biological and psychotherapeutic approaches extends to most mental health related disciplines (Read, Mosher & Bentall, 2004). However, for mental health nurses it raises the additional question of professional identity, and whether 'nursing should follow medicine or position itself in an alternative position' (Forchuk, 2001, p.39). Exploring how mental health nurses position themselves in terms of professional identity in this regard will be a focus of this study.

Supporters of the bio-medical approach purport a need to gather quality evidence to establish which interventions work (Roth & Fonagy, 2005). Biomedics suggest that this gathering of quality evidence surrounding effective psychosocial treatments may be

particularly challenging (Shah & Mountain, 2007). Mental health nurses are accused of stumbling in particular aspects of the relationship process, with nurse leaders suggesting the profession has not articulated what mental health nurses do that helps service users lead more meaningful lives (Delaney & Ferguson, 2014). Mental health nurses need to be able to articulate and evidence their contribution and effectiveness (Simpson, 2013). If mental health nurses are unwilling or unable to engage in such activities, they may find their value and standing becomes limited, and their position may be at risk.

2.7 Mental health nursing reviews and policy context

Reviews of professional disciplines are undertaken periodically to advise governments, to promote the profession, to review efficiency, and to engage and support members of that profession. Nursing reviews can offer professions, such as mental health nursing, an opportunity to articulate their work as a type of claim to particular roles and activities. Mental health nurses have experienced threats to their role and position, for example with on-going drives in the UK for nursing to have generic rather than specialist educational preparation (DoH, 2006; Health Education England, 2015). This has led to the profession advancing claims over their work as they see it, with nursing reviews serving as a form of public announcement. The most recent, *Playing our part* (Butterworth & Shaw, 2017), serves as a reminder to nurses to be more politically active and to play a greater part in developing services, rather than allowing others to steer the direction of the profession. I will briefly discuss previous mental health nursing reviews in this section and their outcomes.

The 1994 review, *Working in Partnership* (DoH, 1994), led by Tony Butterworth set out to identify the future role and requirements for mental health nurses. The report, made 42 recommendations, but was criticised on a number of levels, and mirrored difficulties in establishing the unique contribution of mental health nursing that have existed for many years. The absence of prioritised recommendations, cost benefits and a time frame meant an opportunity was felt denied to nurses to consider how to assess and

evaluate their performance (Smith, 1994). An example perhaps of when a professional group seeks expert guidance, but can be dissatisfied with the outcome.

A decade later, the profession again sought direction in a further review to explore their role (Callaghan & Owen, 2005). A review of mental health nursing in England was requested in 2005, with strategies developed in Northern Ireland, Scotland and Wales around the same time. The English review, *'From Values to Action'* (DoH, 2006) aimed to address the question 'how can mental health nursing best contribute to the care of service users in the future?', with an evaluation commissioned regarding implementation of the report's seventeen recommendations. The review stated nurses needed to widen their skills to improve service users' physical well-being through better assessment and health promotion, and needed to provide more evidence based psychological therapies. New ways of working, new nursing roles, new services, guidance, new laws, and a changing focus were all highlighted (DoH, 2006). *From Values to Action* (DoH, 2006) offered a vision for mental health nursing for the following ten years, so it is unclear why mental health nurse leaders did not appear to realize its potential (Callaghan, Repper, Clifton, Stacey & Carter, 2012). In an evaluation of '*From Values to Action'*, Baker, Playle, Nelson and Lovell (2010) noted dissonance between priorities and implementation in mental health trusts and higher education settings, which reflected the enormity of the task. During this period the Nursing and Midwifery Council (NMC) conducted a national consultation of the future framework of pre-registration nursing, with strong perceptions in the mental health nursing community that the NMC would move to a more generalist approach. Similar changes had occurred in Australia, New Zealand and the USA with no positive outcomes reported from the move (Happell & Cutcliffe, 2011). The NMC consultation may have served as a threat or distraction, and appears to be a factor that took focus away from the mental health nursing review (Baker et al., 2010), with a lost opportunity for the mental health nursing community to articulate their roles.

Increased devolution has led to the loosening of the relevance of central diktat, and led to mental health nurse leaders in Scotland, Northern Ireland and Wales delivering their

own reviews of mental health nursing. In 2006, *Rights, relationships and recovery*, a Scottish review of mental health nursing was developed (Scottish Government, 2006). The focus was on what people need mental health nurses for, and centred on user involvement (McNeil, 2006); with a need to challenge traditional power bases (Lauder, 2006). In Wales, *Realising the Potential: Aspiration, Action, Achievement a framework for Realising the Potential of Mental Health Nursing in Wales* (National Assembly for Wales, 2001), promoted a blueprint for the development of mental health nursing for the following decade. This document summarised aspirations that nursing leaders had identified. Both the Scottish and Welsh reports state that national senior nurse groups would develop year on year action plans to direct actions. The current all age mental health strategy for Wales, *Together for Mental health* (Welsh Government, 2012) proposes that:

> "the nursing workforce is ready and able to maximise its role throughout the entire health and social care system. It will also ensure we raise the profile of the mental health nurse and that we have a valued and thriving nursing profession"
> (Welsh Government, 2012, p.61)

In Northern Ireland, *Delivering excellence, supporting recovery: a Professional Framework for Mental Health Nursing in Northern Ireland* (Department of Health, Social Services and Public Safety, 2010) stated its framework would be supported by implementation strategies from the Chief Nursing Officer. Northern Ireland's current strategy has clear recommended actions, lead roles and time frames, suggesting work will be evaluated at a future point.

Reviews of the profession can be timely, sometimes triggered by threat or challenge. For example, the *Shape of Caring* review (Health Education England, 2015) recommended changes to nurse education with a more technical focus, and a move towards a generalist status. Concerns were raised as there had been little engagement with stakeholders (Coffey, Pryjmachuk & Duxbury, 2015), and potential changes could impact negatively on patient care. Concerns prompted the Butterworth and Shaw (2017) review of the profession, which makes clear statements about the value of mental health nursing. However, developments often occur simultaneously, and during the writing of this thesis the new NMC draft standards of proficiency for registered nurses and draft requirements for pre-registration nursing education programmes (NMC, 2017a; NMC,

2017b) have been out for consultation with much change forecast for the preparation of mental health nurses, which has implications for their future roles and professional identities.

Whilst it seems appropriate that mental health policy makes clear statements about individual professional groups, if there is an absence of strategy to achieve this, statements may be built on empty assurances, with little direction for nurses on the ground. Equally, workers may simply ignore policy, which has been seen in the patchy implementation of the Care Programme Approach in England for over twenty years (Goodwin & Lawton-Smith, 2010). It appears the mantra from Cutcliffe (2003, p. 344) that 'politics and policy are central in influencing what nurses do in their everyday practice', may not hold fast. Policy and practice can be seen as disconnected, leading to nurses feeling insecure about their roles (Hughes, 2006). If nurses do not perceive a link between policy and practice, this may indeed result in confusion about nursing roles and professional identities.

2.8 Mental health nursing roles and professional identities

This literature review chapter has so far considered the historical context of mental health nursing, how competing tensions between the medical model and values-based humanistic approaches exist within the profession, as well as recent professional reviews. This next section will explore concepts relating to professional identity and role, and related areas such as jurisdiction and division of labour in relation to the profession.

Role theory, which explores roles, actions, choices and parts people play, is conceptualised in the sociological and organisational psychology literature (Biddle, 1986; Mead, 1934; Parsons, 1951). From a sociological viewpoint role theory considers everyday activity as the acting out or performing that occurs by socially defined groups. There are similarities between the concepts of role and identity. Whilst identity is more

about who a person is understood to be, for example their gender and nationality; people may also define themselves through the roles that they play in society both at home and work. In my study I sought to explore how mental health nurses construct their roles and professional identities, as well as how nursing roles are constructed by others, such as service users, by examining talk from both parties.

All social roles have a set of expectations, duties and behaviours for a person to fulfil. The idea is that people's behaviour is to some degree predictable, and context specific (Biddle, 1986). As a way of explaining the functions or social positions that people hold, role theory highlights how people have expectations for their own role behaviour and those of others. Certain roles are socially differentiated, such as occupations, and would include a set of behaviours typical for those group members. Biddle (1986) suggested expectations for behaviour are understood by all and adhered to by those performing particular roles. Social roles with their appropriate or permitted behaviour would align with expectations of those roles. For example someone in the role of a nurse would expect (and be expected by others) to carry out certain tasks and functions in keeping with that role. People who occupy roles are usually referred to as actors, and are viewed as having agency. This means that people, as social actors, have the capacity to shape the social world they occupy by their choices and behaviours.

The function of a role is the part it plays in the maintenance or destruction of a system as a whole (Goffman 1961, p.78). In this study I explored what was said about the roles of mental health nurses and their function within the mental healthcare system in one part of the UK. How individuals in such roles view themselves as professional workers will be closely linked to the tasks and functions they are likely to undertake. The reported mismatch between contemporary role expectations placed on mental health nurses and their own personal and professional role expectations can negatively impact upon their workplace experiences (Hercelinskyj, 2010). These differences may lead to stress, and further explain why mental health nurses have reported a lack of clear direction regarding their roles and responsibilities (Brown, Crawford & Darongkamas, 2000; Mann & Cowburn, 2005).

If mental health nurses report a lack of role clarity and direction, this has implications regarding professional identity, and nurses' understandings of themselves as members of the multidisciplinary team. In the workplace Strauss (1978) identified that to a large extent social actors negotiate their roles and work. This means that many aspects of roles and work are not fixed, and can be subject to a range of factors, such as changing boundaries, power balances, stakes held and actors' options (as they may engage in alternative behaviours). This negotiation context in the work setting may be visible between actors in their work roles as individuals seek to establish themselves as members of a team (Mesler, 1989). To a large degree the dividing up of work is accomplished interactively (Hannigan, 2006). This can occur as an on-going process as nurses in both hospital and community settings engage with other members of the multi-disciplinary team. Further negotiation occurs when nurses engage with other nurses, with external agencies, and with service users too.

The division of labour in the workplace refers to the assignment of different parts of a process or tasks to different people, which is part of a negotiated process in which workers may assert their wishes about work they take on. Hughes (1984) suggested this included both the technical division of labour (what a person does) and the moral division of labour (who they are). Hughes (1984) was interested in the periphery and boundaries of occupations and stated that the work of an individual cannot be described without referring to others with whom a person works. Merton (1949) supports this, stating that the division of labour occurs through interaction in various social positions called roles. This is further described by Freidson, who states:

"The division of labour [is] (…) a process of social interaction in the course of which the participants are continuously engaged in attempting to define, establish, maintain and renew the tasks they perform and the relationships with others which their tasks presuppose" (Freidson, 1976, p.311).

Allen (2001) suggested that the division of labour is a social system in which work activities that need to be undertaken, will likely be affected by social, technological,

economic and organisational change. This results in occupational roles changing, with jurisdictions shifting and work activities being modified, resulting in occupations striving to secure their standing (Allen, 2001). Professional groups may feel vulnerable, and experience confusion about their roles. For example, Deacon, Warne and McAndrew (2006, p.752) highlight that mental health nurses in acute settings experience difficulties between the relationship of providing therapeutic activities and the normal activity of everyday life. One exemplar might be a nurse 'engaging in a cognitive behavioural therapy session and next moment serving dinner to the same service user'. Deacon et al. (2006, p.752) note that other members of the multi-professional team do not have to weave such activities together, meaning that nurses work in a very different way to other team members, often leading to 'a lack of understanding over what in mental health nursing practice is seen as meaningful work'. There is a suggestion here that if mental health nurses' work incorporates such a variety of tasks, that role confusion is perhaps inevitable.

It is suggested that mental health nursing work incorporates the roles of caretaker, custodian and gatekeeper (Clarke, 1999), as well as being an intermediary, coordinator, advocate, educator and administrator (Goulter, Kavanagh & Gardner, 2015). Acknowledging the role-related activities of such a varied occupation, it is unsurprising that mental health nursing is considered 'problematic messy work' (Hurley, Mears & Ramsay, 2008, p.56) with attempts to measure the therapeutic relationships deemed impossible.

When consider professional identities, it is useful to clarify the term. The word identity (from the Latin *idem*, meaning same) denotes that we share common identities with others. These shared identities can be viewed as personal or political projects which we participate in, possibly empowered by resources of experience, ability and social organisation (Calhoun, 1994). Identity is seen as an on-going and dynamic process. There are different versions of identity for particular purposes. For example individuals have personal versions of identity, as well as social or outward versions, the latter being constructed in part by us, and also by those with whom we interact. Identity theories

usually relate to either a culture of a distinct group of people, common identification in a social category; or as parts of a self, composed of meanings people give to multiple roles they play in society (Stryker & Burke, 2000). Others have considered identity as a process (Goffman, 1963; Mead, 1934), and something that is achieved rather than innate (Lawler, 2014). Identity can be seen as flexible allowing the maintenance of other connected systems (Hardy & Conway, 1988), and is therefore not viewed as stable or fixed.

Identity with a recognised social group serves to provide a sense of community and belonging (and links with professional socialisation). In terms of professional identity, whilst in a work role there are set role requirements (for example in a job description), individuals will have their own understandings of roles and how both they and others construct that understanding in their interactions. Whilst there are set requirements for any role, there is also an issue of how these are oriented to and constructed by people when any role is in action. Therefore the experience of developing a particular role and identity involves the individual's own agency, which is the capacity of an individual to make choices and act. These actions may be unconscious or purposeful, and certain structures may limit a person's agency. For example, in relation to mental health nursing an individual's agency may be influenced by a number of social systems (Littlejohn & Foss, 2009), including the medical model and organisational systems (Cusack, Killoury & Nugent (2017). Nurses find their agency may be subject to other workers, organisational constraints and health service policies. All of these systems will influence the agency and work of nursing staff.

Identity refers to roles or identity categories as well as an individual's personal sense of who they are (Lawler, 2014). Role theory itself is a collection of ideas that attempts to predict how actors perform in a given role, and may consider under what circumstances certain behaviours can be expected (Conway, 1988). Equally publicly available categories of identity may not easily fit with how people understand those categories.

It is implied that mental health nurses are still striving for a professional identity and a quest for recognition (Crawford, Brown & Majomi, 2008). Nursing has struggled for many years with a deep need for professional congruency and effectiveness; with those outside the profession sometimes seeing nursing as involving routine and basic work (Thupayagale & Dithole, 2005). It is suggested that the public see nurses as subordinate to medics, with attempts to construct a professional identity often connected with morale boosting drives to gain empowerment, autonomy and job satisfaction (O'Brien-Pallas, Duffield & Hayes, 2006). Crawford et al. (2008) highlight this enigma:

> "The puzzle is how practitioners with training, experience, a career structure and a role in the health service should find themselves struggling for recognition in this way"
>
> (Crawford et al., 2008:p.1061)

The word profession originates from the Latin word *profiteri* meaning a public pronouncement on certain principles and intentions, as well as a devotion to a particular way of life (Seale, 1998). The dimensions of a profession usually include an educational period, elements of self-motivation, professional practice based on a theoretical framework, a code of ethics, commitment to lifelong learning, with relevance to social values (Pavalko, 1971). The professional socialisation of nurses is an umbrella term for a number of component activities concerning the education and integration of nurses into the professional environment (Rejon & Watts, 2014). These activities will likely include learning and development, interaction with others, and adaptations; and will occur in the context of educational programmes, working with role models and on the job experience.

Every profession claims to be the most reliable authority on the nature of the reality it manages (Freidson, 1970). As nursing has operated in a primarily medical context, there is a view that nurses are socialised within a medical model, regardless of whether they have internalised these values or challenged them (Beresford, 2004). The founding concept of modern psychiatry, and its professions which includes nursing, has been mental illness, based on assumptions of inherent deficiency and pathology of the mentally ill (Beresford, 2004). As medicine already has such a monopoly in health care,

any minimal autonomy achieved by other groups is likely to be granted or limited by medicine in the first place (Freidson, 1970). Nurses themselves can be seen as not reaching complete autonomy in their practice as they rely on policies, medical orders and direction from the managerial hierarchy (Ousey, 2007). This direction renders nursing as dependent on other professions, at least to some extent, which may be why Freidson used the term 'paraprofession' as a descriptor for nursing.

However nurses can achieve positions of functional autonomy despite medicine, with Community Mental Health Nurses (CMHNs) being a prime example. More is written about the professionalization of CMHNs than inpatient mental health nurses. Claims and work done to advance the claim that CMHNs are autonomous professionals has been a professional project (Godin, 1996). CMHNs found independence and self-governance in developing practice separate from medics, and set up their own professional organisation in 1976 (the Community Psychiatric Nurses Association). A certified training course was established with the English National Board (although not mandatory), with the intention of professionalising the practice of CMHNs (Brooker, 1990). CMHNs began to take their own referrals, thus meeting a key element of Freidson's requirements for a profession; with increasing numbers of these from General Practitioners (GPs) in the 1980s and early 1990s (Hannigan, 1997). However, criticism followed that CMHNs were no longer supporting individuals with long term mental health needs (the population group CMHNs were initially given the remit to work with) (Gournay, 2000). First in the 1950s, and again in the 1990s the remit of many CMHNs was to focus on people with severe and enduring mental illness. The 1970s and 80s saw an increased focus on people with short term mental health problems in primary care settings (Hannigan, Stafford & Laugharne, 1997). As policies changed, CMHNs were seen as key in delivering on government policy for community care (DoH, 1990a), with their division of labour controlled by organisations and medics, and a return to working with people with serious mental illness (Godin, 1996). The profession of nursing therefore does not operate in a vacuum, but is subject to political will.

The distribution of professional work, or the division of labour, is part of a complex and dynamic social system, which is reactive to a range of internal and external forces (Hannigan & Allen, 2006). Literature on the division of labour also refers to similar work concepts, including mandate (the kinds of things groups say they ought to be doing) and licence (what they actually do) (Hughes, 1964). It is notable that professionals engage in activities to secure and advance their jurisdiction, in order to have control over their work (Abbott, 1988). The above example of CMHNs as a professional project has seen a number of changes to CMHNs' roles. It has been suggested that CMHNs are the artful dodgers of the mental health world, increasing the scope of their work by stealing roles previously belonging to other occupations (Sheppard, 1991). Although this criticism is not new, it suggests there may have been more previous agency and autonomy in generic roles, with perhaps a flexible approach to attitude and role development.

Hannigan and Coffey (2011) examined the implementation of UK mental health policy, and identified that as policy makers have attempted to make improvements in the often neglected field of mental health, the result has been a surge of top-down actions. Actions with limited notion of the consequences have paid insufficient attention to the need to build strong partnerships across the system as a whole (Hannigan & Coffey, 2011, p.225). Challenges faced by policymakers and practitioners are said to be 'wicked', implying a malignancy and aggressiveness (Rittel & Webber, 1973), which have led to those in power presenting command and control solutions (Chapman, 2004). Hannigan and Coffey (2011) highlight that historically professionals were employed to address more easily defined problems, and as both society and the NHS have become more complex, so problems have become more wicked or difficult to solve. I suggest that such complexities have made practice more difficult as professional roles and responsibilities have shifted, resulting in disputes over professional boundaries and changing relationships with service users. I will explore the complexities of staff implementing policy change further in Chapter 7.

Professional identity is said to be based on principles rather than tasks, with more fluid jurisdiction occurring with co-worker consensus (Maxwell, Baillie, Rickard & McLaren, 2013). Fluidity could be interpreted as mental health nurses having more flexibility in their roles in a community mental health team, for example, whether nurses' multidisciplinary colleagues are in agreement with that flexibility. Jurisdiction is recognition of the legitimate right to undertake particular work, and is accepted as an area of study relating to power, judgements, and territorial roles. The ability of a profession to sustain its jurisdictions lies in part in the power and prestige of its knowledge base (Abbott, 1988). The knowledge base in mental health nursing is growing and is demonstrated in literature reviews of the effectiveness of mental health nursing interventions (for example, Curran & Brooker, 2007; Zauszniewski, Bekhet, & Haberlein, 2012). Freidson (1970) argued that possession of expert knowledge is the first pillar of professionalism. Knowledge and evidence of mental health nursing research however is still in its infancy in comparison to other professions.

According to Abbott (1988), the academic knowledge system of a profession accomplishes three tasks: legitimization, research and instruction.. It is suggested that these three facets shape the vulnerability of professional jurisdiction to outsiders, as roles or tasks may be vulnerable to claims by other occupational groups (Abbott, 1988). So there may be more strength or power in a profession that is able to sustain its jurisdictions. However, over time roles within mental health nursing have been described as having expanding boundaries, which have become blurred regarding what actual nursing roles should be (Hannigan & Allen, 2011). The historical context of mental health nursing presented here provides some indicators as to why mental health nurses may not necessarily subscribe to one particular role or nursing ethos. It is noted that endless nursing models and frameworks have been proposed, entertained and abandoned, which Clarke (1999) describes as a demonstration of the profession's naivety. Hence perhaps the rush by some professional workers to embrace physical sciences. Clarke (1999, p.9) wondered if this might provide 'a delusion of respectability' for the profession. Certainly struggles with clarity about mental health nursing roles and work have been sought for some time now.

Despite intended guidance from a number of mental health nursing reviews (DoH, 1994, 2006), confusion about the role of mental health nurses has remained. Whilst mental health nurses may have prided themselves on a flexible, resourceful approach, roles may not be granted significance where the focus of day to day tasks is largely considered invisible (Warren, 1989). Allowing role blurring, with a service user focused flexibility might be at odds with developing a clear cut professional identity (Crawford et al., 2008). The term 'Jack of all trades' has been cited in relation to mental health nurses, with implications that nurses view themselves as multi-skilled in a positive sense (Crawford, et al., 2008). This stance implies that nurses' professional identity has adapted to fit with consumer needs and organisational demands. Conversely, Hercelinsky (2010) observes this vision has the potential to place ambiguous and competing demands on mental health nurses. In acute mental health inpatient settings, Cleary (2004) also observed negative associations with the term 'Jack of all trades'. The example from Cleary's participants was that nurses undertook tasks they did not consider to be part of the nursing role, such as buying patients' cigarettes and washing up medicine cups, but they said they continued so as not to compromise patient care. Tasks such as these may have been viewed as work that helps foster relationships, builds rapport and keeps people connected to social support structures.

Apart from tasks that nurses have disputed being part of their role, there has been much development in the mental health nursing field. Many new roles such as nurse prescriber or Approved Mental Health Professional, present challenges in redefining nursing's identity and practice (Coffey & Hannigan, 2013). Nurses can be seen as having scope to negotiate role boundaries with medics, so as to advance their position. Witz (1991) sees nurses resisting medical dominance and trying to extend nursing territory, but also regulating the nursing profession, and defending its jurisdiction. New role jurisdictions require negotiation and may involve changes to the work practices of others (Strauss, Schatzman, Ehrlich, Bucher & Sabshin, 1963). Maxwell et al., (2013) suggests that social identity is a significant determinant in increasing understanding of how workplace jurisdiction is achieved. The current emphasis of imposing legal and public jurisdictions for new nursing roles through national standards and statutory

registration needs to work in partnership with an understanding of how workplace jurisdiction is achieved. If these partnerships are to be achieved this will need to include a signing up by all parties involved.

There has been criticism that mental health nurses find their role difficult to explain (Browne, Cashin & Graham, 2012). It is suggested that more than 150 years after the founding of the asylums, mental health nurses are still engaged in the quest for a unique role (Nolan, 1993). Yet mental health nursing is described as a broad church (Cutcliffe & Barker, 2002) encompassing many roles and identities.

2.9 What mental health nurses do

The actual conduct of a particular individual whilst on duty was termed role performance by Goffman (1961), and relates to how successfully a role is executed. The role performance of mental health nurses may be judged differently by relevant social actors. For example a service user may judge success quite differently from a nurse in terms of role expectations. Research into properties associated with mental health nurses' role performance reported that nurses' dissatisfaction related to overly bureaucratic systems with too much paperwork, resulting in a neglect of the nurse-patient relationship (Nolan, Haque, Bourke & Dyke, 2004). Similarly a study by Wilson and Crowe (2008) explored what Community Mental Health Nurses (CMHNs) found satisfying about their role by studying 12 individuals over a 12 month period and identified that therapeutic relationships were the primary source of satisfaction for CMHNs. Further studies about satisfaction and mental health nursing roles identified that CMHNs reported higher levels of satisfaction than inpatient nurses (Ward & Cowman, 2007), often due to CMHNs citing increased levels of autonomy (Kipling & Hickey, 1998). It is likely this perceived level of independence impacts upon CMHNs and how they perform their roles.

The term role performance in relation to mental health nurses is seldom explored, and this may be due to the wide range of roles that mental health nurses perform. Fung, Chan and Chien's (2014) review of mental health nurses' role performance focused on advanced practitioners and clinical nurse specialists, and stressed that as a profession there is a need to demonstrate competence at providing cost effective interventions. The authors, Fung, Chan and Chien (2014), identified only 14 studies for review from their systematic search, and chose to focus purely on quantitative studies, but later cited this as a limitation. Whilst they noted some significant results from advanced practice nurses working with service users with depression and psychological stress, the low number of studies raises questions. It is difficult to make comparisons with this study and the UK's population equivalent, as there are very few individuals in advanced mental health practice roles. In terms of meaningful data, Fung, Chan and Chien (2014) initially proposed that further well-designed, randomized controlled trials are needed to evaluate the role performances of mental health advanced practitioners, but add that more qualitative data would also be beneficial.

The paucity of peer-reviewed literature about the effectiveness of mental health nursing work reinforces the earlier debate regarding the profession's search for evidence, and the competing factions of both the medical and humanistic approaches. The National Nursing Research Unit's report on high quality care metrics (Maben, Morrow, Ball, Robert & Griffiths, 2012) highlighted that practice initiatives need to show quantifiable evidence to demonstrate impact, but notes that evidence is often insufficient. The report indicates that some nursing specialities require a more individual approach, and there are now moves to gather mental health nursing sensitive metrics, with early developments focussing on inpatient roles (Maben et al., 2012). This highlights the challenges the profession has encountered in gathering meaningful data about the effectiveness of mental health nursing interventions, and may go some way in explaining why the profession has experienced difficulty articulating its role.

In relation to inpatient settings, studies about mental health nurses and their therapeutic engagement with service users have presented some unsatisfactory findings.

McAndrew, Chambers, Nolan, Thomas and Watts (2014) noted that a disproportionate amount of mental health nurses' time is taken up by other activities, with little time spent listening and talking with service users. Equally that in the limited time available for patient contact (42.7% of the workday day, according to Whittington & McLaughlin, 2000), just 6.25% was spent in in therapeutic encounters with service users. It is reported that the limited interactions that occur between mental health nurses and service users on acute admission units are seldom therapeutic or theoretically informed (Cameron et al., 2005; Gamble, 2006). The disparity between nurses working in acute areas experiencing chaos and pressure, whilst service users endured boredom is concerning, with notable dissatisfaction for both groups (Shattell, Andes & Thomas, 2008). As the therapeutic relationship between nurse and service user is often heralded as key to all other nursing interventions, findings that show limited time on this activity is worrying. McAndrew et al. (2014) note that after five decades, evidence relating to the therapeutic relationship is not recognized as a fundamental metric of mental health nursing. Interventions that include respect, affirmation, empathy and holding emotional distress can be difficult to measure, but time spent with service users is certainly quantifiable. There is good evidence that relationships are valued (Simpson et al., 2016a), have possible protective outcomes (Cole-King & Platt, 2017) and can be shown to have some therapeutic effect (Hewitt & Coffey, 2005). These results are not specific to nursing and the issue appears to be that mental health nurses make claims about their effectiveness, but do not show specific evidence for their contribution.

Sharac et al. (2010) reviewed studies that have measured nursing and patient interaction on inpatient units, and identified 13 relevant studies published between 1972-2007; which included study sites in the UK, Canada, Australia, Europe and the USA. 12 of the 13 studies included observational methods; and findings indicated that at best 50% of staff time was spent with service users, and little of this related to therapeutic activities. The authors suggest this indicates a steady trend of limited patient activity or social engagement, with users spending the majority of their time alone, or certainly away from staff (Sharac et al., 2010). Similarly, these findings are supported by Stenhouse (2010, 2011), who interviewed service users in inpatient settings, and her aptly titled paper '*They all said you could come and speak to us'* detailed service users'

expectations, which she reported were not met as participants perceived nurses were too busy with non-nursing tasks. A study by Nolan et al. (2016) noted that with protected time initiatives in place, without the implementation of clear guidelines, little positive impact on users was reported and there was limited positive effect.

Delaney and Johnson's (2014) metasynthesis of 16 qualitative studies regarding mental health nurses' perceptions of their inpatient roles reported three main aspects of nursing work: engagement with users, conditions to enable work, and role difficulties (for example regarding multiple responsibilities and limited support). One limitation noted is that only one of the sixteen studies reviewed included views of users and nurses, the others included only nurses' perceptions of their roles. Delaney and Johnson (2014) identified that whilst the therapeutic relationship with users was viewed as a foundational role, this was actually difficult to achieve:

> "the nurses' humanistic approach was often held in balance with the demands of medical-model treatment"
>
> (Delaney & Johnson, 2014, p.128)

Certain aspects of mental health nursing roles identified as important, including empowering and educating service users, are perhaps challenging aspects to measure. Delaney and Johnson (2014, p.132) use the term 'strenuous reality' in terms of the many roles nurses described undertaking due to the chaotic and ever-changing nature of inpatient units. Flexibility within the nursing role was perceived by participants from many of the studies, and cited in relation to weaving together activities that require different skill sets (Delaney & Johnson, 2014). Weaving together indicates the complexities of mental health nursing work that may be rather nuanced, and not easily described or accomplished.

Nurses have reported struggling to manage dichotomies within their roles, for example in terms of engagements with service users, as well as managing environments (Cutcliffe & Barker, 2002). Cleary (2003) highlighted this as a tension between the role of therapy versus the role of control. Nurses have acknowledged these contrasts in their

role when their work moves away from caring and therapy towards coercion and control, thus undermining the trusting relationship with patients (Godin, 2000). For nurses themselves, these opposing philosophies of custody and caring, may lead to struggles with issues of role development, professional identity, and isolation (Peterneli-Taylor and Johnson, 1995). Clarke (1996) proposed nurses may categorise themselves as either carers or controllers. In his participant observation study on a medium secure unit, at the outset Clarke (1996) was intrigued that the secure unit under study was delivering care based on therapeutic community principles. Clarke suggested that a group of nurses were unlikely to implement both custodial care and dynamic therapy. He highlighted that authoritarian-type nurses are likely to drift towards working in settings that are considered more custodial, as nurses tended to identify with either caring or controlling, as well as recognising overlap.

Clarke (1996) reported that nurses classed as carers were more willing to articulate their approaches with service users, whilst controllers were not. There was some indication that controllers described being jealous of carers' ability to relate warmly with service users, whilst carers reported some envy of controllers' ability to contain safety in ward situations. Clarke (1996) suggested his study was representative of a microcosm for the problems in mental health nursing. In Clarke's (1996) study nurses debated the nature of mental health nursing roles, with one group wedded to safety and security; and the others more aligned to a therapeutic role with individuals. It was noted that whilst management did appear to favour the latter, they always acted in support of safety and security measures.

Mental health nursing is reported to be stressful due to patient acuity, unpredictable and challenging workspaces, violence, increased paperwork and a lack of managerial support (Ward, 2011). For nurses working in inpatient settings, a lack of adequate staffing has been reported as their highest stressor (Jenkins & Elliott, 2004; Totman, Lewando Hundt, Wearn, Paul & Johnson, 2011). Studies that examined mental health nurses' stress across both hospital and community settings highlighted employment insecurity, casualization of the work-force; issues with management and the system,

inadequate resources (Taylor & Barling, 2004), and organisational issues (McTiernan & McDonald, 2015) as being pertinent. These findings indicate that mental health nurses, regardless of work setting, have reported work stress that in the main relates to their experiences of working in a challenging mental health system.

In relation to the relational aspects of nurses' work, Mann and Cowburn (2005) explored the experience of emotional labour in the profession. This refers to the effort involved for staff in regulating their emotions to meet organization expectations in line with their roles (Hochschild, 1983). For example, in the course of their work mental health nurses encounter service users experiencing a wide range of emotions and may be required to interact accordingly. High levels of emotional labour are positively correlated with daily stress levels (Modekurti-Mahatoa, Kumarb & Rajuc, 2014). However, Mann and Cowburn (2005) point out that whilst mental health nurses are not experiencing extremely high levels of emotional labour when compared with non-nurses, their levels of medium emotional labour are a cause for concern. It is the chronic performance of emotional labour that is thought to have negative effects on health, as the more emotional labour experienced overall higher stress levels are evident.

It is acknowledged that mental health is considered by some as the least desirable speciality choice in nursing (Happell, 2002). Mental health nurses have seldom been described as skilled, logical, dynamic or respected (Halter, 2008); with their work sometimes viewed as uninteresting and having a low status (Rushworth & Happell, 2000). It is often said that mental health nurses find it difficult to articulate what they do (Rungapadiachy et al., 2004), as if this were an impediment to professional identity. Happell (2011) stresses that mental health nurses may not wish to reduce their role description to a short snappy statement, given the wealth of roles across a variety of clinical settings, and defences:

> "It would be difficult to identify another branch of nursing that has undergone such radical changes to role and identity that has occurred in mental health"
>
> (Happell, 2011, p.1)

There is perhaps a sense that nurses have just got on with their work, and wanted to make a difference to the lives of people in mental distress, and therefore have not put their energies into promoting mental health nursing as a profession. Browne et al., (2012) suggest that mental health nursing has attempted to develop a theory of the profession under the banner of the therapeutic relationship, but view this philosophy as unmanageable and that an all-encompassing definition may be problematic. There is a however a need for mental health nurses to clearly articulate the contributions they make within that therapeutic relationship (Browne et al., 2012). Leaders in the profession have suggested that for decades mental health nurses have been on a professionalization trajectory (McKeown, 2014). Despite policy change, professional reviews and much change to nursing work, this role articulation seems one challenge that mental health nursing has not managed to address.

Having considered the work that mental health nurses do, the next section explores mental health nursing from the perspective of service users.

2.10 Service users' views of mental health nurses

Service users are well placed to identify desirable qualities and skills for the mental health nursing profession (Aston & Coffey, 2013), and view nursing roles as multi-faceted, requiring both human qualities and specific clinical skills (Bee et al., 2008). Service user-held expectations of mental health nurses include a wish that nurses are able to deliver both practical and social support alongside clinical skills and psychological therapies (DoH, 2006). Interpersonal aspects of care are highly valued by service users (Simpson et al., 2016a; Valente, 2017), as it is time with staff that is most requested.

Gunasekara, Pentland, Rodgers and Patterson (2014) interviewed 10 inpatients on wards at one hospital in Australia, as well as 2 recovery support workers and 8 consumer companions from the same establishment. A conversational, solution-oriented approach was taken to interviews with a focus on two questions: (i) What makes a fantastic mental health nurse?; and (ii) What can we do better? Interviews were rather short in duration lasting mostly 8–10 minutes. After theming transcripts and comparing data, initial thematic analysis was discussed with a consumer and carer feedback group, and results then presented to the nurse participant group for discussion. Participants agreed that personal qualities, interpersonal skills, resources and the environment can influence mental health nursing care (Gunasekara et al., 2014). Participants wanted mental health nurses to be friendly, empathic and to have a respectful approach to service users; and wanted nurses willing to learn about individuals' hopes, goals and aspirations. Carers wanted to be listened to and to have general information about mental health problems. The mental health nurses' perspectives affirmed service users' views, and suggested guidance to support the interventions proposed. Nurses suggested the use of reflective practice to ensure care remained person-centred, and ensuring users understood their rights and responsibilities could help to avoid anxiety and potential conflict. Gunasekara et al. (2014) note their findings are not new, and support others who also highlighted the importance service users place on staff's empathic qualities, giving time, creating a safe environment, and positive interpersonal relationships (Bowers, Brennan, Winship & Theodoridou, 2009; Hansson, Bjorkman & Berglund, 1993). These reports suggest that warm, empathic human qualities in mental health nurses are more desirable than the provision of evidence based interventions. Knowledge about treatment approaches was not identified by Gunasekara et al.'s participants. It is perhaps not only the 'what' that is delivered, but the 'how' it is delivered than is identified as more important to service users.

Whilst studies presented here have highlighted what users want in a mental health nurse, there are many reports from service users of insufficient time spent with nursing staff (Barker, 2000; Stenhouse, 2011; Street, 2004). In a study where protected time for staff to spend time with service users was implemented, little positive effect was reported by service users (Nolan et al., 2016). There are also reports from service users

that nurses have not understood issues from their perspective or attempted to empathise with them (Stewart et al., 2014). As time, empathy and working together in the context of a therapeutic relationship were indicated as building blocks for collaborative care early on in the history of mental health care (Peplau, 1952; Rogers, 1951), it is perhaps surprising that some service users find these absent. In the next section I will discuss the growth of service user involvement in mental health provision and the concept of service users working in partnership with mental health nurses.

2.11 The context of service user and carer involvement

Meaningful service user involvement indicates that there is active engagement and participation from individuals who use services at all levels of service provision (Terry et al., 2018). Service user involvement can take many forms and occurs in many different ways. Essentially it is about making sure that the views of the people who use services have the opportunity to be heard, in order to make real, sustainable changes and improvements, both to their own care and to services generally (Omeni, Barnes, MacDonald, Crawford & Rose, 2014). Involvement by service users occurs in people's own individual care arrangements, in service design and development, in the education of professionals who work in services, as well as in health and social care research. This section includes literature concerning levels and power in relation to user involvement, the development of service user movements, followed briefly by service user involvement in care and then education.

Various involvement, engagement and participation continuums exist, such as Arnstein's (1969) and Tew, Gell & Foster's (2004), which explain the level of user involvement and degrees of power that citizens can hold. Arnstein's ladder shows eight different types of participation, with minimal participatory activities at the bottom, moving up to increasing amounts of participation at the top. Whilst there is a sense that the participation or involvement of citizens is a desirable activity, there is a sense of power present, by others who 'allow' participation in the first place. Suffice to say user

involvement can be meaningful, with individuals experiencing a sense of partnership and influence. Conversely, user involvement may be minimal and tokenistic.

Kemp (2010) suggests that social changes have provided the opportunity for sections of society to have a voice. New forms of governance have evolved requiring the state to collaborate with a range of social actors in networks across public, private and voluntary sectors (Newman, Barnes, Sullivan & Knops, 2004); with the purpose that people's voices are heard. The notion of service user involvement in health services has been a key part of policy making in Britain since *The NHS and Community Care Act* (DoH, 1990a), *The Patients Charter* (DoH, 1991) and *The Health of the Nation* (DoH, 1992). These policy initiatives promoted the importance of consulting with service users when planning and evaluating services. However, the development of service user and carer movements goes back much earlier. In the 1970s an important group formed, The Mental Patients Union, with branches in various parts of the UK, and this can justifiably be called the originator of organised service user action (Crossley, 2002). When it disbanded, it was succeeded by a number of smaller groups: Community Organisation for Psychiatric Emergencies (COPE), Protection of the Rights of Mental Patients in Therapy (PROMPT) and Campaign Against Psychiatric Oppression (CAPO). These groups provided a link between action in the 1970s and developments in the 1980s in the United Kingdom (Campbell, 2005). Since then many third sector groups and charitable organisations, such as Mind, Rethink, and Hafal, have grown and become part of the local and national landscape of mental health provision.

According to Rise et al. (2011) service user involvement is said to be founded on respect, dialogue and shared decision making. It is perhaps unsurprising that service user involvement is viewed differently by different parties. Hui and Stickley (2007) highlight that service user involvement seems to stem from two opposing poles: the top-down interests of the state representing service systems, policies and legislation; versus the bottom-up interests of service users themselves. On occasion where these two poles meet (for example in policy or service development arenas), issues of power are often debated, with the notion that power is a commodity to be won, lost or given away. The

background context is that mental health services have a history of practices where power has sometimes been abused (Cutcliffe & Happell, 2009; Bennetts, Cross & Bloomer, 2011). Unsurprisingly dissent against the mental health system has often been a powerful force behind service user action, and has occurred since the construction of the asylums nearly two hundred years ago (Campbell, 2005). For many years protest has emerged from individuals rather than organised groups. For example, Hornstein (2009) wrote about Agnes Richter, a patient in a German asylum in the late 19th century, who stitched an autobiographical text into every inch of the jacket of her institutional uniform. Hornstein noted that despite efforts to silence people, hundreds of other patients have managed to get their stories out. Indeed the use of different media to share service user narratives, whether through art (Stickley & Duncan, 2007), poetry (Kennedy, 2012), film (University of Central Lancashire, 2017) or blog (Brown, 2017), has certainly increased the presence of service user voices and awareness about their mental health experiences. Activities of this kind raise awareness about mental distress generally, as well as issues of oppression which are commonly experienced by service users.

Part of the success of service user action has been connected with the growing number of people willing to speak openly about living with mental distress (Beresford, 2012; Campbell, 2005). Confronting the silence surrounding this subject is vital to meaningful social inclusion and such openness should have widespread impact by increasing awareness about mental illness and reducing associated stigma (National Social Inclusion Programme, 2009). People with a mental illness diagnosis have gone from being an absence to a presence in the mental health arena. Use of the term experts by experience in recent years illustrates the distance that has already been travelled, and offers further future potential to increase the scope of this work (Campbell, 2005). As involvement of service users is now a legal requirement (Section 11 of the Health and Social Care act, 2001). Lobbying and collective action has brought to the fore the need to engage and fully involve people in their care. However, there is concern that governments seek to locate responsibility for solutions with individuals under a wider mission of governance and social control (McKeown et al., 2014), rather than sharing the accountability and providing appropriate supports.

There remains a sense however that the extent of user involvement is very much dictated at the macro-level, whether this be by government, or service providers in health, social care or education (Rush, 2004). Brandon highlights the phrase 'innovation without change' and wondered about the concept of user involvement really transforming mental health services:

> "is it just the same old paternalism and imperialism with a fresh coat of paint? Perhaps the…staff and patients, are shaken but not stirred?"
>
> (Brandon, 1991, p.1)

In order for user involvement to be meaningful, the service environment needs to be open to consumer participation, with opportunities created by staff for such participation. I stress the use of 'created' here, as currently involvement is still rather a staff-led activity. Service users have reported feeling like the underdog, and that they are often controlled and omitted from decision making (Jönsson, Schon, Rosenberg, Sandlund & Svedberg, 2015) in relation to their care.

There is an overwhelming mandate for user and carer involvement in individual health care experiences from legislation, professional values and service user and carer movements, but it is often ill-defined and its mechanisms and funding are too uncertain for a more comprehensive realisation (Ager & McPhail, 2008). Whilst the principle of involving users and carers should be at the heart of policy and practice in health and social care, implementing this principle is often problematic, and commitment to it can vary from meaningful partnerships to tokenism. Anthony and Crawford's (2000) study explored mental health nurses views about user involvement in care planning, and suggested there was some degree of consensus between nurses about what user involvement means. However, this does not mean to say 'involving someone in their care plan' might be interpreted differently by different nurses and to a degree individual interpretation and style will vary across interventions regardless of activity. Tools developed to assess service user involvement in practice settings go some way in

measuring involvement practices (Storm, Hausken & Mikkelsen, 2010), but if they are developed without involvement from users themselves and are only completed by professionals, this suggests a skewed focus, with service users again denied a voice.

There is an onus on health professionals to provide accessible and timely information to new and existing service users about ways in which they can be involved in discussions and decisions about the care they receive (NICE, 2012). For example, on admission to an acute admission unit service users (and their carers) need to be provided with information about the environment, day to day amenities and activities, as well as information about services users' rights. Equipping and facilitating individuals (and their families) to be involved is the first step.

In health and social care a care plan is a way of signposting care and agreeing service provision. There is little focus on this in the policy and practice literature regarding the skills needed to fully involve people (Lloyd, 2010), so it is imperative that time is spent developing the necessary knowledge in professional education programmes. It is important for mental health nurses to develop the skills of how to involve service users in care planning. This will ensure that nurses learn how service users can be meaningfully involved in developing and evaluating their care experiences.

Rhodes (2012) suggests that following the consumer focused orientation of health and social care service delivery in the UK that user involvement in health and social care education has arisen as a result. There are now regulatory requirements for all health professional programmes to demonstrate how they are doing service user involvement in an educational context (Chambers & Hickey, 2012). Nursing students are being increasingly instructed to recognise the value of working in partnership with service users, with increasing value placed on people who are experts by experience in their own care. The benefits of user involvement for student learning have been well documented, with increased insight into the service user experience a common finding (Barnes, Carpenter, & Dickinson, 2006; Brown & Macintosh, 2006). Further benefits

for student learning suggest that user involvement encourages students to reflect on practice (Barnes et al., 2006; Skilton, 2011; Taylor & Le Riche, 2006), and improves students' communication skills (Rush, 2008), therefore improving their practice.

Guidance indicates that service user involvement should be increased across all aspects of curricula in nursing education (Moxham, McCann, Usher, Farrell & Crookes, 2011), with more transformative approaches employed whereby those with lived experience define programme content, rather than academics (Davidson, Ridgway, Schmutte & O'Connell, 2009). Adopting a more democratic approach to involvement by encouraging service users or carers to outline teaching topics may lead to more relevance and inclusivity, with users in an influential position, increasing the potential for political empowerment and ensuring an active patient perspective (Moxham et al., 2011). Being involved in a university setting can be a challenge, and often involvement activities are 'allowed' or encouraged by supporter or champions, and this in itself can be a battle. Powerful organisations, whether in Higher Education or health services have their own aims, values and targets, and involving local people may not be a priority. Without true involvement of service users in professional programmes such as mental health nurse education, there may be limited opportunity for nursing students to gain awareness and understanding about the values and practice of involvement at an early stage in their career journeys.

2.12 Research aim and objectives

The aim of the study is to explore participants' talk about mental health nursing, and experiences of service user involvement in nursing processes. Perspectives of mental health nursing students, qualified mental health nurses and mental health service users were sought, in order to explore this phenomenon from a variety of perspectives.

The specific objectives of the study are:

1. To explore how mental health nurses construct their roles and professional identities

2. To examine the talk of mental health nurses, nursing students, and service users about their experiences of service user involvement in nursing processes

3. To provide an analysis of how mental health nurses, nursing students and service users understand service user involvement in nursing processes

4. To examine service users' talk about mental health nursing roles and role-related activities

5. To explore mental health nurses' understanding in what they say about their work, and how this can be used to improve services

2.13 Conclusion

This chapter has presented a range of literature about mental health nursing and service user involvement in nursing processes to provide the historical and political context for an analysis of people's talk about mental health nursing. Initially, the background context of mental health nursing was presented, including historical tensions reported in the profession, namely divisions between supporters of the medical model and those who favoured a humanistic approach. This was followed by information about the influence of mental health nursing reviews and related policy, studies about professional identity, and mental health nursing work. Growth in partnerships with mental health service users in policy, practice, and education settings has been highlighted, although it remains unclear what these developments may mean for nurses who work in mental health services.

None of the studies reviewed addressed the gap around people's talk about mental health nursing and service user involvement in nursing processes from multiple

perspectives. The focus of this study is on mental health nursing and service user involvement in nursing processes, and opens up opportunities to achieve new knowledge about how nurses construct their professional identities in this context. This study is ideally placed as it explores the territory of mental health nursing and service user involvement in mental healthcare settings. This study explores continuing tensions which might lead to mental health nurses involving service users considerably more or less in their care, than they do currently. There are serious implications for how service users view mental health nurses, as well as involvement in their care and treatment. This has implications for the credibility of the mental health nursing profession because if policy, guidance and service users are clearly directing involvement activities, then mental health nurses have a duty to deliver. When this PhD commenced in 2011, few studies had explored service users' experiences of involvement in care planning. This is surprising when considering that care plans have been a part of mental healthcare for decades (Newman et al., 2015). Equally few studies had explored how mental health nurses talked about their roles in relation to service user involvement.

The information presented in this review of the literature will be used in a number of ways throughout this thesis. First, in Chapter 3, the methods I have used to explore accounts about mental health nursing from multiple perspectives are described. My decision to examine talk about roles and professional identities and service user involvement in nursing processes through in-depth interviews and focus groups is outlined. I introduce the concept of ethnomethodology and how a researcher might explore the meaning making in people's talk, and the approach I took in terms of analysing the data. In Chapters 4, 5 and 6, the consideration of the literature in this chapter is used to support the developing analysis of talk in research interviews and focus groups about mental health nursing. My analysis will show how professional identity work about mental health nurses was constructed by participant groups.

Chapter 3: Methodology

3.1 Introduction

In this chapter I provide an account of the research approach used in this study in relation to the qualitative research paradigm. I discuss my research aims and rationale for the study topic and methods. I discuss my choice of approach, namely ethnomethodology, and the suitability of using individual interviews and focus groups to explore the meaning making in people's talk about mental health nursing. I report on the ethos of service user and carer involvement in research, and provide an account of early discussions held with local people in order to demonstrate my involvement of service user perspectives from the outset.

I discuss how I negotiated access to commence this study, and relevant ethical considerations, along with my application for ethical approval. I describe my recruitment strategies, the sample population, and a description of the sample. I include my approaches to data collection, recording and transcribing of research interviews and focus groups. I then detail my approach to data management and analysis before concluding.

3.2 Research method

Qualitative research is an overarching term for a variety of approaches and methods that study natural social life or phenomena. Outcomes from qualitative studies often result in cultural observations, new insights and understandings about individuals, societies, human meanings and the critique of social orders (Saldana, 2011). A principal belief originating from the qualitative research paradigm is that an informed interpretation of the world can be gained from conversational and observational methods. Qualitative researchers seek an understanding of phenomena from multiple perspectives, with a real

world context (Anderson & Arsenault, 2001). The aims of qualitative research are to examine the construction of meaning, and to understand the details of people's lives or frames of reference (Gibson & Brown, 2009). This occurs through the exploration of deep descriptions and analysis of social phenomena, examination of taken for granted everyday experiences and an element of interpretation for the purposes of developing new understanding or challenging existing versions of social life.

In this study I was concerned with understanding more about what people's talk could tell us about mental health nursing. Qualitative research can help to broaden our conceptions, beyond issues of subjective meaning, towards issues of language, representation, and social organisation (Silverman, 2011a; 2016). It provides an opportunity to harness and explore how actors in social settings experience and make sense of everyday interactions for the purposes of achieving social action.

Qualitative research has a variety of methodologies, with each usually attached to a particular philosophy. Broadly, qualitative research is based on philosophies that are interpretivist, and concerned with how the social world is understood (Mason, 1996). One such philosophy, phenomenological sociology, is concerned with analysing the process of meaning construction (Edwards & Titchen, 2003). Ethnomethodology has its roots in phenomenological sociology, and its objective is to reveal how the common world depends on this communicative and interpretive work. My rationale for using an ethnomethodological approach was because it is focused on displays of understanding, and using it as a frame enabled me to explore how reality is produced and maintained through people's own talk and actions. An ethnomethodological approach fits with a desire to understand how participants produce and use understandings of mental health nursing in their accounts.

Ethnomethodology is based on a belief system that is connected to a constructionist epistemology, where the emphasis is on understanding, appreciation of context, and acceptance of people as active constructors of meaning; not recipients of externally

defined meanings (Crotty, 1998). Whilst ethnography is the study of culture, ethnomethodology studies the ways in which participants give order to and make sense of their social worlds (Garfinkel, 1967). Ethnomethodology is also described as 'explicating the ways in which collectively members create and maintain a sense of order and intelligibility in social life' (ten Have, 2004: 14). Heritage (1984) compared ethnomethodology to a social microscope, meaning that study is concerned with the magnification of the working parts or elements of social life, and how these are ordered and described.

The central strategy in ethnomethodology is to investigate the participants' own perspective, their particular local native vision of the world (Lopes, 2008). Individuals engage in interpretative work every time they interact with the world, which Garfinkel (1967) referred to as documentary methods of interpretation. In order to make sense of objects or events in the world, individuals may utilise patterns, which work as a form of internal field guide for interpreting and making sense of new experiences. These patterns could be used prospectively to interpret new events, and retrospectively to revise our understanding of the past, by interpreting what has taken place (Lopes, 2008). Individuals develop and construct their own knowledge, and each person interprets what they see and hear in their own way, indicating that knowledge is not an objective truth (Edwards & Titchen, 2003), but is layered with meaning.

There are a range of individuals and groups who may have a stake in what mental health nursing is held to be or how it is viewed, which is why I sought a range of perspectives for my study. It is likely that multiple versions exist and that mental health nursing is constructed differently depending on what is at stake. Concerns may differ for instance for those with a professional interest in contrast to those who depend upon the services of mental health nurses, or those who experience these services as oppressive.

Healthcare professionals and healthcare service users have a common interest in understanding patient experiences and translating these into improvements in healthcare

(Morrow, Boaz, Brearley & Ross, 2012). User involvement in the planning and delivery of health services is a reported objective of many industrialised economies, and has been advocated by United Kingdom governments for over two decades (Rutter et al, 2004; Tait & Lester, 2005; Welsh Assembly Government, 2008a). The involvement of mental health service users in research is seen to have many advantages, including an alternative perspective from the 'illness' model, diverse views and cross-fertilisation of ideas (Crawford et al., 2011). In seeking to capture multiple perspectives I realised it was likely that the occupational identity of mental health nurses would be a complex picture consisting of constructions of multiple actors. Identity work is defined as anything people do, either individually or collectively, to give meaning to themselves or others (Schwalbe & Mason-Schrock, 1996). Through individuals' account giving practice, they seek to accomplish this identity work through their talk (Antaki & Widdicombe, 1998). It was the talk about mental health nursing in people's accounts that I sought as data for this study.

3.3 Research approach for this study

The rationale for my study originates from my own views and experiences as a mental health nurse. In social science, researchers often identify a connection between self and study, and focus on issues that are problematic in their own lives (Lofland, Snow, Anderson & Lofland, 2006). During my nursing career I have noticed that mental health nurses have frequently struggled to articulate their roles (Rungapadiachy et al., 2004). Although they may have seen themselves as having a mental health nursing identity, I have wondered how these concepts of articulating a role and constructing a coherent professional identity fit together.

Although definitions of mental health nursing work have been evolving since the twentieth century, it has been suggested that the scope of mental health nursing is incomplete (Cutcliffe et al., 2013; Deacon & Fairhurst, 2008; Peplau, 1994). It has been debated whether nursing is indeed a profession in its own right.

> "Nursing has for many years struggled with an inner hunger, a deep need for professional congruency and effectiveness. The perception by many people, except those aligned to nursing, see nursing as an inferior and inadequate undertaking to be regarded as a ''profession''."
>
> (Thupayagale & Dithole, 2005, p.142)

These implications provoke thorny questions of what it means to be a nurse and the strength of nursing's claim to be a profession; which has historically been more difficult in mental health nursing than in other specialisms (Nolan, 1993). Mental health nurses have expressed concerns about professional identity, and appear to lack confidence in performing role functions that would be expected for professional groups (Gerrish, McManus & Ashworth, 2003). Role ambiguity and role development was therefore worthy of further study.

Mental health nurses have been found to engage in identity work that focuses on them being 'patient-centred', regardless of particular mental health nursing roles (Crawford et al., 2008). Mental health nurses highlight the therapeutic relationship they have with service users as an essential part of their practice role, but find this relationship difficult to define (Fourie, McDonald, Connor & Bartlett, 2005). Dziopa and Ahern's (2008) literature review on the therapeutic relationship in mental health nursing identified the main constructs of the therapeutic relationship, which included providing support, being available, maintaining clear boundaries and having self-awareness. However, mental health nurses disadvantage themselves by not articulating and evaluating what they do in the therapeutic relationship (Browne et al., 2012; Hewitt & Coffey, 2005). It is suggested that making explicit the further contributions mental health nurses make within the therapeutic relationship would better articulate the mental health nursing role (Happell, 2011). Altschul (1972) noted that mental health nurses believed strongly in what they were doing, but when challenged failed to define what they actually were doing (Barker, 2002). Despite Dziopa and Ahern's attempt to conceptualise how a therapeutic relationship is accomplished, it is suggested by Browne et al. (2012) that there is a long way to go before a clearly defined model of mental health nursing is available.

> "…mental health nurses (…) need to (…), like the other mental health professions, [be] able to clearly describe and define the many and varied contributions they make to the health of the consumers of mental health services"
>
> (Browne et al., 2012, p.39)

Hurley and Ramsay (2008) suggest that how nurses come to view themselves as being mental health nurses may be critical to the survival of mental health nursing as a speciality. I have frequently questioned how mental health nurses develop their professional identity, and why it is perhaps an insurmountable task for them to define their roles. From a structuralist viewpoint, the underlying assumption is that roles are almost fixed positions within society, which have certain expectations attached to them (Conway, 1988). Yet as mental health providers deliver an increasing range of services, mental health nursing roles have expanded, with significant and extra-jurisdictional roles for the profession. Expansions and changes to the mental health nursing role have created implicit challenges for how they practice (Coffey & Hannigan, 2013). It is also suggested that a number of these role changes have been prompted by mental health nurses themselves (Godin, 1996; Hurley & Lakeman, 2011; Morrall, 1998). Certain extensions to mental health nursing roles do 'fit' with established practices, as nurses have developed roles for example in nurse prescribing, and promoting physical health, which may be associated closely with biomedical aspects of nursing (Coffey & Hannigan, 2013). The direction and future of mental health nurse roles is yet unknown, and for those wishing to enter the profession this may present both opportunity and uncertainty.

During the past twenty-five years, I have worked with a range of mental health nurses, and I have remained fascinated by a certain pride individuals have in relation to 'being' a mental health nurse. Experienced mental health nurses have identified that their personal attitudes and attributes set them apart, from nurses in other fields, due to their perceived increased self-awareness and understanding, and that they are in some way different from other nurses (Humble & Cross, 2010). Based on my review of the literature, and prior to presenting findings from my own data, I am seeking to make the claim that mental health nurses experience role confusion and lack coherent professional identity, and attribute this phenomenon (at least partially) to two factors.

First, the difficulty experienced by mental health nurses to articulate their roles, and closely linked to this, frequent change in the roles and remit of mental health nursing. This has led me to question whether there is an examining of the value of mental health nursing/nurses by nurses themselves, and a discrete professional purpose in the eyes of other professionals.

Principles of ethnomethodology seek to offer a detailed interpretive account regarding what is going on in participants' talk, theorising talk as action-oriented, with particular interactional goals. This allows the researcher to focus on participants' own understanding of interactions, as displayed in their talk (Wilkinson, 2011). Using an ethnomethodological frame, the interview is regarded as an account rather than a report. This concept of an account has a firm history in sociological research, with its story-like interpretations and their functions, and consequences to an actor's life (Orbuch, 1997). Interview accounts feature sense-making work by participants as they account for themselves as particular members of a social category (Antaki and Widdicombe, 1998). Examples of accounting are present in participants' talk in my study.

3.3.1 Using individual interviews

An interview is a specialised pattern of verbal interaction, initiated for a specific purpose, and focused on a specific content area (Kahn & Cannel, 1957). The role relationship of interviewer and respondent is highly specialised, its characteristics dependent on the purpose and character of the interview (Mishler, 1986). Interviews can reveal evidence of the nature of the phenomena under study, including the context in which it emerges, and insights into the cultural frames people use to make sense of their experiences (Miller & Glassner, 2011). All interviews are reality-constructing, meaning-making events, whether or not this is acknowledged, through which the speakers co-construct broader social norms (Holstein & Gubrium, 1995; Rapley, 2001). I was therefore aware as a researcher that both myself and participants would be co-constructing data together.

Even though we do not know if our ways of making sense of the world concur with how it really is, we are justified in contemplating and commenting on ways in which we attempt this (Collier & Stickley, 2010). This fits well with ethnomethodology, as this is concerned with how people construct, account for and give meaning to their social world (Garfinkel, 1967). The active interview is a useful construct when considering an ethnomethodological approach:

> "understanding how the meaning-making process unfolds in the interview is as critical as apprehending what is substantively asked…the hows, of course, refer to the interactional, narrative procedures of knowledge production…the whats pertain to the issues guiding the interview, the content of the questions, and the substantive information communicated by the respondent"
>
> (Holstein &Gubrium 1995, p.4)

Interviewing plays a central role in ethnomethodological research, as it is a social encounter in which knowledge is constructed; an occasion for producing reportable knowledge, not just transmitting knowledge (Dowling, 2007). Ethnomethodologists consider the process of meaning production in interviewing is as important as the meaning that is produced (Holstein & Gubrium, 2003). The ethnomethodological view is that knowledge is socially constructed, and created by the action taken to obtain it (Cicourel, 1964; Garfinkel, 1967). This may suggest that knowledge is a product of interaction, although arguably not all knowledge is socially constructed. Indeed knowledge may be constructed independently of social factors. There is a sense though that all knowledge may be tied together with socially constructed knowledge, as perhaps the way we organise and articulate our knowledge is socially constructed. This would be dependent on our beliefs, values, experiences and culture. The implications are that all accounts of the social world are equally valid and that our realities are formed at the interface between our beliefs, our knowledge and our sensory experiences (Collier & Stickley, 2010). It was this interface that I was keen to hear in participants' narratives.
Social order is not imposed on interview data, but is assembled by participants, as they negotiate identities and characterise the worlds they talk about using their membership resources (Baker, 2002). This is shown through the arrangement in interview data, by both participants and researcher, as they assemble what can be viewed as rationality,

morality, social order, and can display culture in action. As members 'document' themselves in an interview interaction, what Garfinkel (1967) refers to as the documentary method of interpretation; patterns and particulars about a person's identity emerge. The activity of interview talk is one interactive event through which people may accomplish a sense of identity. This occurs as both questions and answers are verbalised, and as details are assumed and negotiated through the interaction. During instances of talk, actors will accomplish, manage and reproduce a sense of social structure, and privilege selected versions as part of their talk (Gubrium & Holstein, 2002).

The researcher's presence and conduct are crucial to the particular account that emerges because interviews are naturally interactive (van Enk, 2009). Interviews can be viewed as a behavioural rather than linguistic event. Mishler (1986) however argues that an interview has more the distinctive characteristic of discourse, is about meaningful speech, and that this is a radically different understanding of interviewing to simply collecting information.

As the focus of this study centres on talk about mental health nursing, this can be considered as talk about a profession, an organisation, or an institution. Heritage and Clayman (2010) refer to institutional talk as having characteristics that distinguish it from mundane talk, which includes interactions with goals related to relevant identities, and special inferences particular to specific contexts. Whilst those researching institutional interaction have largely used naturally occurring data from the work-place, others have used ethnomethodological approaches to examine interview data, as these are viewed as a distinct domain of talk (Roulston, 2006). Although participants may be away from the work-place, the social interaction is seen as valid, as members draw on their stock of knowledge to provide description of experiences and events relevant to the topic (Roulston, 2006). It is therefore not always necessary to obtain data about people's roles and work directly in the workplace environment.

3.3.2 Using focus groups

As well as individual interviews, I sought to carry out focus groups as a further method of obtaining qualitative data. Focus groups involve engaging a small number of people in an informal group discussion centred on a particular topic (Wilkinson, 2011), common to all participants (Merton, 1987). The discussion is usually based on a series of questions put to the group by the focus group facilitator (Wilkinson, 2011), whose role is also to keep discussion flowing and encourage members to participate and interact with each other.

The interactions that occur in focus groups provide the opportunity to better understand the group dynamics, which may in turn impact upon individuals' views, talk, and decision making regarding what to say (or not to say) during the focus group (Madriz, 2000; Wilkinson, 2011). Focus groups can be a useful method for sociological research, with the unique aspects of this methodology all relating to the interactions that occur in a group context (Smithson, 2000). Potentially the social interaction generated by participants yields rich insights into people's lives, with a range and depth of experiences presented.

The very nature of people's talk in focus groups is a mixture of personal beliefs and collective stories, thereby revealing social and cultural contexts (Green and Hart, 1999; Kitzinger, 1994). As I sought multiple perspectives on mental health nursing for this study, the focus group method offered the opportunity to analyse mental health nursing students' interactions in a group context. The use of pre-existing social groups can heighten the naturalism of interactions giving researchers valuable access to collective meanings and social contexts as issues are shared and explored through group interaction (Warr, 2005). Equally, participants can re-create aspects of their social relations as participants exchange opinions and engage in processes of persuasion (Delli Carpini & Williams, 1994; Kitzinger, 1994). This does not mean that focus groups represent naturalistic interactions from the life worlds of participants, but facilitating focus groups with people who are known to each other can generate interactions and

discussions of 'real-life' scenarios that are not artificial or manipulated. I considered there was value in that my focus group participants knew each other, as familiarity between participants may allow them to challenge each other in ways that a researcher never would.

Kitzinger (1994) suggested the difference between participants allows us to observe not just how people theorize their own viewpoint, but how they do this in relation to others, and how they put their own ideas to work. Group diversity ensures that participants are bound to explain reasons behind their thinking, whether they give a 'right' answer, and what ideological work participants hoped their talk would achieve (Kitzinger, 1994). Therefore close attention needs to be paid by the researcher to stories participants tell to one another, and how they unfold during the course of the group, without the researcher assuming they know the meaning of these accounts. Researchers choose a focus group approach for the purposes of examining how consensus is built or resisted in a group conversation. This is what distinguishes focus groups from other methods, as the emphasis is on the group interaction, which needs to be reflected in the data analysis.

3.3.3 Field notes and research log

Field notes are recommended as part of qualitative research practice (Phillippi & Lauderdale, 2017), in order to record relevant contextual information. Researchers are encouraged to keep and maintain field notes to enhance data, to provide context for analysis, thereby increasing rigour (Lofland et al, 2006). Field notes can provide non-textual, situational and auditory information about interviews and focus groups, and are useful in understanding participant meaning (Phillippi & Lauderdale, 2017). I wrote field notes after each interview and following each focus group. I wrote these promptly after data collection, in order to ensure I recalled as much as possible about each data collection event. I recorded what had happened, my thoughts and reflections, any unusual occurrences, and how I thought the interview or focus group had been for those involved. I returned to my field notes many times during the period of data analysis in

order to ensure I had relevant information about the context and conditions under which data were collected.

I also kept a research log, as mentioned in Chapter 1 and later in this chapter in the Reflexivity section. Whilst the field notes were context specific to each occurrence of data collection, the research log was more of a daily journal of my on-going activities and reflections, documenting my progress and experiences during each stage of the research journey.

3.4 Involving participant groups in early discussions

I adopted the position that as this study sought to explore mental health nursing and service user involvement in nursing processes, it was morally responsible to ask the views of service users at the outset. Conducting research that relates to, or has consequences for mental health service users should not be undertaken without a level of involvement or view from that societal group. The value of patient expertise is now recognised as a vital part of the research process, and this includes setting research questions and taking the patients' point of view into account (Sullivan, 2003). Service user involvement can assist researchers in understanding other features of research that may not have been considered, by embracing the knowledge that service users have (Armes, Barrett, Hindle, Lemonsky & Trite, 2011). A range of service user viewpoints were therefore essential in the construction and direction of my study.

When the ideas for my study were in the early stages, I conducted initial visits to relevant service user groups, outlining initial aims. This provided the opportunity for discussion, raised my own awareness of related topics, and the potential relevance (or worth) of the study (Ochieng, 2010). These discussions enabled me to incorporate and prioritise the views of potential participant groups. The views of local mental health service users were unknown at this early stage, and I wanted to gain their perspectives. Mental health service users are recognised as a seldom-heard group, and discussion at

the outset was a way of incorporating the types of questions that are important to service users (Morrow et al., 2012). These insights were essential to my developing knowledge as a researcher.

Preliminary meetings were held in January and February 2010 with individuals in local service user groups to discuss the research proposal and related ideas. Discussions revealed that service users had views to share about mental health nurses that they had met in the past, and their ideas about the concept of user involvement. A comment was made about mental health nursing students and their experience during nurse education when on placement in a local hospital. A service user said "it's like taking all that enthusiasm and dropping it into a pond full of apathy". These words have stayed with me throughout the process of this study, and will be explored later in Chapter 7, my Discussion chapter.

I also held discussions with key individuals in voluntary sector groups and with users of mental health services about an early version of the service users' participant information sheet. Whilst the inclusion and exclusion criteria were found to be clear, it was suggested that the term 'service users' be included on these participant information sheets, as people often see themselves as a service user even when their involvement with mental health services was many years ago. The terms 'former' or 'ex-service user' had no meaning to people, therefore the term 'service user' was placed on these participant information sheets because the phrase is well known and supported by the group for whom it was intended.

As a nurse educator who spends extended time with mental health nursing students in university, and former students, who are usually qualified mental health nurses, I considered whether to conduct prior discussion with them. I concluded that through student contact and time visiting clinical link areas, I already had regular conversations about the topics under study with these groups on a frequent basis.

3.5 Negotiating access and ethical considerations

This section details the relevant processes relating to negotiating access and ethical considerations and that were taken into account as part of this study, including the researcher's responsibilities that needed to be addressed (Ryen, 2016; Silverman, 2011b). In this section I will begin by discussing ethical principles relating to aspects of this study, and my subsequent approaches. I will then describe my activities regarding negotiating access and the seeking and gaining of ethical approval.

Researchers must give due consideration to the effects of their research upon participants. The four moral principles: respect for autonomy, non-maleficence, beneficence, and justice were considered at the outset (Beauchamp & Childress, 2009). I will now describe how I addressed each of these in relation to this study.

In terms of autonomy, providing the opportunity for informed choice regarding potential participants' decisions to participate was vital. Detailed participant information sheets go some way to inform potential participants about research studies and what would be involved (see Appendix 4). For those agreeing to participate, at the time of data collection seeking consent is essential. I had a conversation with each participant about consent before each interview and focus group, reiterated the purpose of the study, and asked if they had any further questions, before asking individuals to sign a consent form. The action of consenting reinforces that participants are taking part of their own freewill. Franklin, Rowland, Fox and Nicolson (2012) state that it is of fundamental importance that research participants understand what the research is about, who is undertaking it and why. I also stressed to participants that they had the choice to stop or withdraw at any point, which served to give people control over their participation.

Non-maleficence is concerned with doing no harm, and researchers need to consider if there is potential for harm for their participants. Potentially participants could become upset during the interview process, as they reflected on their perspectives and experiences. Although the topic was not considered sensitive, I was aware participants may be talking about times in their lives when they had experienced distress or challenge. Equally mental health service user participants could be considered vulnerable, so it was important that all participants met the criteria of considering themselves to be experiencing positive mental health at the time of interview (for example, that they considered themselves to be well). As an experienced mental health nurse skilled in identifying mental distress, I was attuned to ensuring that participants were able to participate and in the event of someone appearing unwell I would not have proceeded to ask about issues personal to them. In such circumstances it would be appropriate to provide support in terms of listening, to offer to stop audio recording, and only to continue if the participant wished to do so. For example, two qualified nurse participants became briefly tearful, as during interview they recollected memories of particular individuals who had been significant in their mental health nursing journeys, but both wished to proceed with the interview process. In another example, one service user participant and one nursing student became tearful during interview, and on each occasion I offered to stop the recording, and provided support and listening. A further ethical issue identified regarding non-maleficence was that participants may not have wished to divulge information that they saw as identifying them as individuals in relation to the research. Therefore all were assured of anonymity and confidentiality. This was stated on participant information sheets (Appendix 4), consent forms (Appendix 5), and an issue I spoke about verbally before the start of each interview. In order to ensure anonymity I removed names from interview transcripts, used interview identifiers that hid participants' identity. I also removed place names and people names from accounts so that participants were not inadvertently unmasked.

The principle of beneficence requires that benefits, risk and cost are considered for those taking part in research. Participant information sheets for this studied stated that:

> "Whilst there are no immediate benefits for those people taking part in the study, it is hoped that the findings will inform the future content and delivery of mental

> health nursing education and service user involvement in both education programmes and local mental health services.
>
> (Participant information sheet, Appendix 4)

I could not suggest to participants any immediate benefit for them by taking part. However, I was able to treat each participant/potential participant in an ethical manner, not only by respecting their decisions about whether to consent, but also during data collection by ensuring people's comfort, offering refreshment and short breaks if required.

In terms of the ethical principle of justice, I saw this relating to fairness and equality; and was part of the rationale for involving service users at the outset of my study. In order to enable participation, I sought to ask participants to engage in interviews at locations convenient for them, which included rooms in the university, local education centres or participants' homes. This was to ensure limited cost or inconvenience to participants. I was mindful about seeking to balance both burdens experienced as well as potential benefits for participants. It was important the people felt they were treated equally and that their time was valued and not wasted.

Adhering to the four moral principles can be achieved through thoughtful and ethically responsible research practice for the entirety of a study and beyond (Silverman, 2011b; Ryen, 2016). Ethical practices in research relate to the conduct of the study, and although research activities may conclude with the dissemination of findings, participants remain entitled to on-going protection. This would be in terms of maintaining confidentiality and anonymity through publication and presentation processes. The on-going retention and secure storage of research data; needs to comply with the terms of the Data Protection Act and Freedom of Information Act (Swansea University, 2013), until such a time as the data is disposed of appropriately, or deleted.

Researchers must not only examine their values, but act and engage in a morally responsible way with all those involved in their study. Ethical decisions, such as

considering whether potential participants have had enough time and information to provide informed consent, need to be made during the research process. This goes far beyond gaining approval from an institutional research ethics committee (Scerri, Abela & Vetere, 2012). Throughout these stages the researcher needs to develop their ethical and emotionally intelligent capabilities and engage in self-observation within the research relationship (Hurley, Linsley, Macleod & Ramsay, 2011). I employed intuitive responses throughout the course of data collection in terms of my own ethical practices. For example, on more than one occasion I read out participant information sheets and consent forms if people did not have their glasses or if they had difficulty reading the material.

At the outset, I considered the focus of the study to be primarily about the roles and professional identities of mental health nurses in relation to nurse education. The rationale being that nursing studentsbegin developing their professional nursing identity as well as their views and practice in service user involvement in nursing processes during their neophyte phase. Therefore advice was sought from the National Research and Ethics Committee in March 2011 regarding the nature of this study, and they confirmed in their view this study was seen as an educational evaluation, as it was situated within an education context (Appendix 6). Advice was also sought from the Research and Development Departments in two local Health Boards in July 2011 (Appendix 6), who agreed they did not need to give permission for this study, but would keep a record on file. Discussions occurred out of courtesy with the mental health directorate Heads of Nursing in two local Health Boards, as former student participants may be employed in local areas as mental health nurses. However, they were not being sought as NHS staff, but as participants who had completed a pre-registration nurse education programme, and were approached in the context of their educational experience. Service users were not sought as NHS patients but as people using Third Sector organisations, who had used mental health services in the past. The ethics application reflected all three participant groups.

I submitted an application for ethical approval to the College of Human and Health Sciences and College of Medicine Research Ethics Committee in September 2011. Initially the committee's decision was that chair's action was required regarding four queries, which I will discuss here, and in the next section. I was required to produce the then Criminal Records Bureau (CRB) documentation, and also to update the names of my PhD supervisors on my proposal, as my initial second supervisor had moved to a different institution. On 12th September 2011, full ethical approval was confirmed by the Chair of the College's Research & Ethics Committee (see Appendix 7).

3.6 Recruitment and sampling

In order to recruit participants I sought initial approval from relevant gatekeepers to employ a recruitment strategy for each participant group. Regarding nursing students, permission from the appropriate Framework Director for pre-qualifying programmes was obtained at the outset, which was also a requirement of the permissions from the College ethics committee. Equally having support and agreement from this individual was useful in terms of gaining agreement to timetable both the research invitation presentations as well as focus group sessions. Gatekeeper agreement ensured there were no timetable clashes and that students were available if they wished to participate in the study.

The first and third year mental health nursing students were drawn from a population of approximately sixty and forty-five students respectively. The aim was to have sufficient participants to hold focus groups for each cohort. I gave a verbal presentation to student groups in May and July 2012 inviting them to participate, across two sites. My own personal students were not invited to participate. This was an ethical decision, in case they felt a sense of obligation to participate, or may have had concerns regarding their on-going tutorial relationship with me. After the initial verbal presentation, participant information sheets were distributed, and students were provided with the opportunity to ask further questions. Later on the same day a third party, the student set representative,

gathered completed folded-up opt-in forms from the end of lecture theatre rows. The College ethics committee chair asked that I clarified and ensured a time gap between the presentation and the opportunity for potential participants to respond, which was agreed at between two and three hours following the presentation. All students, whether participating or not were made aware that focus groups would appear as 'optional' on their timetables. I then contacted students who had opted-in to the study with the dates and times of the focus groups to be held on each respective university site.

Qualified mental health nurse participants were recruited from a provider of pre-registration nurse education in Wales, from records of former students who had completed a pre-registration mental health nurse education programme. A target of fifteen former student participants were sought for research interviews, with the intention of gaining experiences from a range of newly qualified staff, and those who had been qualified more than four years. Qualified nurse participants were approached through an email invitation from the academic registry department acting as an intermediary. This invitation included the participant information sheet and asked those interested in participating to contact the researcher directly. I contacted relevant Heads of Nursing in local Health Boards out of courtesy (Appendix 8), as by this point in time potential nurse participants may have been working in local Health Boards.

The sample of mental health service users were recruited from voluntary sector agencies across South and West Wales; with a target of fifteen user participants sought. Permission to advertise the research was obtained at the outset from gatekeepers at these organisations. Verbal presentations were made at voluntary sector groups to advertise the study and to encourage participation, as a recruitment strategy. Participant information sheets and reply slips were distributed through these networks. Additionally, key individuals agreed in principle to act as points of contact to distribute and circulate the invitation to participate. In total, verbal presentations were made at five voluntary sector agencies, with a further four agencies contacted by telephone with detailed information provided in a follow-up email. Mental health service user participants were asked to volunteer, and those interested in participating contacted the researcher via the reply slip or by email. This process increased my awareness that

negotiating access is not an isolated activity, but is renegotiated and on-going throughout the research (Lofland et al., 2006). Negotiation in relation to participant recruitment has been a key part of my journey as a developing researcher.

Service user participants were invited to volunteer to participate in individual interviews to enable them to give an account of their knowledge and experiences of mental health nursing. Mental health service user participants were informed that questions would not relate to their own personal mental health issues. Many third sector organisations were supportive of the invitation to service users to participate, and allowed me to use quiet rooms in their premises for interviews.

Whilst individuals in traditional gate keeping roles have the power to allow, deny or guard access to potential participants (Lofland et al., 2006); I found value in the involvement of intermediaries during the recruitment phase. Individuals had established connections with potential participant groups. In my study, key individuals in voluntary sector agencies assumed the role of gatekeeper, as they helped to identify and facilitate contact with participants, sometimes providing reassurance regarding the researcher's credibility (King & Horrocks, 2010).) The advantages are that a gatekeeper can act as a bridge (providing a link), a guide (mapping a way through unfamiliar terrain); and as a patron (who by associating with the researcher helps to secure the trust of those in the setting (Lee, 1993). In Whyte's case study of an Italian slum in Boston, he relied on 'Doc' to be in a gatekeeper type role, which allowed access for Whyte, and also protected him from potential antagonism (Whyte, 1993). I experienced similar benefits, which helped to facilitate contact with potential service user participants. This was part of the process of gaining entrée to the field under study, and has been referred to as part of the 'getting in and getting along' process (Lofland et al, 2006). The benefits of such facilitation and sponsorship were also a key part of my learning as a researcher. The final requirement from the College's ethics committee was that I clarified a phrase 'reviewing recruitment' with gatekeepers. This referred to on-going discussions with gatekeepers regarding recruitment to the study to enquire whether I needed to re-visit

settings and supply further copies of the invitation to participate and invite participants, or whether responses had been sufficient.

I learned too that there may be disadvantages in this regard as those in a gatekeeper role may potentially introduce other types of bias; as the researcher has no control regarding how the study might be portrayed or 'sold' to potential participants. Equally, the researcher may not know what agenda gatekeepers might communicate to potential participants. Researchers may run the risk of assuming that others understand our rationale for research, but it is more likely that those in a gatekeeper role see it as a mix of opportunity and threat. For example, I was surprised to see a poster on a noticeboard advertising my invitation to participate in a voluntary sector agency. The poster advertised a lunch-time buffet and had the tagline 'come along and have your say'. Participants' accounts may be self -serving, as those from marginalised groups may welcome the researcher's presence as an opportunity to tell all or set the record straight (Lee, 1993). However, ethically the issue of informed consent was essential. This prompted me to ensure that potential participants knew what the study was about, and had the opportunity to ask questions. I also endeavoured to ensure individuals had adequate information in order to make an informed choice regarding whether or not they wished to participate. I accomplished this by spending time informally in three third sector organisations.

I found that intermediaries provided some distance between myself and potential participants. Namely that initial contact with participant groups was sometimes made by an individual other than myself. As I was researching small connected communities, I was aware of my own mental health nurse status, so adding another layer between participants and myself was one method of reducing possible coercion.

3.7 Description of Sample

Morse (2000) proposed that the sample size depends on the scope of the study, the quality of the data, the nature of the topic, as well as the method and study design used. The heterogeneity of the population, that is the diversity of the population under study, need consideration, as the researcher will want to capture variability with regard to experiences and world views (Baker & Edwards, 2012). My intention was to have the opportunity to explore the topic from the view of novice (first year) and more experienced students (for example, third years), through to newly qualified, and experienced mental health nurses, who had completed their nurse education with the university. My rationale being that I could engage with people who were at different points or stages in their mental health nursing journeys.

As this study utilised an ethnomethodological approach exploring participants' talk, at the outset it was less appropriate to consider a sample size, and more important to consider that the sample would comprise the community or culture under study as the sample frame (Higginbottom, 2004). The focus on roles and professional identities of mental health nurses, how those identities develop, in the context of service user involvement informed my choice of a purposive sample. These social actors demonstrate membership of the cultural groups under study, and whilst qualitative studies often have small samples, the size needed to be large enough to assure that a range of perceptions that may be important were covered (Mason, 2010). The rationale for exploring the talk of mental health nursing students and mental health nurses was that they are ideally placed to talk about their individual experiences of becoming and being mental health nurses. I sought a sample of 15 mental health nurses, and sufficient first and third year students to hold focus groups on two university sites. I reviewed my progress of successful research interview completions at regular points in supervision.

The inclusion criteria for nursing student participants were that first year students must have attended at least one mental health practice placement, during their university nurse education programme. Qualified mental health nurses were those who had

completed their pre-registration nurse education with the same university and may have recently qualified, or been qualified for many years. The intention was to seek maximum variation in the range of experiences of participants. Former students may be employed and practicing as Registered Mental Health Nurses in the South Wales geographical areas served by the University, but were sought first and foremost as former students of a mental health nurse education programme.

The sample also included mental health service users, who had experience of mental health nurses as part of their care and treatment in the past. It was important to examine narrative accounts from different groups, in order to make differing views and tensions visible that exist between one vulnerable group, and those working with them (Briggs, 1996; Coffey, 2011). The majority of research in mental health is written from the viewpoint of professional staff, who ultimately decide what is considered evidence, with studies offering service user perspectives falling short in delivering equivalent versions (Coffey, 2011; Rose, Thornicroft & Slade, 2006). Research that upholds co-existing accounts from both staff and service users allows for contentions to be examined (Briggs, 1996). The inclusion of both nurses' and users' viewpoints in my study provided the opportunity to highlight distinct positions, regarding role and identity claims, that relate to mental health nursing. Each subject position adopts a world view consistent with their membership category, which includes their sense of self and conceptual repertoire (Davies & Harre, 1990). My intention is that examination of these narratives, and views and tensions that exist between them, will demonstrate new understandings about mental health nursing roles and professional identities and service user involvement in nursing processes. I sought a sample of 15 mental health service user participants from a range of third sector organisations.

The inclusion criteria for mental health service user participants was that they lived in the South Wales geographical area served by the university, and viewed themselves as in a stage of recovery, or were experiencing a period of mental health as defined by themselves. Mental health service users were not contacted as NHS patients, but through local points of contact, such as voluntary sector agencies. During service users'

previous contact with mental health services, they needed to have encountered mental health nurses within a hospital or community setting (within the last ten years), in order to give their perspectives in relation to mental health nursing roles and service user involvement.

Exclusion criteria were stipulated in order to protect respondents who may be considered vulnerable or could have perceived a sense of coercion. For example, no students for whom I was personal tutor to at the time were invited to participate. Equally mental health service users were not invited to participate if they were experiencing acute symptoms of mental illness.

Service user participants were reassured that interview questions would not relate to their own personal mental health issues, but would be about their experiences of encountering mental health nurses. On-going mental ill-health need not be criteria to exclude people from participating in research, and indeed I was not seeking people's views as current service users. I was seeking the views of service users, who had met mental health nurses at a point in the past in the South Wales area. This could be considered a limitation of the study, as perspectives provided were in the main more historical rather than current.

I did not collect demographic data from any groups in the sample in this study, as this did not have relevance to the questions I was interested in addressing, instead I sought a mix of participants. First and third year pre-registration mental health nursing students, and qualified mental health nurses were both male and female aged between 18 and 65 years of age. Mental health service user participants were also over 18 years of age, and included a gender mix.

3.8 Data collection

The recruitment response from nursing students to participate in focus groups was positive, which enabled me to facilitate three focus groups across two university sites, two groups of first years and one group of third year students. Insufficient numbers of third year students agreed to participate, so it was not possible to hold third year focus groups on both sites. The smallest focus group had four participants, and the largest group had eight, with discussions ranging from 51 minutes to 1hour and 26 minutes. In total 18 mental health nursing students participated across the three focus groups.

The first invitation to qualified mental health nurses was communicated via Academic Registry to people who had qualified as a mental health nurse from this institution in January 2012, resulting in sixteen initial respondents, with eleven of these successfully interviewed. A further invitation was sent in January 2013, in an attempt to recruit further participants to increase the sample size, which resulted in eighteen further initial respondents, and six of these successfully interviewed. Out of the thirty-four initial respondents, a total of seventeen were successfully interviewed. Regarding the remaining seventeen who were not interviewed, two did not meet the inclusion criteria as they no longer lived in the geographical area served by the university, and now lived in England; so it was not feasible to arrange face to face interviews with these respondents. A further two respondents had been focus group participants, and had already contributed their views through this medium when they were mental health nursing students, and did not meet the criteria for further involvement in the study. The remaining thirteen respondents, who initially expressed a willingness to be interviewed, may have lost interest or were busy with work commitments and stopped replying to follow up email enquiries.

Multi-tiered strategies are suggested for participant recruitment, where non-respondents are contacted a second or third time until a response or refusal is received (Patel, Doku & Tennakoon, 2003), and I adopted this method. Researchers may not always know

why respondents indicate interest, but do not continue to the interview stage. Some did acknowledge difficulties in arranging time to meet for interview regarding availability and shift patterns. Patel et al. (2003) highlights that researchers need to be accommodating and flexible, and minimise time, travel and inconvenience costs for participants, which I attempted to do by arranging interviews at geographical sites convenient for participants. Dundon and Ryan (2009) note that despite researcher efficiency, such as regular contact and reminders, in terms of organising and confirming interview dates and times; the simplest explanation is that respondents withdraw due to time pressures or unplanned commitments.

The response from service user participants in third sector organisations was also positive, with interest shown in many third sector organisations I visited and contacted. It is not strictly possible to say how many service users were approached as my recruitment strategy involved presenting the research invitation at group meetings, in informal gatherings, or via a gatekeeper who forwarded the invite to email networks. I contacted nine third sector organisations, and I successfully interviewed people from six of these organisations. I am not able to say why service users from the remaining three organisations did not participate, except that where I was able to gain access to invite participants people did not indicate interest in participating. Out of the nine third sector organisations contacted, I successfully interviewed thirteen mental health service users.

Individual interviews for both mental health nurse and service user participants were arranged directly with each person after I had received a written confirmation that they wished to participate, via either a completed reply slip or email. Interviews were arranged at a location geographically convenient to the participant, which were either a quiet room in a third sector organisation, at the university, or in a participant's home. Each encounter commenced with me summarising the study's aims, ensuring the participant was aware I would be recording the conversation, that they could ask any questions; and could stop at any time. After these issues were addressed, and a consent form signed, each interview commenced with me asking a 'grand tour' type question (Spradley, 1979). This is a broad question which usually makes sense to participants,

and prompts a descriptive answer, often about a pattern of events (Spradley, 1979). My grand tour question focused on the participant and was in relation to mental health nursing. For example, for qualified mental health nurses this was along the lines of 'how did you come to start mental health nursing in the first place?'.

In terms of preparing for all interviews I developed a topic guide of questions (Appendix 9) at the point of applying for ethical approval), which was informed by my literature review and further reading about mental health nursing. I became aware that adhering to a list of questions was not the way to conduct either an individual interview or a focus group, so I did not adhere to them rigidly, but used them as prompts and an aide memoire.

My focus was on participants' talk, and in terms of the focus group context I was aware that the naturalistic possibilities of data are enhanced because of group dynamics. There should be a minimum of intervention from the moderator, as participants invariably bring different issues into the discussion (Frey & Fontana, 1993; Frith, 2000; Johnson, 1996; Morgan & Kreuger, 1993; Wilkinson, 1998). In addition to the use of a topic guide, I read out a short list of focus group ground rules at the start of each group (Appendix 10). These included requests for participants to participate both in talking and listening, to speak one at a time, to maintain confidentiality of opinions; and to focus on issues for discussion not on individual responses.

The sample of three different participant groups provided multiple perspectives on the research topic. These participant groups also had a range of experiences, and had seen changes in mental health nurses and nursing over several years. Although demographic data in terms of participants' ages were not collected, mental health nurse participants were asked how long they had been qualified, and this is recorded in Figure 1, p.106. As I discuss and examine accounts in the findings chapters, where known I will make relevant the context. For example, I will state the type of environment mental health nurses worked in, as well as the type of settings mental health service user participants

were referring to, without breaching confidentiality. Although user participants were required to have met mental health nurses at some point in the past, it transpired that they had all had an admission as an inpatient to a mental health unit (although this was not a requirement to participate). The vast majority if not all of the service user participants also had experience of meeting mental health nurses in community settings.

In summary, following recruitment I successfully interviewed 13 mental health service users and 17 mental health nurses. I also held 3 focus groups with 18 nursing students across two university sites. Following each interview and focus group, participants were thanked for their time. I typed up field notes, recording my own reflections on the event, and downloaded and saved the digital audio files on the university's password protected server. The individual interviews constituted 30 hours 28 minutes of audio recording, and the focus groups totalled 3 hours 41 minutes. Pseudonyms were used for all participants on transcripts, and identifiable place names were changed.

In Table 3.1 below I have summarised the amount of audio-recorded data related to this study.

Table 3.1 – Amount of audio-recorded data

Data set	**Minutes**
Mental health nursing students (Focus groups x 3)	205mins
Mental health nurses x 17 (individual interviews)	1098mins
Mental health service users x 13 (individual interviews)	719mins
Total	**2022mins**

In Tables 3.2 to 3.4 I have summarised brief demographic information about each participant group to allow judgements to be made about similarities or differences of this sample in relations to other studies. I have included detail regarding the length of individual interviews and focus groups. Figure 1 shows the number of years mental health nurse participants were qualified as nurses, to indicate that participants had a range of levels of experience. I have also included participants' pseudonyms and types of work environment as reference points.

Table 3.2 - Mental health nurse participants – number of years qualified and type of work setting

MHNurse participant	Pseudonym	No. of years qualified	Length of interview	Work setting
1.	Mary	18mths	59mins	Acute inpatient
2.	Ann	11	1hr 3mins	Day centre
3.	Josie	3	1hr 8mins	Day centre
4.	Jenny	3	1hr 8mins	Rehab house
5.	Pippa	4	1hr 13mins	Community
6.	Paula	4	42mins	Community
7.	Tina	3	1hr 11mins	Acute inpatient
8.	Denise	2	1hr 14mins	Older people inpatient
9.	Dora	2	1hr 14mins	Community
10.	Ben	4	58mins	Community
11.	Laura	4	1hr 4mins	Nursing home
12.	Lucy	5	57mins	Rehab house
13.	Sally	4mths	55mins	Forensic ward
14.	Emma	4	1hr 10mins	Forensic ward
15.	Lorraine	4mths	1hr 14mins	Independent sector
16.	Nicola	4	1hr 2mins	Community
17.	Angela	4	1hr 5mins	Community

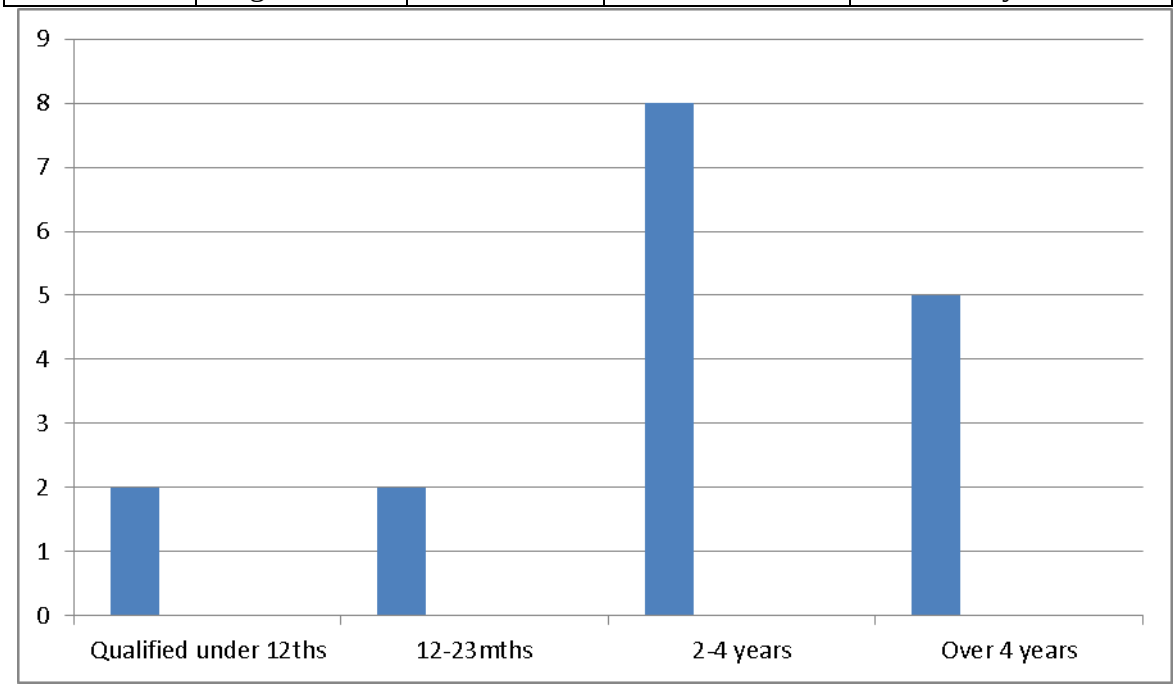

Figure 3.1 - Mental health nurse participants: number of years qualified

Table 3.3 - Mental health service user participants

Service user participant	Pseudonym	Recruited from:	Length of interview	Interview setting
1.	James	Third sector group	51mins	Participant's home
2.	Judy	Third sector group	1hr 36mins	Health board education centre
3.	Brenda	Third sector group	1hr 10mins	Participant's home
4.	Gary	Third sector group	26mins	Third sector
5.	Emlyn	Third sector group	56mins	Third sector
6.	Jack	Third sector group	40mins	Third sector
7.	Steve	Third sector group	16mins	Third sector
8.	Amy	Third sector group	1hr 14mins	Third sector
9.	Sian	Third sector group	1hr 29mins	University
10.	Simon	Third sector group	1hr 4mins	Third sector
11.	Doreen	Third sector group	34mins	Third sector
12.	Sandra	Third sector group	57mins	Third sector
13.	Irene	Third sector group	53mins	University

Table 3.4 - Nursing student participants in focus groups

Focus group	Year of programme	No. of participants	Length of interview	Interview setting
Focus group 1: : 1.Lesley 2.Naomi 3.Eve 4.Helen 5.Michelle 6.Molly	3	6	1hr 8mins	University
Focus group 2: 1.Abby 2.Ruth 3.Sophie 4.Grace 5.Neil 6.Ellie 7.Sam 8.Cheryl	1	8	1hr 26mins	University
Focus group 3: 1.Jill 2.Rhian 3.Nicole 4.Debs	1	4	51mins	University

3.9 Audio recording and transcription

I recorded all individual interviews and focus groups in MP3 format using a digital audio recorder, with the consent of participants. On each occasion I placed the audio recorder near to both participants and myself. I had stressed the need to audio record interviews and focus groups at the outset, and asked participants each time when they were ready for me to start recording. There were no concerns raised about the recording.

Equally at the close of each interview I informed participants when I was switching off the recorder. Following each interview and focus group I then downloaded audio files onto the university's password protected server for later transcribing; with the audio recorder kept in a locked filing cabinet in the university.

It is suggested that researchers consider the type of transcription that is useful for their research purpose at the outset (Kvale, 1996). Transcription is not merely an administrative process, it warrants examination, and choices made regarding layout, style and conventions need explanation. As this study is concerned with how roles and professional identities of mental health nurses are expressed through participants' talk, it was important to consider the transcription of that talk. Whilst verbatim data transcription can facilitate data analysis by bringing researchers closer to their data (Halcomb & Davidson, 2006), this is only part of the process. The term verbatim is taken as an uncomplicated description of the process. My view is that transcripts need to re-present the event as faithfully as possible, in correspondence with the methodology.

Talk is not merely written down; it has been constructed by the researcher for a particular purpose, who is then re-presenting that data (Bird, 2005). In order to establish a greater degree of trustworthiness, careful attention should be paid to each step of qualitative data collection to minimise errors (Easton, Fry McCormish & Greenberg, 2000). Cross checking of the audio file should be undertaken, and preferably researchers should transcribe their own interview data, given their first-hand knowledge of the account, and verbal and non-verbal exchanges with participants (Poland, 1995). Noting the costs of transcription regarding time and the physical and human resources (Halcomb & Davidson, 2006), I elected to transcribe all the focus group interviews myself, and the first two individual interviews with service user participants using Express Scribe transcription software. I then employed an external transcriber to undertake transcription of the remainder of the individual interviews. This individual was experienced in transcribing both interviews and focus groups, did not live in Wales and had no known connection with the geographical area.

In an attempt to minimise transcription errors, my field notes became increasingly important, as did the process of listening back to interviews to ensure transcripts were as accurate as possible. I was also mindful of literature that suggests transcription is the first part of data analysis (Stuckey, 2014), so I sought an active role in this by reading the transcripts again for accuracy while listening to the recordings and made any necessary corrections.

I have used pragmatic transcription, which is described as a verbatim format that best suits the needs of the researcher (Evers, 2012). Transcription symbols are used to represent characteristics of talk besides the words themselves. I have based my transcription conventions on Jefferson's (1992) transcription system (see page 9), and included words as spoken, sounds, and silences recorded with timings in brackets. I included brief descriptions of interruptions (for example, telephones ringing) and participant behaviour (such as an individual blowing their nose, or non-verbal communication); which are denoted within round brackets. I have also included 'erms' and 'ahs' and false starts, as they are all part of people's talk.

3.10 Data management and analysis

As there is no single approach dictated for qualitative research data analysis (Gubrium & Holstein, 2002), I took a flexible route which allowed me to draw on a range of perspectives. The interactive work that occurs during the interview process sees participants engage in conversational interaction using resources drawn from their membership in other settings. An ethnomethodological approach to analysis allowed me to explore how participants actually 'do' interaction, how they make sense of each other, negotiate identities and characterize and connect the worlds they talk about (Baker, 2002). This interaction occurs in both individual interviews and focus groups. Therefore incorporating a description of dynamics during interviews as part of the analysis can illustrate how consensus was achieved by participants, and how opinions may have been modified during discussion (Carey, 1995; Webb & Kevern, 2001). I

include elements of these activities in my discussion of the data in the thesis findings chapters 4, 5 and 6.

I began by reading and re-reading all data transcripts and listening to the audio files. I then undertook early coding manually noting initial codes in the paper transcript margins. I produced a one sheet of paper (osop) or summary page for each interview transcript, and a summary page for each focus group. This inductive approach was data-driven, as I was not attempting to fit the data into any pre-existing coding frame. Manually recording initial codes onto summary sheets reduced large amounts of data from each transcript into a more manageable form (Harding, 2013). Placing one summary sheet alongside others enabled me to identify basic similarities and differences. I put all the codes manually on a table and organised codes into early categories. I used the same approach for both individual interview and focus group transcripts. The purpose of identifying early categories was to allow me to present the findings in a coherent manner.

As a novice researcher I was also keen to explore an electronic data management system, and sought to combine the best features of manual and computer assisted qualitative data analysis (CAQDAS) (Welsh, 2002). Early manual coding enabled me to construct summary sheets and visual diagrams, and have a sense of what was in the data. Computer Assisted Qualitative Data Analysis Software can help to organise data, with coding and retrieval elements, increasing the researcher's capacity to analyse samples, thus improving rigour (Silverman, 2013). I chose to use QSR NVIVO version 10. Another advantage of CAQDAS is more than one code can be applied to sections of text, and as the researcher you can see coded material in its original context. The retrieval speed on a CAQDAS system meant I could devote more time to creative tasks and deeper analysis (Silverman, 2013), and less on manually searching through the data.

I coded using free nodes initially on QSR NVIVO 10 software to assist in data management, which enabled flexible approaches to coding and retrieval of data. I

initially identified a list of 57 free nodes, which helped me to gather emergent ideas (see Appendix 11). I then began to see that coding could be hierarchical with tree-branching arrangements, and so developed parent and child nodes from these initial free nodes with short descriptors. This helped me to better manage the data, and I could also see which participant groups featured under which nodes.

By the time I had manually and electronically coded all the data, I had conducted this both inductively and deductively. Inductively, being driven by the talk in the data; and deductively as I returned to my research questions regularly in order to search interview transcripts for talk in this regard. Welsh's (2002) stance that qualitative research is like a rich tapestry and that the researcher (as the weaver) is pulling together using NVIVO software as a kind of loom. Software programs can help to enhance the trustworthiness, quality and rigour of the research process (Welsh, 2002), but it is essential that the researcher has an overview of what they are trying to produce. I found that QSR NVIVO 10 was efficient in data management and data retrieval, but that combining electronic and manual methods helped me to engage more thoroughly with the data corpus.

During the process of preparing the data for analysis, including the fragmentation and then reconstitution into categories, the researcher risks situated meanings becoming lost, as the original context of participants' accounts is located elsewhere (Stenhouse, 2009). In the reporting of findings, I have attempted to restore that context to a degree, by providing details about participants' environment, circumstances and relevant issues that relate to the data extracts. This attempts to address the potential loss of the individual within the data that is presented (Clarke, Febbraro, Hatzipantelis & Nelson, 2005). Data segments presented in my findings chapters are sizeable as they include exchanges and responses between participants and myself.

I then began to examine participants' talk in more detail by applying an ethnomethodological lens to see what people were doing with their talk. Within my

early categories I began to search the data for talk that related to my research questions, along with accounts about mental health nursing and service user involvement in nursing processes. I noticed how people talked about such activities, what was said and unsaid. At a later point I developed Word Clouds (see Appendix 12) in relation to each findings chapter to assist me in continually revisiting emerging ideas about the meaning making in people's talk.

3.11 Conclusion

This chapter has sought to provide an account of the chosen research approach and methods used in this study. I have chosen an ethnomethodological approach, as this framework provides a contextual account of social processes, regarding what is going on in participants' talk. Ethnomethodological methods offer interviews as detailed interpretive accounts, which feature sense-making work by participants as they account for themselves as particular members of a social category. This may include participants explaining, describing, and finding order in their talk about people, places and actions they talk about (Baker, 2002). The meaning making in participants' accounts was where I focussed my analysis.

The focus of this study is the roles and professional identities in mental health nursing that are displayed in the talk of relevant social actors. I selected mental health nursing students, qualified mental health nurses and mental health service users as participants to portray multiple perspectives. Both individual interviews and focus groups provided the opportunity to gather data in the form of participants' talk. As participants were interviewed as members of specific social categories, their talk would potentially feature the production of identities, and how people re-present themselves (Antaki & Widdicombe, 1998). People present themselves in a particular way for a particular purpose. Therefore the work people's talk is doing was extremely relevant in answering my research questions.

During this chapter I have considered relevant ethical considerations, in relation to safeguards, consent, anonymity and confidentiality in my research relationships with participants. I have also reported my ethical responsibilities in relation to invitations to participate, the recruitment process, the management and storage of data, and the ethical approval process. The consideration of my own position as a researcher, in terms of reflexivity, has been an important process throughout this study.

Chapter 4: Mental health nursing roles and tasks

4.1 Introduction

In this chapter I begin to present the findings from my analysis of accounts from mental health nurses and service user participants about mental health nursing roles and service user involvement in nursing processes. I decided to write three chapters, as my findings from participants' talk led me to identify aspects of accounts that focused on the particular interests of speakers and which I have used to organise and present my findings. In each chapter I will illustrate the topic with sub-sections and examples of talk from my data. This chapter centres on talk related to mental health nursing roles and tasks. The decision to report my findings in this way is to present a logical arrangement of issues presented in participants' talk about mental health nursing work, and later how participants talked about service user involvement in relation to such work.

In this chapter I examine talk about mental health nursing roles and tasks from multiple perspectives, and what was being accomplished in participants' talk. People's narratives offer first-hand accounts about mental health nursing from the inside, which permits people to narrate their experiences of mental health nurses and mental health nursing. People's talk can explain the subject matter, and allow the researcher access to reports about people's experiences. Different speakers from different participant groups provided accounts on differing aspects of mental health nursing. These aspects included related work tasks, the time service users perceived available to them from nurses, and the myriad of roles that are considered related to this field of nursing.

In this chapter I will present findings from the talk of participants in relation to mental health nurses' roles and their role-related activities. My findings will show how

accounts are organised to demonstrate awareness of the tensions that exist with regards to mental health nurses' roles for relevant social actors. Stevenson (1996) suggests one way of knowing more about the professional identities of mental health nurses is to listen to their accounts of social processes they engage in as part of their everyday activities. Equally the narratives of mental health service user participants are included as they have knowledge and experience of meeting mental health nurses while they are engaged in nursing work. This chapter reports on participants' talk about mental health nursing roles and tasks.

In the following findings chapters I have made the decision to present data extracts of participants' talk that exemplify prominent patterns in my larger data set for this study. This decision is based on my awareness that detailed qualitative analysis of talk requires the use of substantial data extracts as exemplars rather than multiple smaller extracts that can seem a vain attempt to show a form of quantitative support for any analysis provided.

4.2 "You're supposed to be able to talk to her, but she quite often hasn't got time": service user expectations of inpatient mental health nurses

Mental health nursing roles have been the subject of recurrent debate in terms of validity and purpose. This may be because 'real nursing' is considered by many to occur solely in adult general hospitals where biomedicine is seen as superior because of its associations with medical advances and technical equipment (Coffey, Pryjmachuk & Duxbury, 2015). Mental health nursing work includes assessing people with regards to self-harm, understanding the social determinants of mental illness, and working with people in distress, which indicates a need to focus more closely on a social rather than biomedical perspective (Coffey & Hannigan, 2013), and is fundamentally different to other fields of nursing. Professional identity in relation to nursing may seem a rather theoretical concept as the work can be considered practical; however concerns around identity can have great consequence. For example, workers can experience role

ambiguity, which in turn can impact upon recruitment to specific fields of nursing (Hercelinskyj, Cruickshank, Brown & Phillips, 2014). It has been highlighted that mental health nurses have worked hard over the past few decades to discard the image of a custodial asylum attendant, and have sought to develop understandings and involvement with service users, and a commitment to social models of care (Ion & Lauder, 2015), in order to promote better care and a more positive image of the profession.

Academic and policy literatures have debated what constitutes the role of a mental health nurse (Nolan et al., 2004; Department of Health, 2006; Crawford et al., 2008). Although mental health nurses themselves have tried to articulate their distinctiveness as a group, it has been suggested that the search for a modern mental health nursing identity is doomed to fail (Hurley et al., 2008), perhaps because the discussion has continued for decades with little resolution. In addition mental health nurses have reportedly been under threat with proposals for moves to a more generic nurse, which would be at the expense of field specific education, with the first two years of training suggested as generalist learning (Lintern, 2014; McKeown & White, 2015). The notion of the generic nurse has been politically gaining momentum, with consultations which question the future of specific fields of nursing (Nursing & Midwifery Council, 2017a; Willis, 2015). These debates have resulted in the mental health nurses' role and its future being brought into question both inside and outside the profession.

Freidson (1970) claimed that a full professional identity usually indicates that workers have a significant amount of control over their work, their working patterns and everyday work activities. Notably, the mental health arena already has psychiatrists as an established professional group (McKeown & White, 2015). The question as to whether or not nursing is a profession has been debated for years (Messer, 1914), with nursing considered to have only semi-professional status, as a group allied to medicine, and a limited degree of autonomy. For mental health nurses to be regarded with a distinct role and status would go some way in strengthening this profession. Mental

health nurses themselves are aware of the wide range of roles they occupy, but have still voiced difficulty in articulating what they actually do (Rungapadiarchy et al., 2004).

In line with social models of mental health, the recovery movement has gathered pace and focuses on a process of changing attitudes, goals and skills to live a satisfying life beyond the catastrophic effects of mental illness (Slade, 2009). Since the late 20th century, the mental health nursing profession has begun to focus on psycho-social and values-based approaches. Values-based practice is about principles and priorities, and aims to provide 'a framework and skills to enable people to work in a respectful and sensitive way with the different values and perspectives present in practice' (Woodbridge & Fulford, 2004, p.7). Values-based approaches are not specific to nursing, and were developed by the National Institute for Mental Health in England and the Sainsbury Foundation for Mental Health (Woodbridge & Fulford, 2004), as a set of mental health-specific capabilities to complement more generic frameworks for health professionals' competencies (Department of Health, 2004; NHS Education for Scotland, 2007). The Essential Shared Capabilities relate to both values-based and evidence based practice, and provides a benchmark of the core attitudes, skills and knowledge needed for the entire mental health workforce (Lamza & Smith, 2014). The Essential Shared Capabilities for mental health staff include working in partnership, respecting diversity, promoting recovery, well-being and self-management, and providing person-centred care. The development of such principles for practice does set a marker for the work of mental health nurses.

Mental health nurses who work in inpatient settings have reported being aware that what they actually do as work is not as professionally valued as therapy, and is not articulated in nursing texts (Deacon, 2004). Witnessing prestige in general nursing colleagues with advancing practitioner status has perhaps led to mental health nurses seeking the equivalent by delivering therapies and techniques from other disciplines (Hurley et al., 2008). It is the measurement of professionals' effectiveness that is seemingly valued, and mental health nurses who have attempted to define their field and

measure the nurse-patient relationship have found this challenging. Research indicates that:

> 'within mental health practice, a disproportionate amount of time is taken up by other activities, with little time being spent listening and talking to service users (...) resulting in limited evidence of the effectiveness of the therapeutic relationship in acute mental health wards and (…) why, after five decades, it is not recognized as a fundamental metric of mental health nursing'
>
> (McAndrew et al., 2014, p 212)

A focus on the scarcity of time spent by nurses with service users in inpatient settings are revealed in the accounts of mental health service users in my study. This has implications for the time required to develop trusting therapeutic relationships, and that insufficient time is available for such relationships to develop. The distance observed between nurses and service users can be attributed to the organisational need for order (Bray, 1999; Porter, 1993), with nurses avoiding therapeutic interaction so that they might maintain the institutional status quo.

In the following account I asked Simon, a mental health service user, about his encounters with mental health nurses. Simon, in talking about his experiences of mental health nurses in this extract, focused upon his time spent in inpatient mental health settings. The research interview with Simon, lasted 1 hour and 4 minutes, and was conducted in a third sector organisation setting.

JT: What did their job seem to mostly be about, what they did, their role, in the hospital perhaps first?

Simon: *[laughing]* It's very hard to say actually. What were they doing? They seemed to walk up and down a lot, I don't know what they're doing (laughing). They seem to spend a lot of time walking up and down the ward, you know. I don't know whatever they're doing, I really don't know.

JT: No

Simon: There's…there's too much of a division between the staff and the patients really.

JT: Yes. So it actually wasn't clear what they were doing some of the time?

452 **Simon**: Not at all, exactly.

453 **JT**: Did you have a sense of what they were doing for you on the ward? If you know
454 what I mean.

455 **Simon**: Erm, well, you do have…you have a named nurse and er and if you've got a
456 problem you can talk - you're supposed to be able to talk to her, but she quite
457 often hasn't got time. And if you…There's a - there's a central area where
458 they…they've got their office

459 **JT**: Yes

460 **Simon**: And erm if you knock on the door - You have to knock on the door erm
461 to ask things and erm quite often you get a negative response

462 **JT**: Right

463 **Simon**: That they're busy or…erm…well, things like that, that they're too busy er you
464 know, or…or…or they've got a very erm…they've got a very erm, er for want of
465 a better word, a silly rule

466 **JT**: Yes

467 **Simon**: About something, that's not…that's not helpful

[Simon, Mental health service user 10, lines 442-467]

Simon was a mental health service user who had experienced several admissions to acute inpatient wards in different geographical areas. In the above extract Simon was responding to my question about mental health nurses' roles in hospitals, and what their job seemed to be about. Simon laughed and replied "It's very hard to say actually" in line 444. In this turn he used the words "I don't know" on three occasions, implying that to him the nurses' roles were unclear and that he had some uncertainty about claims made on behalf of these role functions. Simon added "they seemed to spend a lot of time walking up and down the ward" (lines 444-445). In his account Simon is making 'the social structures of everyday activities observable' (Garfinkel, 1967, p.75), and in doing so is putting the workings of this social setting on display as he understands them. These activities are not ordinarily known to the general public and Simon's account therefore brings them to the fore and highlights activities that are not ordinarily available for discussion.

According to Edwards and Potter (1992), in human discourse people display their memories of action that occurred, and provide a version to the listener. To an extent this display is always self-interested, and in his talk Simon is displaying his own understanding of events, of nurses walking up and down the ward, suggesting a sense of busyness. Interestingly whilst Simon conveyed a sense of nurses being busy, there is no implication of nurses being busy directly with patients. Simon was unable to say what the nurses were doing, as from his account; the activities did not appear to involve him. In this sense it can be seen that Simon is highlighting a disconnection between him and the nurses on the ward, and he goes on to elaborate on this later in his account.

Simon then said "there's too much of a division between the staff and the patients really" (lines 449-450), which served to reinforce the separateness of nurses and service users. Ideas are constructed in talk using particular phrases, and in this way are action-oriented, they are doing work to convey a particular message. The message here of separateness is furnished sequentially in Simon's account with incremental additions of uncertainty and phrasing such as 'too much division'. Some division may be acceptable but for Simon perhaps this has gone beyond what he would expect. There are a number of occasions in the above data extract where Simon provided examples of divisions between the nurses and service users as he saw them. Simon's talk of divisions centred on a lack of time to talk with nursing staff, which I shall explore first, as well as the location of the inpatient nurses who are reported as being located separately from service users, and are primarily in the ward office.

There is an apparent mismatch between Simon's experiences of mental health inpatient nurses and his expectations of their role and work. This is most notable in lines 455-456, "you have a named nurse and er and if you've got a problem you can talk - you're supposed to be able to talk to her, but she quite often hasn't got time". Simon showed awareness that he is assigned a named nurse. The purpose of having a named nurse is that patients have not only continuity of care, but also experience relationship-based intervention which is co-ordinated by a named health professional (Manthey, 2002).

This model of healthcare has been evident across settings including adult nursing, and general hospital settings as well as mental health.

After Simon introduced the listener to the idea that a patient could talk to their named nurse, Simon then signalled doubt in line 455-456. He said "if you've got a problem you can talk - you're supposed to be able to talk to her". This self-initiated repair from "you can talk" to "you're supposed to be able to talk to her" suggests a dichotomy between the ideal and the actual experience of care. Simon's explanation for this contradiction is that "she [the nurse] quite often hasn't got time". Simon's talk does the work of positioning his claim of a discrepancy between what he expects ("supposed to be able to talk to her"), and what he perceives ("quite often hasn't got the time").

The apparent busyness of staff indicated in Simon's account in this study is reflected in other research. Service users have reported inpatient mental health nurses to be inaccessible with distancing behaviour highlighted (Moyle, 2003), and a conveyor belt type of relationship experienced which meant only a passing relationship with a named nurse (Bee et al., 2008). This raises a question about how inpatient mental health nurses are spending their time. Simon indicated this was unclear to him (lines 451-452).

A study by Fourie et al. (2005) observed nursing practice in inpatient settings and explored nurses' perceptions of their roles and reported many work roles related to stabilising patients' symptoms, crisis management and discharge planning. Nurses' roles were considered to be complex and the authors suggest their research 'gave voice to what at times seems like an invisible practice' (Fourie et al., 2005, p.134). It is suggested that the nature of mental health nurses' work needs to be demystified to mental health service users, which would provide opportunity for further empowerment (Michael, 1994). Simon's account resonated with disempowerment, which could potentially be altered by nurses spending more time making their role-related activities more visible and transparent to service users.

It is reported that the limited interactions that occur between mental health nurses and service users on acute admission units are seldom therapeutic or theoretically informed (Cameron et al., 2005; Gamble, 2006). What service users value in nurses includes reference to professional knowledge and attitudes such as conveying hope and respect to service users (Lloyd & Carson, 2012; Rydon, 2005). Positive personal qualities that service users wish to experience from nurses include empathy, respect and compassion (Breeze & Repper, 1998; Greasley, Chiu, & Gartland, 2001). Expectations from mental health inpatient service users include individual attention from staff, with this interpersonal relationship proposed as the framework for all other caregiver roles as part of inpatient treatment (Hopkins, et al., 2009). Peplau (1952) first proposed that this interpersonal relationship was to be the focus of mental health nursing, with her theory of interpersonal relations. Gilburt, Rose and Slade's (2008) study, conducted by service users with 19 individuals who had experienced inpatient admission, sought an understanding of the processes which define the service user experience of hospitalisation, and identified that the central role of relationships was at the heart of the inpatient experience. However, despite arguments that promote the nurse patient relationship as being central to patient care, emerging evidence indicates that although service users value this nurse patient alliance, the relationship is not sufficient on its own (Hewitt & Coffey, 2005). Service users have suggested that they would value increased access to technical aspects of therapy, such as Cognitive Behaviour Therapy (Coffey, Higgon & Kinnear, 2004), suggesting that they may be wanting far more than what nurses are offering.

Certainly service users, as indicated by Simon, have expectations of mental health nurses, and what might feasibly be anticipated from them. Stenhouse's (2009) narrative analysis of service users' experiences of care on an acute inpatient ward indicates similar expectations. The quote from one of Stenhouse's participants "they [nurses] all said you could come and speak to us" highlighted a notion of accessibility that was inconsistent with participants' experiences as they found the nurses were too busy to talk (Stenhouse, 2009, p.119). Unfulfilled expectations of being able to talk with nurses are mirrored in Simon's account in my own study. Service users with hopes of engaging

with nursing staff, who then have these opportunities for engagement denied or cut short, are likely to experience dissatisfaction with their healthcare experience.

Frustrations may escalate into further distress including anger and aggression. Bowers et al. (2015) highlighted that interventions that sought to improve staff relationships with service users can reduce the frequency of conflict and containment situations. In terms of how mental health nurses prioritise their workload and allocate time to role-related activities, if further time was spent engaging directly with service users this may result in fewer incidences of complaints, aggression and distress. Furthermore, if people are not offered the time to engage in therapeutic encounters with nurses to understand their conditions and to learn techniques for handling symptoms, there is a lost opportunity to have help with the problems that led to a hospital admission in the first place. Inpatient wards can become warehouses for people who are sufficiently medicated or have an adjustment to supports they receive, but not actually places for building recovery.

In Simon's narrative he hinted at variances in power held by both nurses and service users. In his talk, Simon gave examples of this lack of power. In lines 449-450 Simon highlighted that "there's too much of a division between the staff and the patients really". This appears to relate to a split regarding location of social actors present. Simon said in lines 457-458 "there's a central area where (…) they've got their office". Simon's talk of "division" also functioned to highlight differences between the nurses and service users in relation to power. The descriptions in Simon's talk suggested there is a process for engaging with nurses in an inpatient unit who are in the office. He said "if you knock on the door", and stressed "You have to knock on the door erm to ask things" (line 460-461). Simon's account achieved the explanatory work of accounting for how service users gain access to mental health nurses who are in the office. The display of understanding that Simon presented in his talk reinforced that not only are service users required to follow these rules, but reinforced the "division" he talked about in line 449, and indicated the power that he viewed nurses have.

Simon's account here indicated an unwritten rule that may influence how service users and staff can behave in this inpatient setting. Staff are seen to be in charge and hold power, whilst service users are meant to respect this and wait for attention. Simon's account is sequenced so that these lines about the office follow on from a description of staff who seem to be busy, but not visibly doing anything that an observer might call nursing. The account displayed Simon's understanding that the organisation of mental health nursing work from his experience can appear to be nonsensical or difficult to decipher. The profession claims to have person centred values, and provides patients with an allocated nurse, but in Simon's account the nurse then busies themselves with activities which do not relate to him. Simon's account brings this lack of congruity to the fore with his example about attempting to secure the required attention from the nurse, but being told to wait outside an office door. The account does the work then of showing how Simon understands inpatient care to work. It can be read as ultimately disempowering and placing the needs of the system before service users. In this sense nurses too can be seen as just part of the system, their primary role being to ensure the smooth running of the organisation, which at times can conflict with notions of being person centred. Godin (2004) makes a similar point in his study about how mental health nurses manage risk, and that due to an emergent culture of blame nurses adhering to system requirements is considered important. Godin's position is that nurses become mere functionaries in the system so that their role is to administer rules rather than to focus on care.

Simon, having described waiting outside the ward office door, goes on to say that "quite often you get a negative response" (line 461). There is suggestion that 'it is hardly surprising that patients report their requests are not heard, that they receive unsympathetic responses from over-stretched nurses, who spend most of their time in the office' (Fagin, 2007, p.131). The subject of the nursing office in mental health settings is much explored in the literature, and it is noted that staff do indeed 'retreat to the office' (Grandison, 2007, p.61). There could be a number of reasons for nurses seeking sanctuary or withdrawing to the office. Deacon et al., (2006) report findings from an ethnographic study that nurses in acute settings can be approached and

bombarded with demands from patients and visitors, and consequently have to prioritise their on-going work, which suggests demand outstripping available resources. Acute environments will include service users who are usually the most unwell, vulnerable and disturbed (Bowles & Dodds, 2002). Nurses who feel ill-equipped to manage or feel stressed by unrelenting demands may be another reason for nurses wishing to withdraw to the office. Retreat to the office may be a coping mechanism for handling stressful or emotional issues that mental health nursing work can involve. There is suggestion that nurses struggle with the reality of inpatient work and are 'serving a system' rather than the patients (Fourie et al., 2005, p.139). A Department of Health (1999b) report 'Addressing acute concerns' highlighted that inpatient units have become more custodial, with little therapeutic activity, and service users having much less contact with nurses than they would wish. Simon's account appears to support this.

Simon's narrative indicated there is a public version of what happens in mental health settings, and also a more unseen set of operational rules that apply. Simon described the nurses as appearing busy, but highlights his experience was to be treated as less important than invisible tasks that required nurses to rush up and down, and be more concerned with activity that is sometimes positioned by nurses as only to be completed in the office. In reality note-writing can be undertaken in other ward areas, and often with the service user concerned. The account Simon provided appears to suggest a system that downplays humanness, as the focus on nurses' time did not appear to be centred on the relationships with service users.

In the next extract I continue to explore role-related activities of inpatient mental health nurses with an account from Mary, a mental health nurse who at the time of interview was working in an acute inpatient setting.

4.3 "I sit in the office most of the time": positioning the inpatient mental health nurses' role

Qualified nurses in hospital settings have highlighted that, due to the extensive amount of tasks and administration work required for their role, they spend a lot of time in the ward office (Whittington & McLaughlin, 2000). According to historical nursing records, repetitive task performance was previously highly valued in nursing (RCN, 1948), perhaps because a sense of orderliness and occupational rituals help to minimise the effects of crisis. The profession has been reported as having cultural resistance to changing established patterns of work, with some staff who are reluctant to change their practice and keen to maintain the status quo (Brown, Wickline, Ecoff & Glaser, 2009). The nature of task-oriented nursing has been reported as a particular barrier to change initiatives such as implementing evidence based practice (Fink, Thompson & Bonnes, 2005). Throughout the course of my study in interviews with mental health nurses and service users there were repeated mentions of tasks relating to mental health nurses' role related activities, particularly in relation to inpatient settings. This suggests that task-oriented nursing is still very present in mental healthcare, and that nursing work may not have changed or progressed as much as it might have.

Bowers (2005) purports that the main task of acute inpatient care is to provide a safe environment, and that it is 'a continuous task for mental health nurses to provide comfortable, clean accommodation with regular meals and adequate leisure and recreation facilities' (Bowers, 2005, p.235). Organisational provision appears to reinforce routine, with many inpatient activities governed by time (such as mealtimes and medication rounds). Habitual and predictable work often emanates from the orders of medical staff and may result in nurses feeling their own autonomy is somewhat limited (Brown et al., 2009). Freidson's (1970) seminal work which examined the sociology of the professions remains relevant today. He highlighted that routine work is often delegated downwards by medics. This professional dominance relates to doctors control over healthcare work, with nursing staff considered to be in a more subordinate position (Hughes, 2002). New roles for mental health nurses, such as approved mental health professionals and nurse prescribers, extend the responsibilities and powers of

nurses into unchartered areas (Coffey & Hannigan, 2013), and suggests that nurses are no longer considered as doctors' handmaidens. However, Goulter et al., (2015; p.449) suggest 'the interactional work of mental health nursing has been eroded and redirected to the task-based roles of medicine'. This suggests that nursing work has continued to be heavily influenced by direction affiliated to the medical model.

A study that identified nurses working in a task-oriented system is Aston and Coffey's (2012) research about what recovery meant to inpatient mental health nurses and service users, with findings indicating that a task focus resulted in difficulties adopting recovery-based practice. Service users reported feeling alone whilst nursing staff were in the ward office, which impacted on communication and reinforced divisions between those providing and receiving services (Aston & Coffey, 2012). It is relationships with staff that are reported to be the core component of recovery-focused care for service users, which incorporates effective communication, cultural sensitivity and a sense of trust (Gilburt et al., 2008). It is difficult to see how nurses can provide these therapeutic relational opportunities if their task-based work requires them to be segregated in a ward office, inaccessible to patients for interaction.

The following data extract is taken from a research interview with a mental health nurse, whom I shall call Mary. She chose to be interviewed in a room at the university campus. At the time of the interview she had been qualified for 18 months, and worked on an acute inpatient unit. This extract is taken from near the beginning of the 59 minute interview which began with me asking Mary questions about her current role. She describes her work in relation to the tasks performed on an average shift, which includes reference to a range of task-oriented activities and being in the ward office.

JT: So in terms of erm your role as a mental health nurse, what are some of the things that you do on this ward?

Mary: Um, daily you'll come in from the start of the shift and have your handover. Um, say it's a morning shift, you might check the diary then to make sure what's planned that day. If you've got ward round you get the notes ready and everything else ready for ward round. You do the medication erm between 9 and 10 o'clock and make sure everybody's had that. If you need to order any medication then you order that and then you just work through the diary. You might have to run around and chase up this person or make appointments for people, and then you tend to have to do notes by about 12 o'clock so, um, you're writing down on each and every patient, and then you're handing over then at 1.00 to the next staff. But then you're also - You've got, ah, new - nurse the patients. So you've got specific patients that you've got and you'll be doing care plan reviews with them, um, assessments that need doing such as, er, SESCAM.

Um, so you do that, either weekly or fortnightly depending on how quick the person's changing, how long they've been in, and we also deal with new admissions and discharges. So if the patient's discharged we make sure that they've got medication to take home, send that down to pharmacy and forward the information onto the CMHT, see if they need, um, follow-ups. We arrange the follow-ups or if the crisis team are going to be involved we ask them to come and assess, and then for new admissions it's just you've got a whole load of paperwork to go through with them such as taking all their basic details, risk assessments, doing the care plans, um, showing them around the ward, settling them in, getting hold of the GP to confirm any regular medications and things like that.

JT: There's a wide number of things that you get involved in [

Mary: Yeah.]

JT: In your role there. Staying with the erm adult acute admission ward and yours is an area that works with just female clients. Erm, if one of your service users was here and I said to them tell me about the nurses' role on the ward, do you think they would say …What do you think they would say?

Mary: I sit in the office most of the time.

JT: I have heard patients say that a lot over the years. Why would they say that?

Mary: Because they tend to spend more time with the erm NAs, because the NAs are kind of what we say out on the floor.

JT: Yes.

Mary: Whereas erm the nursing staff are either doing medication, doing the paperwork or dealing with the phone calls. So we don't tend to have that much time to actually sit down and spend with the patients which is a shame really.

[Mary, Mental health nurse participant 1, lines 61-98]

Mary gave a detailed account "from the start of the shift" (line 63). She worked to construct a description of her role by presenting a list of tasks which included "check the diary then to make sure what's planned that day" (lines 64-65), and "if you've got ward round you get the notes ready" (lines 65-66)'. Mary's account then started to link nursing work with times of the day, such as "do the medication erm between 9 and 10 o'clock" (lines 66-67). Mary continued to use clock times as a sentence construction device to sequentially account for daily tasks in which she engages (lines 71-72). Her descriptions were aligned to a task-oriented approach to nursing and the current system of work, which is reinforced in line 68 when she says "you just work through the diary". Nurses have been reproached for concentrating too much on the tasks of the day, which may be harmful to both themselves and those they care for (Stacey, Johnston & Stickley, 2011). Task-based systems of work may have perpetuated in institutional settings and become routine practice.

Mary referred to the ward diary twice in her account (lines 64 and 68), and this talk about the diary suggested it served as a tool in the localised system of work. Hughes (1971) suggests the world of work is best considered as a dynamic and interrelated social system. A system will include various occupations in a larger system of work, such as the multi-disciplinary mental health team. There are specific bundles of tasks associated with particular occupational groups, and both the task aspects of a role (what a worker does) and role aspects (who they are) inform their work-related activities (Allen, 2001). Abbott (1988) employed a systems approach to the study of professions, and considered the notion of jurisdiction when referring to the control that people have over their area of work. Jurisdictional claims regarding work roles indicate the territory of activity of that particular professional group, and areas where individuals have power to make decisions. In Mary's account it would appear that the details listed in the ward diary are the jurisdiction of the ward nursing staff. From Mary's talk it was apparent that the diary functioned as a mechanism for nursing staff, as their bundles of tasks or role-related activities for the day were recorded in there. I suggest that how Mary talked about the diary implied that it was used by nursing staff to reinforce and perpetuate a task-based work system.

In this extract Mary described a typical shift on the ward, and got as far as "you're handing over then at 1.00 to the next staff" (line 71), when she made a repair in her talk. She appeared to show awareness of an omission; she has not yet mentioned interacting with the patients on the ward. She said "but then you're also - You've got, ah, new - nurse the patients" (line 72). The 'but' served the purpose of being a conjunction to link two contrasting clauses or topics. It was as though Mary was talking about her work and all these tasks and had forgotten about the patients, as if they were somehow separate. One virtue of examining participants' talk is that it can reveal issues of reported fact and personal responsibility which are frequently at stake for participants (Edwards & Potter, 1992). As Mary was constructing a version of her roles and responsibilities as a staff nurse, the account needed to work to achieve a credible description of her role on the ward. She appeared to use this self-initiated repair to present herself as a nurse who did prioritise patients. Mary's repair functioned to change topic to ensure that patients are mentioned and part of her account of herself as an inpatient mental health nurse.

In a study about what keeps nurses busy in acute inpatient settings, Goulter et al., (2015) observed the proportion of time nurses spent in various activities, and found only 32% of time related to direct patient care (with 51% on indirect care and 17% on service-related work). Goulter et al. noted a need for nurses to re-establish their therapeutic availability to service users, in order to maximise people's healthcare experiences. Whilst expectations of care delivery are held by service users and nurses, both parties acknowledge there are barriers to care delivery in inpatient mental health settings. A study by Simpson (2004) on care co-ordination for people with severe mental illness suggests that these obstacles can include psychiatrists who act as a barrier to change, hold the most power and can hinder innovative ideas. Equally there are psychiatrists who champion change, promote contemporary ways of working and encourage mental health nurses to follow a more recovery-focused model. When nurses remain focused on a task-oriented model it almost appears to be keeping them away from the very people for whom their roles exist, as the tasks could be seen as the focus of work rather than working closely with service users. Although the area of mental health nursing work in inpatient settings is under-developed in the literature, there are increasing reports that work structures are organised for nurses to work separately from

service users (Goulter et al., 2015; Handsley & Stocks, 2009; Whittington & McLaughlin, 2000). Family members have reported observing a 'them and us' mentality between nurses and patients when they have visited ward settings (Scally, 2007), because they have observed the two groups to frequently occupy separate areas in the inpatient environment. It is apparent then that evidence indicates nurses in inpatient settings may follow a task-oriented model which results in meaningful interactions with service users being limited.

In Mary's talk from line 75 she continued to highlight further elements of her role-related activities. She mentionned the nursing work on her ward related to service users who were both being discharged from hospital, those who needed follow up and those who were being newly admitted. Mary noted that for new admissions "you've got a whole load of paperwork to go through" (line 81). Mary's account did the work of establishing how busy nursing work was on this particular ward. Indeed nurses' concerns about the volume of paperwork are not new. Paperwork is particularly well reported in the literature by nurses who work in inpatient settings as being a stressor (Burnard, Morrison & Phillips, 1999; Fourie et al., 2005), for community staff (Simpson, 2005); and an activity staff report that reduces time with patients (Thomson & Hamilton, 2012).

It is suggested that nurses employ measures to manage the demands and busyness of their role, with 'protection afforded by the task-list system' (Menzies Lyth, 1959, p.444). The idea behind this is that nurses working in inpatient settings are beset by discomforting feelings that emanate from working with people who are ill. It is suggested that such unease prompts nurses to employ emotionally protective measures or practices in order to compensate and cope with such moral distress. This can be defined as negative feelings that are experienced when a person knows the morally correct response to a situation but cannot act accordingly because of institutional or hierarchical constraints (Jameton, 1984). The concept of moral distress involves the physical and psychological pain and unsettling interpersonal relationships that arise from patient care, where a nurse makes a moral judgement regarding their course of action (Corley, 2002). Nurses frequently experience moral distress when confronted

with ethical dilemmas in their practice (Oh & Gastmans, 2015). Challenges include times when nurses are unable to act according to their individual standards, when they experience conflicts about care decisions and uncertainties about who is in charge (Crippen, 2016). Anxieties of this nature may lead to protective measures being employed to manage this moral distress and may include splitting up the nurse patient relationship, so time spent with patients is limited, and other time is used to engage in task-oriented routines. There are similarities here with the concept of emotional labour, first defined by Hochschild (1983), in that employees engage in a process whereby they are expected to manage their feelings in line with organisational rules and guidelines (Wharton, 2009). Likewise emotions aroused by work situations require control to fit the display rules of particular situations (Goffman, 1959), meaning that employees will regulate their feelings and thoughts, often by taking some form of action. I suggest this is similar to how nurses are managing the busyness and demands of their role, and that in inpatient units they may cope with the demands of their role by engaging in task-based routines, and by retreating to the office.

Lines 68-74 served to provide further information from Mary about ward activities, with expressions used such as 'you run around (…) chase up (…) do notes (…) handing over'. The use of these verbs in Mary's talk conveyed a sense of busyness and activity. Mary gave the view that service users on the ward would see her "in the office most of the time" (line 91). This has similarities with Simon's account earlier in the chapter. Simon too spoke about nurses being busy, rushing about, and seemingly having little time for direct patient interaction. The nursing work that occurs in the ward offices serves to remove nurses from the main ward environment, rendering them inaccessible to services users. Nurses may list tasks they need to undertake in the office, as Mary did, but I wonder if retreating to the safety of the office has also become a routine staff practice. Withdrawing to the office has been highlighted as an activity that nurses engage in to retreat from patients' demands and distress, and can be considered as an emotionally protective measure (Hardcastle, Kennard, Grandison & Fagin, 2007). As suggested such practices, which may in part meet the psychological needs of nurses, have become part of routine nursing work, with nurses maybe failing to question why they do spend long periods in the office.

In Mary's account she highlighted that the service users may view her role as sitting in the office most of the time. She said service users tend to spend more time with "the erm NAs [nursing assistants], because the NAs are kind of what we say out on the floor" (lines 93-94). The expression 'out on the floor' is used by employees who are referring to the main area of work or the 'shop floor', which would be the main pubic areas of the ward. Mary's talk about the nursing assistants' location functioned to recognise their availability to service users. Mary's account was also doing the work of showing her awareness of jurisdictional boundaries. She described her own nursing work as taking place in the office as a qualified nurse "doing medication, doing the paperwork or dealing with the phone calls" (lines 96-97). This is fundamentally different to the work of the nursing assistants, who are available to the service users. Mary's account functioned to accomplish particular types of professional identity work, in that the roles of nursing assistants and qualified nurses are seen differently. In terms of jurisdictional claims, some professionals control the work of others (Abbott, 1988), and qualified nurses would dictate and delegate work to unqualified staff. In lines 97-98 Mary reaffirmed the situation with "we [qualified nurses] don't tend to have that much time to actually sit down and spend with the patients which is a shame really". This rather reinforced a sense of status quo in an inpatient setting.

Additionally, the 'we', in line 97, served the purpose of sharing the responsibility wider with other nurses who work on the ward, so that Mary does not imply it is just her who does not have time. In her account she worked to shift any potential blame that might be attributed to her. The word 'we' may also indicate a sharing of characteristics, in that Mary is identifying herself as part of a group of other mental health nurses, with whom she shares traits. Whilst the earlier part of this sentence could stand alone 'we don't tend to have that much time to actually sit down and spend with the patients', Mary made an addition. She said 'which is a shame really', which served to indicate that given the chance, she might like to sit and talk with patients more, as opposed to being in the office. This addition at the sentence end, served to portray Mary in a positive light.

An ethnomethodological lens can help reveal how social facts are displayed and made observable by society's members (Bowers, 1992). Mary, as a member of ward staff,

revealed through her account how everyday activities occur in an acute inpatient environment. Earlier in this chapter Simon, as a mental health service user, claimed that many of the role-related activities of mental health nurses were unclear to him. In Mary's account, she has made her work activities visible probably because she works in the role of a mental health nurse, and has particularly focused descriptions of her work on a range of tasks. When considering Mary's talk about nursing work on the ward where she works the dominance of a task-oriented system is clearly apparent. This is evident in talk such as "get the notes ready and everything else ready for ward round" (lines 65-66), where the nurse's role is apparently subservient to the medic, with nursing work focussed on carrying out instructions and administering prescriptions.

Mary's account focused on task oriented activities in the main. There is almost a complete absence of talk about therapeutically engaging with service users, or engaging in recovery-related activities. Key areas of knowledge required for mental health nursing practice have been identified as recovery-oriented skills, therapeutic strategies, physical health skills, resilience, and knowledge about well-being (Evans & Hannigan, 2016; McAllister, Happell & Flynn, 2014). The ethos of mental health nursing is considered to centre on the therapeutic relationship nurses engage in with service users, and it is through this medium that other care based activities can be achieved. However, nurse participants more generally in my study tended to talk about tasks rather than therapeutic activities.This narrative extract from Mary demonstrated an emphasis on task oriented work for inpatient mental health nurses, and in terms of choice about nursing activities it is difficult to assess the level of autonomy she has in terms of how she carries out her day to day work. Autonomy is a multi-faceted concept concerned with the capacity for self-governance and independence (Harnett & Greaney, 2008). As mental health nurses work in a range of different settings, it is feasible to expect their levels of autonomy to vary. This is because mental health care settings differ and degrees of autonomy may be influenced by other members of the multidisciplinary team, as well as the types of mental health work undertaken with service users.

The next data extract is taken from a research interview with a mental health nurse whom I have called Laura. During the conversation Laura made comparisons about

autonomy as she perceived it, between mental health nurses who work in the community compared to those in hospital settings.

4.4 "Toing and froing from different people, it's more varied, you're not kind of stuck in an environment": perceptions of differences between community mental health nurses and ward nurses

Narrating refers to the process of telling a story or giving an account. Narration situates experiences as closer to, or more removed from one's identity, which helps the narrator to tell the story of who they are (or who they are not) (Westerhof & Bohlmeijer, 2012). Telling stories about oneself is considered to be a process of 'selfing' (McAdams, 1996). Individuals identify with their own personal experiences and, through the telling of their accounts, identify with these experiences in relation to their identity. Westerhof and Bohlmeijer (2012) suggest that there is an inner proximity between experience and identity, in that the timeline of a person's story shows growth or change as a result of their experiences, from the past to the present. The communication of identity in people's talk to others says much about how a person does (or does not) see themselves. In this section I explore how the professional identity work of mental health nurses is constructed through participants' stories. I focus on talk about working in community settings compared to the hospital environment as constructed by participants in their talk, which indicates awareness of variance and complexity in professional identity work.

Sacks (1966), a sociologist whose work focused on analysing conversation, highlighted that when people talk about others, they may categorise them as certain types of members of society. Categorisation does the work of analysing and interpreting the social world in an attempt to make sense of it. In Widdecombe's (1998) research on different social groups, she highlighted how actors draw comparisons and mobilise distinctions during interactional talk. Widdecombe noted how people categorise their own identity and those of others that they see as different to them. In the following section I will show how participants made use of categorisation in their talk about mental health nursing.

One way that narratives function is that they are used to describe events and can make events appear literal, with narratives structured to appear as more than just a claim or a speculation. It is the function of description in accounts that aims to establish the account as the definitive version (Edwards & Potter, 1992). When individuals talk about work roles they may be constructed in an idealised way, when one type of role is compared to another. There are many versions of mental health nursing roles which occupy the profession. Participants in my study positioned professional mental health nursing identities in talk by highlighting elements of their work. This included competing versions or differences between roles as they saw them.

Autonomy is characterised by volition and agency. Volition being the capacity to exercise free will to make a choice (Haggard, 2008). Agency is the capacity to act with voluntariness and the exercise of this capacity (Chambon, Wenke, Fleming, Prinz & Haggard, 2013). Nursing can be considered an autonomous, self-governing profession with its own unique scope of practice. However, a range of factors may impact on mental health nurses' autonomy. For example, the historical nature of the profession's relationship with psychiatry has continued to influence and sometimes limit the autonomy of mental health nurses. Hannigan (2006) suggests that as mental health nursing has grown out of the asylum system that the profession has largely shared a biomedical knowledge base with psychiatry. It may be these long standing links with psychiatry that indicate nursing's autonomy is limited, because historically nurses have taken instruction from, and been trained by medics. In the following account I will first explore categorisation work about mental health nursing, followed by how the notion of autonomy in mental health nursing is handled in talk.

The following data extract is from Laura, a mental health nurse participant in my study, who considered through her talk how CMHNs may be different from inpatient nurses. The interview lasted for 1 hour and 4 minutes. Laura chose to be interviewed in the university setting and had been qualified as a mental health nurse for 4 years. At the time of the interview Laura had a number of misgivings about her future in mental health nursing. She had returned to the university as a student and was part way through

a history degree. She was also working part-time in a nursing home to fund her studies. In the interview I asked Laura about her nurse education experience and she described her experiences of hospital placements as "quite negative. I don't remember an awful lot of positivity" (line 95). Laura said she perceived an attitude of cynicism and that patients were "fobbed off sometimes with inadequate explanations of things" (line 85). During the interview Laura did say that she had considered giving up her nursing course up after her first placement, which was in a hospital setting. Laura said she found her community placements far more beneficial, and noted the differences as she saw them between the roles of nurses working in both hospital and community settings. It is the differences that Laura perceived and the categorisation between these two types of nursing roles, which is the focus of my analysis in the following section.

165 **JT**: What was different about working in the community for you?

166 **Laura**: Erm, probably…I think it was nice being in people's homes

167 **JT**: Right

168 **Laura**: Because you can see their sort of personal surroundings. It's more relaxed
169 because you haven't got to think about anybody else and perhaps they can be a bit
170 more honest because they know they're not in hospital. They might feel they
171 haven't got to say certain things to try and play the game (laughs).

172 **JT**: Yes

173 **Laura**: Erm…and I think the staff that were in the community, certainly the placements
174 I had, were perhaps a little bit erm a little bit more switched on, perhaps they're
175 not dealing with people that are in such crisis maybe, because they're in the
176 community. They had a bit more time to talk, they knew the people a bit better
177 possibly.

178 **JT**: Yes, yes

179 **Laura**: Erm…I think, yeah, just none of that institutionalised feel. You know, you've
180 got your own clothes on, toing and froing from different people, it's more varied,
181 you're not kind of stuck in an environment.

182 **JT**: Yes

183 **Laura**: It was just a lot more engaging I found

184 **JT**: Mmm

185 **Laura**: And the staff, the…the mentors that I had in the community were much more
186 (3.0) much more willing to try and teach and explain, a good sense of humour.

187 **JT**: Yes

188 **Laura**: Little things, characteristics that I felt much more comfortable with.

189 **JT**: Right, right, yes.

190 **Laura**: They seemed happier in their jobs, possibly.

191 **JT**: Yes, yes. Yes. What do you put that down to?

192 **Laura**: Erm…(6.0) Probably…Certainly one thing would be maybe they feel they've
193 got more autonomy over their role and their job. Erm.. (4.0) Yeah, probably
194 mostly that, more autonomy I think.

[Laura - Mental health nurse participant 11, lines 165-194]

Prior to this point in the interview Laura had been talking about her placements when she was a nursing student, particularly when she had been placed in hospital settings. As part of Laura's narrative she spoke about the difference in the roles of mental health nurses in hospital and community settings as she saw them. Laura reported early on in the interview that her experiences as a nursing student were more positive in community settings, and made observations about her perceptions of role differences between CMHNs compared to those working in inpatient environments. In the data extract above Laura appeared to be positioning competing versions of nursing roles in both hospital and community environments.

In Laura's account she drew on her background knowledge, "in the community, certainly the placements I had" (lines 173-174), to position community work in a favourable light. Throughout this extract there were indications of competing versions, although Laura did not explicitly say which other nursing roles she was comparing community mental health nursing work to. For example, Laura said "it's more relaxed" (lines 168-169) and that the community nurses "had a bit more time to talk, they knew the people a bit better possibly" (lines 176-177). Laura did not explicitly say "more relaxed" in relation to who or where, or "more time to talk" than whom. In line 179, Laura did say "none of that institutionalised feel", which is a clearer indication that she is categorising differences between hospital and community settings. She quantified this as being due to the fact that "you've got your own clothes on" (line 179-180). In her account Laura's talk worked to show some categorisation differences between both hospital and community settings.

Laura highlighted that it was "nice being in people's homes" (line 166) and said this is "because you can see their sort of personal surroundings" (line 168). As Laura described the environment, she began to account for differences she noticed. Her comment "it's more relaxed" (line 168-169) appeared to relate to direct patient care, as Laura followed this up with "because you haven't got to think about anybody else" (line 169). There is much written in the nursing literature about the busyness and demands on staff in inpatient settings, and how these impact on mental health. For example, the chaos and crisis of acute admission environments is highlighted by researchers (Deacon, 2003; Deacon et al., 2006), as nurses are reported as having to continually prioritise and re-prioritise their work due to persistent demands. There is perhaps an expectation from staff that '*Something always comes up'*, which is how Cleary and Edwards (1999) titled their paper about the continual interruptions to nurses' planned activities in acute settings. Although at the time of interview Laura was employed in a nursing home, she had been placed on at least five wards during her student experience, and had background knowledge of inpatient environments. Therefore, Laura's comment that "you haven't got to think about anybody else" highlighted a difference that she perceived for community mental health nursing work. Conversely there is evidence in the nursing literature about CMHNs experiencing challenges regarding time and care delivery (Henderson, Willis, Walter & Toffoli, 2008a; Henderson, Willis, Walter & Toffoli, 2008b; McTiernan & McDonald, 2015). In her account Laura's talk worked to contrast hospital and community settings, and she shows a particular preference.

Some studies report that CMHNs are just as stressed with interruptions that disrupt their planned time with patients (Coffey, 1999; Edwards, Burnard, Coyle, Fothergill & Hannigan, 2001). Whilst Laura appeared to be suggesting that a CMHN can concentrate on one servicer user at a time in the community, in practice CMHNs have caseloads of service users with varying needs and priorities. Over the years there have been reports of the average number of service users on CMHN caseloads varying greatly (McCardle, Parahoo & McKenna, 2007; White and Brooker, 2001). Caseload numbers certainly do not detail the intensity of work and time needed with each service user. Laura's comment "you haven't got to think about anybody else" (line 169) referred back to her

time and observations made when she was a nursing student when her experience would have been limited. However, it might be argued that Laura's phrase in line 169 is a way of emphasising the one to one nature of community work and that usually there may be more time to undertake face to face work with service users than in a ward setting. Equally Laura's references to not having to consider others may relate to an awareness of there being no others present to judge a nurse's one to one work in community settings. Nurses are reportedly less than confident about using one to one therapeutic techniques (Place, 2003), particularly in a ward setting when others may be present. In the community, one to one work may be carried out by nurses less self-consciously. Throughout the extract above Laura was categorising by comparing different aspects of mental health nursing.

Categorization is something that happens discursively (Edwards 1991), often by making one particular category more relevant for a specific purpose during interaction. Therefore such categorizing is normally done to accomplish something other than just categorizing (Hausendorf, 2000). One aim in interaction may be for the speaker to distinguish how 'we' are different from 'them', which is one of the most general categories people have at their disposal (Leudar & Marsland, 2004). Individuals compare their own group to others, which suggests a form of benchmarking in the social world. Mental health nursing is made up of many groups, as individuals work in a range of settings, with a variety of groups of service users. People receiving services may be delineated into categories such as age, mental health need or service requirement. Although nurses may simply be termed by the job title 'mental health nurse', roles may differ according to the service user group they work with and the type of team or service provided. For example, mental health nursing work with forensic service users in an acute setting may be fundamentally different to working with older people in a day centre facility.

In Laura's account her talk functioned to position differences she perceived about CMHNs compared to other groups. Superordinate identity refers to commonalities between sub-groups, who are under the same category (Hogg, 2006). In this instance the

superordinate category of focus is mental health nurses, and sub-group identities includes inpatient nurses and CMHNs. Laura positioned community mental health nursing work in a more positive light, and creating a notion of difference for her own particular purpose. Laura may not have wished to identify with institutionalised behaviours and negative attitudes that she reported witnessing in ward environments in the wider interview. In her talk she indicated that inpatient care is something she was not keen on, whereas community work was more to her liking. She furnished both categories by using contrast in her talk.

Another contrast made by Laura in her account about the difference between hospital and community settings, related to a reference about service users' behaviour. She indicated that service users in the community were perhaps "a bit more honest because they know they're not in hospital" (line 169-170). Laura then added "they haven't got to say certain things to try and play the game (laughs)" (line 171). Laura did not elaborate on this further, but implied there are unwritten rules that influence service users' behaviour in hospital, and that this applied differently in the community, so individuals can be "more honest". Service users' competence about compliance is evident in Edgerton's (1967) work about people with learning disabilities and their expertise. In relation to mental health inpatients, after a short time in hospital people would know about locked doors and the numbers of staff resources that can be summoned. Inpatients would be aware that permission is needed to leave so that patients 'play the game' when it comes to working out how to leave.

In some respects community nurses do not have as much power to limit liberty, and people do not have to "play the game" as much in the community. Laura demonstrated in her talk that different rules hold in each setting. In a study of service users' experiences of ward rounds in acute settings, Cappleman, Bamford, Dixon and Thomas (2015, p.235) noted that service users spoke of unwritten rules in hospital settings, with one participant stating 'I wasn't entirely aware how to play the game'. Whilst this phenomenon is little reported in the mental health literature, the idiom 'play the game' is perhaps familiar to both staff and users of services. Playing the game can be taken to

mean behaving in a way that is accepted or required from those in authority, and in an inpatient setting could be construed as keeping to hospital rules or expectations, and failure to do so may result in a deprivation of liberty. For example, service users, when asked, might minimise the severity when describing their symptoms, in order to obtain leave from the ward. In the community Laura was perhaps implying there is less 'playing the game', as she states in line 169, people "can be a bit more honest", which she implied was preferable to the less authentic occurrences (or game playing) in a ward and a further difference she saw that mental health nurses experience in comparison to ward environments.

Laura talked further about what she considered positive aspects of nurses working in community settings and says "you're not kind of stuck in an environment" (line 181). Although Laura did not include details or descriptions of the work activities of CMHNs in her talk, she did indicate many reasons why staff in the role appeared to experience more job satisfaction with their role, compared to inpatient nurses. In lines 185-186 Laura stated that the CMHNs, particularly her mentors, were "more willing to try and teach and explain, [had] a good sense of humour". Laura provided a justification for this positive behaviour, and said these staff were "happier in their jobs, possibly" (line 190). I asked Laura how she accounted for the difference in the happiness of these different types of mental health nurses. Laura replied "maybe they feel they've got more autonomy over their role and their job" (lines 192-193, and then reinforced this with a repeat "Yeah, probably mostly that, more autonomy I think" (line 193-194). Aspects of Laura's account can be considered rather idealised; as she presented a version of community mental health nursing that was very positive and compared this to her negative view of the hospital nurses' role.

One of the techniques of construction in people's accounts is termed extreme case formulation (Edwards & Potter, 1992), and draws on extremes of judgement. The suggestion here is that such accounting makes sweeping statements implying the same is true for all in a particular category. In Laura's case she put forward a case formulation that CMHNs "seemed happier in their jobs" because "maybe they feel they've got more

autonomy over their role and their job" (lines 190-193). According to Scott and Lyman (1968), accounts are frequently justificatory in nature and include explanatory linguistic devices. These devices are 'employed whenever an action is subjected to valuative inquiry (…) and prevent conflicts from arising by verbally bridging the gap between action and expectation' (Scott & Lyman, 1968, p.46). It is possible that Laura was demonstrating awareness of being interviewed by a researcher who might have knowledge of these nursing roles. Laura may therefore have been attempting to justify why she perceived CMHNs to be happier in their jobs, and rationalised this as being down to the autonomy that she perceived these nurses have.

Laura's account worked to achieve why she found being placed in community settings more preferable to ward settings. She voiced advantages for herself in a nursing student role (such as more teaching and explaining from her CMHN mentors). Laura also stated merits, as she saw them, for the CMHNs themselves which include being "more relaxed", "not stuck in an environment", "happier in their jobs" and "more autonomy". Job satisfaction that Laura suggested CMHNs experience, is reportedly linked to their having autonomy, because the independent decision-making that is part of the CMHNs' role is highly valued (Farmakas, Papastavrou, Siskou & Karayiannis, 2014; White & Cudless, 2008). Generally CMHNs tend to describe their working environment in a more positive way to hospital nurses (Farmakas et al., 2014), which is echoed in Laura's account.

In this section I have shown how mental health nurses categorise their work in different settings. My analysis shows that nurses introduce the concept of autonomy and associate it more with community mental health nursing than ward nursing, suggesting that some may see that as a preferable environment in which to work. Talk about different types of mental health nursing was a feature of people's narratives in my study. Participants also referred to mental health nursing roles and implied categorisations with the term 'Jack of all Trades'. This term was used to imply expertise, but also work considered to be just passable or dabbling. There is a sense that the autonomous nature of mental health nursing is greatly valued by some nurses, and it

is this that leads nurses to explore specialisms and to advance skill sets. In the next section I will show that a lack of clarity for mental health nursing roles has led to the term a 'Jack of all Trades' being used in relation to the profession. Nurses have voiced frustration that they have not succeeded in clearly 'articulating what their profession adds to the care and treatment of psychiatric patients' (Koekkoek, van Meijel, Schene & Hutschemaekers, 2009, p.822), nor achieved role recognition (White & Cudless, 2008). This 'Jack of all trades' term is viewed in both a positive and negative manner, and is examined in the next part of this chapter.

4.5 "You are that Jack of all trades, master of none in some respects": developing a mental health nursing identity in the face of a contested label

Mental health nurses are involved in a wide range of activities which include working with families, assessing people for self-harm, suicide and risk of violence, and managing distressing symptoms (Coffey, Pryjmachuk & Duxbury, 2015). Aspects of mental health nursing work occur in both hospital and community settings. For nurses in ward settings the limited number of available beds has an impact on nurses' stress (Taylor & Barling, 2004), because there are frequently an insufficient resource for patients requiring hospital admission. In addition a high volume of task-based activities and a lack of resources have long been highlighted as an everyday reality for hospital nurses (Currid, 2009; Nolan & Cushway, 1995). Comparably, community mental health nurses experience similar challenges, such as limited resources, high caseloads, and long waiting lists (Koekkoek et al., 2009; Keogh, Callaghan & Higgins, 2015). In order to accommodate a range of demands, the mental health nursing role may require nurses to have knowledge of a wide range of topics, and a flexible approach regarding how they undertake their work.

In addition to the profession requiring flexibility, a need has also been identified for nurses to demonstrate increasing specialisation. For example by being able to engage in talking treatments like Cognitive Behavioural Therapy (Malik, Kingdon, Pelton, Mehta

& Turkington, 2009), and specialist risk assessments like the Historical Clinical Risk assessment (HCR 20) (Royal College of Psychiatrists, 2008). However, the pressures on mental health services may militate against such interventions, and nurses may have an idea that these roles (often requiring further training) are not adequately rewarded. Nurses certainly are already tasked with fulfilling a wide range of roles as part of their professional work.

The phrase 'Jack of all trades' has been used in relation to the mental health nursing profession mostly because duties of the role have become increasingly varied and diverse (Deacon, 2004; McCrae, Askey-Jones & Laker, 2014). The expression 'Jack of all Trades' featured in the talk of two mental health nurse participants in my study, and I will explore their use of this idiomatic phrase in this section. As the nursing role increasingly includes more role blurring and overlap with other professional workers, it is suggested that a singular professional identity remains elusive (McCrae et al., 2014). This 'Jack of all trades' term has been used by mental health nurses themselves about their professional identity in studies in the United Kingdom (Crawford et al., 2008; Skidmore, Warne & Stark, 2004), and other countries including New Zealand (Bishop & Ford-Bruins, 2003) and Australia (Cleary, 2004). The term can signify that mental health nursing work encapsulates a range of skills and is a multi-faceted role, or conversely is considered to be an occupation requiring multiple skills at a purely superficial level.

In this section I present analysis from two research interviews with mental health nurse participants and their talk about professional roles. As both these nurse participants, who I have named Emma and Angela, used the term 'Jack of all Trades' in their talk, I am using this example as a way of exploring their identity narratives. It is possible that the 'Jack of all Trades' term can be seen as a threat to a perceived professional identity. This identity label foregrounds analysis later in Chapter 6 which explores mental health nurse participants' perceptions about role blurring and role ambiguity, particularly in relation to care co-ordination.

In this section I will show how participants reject the notion of mental health nurses having a 'Jack of all Trades' identity, and instead how nurse participants in my study supported a position that nurses identify more with a specialist identity and dispute the 'Jack of all Trades' term. The first of these two examples is taken from a research interview with a mental health nurse participant who I have named Emma. The interview took place in Emma's work office and lasted for 1 hour and 10 minutes. At the time of the interview Emma worked in a forensic inpatient setting, and had been a qualified nurse for 4½ years. I had asked Emma broad questions about her expectations of the nursing role, and her journey as a nurse. She said how when she was a student she had wanted to complete her training and be "a good nurse", and was not worried about employment as there always seemed to be jobs at that time. Emma then began to talk about how she saw her nursing role.

513 **Emma**: You know when you finish your third year student nursing, you know
514 you're not a perfect nurse, I don't think you ever are, I think you're always
515 evolving, I think you're always learning. You know every day you come across
516 something that you don't know about, so you need to find out the answer or
517 information somebody gives you that you didn't know. And I think you are that
518 Jack of all trades, master of none in some respects, or you become very
519 exceptional in the area of which you work. I mean I…I've worked here for
520 4½ years; if I had to go over to EMI to work tomorrow I'd probably be less than
521 useless. 'Cos I think even though we're registered mental health nurses I think
522 you special - specialise within the area of which you work really, that's where
523 your expertise comes.

[Emma, Mental health nurse participant 14, lines 513-523]

At the start of the above extract from the research interview with Emma, she introduced the notion of knowledge development and time in relation to an individual's development as a nurse. In narrative analysis both Mishler (1986) and Reissman (2001) identify that speakers can temporally position their talk. This means that they use the concept of time to provide some order, so the talk is temporally organised. At the start of this extract Emma made reference to the undergraduate nurse education programme, which is usually three years. She said "when you finish your third year student nursing" (line 513) and included herself in this, as in the past she has negotiated and completed

this phase. Both temporally and chronologically Emma was making use of the three year nurse training as a resource to establish the authenticity and credibility of her account. Emma said that at the point a nursing student completes their "third year student nursing" that they are "not a perfect nurse", suggesting that they still have more to learn after this neophyte period. Emma's talk about three years nurse education, and later her 4½ years' experience on her current ward, did the work of setting contextual background, as she was setting out her story regarding her length of experience.

Emma then added "I don't think you ever are [a perfect nurse], I think you're always evolving, I think you're always learning" (lines 514-515). These elements of Emma's talk demonstrated her view that there are temporal aspects to identity. Her talk positioned her nursing or professional identity as something that is mutable and remains open to growth and development. Considered as neither fixed nor simplistic, identity can be viewed as dynamic and contextual. For example, Emma's use of the word 'evolving' was a word choice made to suggest positive movement towards increased knowledge and higher states rather than something else which might suggest regression. Emma was therefore positioning her professional identity as something progressive.

Additionally, Emma may have been demonstrating awareness that as a registered nurse she is required to meet professional expectations of being a lifelong learner. Reflection and growth is something explicitly indicated in these professional expectations. For example, the Nursing and Midwifery Council (2016a) currently require nurses to provide evidence of engaging in educational and reflective activities when they undergo triennial checks to re-validate their nursing registration. At the time of Emma's interview, before re-validation was implemented, there was a still a requirement that nurses undergo a process of continuing professional development and maintain a portfolio of their learning.

Emma continued with the notion of on-going learning being a part of the nursing role when she said "every day you come across something that you don't know about" (lines

515-516). She was indicating her understanding that learning never stops, and that even as a qualified nurse she was regularly challenged in terms of her knowledge. Emma's account functioned to show her awareness of learning being a continuous process, in that this aspect of nursing is advancing, and not static. In the research interview I had asked Emma about her expectations at the start of her nurse education, and how she thought things were going to pan out. Emma voiced surprise at becoming an acting ward manager within four years of qualifying as a nurse. In her account she was rejecting the notion of fixed identities in mental health nursing, which she accomplished by showing the "evolving" (line 515) nature of her own role. She was accounting for how she herself has evolved and progressed in terms of her mental health nursing identity.

Emma then used the phrase "I think you are that Jack of all trades, master of none in some respects" (lines 517-518). Drew and Holt's work (1988) on clichés and idiomatic expressions indicates that speakers use figurative language in their talk often when they are making a complaint. For example, Emma's use of the idiom "Jack of all Trades" (line 517) did the work of emphasising the multiplicity of professional identities that mental health nurses are perceived as having.

The 'Jack of all Trades' expression may be a notion that individuals take pride in a sense of flexibility in their work roles, as such adaptability may be seen as a form of mastery. Cutcliffe et al. (2013) suggest the 'Jack of all Trades' term is not definitive in terms of uniqueness, and may have a range of meanings. The 'Jack of all Trades' term had been compared to a handyman identity, in respect to someone fixing something uncomplicated (Hurley, 2009). Whilst flexibility in a role can be seen as desirable (Crawford et al., 2008), others have noted the pejorative language in such metaphors, including 'general dogsbody' (Cleary, 2004) meaning a general labourer, which has also been used in relation to the profession. Emma's use of the phrase highlighted to me that she sees mental health nurses as doing so many roles; they may not be viewed as having specialist skills. This notion is reflected in mental health literature where nurses have been considered by other professional groups to be skilled generalists, with limited

specialist skills (Sheppard, 1991). The nursing role has reportedly focussed on collecting information and performing a range of co-ordinating and administrative tasks (Gijbels, 1995; Nolan, 1993), perhaps suggesting limited scope for specialist knowledge and application.

The suggestion that health professional roles may be generalist is attributed to other professional workers including general nurses, where a range of skills may be required (for example on a medical ward). Oliver (2016) claims that generalist roles are no less expert, and 'expert generalists' have a lot of specialist knowledge and skills that overlap, which is deemed useful as patients often present with a number of co-morbidities. It may be that the 'Jack of all Trades' term, or the use of the word generalist, signify a wider anxiety from health professionals about roles and the place of nursing in modern healthcare.

There is a sense that in multi-disciplinary mental health teams nurses can perceive other team members as:

> 'taking all the 'clean' and 'tidy' work that can be neatly categorised into their specialist protocols. The untidy work that remains - the clients that are referred to the nursing team – have complex issues that cannot easily be categorised.'
>
> (Dryden, 2010, p 6)

There is suggestion here of nurses engaging in work that other workers do not want to do, which may further explain the 'Jack of all Trades' term being used in association with mental health nurses. When expressions such as a 'Jack of all trades' are used in relation to mental health nursing this is worthy of further exploration because it implicates a possible shared understanding of challenges. These challenges may include issues explored previously in this chapter like actual time with patients, task-based work, and working in different environments. The 'Jack of all Trades' term can be viewed both constructively and pejoratively. For example, it was observed by Crawford et al. (2008) that in relation to the profession the term can imply flexibility and resourcefulness with staff being multi-skilled. The latter half of this saying is also used

at times, which is 'Jack of all trades and Master of none', which has been considered to reflect the low status with which mental health nursing has sometimes been viewed (McCabe, 2000). Countries that have withdrawn mental health nursing specific education, have found students on general nursing programmes have only limited exposure to mental health placements. McCabe (2000) suggests a unique body of mental health nursing knowledge is becoming harder to identify (McCabe, 2000), because nurses are simply not being afforded such placement experiences.

A study by Skidmore et al. (2004) about mental health team working sought to explore how mental health nurses were viewed by themselves and others in mental health teams, with 32% of respondents (n = 43) agreeing that nurses felt like a 'Jack of all Trades', whilst 41% (n=55) disagreed. However, the researchers did not provide a definition of the term to participants which suggests the data is inconclusive, and that the term has different meaning to different people.

In her account, Emma made a comparison suggesting that mental health nurses are either generalist or more specialist. She positioned herself as more specialist in this account. First, she located her specialist experience in a forensic mental health setting with "I've worked here for 4½ years" (line 519-520), which did the work of establishing her level of experience. She implied that this is a period of time sufficient to claim specialist knowledge and skills. Emma accomplished her mental health nursing identity by favouring the idea of specialism. This was not just exceptional but "very exceptional" (line 518-519), communicating how she wished to be known.

Emma then described how if she were to go and work with another service user group (and refers to "EMI" – people regarded as the elderly mentally ill) "tomorrow" that she would "probably be less than useless" (lines 520-521). Emma summarised this part of her account by saying nurses "specialise within the area of which you work", and added "that's where your expertise comes" (line 523). Emma's account here was doing the work of highlighting that different mental health nurses require different specialist skills

and knowledge in different areas, and that whilst a nurse can be experienced and "exceptional", it does not translate that they are able to immediately transfer over to working with a different client group. This refutes the 'Jack of all Trades' term, as if knowledge and skills were superficial they would be easily transferable. In her narrative Emma appeared to have rejected the 'Jack of all trades' stance, and was establishing that her own work is highly specialised and not something that just anybody who is a mental health nurse could do.

In her talk Emma accounted for herself initially as a nurse who was often required to learn something new every day, with a need to be flexible and to respond to change in her role. She accounted for these malleable elements in her role with the phrase a 'Jack of all trades'. Emma then highlighted her perception that actually rather than "master of none" you can become "very exceptional in the area of which you work" (lines 518-519). The term specialist 'attracts high value and worth with expectations of highly developed knowledge and competence' (Hurley, 2009, p.385). Certainly discussion in nursing literature has indicated that advanced practice roles help to further define the profession of mental health nursing (Elsom, Happell & Manias, 2005), and lead to higher service user satisfaction.

Somers (1994) states that people construct identities, which can be multiple and changing by locating themselves in a repertoire of stories. Emma retained flexibility in her narrative by assembling experiences that have become part of her professional identity story. Having said "I think you are that Jack of all trades, master of none in some respects", Emma then said "or", which does the work of showing she was considering alternatives. She followed this with "or you become very exceptional in the area of which you work". Emma highlighted that whilst some mental health nurses may be considered to have a more generic role, others can be termed as having specialised. Emma's talk here functioned to create a dichotomy, in that it showed her awareness of different versions of the notions of generalist versus specialist.

Potter and Edwards (1999) suggest that speakers use dichotomies in their talk to either display concern for a particular difference or to orient towards it. Emma made the case for generic mental health nursing skills and knowledge that allows movement between specialisms. She may also have been acknowledging that highly specific skills and knowledge in a specialist setting take further time to become expert in. Emma's talk implies that she found the 'Jack of all Trades' to be an accurate if limited description of mental health nursing and one likely to be disputed by nurses with specific types of experiences in highly specialist settings. Emma's account can be considered to be disputing the very claim which she herself has raised. As Emma has raised this 'Jack of all Trades' issue, it can be suggested that this is a concern for her. She saw it as a potential criticism so by her showing awareness of competing accounts, her own account is organised around refuting the label in favour of claims to specialist knowledge and skills.

Emma's account worked to identify her as someone with specialist knowledge. This is a form of impression management or self-presentation (Goffman, 1959). Impression management is defined as the process by which individuals attempt to control the impressions others form of them, which in turn may have implications for how others perceive and treat them (Leary & Kowalski, 1990). In terms of the impression that Emma was making or was seeking to make, she chose to present herself more as a specialist, than as a 'Jack of all trades'.

Another mental health nurse participant, whom I have called Angela, also spoke about mental health nursing identity in relation to the notion of 'Jack of all trades'. Angela highlighted the issue of role blurring and role overlap in her talk in relation to professional nursing identities, which are analysed in this section. Angela worked in a community setting, and had been a qualified nurse for 5 years at the time of the interview. Angela had additional qualifications in talking therapy, and worked in a specialist team which focused on providing early intervention to service users. The following data extract is taken from a research interview with Angela that lasted for 1 hour and 5 minutes. At this point in the interview Angela had been talking about change

to mental health nursing roles, and how in her view some nurses felt quite threatened by this.

Angela: I agree that erm you need to be in some level a specialist in what you do, rather than a Jack of all trades. Erm, you know, I'm not saying that we should do absolutely everything. I'm not an occupational therapist, you know they've got skills and knowledge that I certainly don't have. Erm, I'm not a psychologist or whatever. Erm, but a lot of it I think, well, why can't we do that, if it's part of our role? If it's going to improve services or improve me as a nurse or improve outcomes for the people that I'm working with, then you know why can't we do that? Just because we've always done it that way doesn't mean to say we've got to carry on doing it.

JT:Yes, yes

Angela: But people can get erm….yeah, it's not my job, it's not my job. I think – hmmph. Our job is to try and help these people and if helping them means we do that, then isn't that our job?

[Angela, Mental health nurse participant 17, lines 834-846]

In the data extract from Angela the notion of a mental health nurse being a 'Jack of all trades' was given short shrift and instead she seemed to indicate she would like to diversify in order to help service users. The diversification that Angela suggested would include skills not typically considered to be part of the mental health nursing role.

In her talk Angela was accounting that "you need to be in some level a specialist in what you do, rather than a Jack of all trades" (lines 834-835). Angela was clearly stating here that being "in some level a specialist" is preferable to the 'Jack of all trades' concept. Angela's resistance to the 'Jack of all trades' term was shown in the way she moved swiftly on to use the idea of specialism, and put forward the moral case in terms of improving services. I suggest Angela's resistance to the term 'Jack of all trades' indicated her agency in choosing to pursue specialist nursing roles over generalist routes. Angela had already demonstrated her agency by pursuing a more specialist role herself.

Crawford et al. (2008) highlight a point of tension between mental health nurses assuming the identity of a 'Jack of all trades' and accomplishing a clear professional identity. This tension may suggest that the two descriptions do not go together, and a worker cannot identify as a mental health nurse if their practice is so diverse, and perhaps is not deserving of professional status. In Angela's account she showed awareness that the specialist descriptor is preferable to her. Hurley (2009) suggests the term generic specialist, as opposed to Jack of all Trades, is more apt in terms of a role label as it highlights a multi-skilled approach with specialist knowledge. The words "in some level a specialist" are used by Angela. She was saying that mental health nurses do not do "absolutely everything" (line 836) as part of their role, which may lead to them avoiding the 'Jack of all trades' description. Certainly a professional worker with a qualification for a specific role would likely reject the 'Jack of all Trades' term, as they may consider it inaccurate. In my study both Emma's and Angela's accounts appeared to reject the 'Jack of all Trades' notion, as their talk indicated that being seen as a specialist was preferable to being considered more generalist.

There are competing versions in Angela's talk as she suggested "I'm not saying that we should do absolutely everything", and later added "but a lot of it I think, well why can't we do that, if it's part of our role" (lines 838-839). This did the work of highlighting that Angela as a mental health nurse did wish to present an argument for widening her role, or at least for some flexibility. However there was a sense from her account that this flexibility was prevented and that Angela was somewhat disempowered with it affecting her agency. I can only surmise that this may be due to organisational constraints. She initially acknowledged that she is "not an occupational therapist" or "a psychologist", with the words "they've got skills and knowledge that I certainly don't have" (line 837). This served to acknowledge that Angela saw differences between various professional roles in mental health teams in comparison with her own role as a nurse.

Angela's talk also indicated that she saw potential for flexibility in the mental health nurse's role. In her talk Angela was challenging any notion of rigid constructions about

her role, and indicated that there was scope for moving into areas that require more specialist skills. Angela is using the Occupational Therapist and Psychologist roles as reference points for the type of work that mental health nurses could be doing, not the same work, and Angela was clear about this, but work of a similar more specialist status. Status may have similarities with my earlier reference to Dryden's (2010) description of the clean and tidy work of other mental health professionals who are not nurses.

Angela's talk about "why can't we do that, if it's part of our role? If it's going to improve services or improve me as a nurse or improve outcomes for the people I'm working with" (lines 838-841) worked to achieve a moral position. Angela was accounting for her wish to take on further roles and work when she suggested "if it's going to improve services" (line 839) and "improve outcomes for the people that I'm working with" (lines 839-840). Her talk in this context indicated the moral position of her as a speaker, and functioned to achieve moral identity work. A person's moral identity is displayed when they align themselves with moral goals, which is achieved through interactional talk. For example, people show moral identity work by indicating they are caring, socially responsible, decent and honourable. There is also a suggestion that certain activities are valued, and hence have a moral quality, whilst other activities do not.

Angela's moral identity work can also be considered as an explanatory device as through her talk Angela was working to achieve a justification of why she believed mental health nurses should be able to extend their roles. However, another view would be that Angela's wish to extend her practice may be self-interest and to further her career.

Angela indicated in her talk that she and other mental health nurses could expand their roles more when she says "why can't we do that, if it's part of our role?" (lines 840-841). The phrasing of this question twice may indicate her frustration at the apparent

status quo. There is a sense that Angela was communicating that she was not empowered to act in the way she wished she could to help service users.

There was a sense of interest from Angela for mental health nurses to extend their roles and engage in role overlap with other professionals. Hannigan and Allen (2011, p.4) noted that in community mental health teams there is 'a high degree of occupational boundary blurring between nurses and social workers', with more generalist roles apparent. This indicates to me that practice examples exist where nurses are expanding their roles and territories. I am reminded of the comparison made by Sheppard (1991, p.161) who termed CMHNs as 'artful dodgers' because he saw them as increasing the scope of their work by taking roles from other professionals. Mental health nurses themselves have indicated that the diverse aspects of the role have made the work more appealing (Lloyd, 2006). In terms of relating this to Angela's talk, she indicated that in her view it was certainly desirable to expand the mental health nurse role.

Angela's moral claim for improvement (to services, to self or to people's outcomes) was tempered by the nature of her role, in terms of what nurses are meant to do. She seemed to reference this herself by highlighting unnamed others who say "it's not my job", and how she saw this differently. This talk was an example of Angela contrasting herself with others for the purpose of a favourable judgement of the speaker's position. Angela was questioning why nurses cannot diversify and do more, and said "why can't we do that?" twice in this extract. She was showing that she was aware of competing versions which may challenge her wish to move beyond the confines of her role. She may indeed be limited by institutional or organisational contingencies. Each profession has its own jurisdiction or control over its work (Abbott, 1988), and professional groups will try to both defend and advance their roles in that system of work (Coffey & Hannigan, 2013). In Angela's account she can be seen to be attempting to make the case for a role extension, but in doing so seems to portray her own impotence. She did not indicate who she might need permission from to extend her role. Instead Angela appeared to be making a complaint and using the moral case for better service provision

as a device to reinforce her claim of feeling unable to demonstrate her own autonomy, although her reason was not clear.

In this section using the term 'Jack of all Trades' in their talk, my analysis has show how both Emma and Angela have gone on to indicate a dichotomy as to whether mental health nurses might be considered generalists or specialists. A further dichotomy that sociologists suggest exists in society is one between agency and structure (Francis & Hester, 2004). Individuals in society possess agency, which refers to knowledge of their circumstances on which they act. Structure refers to the situation in which a person finds themselves. So whilst a person's actions may be explained in terms of their motives, other elements may only be accounted for in relation to that person's social structures, some of which may be beyond their control. Whilst people's actions can be explained in terms of structure and agency, but that is not to say these are exclusive. Certainly actions are shaped by the organised nature of social life, which for Angela may mean working in that particular mental health service. Organisations where people work have cultures that pre-exist people and their actions, in that certain influences may have been there before that person started their work role. Equally people act as they do because of how they interpret their situation. Angela's 'why can't we' talk suggested she may perceive a barrier in terms of organisational structure that she saw as limiting her own agency.

Angela indicated in her narrative that other team members can be resistant to the idea of extending their roles, as she presented talk from others who said "it's not my job, it's not my job" (line 844). Her own reaction to these views was clearly present in her talk as she said "I think – hmmph" (lines 844-845), indicating her disapproval. Angela stated the aims of her role with "our job is to try and help these people and if helping them means we do that, then isn't that our job?". In her account she was seeking to persuade the listener with these rhetorical devices which function to challenge competing versions (Edwards & Potter, 1992).

Angela's case seemed to be that there are a number of skill sets which mental health nurses can adopt for expanding roles and that these can be deployed for the greater benefit of services and service users. Other mental health nurses may not wish to do this, but Angela did. Her rhetorical questions were perhaps an indication of a complaint that she saw structural impediments to realising her agency, and may have felt restricted by such confines.

4.6 Conclusion

In this chapter I have used my emergent new knowledge to show how aspects of mental health nursing roles and work are handled in the research interview talk of both nurses and service users. This provides insights into how service users perceive and experience mental health nurses. Additionally such talk provides some indication as to how mental health nurses may see their own roles and professional identities.

Some participants indicated that mental health nurses fulfil a myriad of roles, yet to service users this can be experienced as confusing. Also service users perceived the time that nurses spent with them was limited. If mental health nurses find that aspects of their role limit therapeutic encounters, there may be elements of their practice that require review. Everyday understandings of mental health nursing work are used in the construction of participants' accounts in my study. If everyday reality for service users in inpatient or community settings means experiencing a lack of therapeutic time from mental health nurses, with this attributed to nurses being focussed on task-oriented activities, this suggests a need for increased awareness in nurses about the demands on their time. Rydon (2005) suggests that if mental health nurses cannot practice therapeutically, they may struggle to articulate both the characteristics and distinctiveness of their work. Nurse participants in my study indicated that their roles were often misunderstood by those outside the profession.

Analysis of participants' narratives showed that their talk included explanatory devices which functioned to achieve professional identity work. Nurses' talk of having little time to spend with patients is presented in interaction as a fait accompli. There is little talk from participants about how mental health nurses work with and engage service users. It is noteworthy that the term or descriptions about service user involvement in nursing processes occurred little in the talk of participants, particularly in relation to the mental health nursing role. Nurse participants focused their talk on what it is to be a mental health nurse and also showed awareness of different versions of mental health nursing. My participants showed that they favoured certain aspects of the role and rejected others. This positions them as a certain type of mental health nurse, that is they are constructing their professional identity in specific ways to advance particular moral concerns.

Competing versions were presented in participants' talk in this study about notions of autonomy and agency. The idea that community nurses have more autonomy is refuted by some studies (Brown et al., 2000), as such nurses experience an array of challenges outside their control. Equally nurses like Angela voiced a desire to extend her role, but was aware of constraints and limits that restricted her agency.

Nurses' narratives included descriptions about separateness from service users, and being in the ward office. Similar behaviour is apparent in previous studies (Fagin, 2007; Menzies Lyth, 1961) in terms of measures that nurses employ to achieve space from the demands of nursing work, or requests from service users. Whist my study participants did not necessarily state reasons for being in the office, service users were very aware of this separateness, which rendered nurses less accessible to them.

Mental health nurse participants' talk indicated preferences that they considered their role to be specialist rather than generalist, as the latter may indicate that specialist skills or knowledge are not required. The mental health nursing profession has been considered marginalised and under threat for some time (Happell, 2010; Happell &

McAllister, 2014; Hemingway, Clifton & Edward, 2016). There have been moves to discontinue mental health nursing as a speciality at the pre-registration education level on more than one occasion. It is in the interests of mental health nurses to account for the work they do in mental health services, which in turn strengthens the requirement for the role. However, whilst some participants spoke about wanting to widen and develop their roles, and introduce innovations, many were aware of institutionalised cultures they were under pressure to comply with, as well as organisational and legislative burdens that limited their work.

In the following chapter I will present findings from my analysis of what participants said in relation to understandings of mental health nursing. The focus of this next chapter will be the context of service user involvement and people's understandings and experiences of service user involvement in relation to mental health nursing work.

Chapter 5: Service user involvement in mental healthcare: understandings and expectations

5.1 Introduction

Service user involvement is gaining momentum as a meaningful part of health service development, professional education programmes, and in European mental health policy (Lathlean et al., 2006; Storm et al., 2010; Stringer, Van Meije, Devree, & Van Der Bijl, 2008). This impetus for service user involvement has been driven by policy directives from successive governments (DoH, 2000; 2001; 2008). Additionally, the information revolution has propelled service users to be more active recipients of healthcare (Bower et al., 2015). Assertions such as 'nothing about us without us', quoted by the Department of Health (2010) in policy, originate from disability rights activists who brought the term into common usage following Charlton's (1998) book of the same name. In mental healthcare, ideas of paternalism with professionals dictating treatment choices have begun to change with the advent of shared decision-making (Charles, Gafni & Whelan, 1997). The era of neo-liberal politics has shifted the focus of responsibility from the state to the person, with notions of self- management now seen as a moral obligation (Townsend, Wyke & Hunt, 2006). Further changes include growing service user movements and more accepted notions of therapeutic partnerships and service user expertise (Bee, Brooks, Fraser & Lovell, 2015). A key principle for modern health policy is that service users and carers are now considered stakeholders in service delivery (Bee et al., 2015a) and are to be regarded as participants rather than solely as recipients of mental healthcare.

Service user involvement is about 'an active and equitable collaboration between professionals and service users concerning the planning, implementation and evaluation of services and education' (Lathlean et al. 2006, p.733). Involvement concerns service

users having choice, being empowered and participating in their own care decisions. This has shaped mental health service delivery to the extent that guidance now states 'the outcome of any assessment will be a care plan developed with the service user, a member of the care team and other appropriate parties, such as families and carers' (Bower et al, 2015, p.2).

For involvement to be meaningful as opposed to tokenistic, service users must be able to see how their influence makes a difference. This involvement might be individual, in terms of one's own treatment, or wider for example in service delivery. The many terms for involvement indicate different levels and ways that people may be involved. Models of service user involvement that exist include collaboration, engagement, co-production, partnership and user control (Glasby & Tew, 2015). These terms differ in regards to where the responsibility lies for outcomes. For example, collaborative engagement is a two-way process, with the responsibility for outcomes often remaining with service providers.

Principles of service user involvement may be fundamentally different to other aspects of the mental health nursing role. The nature of mental health nurses' work can involve power and control, such as compulsory treatments within the confines of the Mental Health Act 1983. Researchers highlight elements of working in partnership with service users exist alongside practices that focus on control and safety. This can lead to nurses experiencing conflicting tensions as they struggle to incorporate these opposing elements into their practice (Hannigan & Cutcliffe, 2002). Björkdahl et al., (2010) termed these divergent positions the bulldozer and the ballet dancer, as a way of encouraging nurses to reflect on how they integrate paternalistic nursing approaches with holistic care. The bulldozer approach functions as a shield of power as nurses seek to retain control and safety, whilst the ballet dancer style focuses on initiating and maintaining relationships with service users (Björkdahl et al., 2010). Whilst both elements of partnership working and control may co-exist within a mental health nurse's remit, how nurses accomplish such seemingly opposing activities is under-reported in the literature.

Service users and nursing students may experience involvement principles and practices differently. In this chapter I present findings from my analysis of what service user participants said about their experiences of involvement in their care. Their experiences of user involvement may depend on the mental health nurses they have met and their perceptions of those nurses. Stories told by participants in this study devoted time to notions of why service user involvement in nursing processes may not be commonplace and the barriers to involvement as they saw them. In particular, students' accounts suggest a lack of good practice examples for them to emulate. This may have relevance to the low confidence that was observed in some mental health nurses' involvement practices, as accounted for by some service user participants.

There is a need for more empirical knowledge as to how mental health professionals actually carry out service user involvement activities in practice (Storm et al., 2010). Gaps have been identified regarding involvement between rhetoric and reality (Glasby & Tew, 2015), and there is a need to understand why this gap exists (Borg et al., 2009). In order to ensure service user involvement occurs in practice, change is required at strategic, operational and individual levels (Perkins & Goddard, 2004).

The term service user involvement, although frequently used, has been said to lack clarity (Millar, Chambers & Giles, 2015). There are three main factors that have influenced the development of involvement activities: deinstitutionalization, the questioning of biomedical theory and the practice of consumerism (Pilgrim & Waldron, 1998). Noting there are micro and macro levels to service user involvement, Perkins and Goddard (2004) suggest that the main challenge for professional workers is ensuring meaningful service user involvement in individual care. Aspects of the mental health nursing role include elements that can work against involvement, as healthcare may be imposed or against a person's wishes. Evidence from the literature indicates that there may well be more rhetoric around involvement than actual involvement that people using mental health services experience themselves.

For the purposes of this chapter I will present an analysis of participants' displays of understanding told in relation to service user involvement in care. Participants were asked to talk generally about their experiences of mental health nurses, and within the research interviews I asked further questions about participants' experiences of service user involvement in a broad sense. The analysis of narratives that I present here focuses on how mental health service users, nursing students and mental health nurse participants account for service user involvement in relation to mental health nursing roles and professional identities.

Nursing students, mental health nurses and service user participants in this study established claims about their experiences of involvement. Participants' accounts demonstrated awareness that service user involvement varied in relation to a range of factors, and respondents suggested staff engagement in the process could be mixed.

5.2 "They try to get clients now to (…) be involved in their care plans": students' contemporary understandings of service user involvement in nursing processes

Accounts provided by service user, mental health nurse and nursing student participants in this study demonstrated attempts to access taken-for-granted understandings of service user involvement in nursing processes. Participants in this study showed awareness that there can be differences about service user involvement with regards to rhetoric and experiences, as sometimes involvement is actually occurring but other times is merely talked about. In the majority of research interviews service user involvement was a topic that I had to ask about specifically, as it seldom arose without direct questioning. This led me to consider if the topic of involvement was conspicuous by its absence or not present where I expected it to be, and I considered the significance of this in my analysis of participants' talk.

I will begin my analysis in this chapter with an extract from a focus group of first year mental health nursing students. The group comprised students who were in their first year of nurse education, on this occasion there were eight participants and the group lasted for 1 hour and 26 minutes. Focus group 2 took place in a classroom in a university building, situated on the campus site these students' had been attending for the past ten months. At this point in their nurse education these nursing students had attended three practice placements. The extract below includes a prompt from me as the focus group facilitator enquiring about participants' understanding of service user involvement.

JT: some of you will have heard the term service user involvement a little bit or may be on placement, or not heard it much at all, I don't know. What, in the first year of the course, what's your understanding of the term service user involvement?

Neil: Is that something to do with the -erm is that the Welsh measure or something where they try to get clients now to write - be involved in their care plans, and draw up their care plans, and what they want to get, and where they want to be. Something like that?

JT: Yes, certainly will be a big part of [

Neil: Yeah,] they actually form part of their care - form part of their plan, their care plan, what they want and what they want to achieve, and where they want to go, so they're more involved in the process

JT: Mmm

Ellie: That's what I thought it was, was the client being involved in their care. Seeing what they want done and…their aims and what -'cos you said what they want to achieve, you know. Their hopes and aspirations and things like that

JT: Mmm

(4.0)

Ruth: You don't see much of that though.

[Focus group 2, first years, lines 1175-1193]

This section of the focus group started with me as the facilitator asking the nursing student participants about their understanding of service user involvement. Neil's knowledge claim was slightly hesitant as he said "is that something to do with the –erm Welsh measure or something where they try to get clients now to write – be involved in their care plans" lines 1179-1181). The Mental Health (Wales) Measure is a law in Wales that places legal duties on Local Health Boards and Local Authorities in relation to the assessment and treatment of people with mental health problems (Welsh Government, 2012). The purpose of this law is to ensure care and support is available and in place, and that mental health service delivery is appropriate to people's individual needs. Co-production is a way of working whereby practitioners and people work together as equal partners to plan and deliver care and support (Care Council for Wales, 2017). However, despite featuring in legislation, students may be unaware of such developments in practice.

Neil indicated that his knowledge claim about involvement was cautious when he asked "something like that?" at the end of his turn. Neil's account demonstrated that he did have some knowledge about service user involvement. In terms of how he prioritised his talk, he gave an account that related to one area of service user involvement in mental healthcare in Wales which related to current law and policy. In terms of context the majority of the early implementation of the Mental Health (Wales) Measure occurred during 2012, and Focus group 2 took place in the same year. Reference to current policy was therefore not surprisingly a feature of Neil's talk. It might be expected that Neil's talk was uncertain as he was referring to a new policy only recently introduced, and that people were not fully familiar with. Equally his tentativeness may be that this was the only example he could directly reference.

Talk about this legislation was referred to by a range of participants in this study who often referred to it simply as ''the Measure'. One of the principles of the Welsh Measure is that the process of care and treatment planning is undertaken in partnership with service users 'to the fullest possible extent' (Welsh Government, 2012b, p.6). Policy and professional opinion advocate that person-centred principles are threaded

through care planning processes as good practice (Lloyd, 2012) regardless of geographical area. The Welsh Measure goes a step further in that these processes are now in statute. In the above data extract Neil demonstrated a knowledge claim about this, when he talked about service users and said "they actually form part of…their care plan" (line 1184). Neil's talk included the phrases "what they want and what they want to achieve, and where they want to go, so they're more involved in the process" (lines 1185-1186). He was accounting for these practices as being very much part of the intended ethos of the Welsh Measure. However, Neil's phrase "get clients now to write…" (line 1180) suggested making people do something they do not wish to do, indicating a sense of perhaps reluctance to engage in something being enforced from above.

It was evident in the above extract that Neil, when referring to service users, made use of the words 'they' and 'their' frequently. Initially in his description of user involvement he suggested this might be: "something where they try to get clients…to write – be involved in their care plans". The first 'they' in this sentence referred to professional workers. In terms of context, Neil highlighted the Mental Health Wales Measure (2010) so he was demonstrating some awareness that user involvement is mandatory, but the responsibility elements remain vague. There is limited literature about the use of pronouns in people's talk, for example Nevile's (2004) work about the use of 'we' portraying a sense of partnership for co-pilots in the airline cockpit. However, Neil's further use of the word 'they' in this extract appeared to refer to service users (lines 1181-1182 and lines 1184-1186). This use of the word 'they' is evident in sentences such as 'they actually form part of their care…plan, (…) what they want (…) what they want to achieve, (…) where they want to go, so they're more involved". One reading of this is that overuse of the word 'they' signified a specific category of person that is a different category to the speaker. This suggests what is known as – 'othering', in which a group or individual are cast into the role of other (Lévi-Strauss, 1955), and thus one's own identity is established through the process of opposition. Perhaps this is an indication of the existence of 'them and us'cultures, which I shall return to in Chapter 6.

After Neil's response to my question about what service user involvement means, Ellie joined the conversation. There were similarities between Ellie's and Neil's accounts that suggested similar processes were being experienced by nursing students across multiple mental health service delivery sites. In terms of context, both this extract and one that follows are taken from focus groups with first year nursing students. It is a reasonable argument to suggest that novice practitioners may be preoccupied with learning skills they see as concrete and discoverable. This could mean that as first years they are not yet aware of less visible skills that relate to relational aspects of the mental health nurse's role, and how to work in partnership with another person in terms of care planning. Benner (1984) identified that novice practitioners' early knowledge is propositional (theoretical) and that novices may not yet have had the experiences to apply this knowledge in practice. This early comprehension is significantly different to later knowledge, that Benner (1984) termed tacit and experiential and is the hallmark of becoming an expert. Therefore Neil's hesitance at a definition and the students' lack of examples may be indicative of their limited experience of involving service users out in practice at this point in their education.

Ellie laid claim to the knowledge about what service user involvement means to her with "that's what I thought it was" (line 1188). She then elaborated on this with reference to elements of recovery-focused practice, such as referring to "aims (…) hopes and aspirations". This strengthened and worked to corroborate her knowledge claim. Ellie achieved a sense of moral worth in her talk, as she provided an account to me (as a nurse lecturer) that I may have been expected to value. People's talk serves to achieve a range of functions. Gergen (1985) suggested that social actors seek to demonstrate their legitimacy and moral worth, often with attempts to achieve an agreeable outcome. As a person's sense of self is socially constructed, an individual may construct themselves in a way that is seen favourably by others.

Individuals whether speaking alone or in a group provide versions of events and experiences. Orbuch (1997) refers to these as accounts, which are story-like interpretations, and their functions in that person's life. Accounts are useful for gaining

insight into the human experience in order to arrive at meanings and explanations (Orbuch, 1997). In the first part of this extract Neil and Ellie can be seen to be accounting for having some knowledge of what service user involvement may be about. At the close of this focus group data extract there was a 4 second pause in the group's talk, which may be indicative of them considering the topic being discussed. In focus group situations, attentive pauses are sometimes viewed as allowing people time to comment on the current topic (Wilson, 2014). The pause was broken by Ruth, who had been one of the quieter members of the group. Ruth said "You don't see much of that though" (line 1193), in relation to previous comments by other group members about user involvement in care planning.

In this extract from a focus group comprised of first year nursing students, participants set out to achieve a description of their understanding of user involvement. It is possible that narrow experience may explain their limited explanations of this phenomenon. Despite Ruth's comment that "You don't see much of that though", this need not be read that user involvement is not happening in practice, but maybe that these particular students have only limited experience of such activity at this point in their preparation. Ruth was clearly putting forward that "you don't see much of that" had been her experience to date. In the focus group talk that followed Ellie confirmed Ruth's observation and said "it's just done" (line 1196), and that patients are "kind of talked about rather than to" (line1201). The only challenge came from Abby who reported she had seen patients asked about their feelings in a ward round. However, recent research indicates that there is insufficient service user involvement occurring in care planning (Grundy et al., 2016; Simpson et al., 2016b). Findings from my study suggest student participants' views are clear that elements of service user involvement in care planning are not widely evident.

The data extract below is taken from focus group 3, which took place in a classroom setting and lasted for 51 minutes and included a different group of 4 first year nursing students. The data extract presented here occurred at a point in the focus group where I prompted the participants to clarify their understanding of the term service user

involvement. By this point in the focus group the nursing student participants had been describing their experiences on placement in a range of settings. They had highlighted a number of practices that could be considered to be related to involving service users in their care, but had not used the term 'involvement' or a similar word. I prompted the group participants at this point to explore their understanding of the concept of user involvement.

JT: I suppose we haven't mentioned the words service user involvement yet, but you've actually all been giving some good examples of the different ways that we can involve service users in their care. I mean, after just a year, service user involvement, does that have any sort of you know, does that ring any bells for you? Different places that you've been or -

Debs: You see more to do with service users in the community, is that what you mean?

JT: Well, service user involvement is like er erm, nowadays we're expected as nurses to do more of it

Rhian: They want to be cared and stuff, isn't it?

JT: Yes, yes

Rhian: But I don't think…I can't really say I've seen that to be honest, no.

JT: 'Cos you've started actually to give some good examples of it, like the choice and the flash cards

Rhian: So actually sit with the patient and say ask them what they want?

JT: Yes

Rhian: I haven't seen that, no. Whether I've missed it, I don't know, but I haven't seen…actually seen it with my own eyes

JT: Yes, that's fair enough. Anybody else?

Nicole: Well like I said because I've done EMI and adult now, I can't say there's much service user involvement. But in my previous job, because I used to work for the NHS, with substance misuse, you write care plans up with the clients, you set targets and goals with the clients, so it does depend on what client group you are working with.

Chorus: Yes

611 **Jill**: No, I saw more service user invol…in my previous job as well, and the whole
612 ethos of what we were doing was that you're not doing it for them]

613 **Nicole**: You're] doing it with them.

[Focus group 3, first years, lines 587-613]

Having asked about service user involvement and "does that ring any bells for you?", the group began to check out that they had understood me correctly. Debs suggested "you see more to do with service users in the community", and followed this with "is that what you mean?" (line 592). These comments from participants began to suggest to me that these nursing students had little confidence in providing or defining a concept of service user involvement, and were possibly making suggestions to try and please me as the researcher, or were enquiring to see if they were on the right track.

The participants in focus group 3 were seemingly unaware that their talk appeared disempowering in how they oriented toward people using mental health services. Rhian's suggestion that user involvement might include notions of "they want to be cared and stuff, isn't it?" (line 595), has little to do with enablement and recovery principles. Disempowering attitudes arise when professionals work on presumptions of what is in a person's best interest and often result in decisions being made on someone's behalf. Historically, beliefs that people with mental health problems cannot care for themselves are out-dated, and can result in social distance which reinforces the stigma of mental illness (Corrigan, Edwards, Green, Diwan & Penn, 2001). This is far removed from an approach that embraces the elements of recovery, with the service user taking control and accessing opportunities to participate in society (Repper & Perkins, 2015), which is the ethos of service user involvement.

One of the challenges in securing representations of the social world from participants is to provide opportunities to 'harness respondents' constructive story-telling' for the purposes of elaborating the phenomena under investigation (Holstein & Gubrium, 2003, p.75). In the spirit of an ethnomethodological approach, I did not see the data taken from focus groups as having a pre-determined content that existed for me to access. The

very nature of focus groups suggests that the data is co-created, as it is formed by a group of people. What occurred in this focus group was a demonstration of how a group of nursing students attempted to achieve consensus and understanding about their perceptions of service user involvement. The co-construction by this group may be similar to any group of mental health nursing students with similar sets of experiences, who might come to construct their understandings in a similar way and with a similar outcome.

Rhian began to clarify her position about her experience of service user involvement when she said "but I don't think…I can't really say I've seen that to be honest, no" (line 597). Rhian's status as a neophyte was a warrant allowing her not to know everything, although she does not invoke this directly. She showed self-awareness with "whether I've missed it, don't know" (line 602) suggesting some doubt that perhaps her role as a student could mean she did not see something that perhaps she should have. Prior to this, Rhian's talk included a lot of clarification turns with me to establish precisely what was being asked. She was therefore fairly certain of her ground when she replied that she had not witnessed service user involvement but couched it to allow for her novice student status.

Nicole on the other hand stressed her experience to the group with "I've done EMI and adult now" (line 605). She was establishing the basis for what she was about to say. Her authority to say what she would say was positioned here for other speakers in the group who could hear what was said in terms of context, and then be able to accept or challenge it on that basis. So having stated her placement experiences, Nicole then went on to make a knowledge claim in line 605-606 with "I can't say there's much service user involvement". In her next sentence, Nicole went on to follow this with a comparison (about her previous NHS role in substance misuse services), to show further knowledge and perhaps to indicate that she could be considered to know what she was talking about. Nicole's claim that service user involvement "does depend on what client group you are working with" (lines 608-609), was then honoured by the group with a chorus of "yes", indicating consensus in their views.

One of the aims and opportunities provided by the focus group method is that respondents can openly discuss topics and realise each other's viewpoints. Consensus is not sought, although it is observable in focus group discussion when respondents appear to hold shared perceptions of the topic in question (Kitzinger, 1994). This consensus may be noticeable by simple nods of agreement and verbal interjections of 'yes' and 'yeah' from other group members. There was however no reasonable argument given by group members as to why they thought user involvement activities should depend on the population group. It is possible that these nursing students were reporting what they had witnessed, and if they perceived a lack of involvement relating to a population group, they may have been unsure why this was. These participants in focus group 3 had checked out with me what was meant by service user involvement, disputed it happens, and shown awareness of what involvement in relation to care was from their previous experiences. This collective response worked up the claim that the mental health services they had been placed in as nursing students did not on the whole do much that could be labelled as service user involvement.

This data extract from focus group 3 provided some insight into the nursing student participants present and their claims about service user involvement. Similar to participants in focus group 2, there appeared to be some notions that user involvement was an added task rather than an implicit part of values-based practice. It was also evident that such novice practitioners have included some distancing in their talk, as service users have been referred to as 'they' and 'them' in several instances, implying a sense of othering. There was talk that service user involvement is restricted to certain population groups, and therefore excluded others, and few examples of actual involvement in practice. Student participants in my study responded based upon their current sets of experiences which might reflect a system in which workers and others interpret obligations of involvement as applying to some groups but not others. Students have displayed in their talk their understandings in a way that suggests wider issues with involvement and how it may or may not be actioned by professionals in multiple settings. In their discussions students have oriented towards contemporary

understandings of service user involvement as encountered in their practice placement settings.

Although 'service user' and 'involvement' are not complex terms, students did seem confident to discuss possibillities in terms of care provision. There was little discussion of values, and participants have perhaps talked about user involvement as if it were a discrete strategy, rather than a principle or belief that they incorporate into their everyday practice. This is reflective of nursing students' education, and I suggest that by this point in these participants' preparation input and involvement from service users would have been minimal. Gutteridge and Dobbins (2010) note that in order to have maximum impact on learners, the philosophy of involvement needs to run through education programmes, not appear as a bolt-on. Participants in Focus groups 2 and 3 gave an impression of passive learners who have set aside previous learning perhaps for the purposes of fitting into their new professional social struture. Their focus group contributions about involvement read as if they have never thought about this before until challenged by my questions. It might be argued that this challenge has not come at all in the first year of their course either in university or in practice. Even if structures to support involvement are present, they are not sufficient unless supported by a culture of inclusion that reflects user-centred values (Tee, 2012). Cultures that demonstrate co-production and partnership working would help novice practitioners to assimilate their learning about user involvement in practice.

My analysis above indicates limited awareness about user involvement in mental health nursing practice from nursing students. In the next section I will show further displays of talk about user involvement in mental healthcare in both inpatient and community settings. In the main this refers to user involvement in care planning. It seems surprising that despite legislation in Wales dictating that users should be as fully involved as possible in care and treatment planning processes, that reports by various social actors involved are often to the contrary.

5.3 “Some people when they're doing their care plan reviews won't really have an in-depth discussion with the patient”

The remaining sections of this chapter focus on narratives from one mental health nurse and two service user participants, and how they talked about service user involvement in care planning. The rationale for this focus is to show that narratives from my participants overwhelmingly indicated that stories about service user involvement in care planning as a specific area of mental health nursing practice were inadequate. If social actors involved in care planning activities have a sense of limited engagement by mental health nurses in relation to involvement, it indicates that mental health nurses are taking not ownership of such activities.

There has been a focus in mental health policy and guidance that service users are to be involved in their care plans (DoH, 2008; Healthcare Commission, 2008; DoH, 2011). Recovery and personalisation together means that professionals would ideally be tailoring support and services to fit the specific needs of the individual; with people taking more control over their condition and lives (Simpson et al., 2016a). However, users have reported that limited collaboration has been the reality (Newman et al., 2015). Interestingly, research in the area of personalised, recovery focused care planning in mental health is under-developed (Simpson et al., 2016b), with limited peer-reviewed articles in the mental health nursing literature in this area. The participants referred to in this section provided accounts that suggest the activity of involving users in care planning occurs seldom, and that nurses have limited skill and confidence regarding how to accomplish such activity.

The following data extract is taken from a 59 minute research interview with Mary, a mental health nurse participant. An earlier part of Mary’s account is present in Chapter 4. At the time of the interview Mary had been a qualified nurse for eighteen months and worked on an acute admission unit. Mary talked initially about her work role in this ward environment. We began to talk about user involvement and the role of the mental health nurse. Mary identified a need to spend time with people to learn about their

individual needs, and that although some users did not want to engage, it was better if nurses and service users could work together. I then began to ask broader questions about service user involvement.

JT: Erm, I mean obviously your mental health nurses work with patients, you know, service users. Are there some nurses who are more likely to be affected by user involvement?

Mary:I think there are some, because some people when they're doing their care plan reviews won't really have an in-depth discussion with the patient. They'll just sit in there and write it from what they've seen, from their perspective in the first place. Erm, but I would say the majority of the…the nurses would involve the patient, if the patient's willing to speak to them or even if they're well enough because sometimes when you know that they're that unwell, you kind of think, well, sitting down and talking to me about a care plan was the last thing that they need. So you do it on their behalf then, but hopefully as they get better, you can start involving them more, because you can discuss with them what activities do they want to do, like if …and then ask OT to come and have a chat with them. We can refer them to (local day centre), because they…the staff come up from there once a week, and they ask us is there anybody you think is suitable, whereas if you've already had that chat with some…one of your patients the day before or whatever you can say, yeah, so-and-so's looking for this.

JT: Yeah.

Mary: And then at least they've got an idea then of what they need to speak to them about.

JT: Right, right. So *[cough]* service user involvement could be a bit dependent on people as actually as individuals.

Mary: Mmm

JT: What about nurses in different mental health roles, are there some like… more likely to be affected than others?

Mary: Erm, I think the CPNs might be more affected because there's a plan now that every patient that comes into hospital has to be care managed when they …on discharge as part of the CPA. So that's going to have a huge effect on the…on the community staff because they can see their work being increased.

[Mary, Mental health nurse participant 1, lines 763-791]

Mary began by replying to my question as to whether some nurses are more likely to be affected by service user involvement in nursing processes than others. I did not stipulate any further detail, leaving the topic open to Mary's interpretation. Mary responded by

talking about certain ward nurses who either did or did not involve service users in the care planning process. The purpose of analysing such talk is not to discover the truth about what really happens with care planning in mental health settings, but to explore the rhetorical organisation of participants' talk. It is how participants organise their talk for the purposes of attempting truth claims that is of interest. Edwards and Potter (1992, p.57) refer to this activity as 'discursive practices of reasoning. When giving verbal accounts, people's practice is to attempt to establish or agree the truth of what happened, which is the focus for this type of analysis rather than any attempt at verification of the events themselves. The focus is on how people talked about what happened.

Mary provided an account about some nurses on her ward who "when they're doing their care plan reviews won't really have an in-depth discussion with the patient. They'll just sit in there and write it from what they've seen, from their perspective" (lines 766-768). Mary's words "they'll just sit in there and write it from what they've seen" indicated that some nurses write care plans separately from service users. This may also mean a physical distance away from users, presumably 'in there' (line 768) referring to the ward office. Mary provided a balance or counter-argument, as she followed this sentence with "but I would say the majority of the…the nurses would involve the patient" (lines 769-770). In her narrative Mary was acknowledging that some nurses do not do as they should with regard to involving people in care planning, but she claimed that most nurses do. Mary used the word "the majority" to counter competing versions of practice that exist. It is difficult to say what involvement actually meant to Mary, as she did not elaborate. Whilst good practice and legal requirements are embedded in the principles for care and treatment planning (Welsh Assembly Government, 2008b; Welsh Government, 2015), individual practices are subject to interpretation. For example in a recent study of care planning practices professional workers reported that if they had spoken to a person about their care plan that was tantamount to involving them (Simpson et al., 2016a). Equally, it has been reported that just because staff speak to service users about their care plan, it does not translate that people's comments are transferred to the care plan (Fisher & Perkins, 1996), as their priorities may have been considered subordinate to staff's priorities.

Mary then continued in her talk to account for why in her view nurses do not involve service users in care planning and implies this was dependent on the service user. She said "if the patient's willing to speak to them or even if they're well enough" (line 770). Mary then highlighted that "sometimes when you know that they're that unwell, you kind of think, well, sitting down and talking to me about a care plan was the last thing that they need" (lines 771-773). In terms of what Mary was doing with her talk she was accounting for why nurses might not always involve users in care planning. Scott and Lyman in their work on accounts (1968), refer to this type of talk as an excuse. Excuses are socially approved talk with the purpose of vindicating responsibility. These types of accounts include talk about an act that the speaker accepts is wrong, but avoids acceptance of responsibility for the act. Mary's talk functioned to excuse nurses from involving clients in care planning. For example in lines 767-769 Mary has acknowledged that nurses do not include users in care planning, and she would know this to be contrary to good practice and guidelines.

Guiding principles in the new Code of Practice state that users' independence should be encouraged and supported with users fully involved about care and treatment decisions (Welsh Government, 2012b). Mary's comments in lines 766-767 that "some people when they're doing their care plan reviews won't really have an in-depth discussion with the patient" were contrary to both professional and legal requirements. Mary's use of the term "some people" indicate she was not including herself in this. She did not indicate what involvement means to her, suggested there are caveats to involvement practices and then shifted the conversation to other agencies. Her talk served to portray the majority of nurses as benevolent, which meets with wider expectations of what nurses should be doing.

Mary has produced this account for me as a researcher, and in a sense it would be difficult for her to do anything else. Edwards and Potter (1992) refer to this as an example of a 'they would say that wouldn't they' defence. As a registered mental health nurse, Mary not unusually asserted that she and "the majority" of her colleagues engage

in best practice. She presented caveats to show the complexity of judgements required by nurses and indicated that there is a graduated response from nurses to greater service user involvement as patients conditions improve. As this is Mary's account this is difficult to dispute. However, in my study I also had nursing student participants suggesting they have never seen involvement, service users who are rather sceptical, and literature which challenges idealised notions of service user involvement (Stickley, 2006). I suggest that Mary is aware of this, but still presented the professional account, as to do otherwise would present her in a morally ambiguous position.

In her account Mary has drawn on a range of resources to establish her excuse, for example "if the patient's willing to speak to them" (line 770) or "if they're well enough" (line 770). Mary's talk here served to imply that service users may be difficult, hostile or reluctant, and that it may be excusable for nurses not to involve service users in care planning. This talk worked to invoke ideas of unreasonable or irrational people. In a way Mary's account played into accepted notions of difficult mentally ill people. By calling upon these ideas Mary may be anticipating any negative judgements about her professional practice. Her account can be considered as presenting an alternative version of involvement in which idealised notions are amended to allow for circumstances where it may be difficult to accomplish these.

Mary may also have been aware she was speaking to someone familiar with care planning in inpatient settings, and may have expected criticism about a lack of user involvement. She provided some cover for herself so that the account could establish her moral status as a caring nurse by offering her concern for the welfare of the person as a key element in her claim. This is visible in lines 772-773 with the words "talking to me about a care plan was the last thing that they need", implying it was compassionate to exclude them from such an activity. Mary's account therefore worked to establish her moral status as a caring health professional.

In the interview, in lines 786-787 I moved on to ask Mary about other mental health nursing roles that in her view might experience a greater or lesser impact in terms of involvement. Unfortunately I used the words "affected by service user involvement", which suggests involvement to be an external agent. Mary replied by stating "I think the CPNs might be more affected because there's a plan now that every patient that comes into hospital has to be care managed when they …on discharge as part of the CPA" (lines 788-790). Mary was referring to "the CPA", the Care Programme Approach, which is a system used to organise people's care in secondary mental health services. The CPA has been in existence in England since the early 1990's, and in Wales since 2004. Mary's claim was that the new guidance on care and treatment planning in Wales (Welsh Government, 2012) would have "a huge effect on the…on the community staff because they can see their work being increased".

Mary's comment about user involvement related to workload, and how it may impact on staff in her view. There is no mention that user involvement might be good for service users, or might lead to improvements in care. It could be said that Mary's talk in lines 790-792 functioned to distance the practice of user involvement somewhat from ward nurses, such as her. In terms of user involvement as part of a mental health nursing identity, Mary's account did not provide support for this, and provided an account to the contrary. Brooks et al. (2015) suggest that organisational cultures can be an inhibitor to care planning, with a lack of time, much paperwork and bureaucracy cited as pressures. Inpatient services seem to prioritise targets and bed occupancy, rather than user involvement in care. A focus has been more on quantitative measures such as whether users have a copy of their care plan as opposed to the quality of care plans and how people may have been involved in the development of individualised care (Brooks, Sanders, Lovell, Fraser & Rogers, 2015). Interestingly as Mary suggested user involvement would result in an increase in workload, her talk here operated as a fear about an uncertain future effect.

5.4 "She sort of rushed it a bit and, she just wanted to get it done and written out and put away": experiences of involvement in care planning

The next data extract I have chosen comes from a research interview with a service user, Amy. In her account Amy described her experience of developing her care plan with her CMHN. The research interview was held in the offices of a third sector organisation and lasted 1 hour and 14 minutes. This excerpt is taken from near the beginning of the interview as Amy talked about the help she received and the role of her CMHN.

Amy: We did my care plan a few weeks -- probably a couple of months ago now, which was the new care plan then

JT: Right

Amy:That needs to be done by law. Er, it's the first one I've ever seen

JT: Right

Amy:When technically I should have seen several by now (laughs) because I've been in the service since I was 15.

JT: Mm

Amy:Erm, she was quite…she sort of rushed it a bit and, she just wanted to get it done and written out and put away.

JT: Mmm.

Amy:And erm (3.0) She missed out a couple of sections as well which I didn't think she was supposed to do

JT: Right

Amy:Erm, because she said it wasn't relevant to me. But erm she was taking it very…rigidly and things like relationships and stuff she was like, oh, we don't have any relationship problems at the moment, so we'll leave that, but then I was like well, it's not just about my boyfriend you know, there's family (?that hasn't been there)

JT: Mmm

Amy:It's like you've got no…no children or anything that you…anyone that you care for so we don't need to look at that bit either, erm which is true, I don't. But erm (3.0)…

JT: Sounds like you wanted a bit more from that process though?

63 **Amy:** Yeah, because it…it plans my treatment, doesn't it, for the next…well,it's six
64 monthly they do them which I think is a bit silly anyway because things change
65 more frequently than every six months.

[Amy, Mental health service user 8, lines 39-65]

Amy began to talk about doing her care plan with her CMHN, and said "we did my care plan" (line 39), which implied a sense of partnership and the undertaking of the activity together. Amy then contextualised this activity further when she said "that needs to be done by law", demonstrating a knowledge claim that not only is the care plan a legal document, but that the process of its completion is defined by law. Interestingly Amy added a further point about her care plan when she said "Er, it's the first one I've ever seen…when technically I should have seen several by now (laughs) because I've been in the service since I was 15" (lines 42-45). Amy accounted for her experiences in relation to care planning, and highlighted that now there is a law stating she must have a care plan. She was aware though that as she had been a service user for several years (Amy was in her mid-20s), that this was the first care plan she had seen. Her laughter here was perhaps ironic, as the notion of not having a care plan and certainly not being involved in developing one is far from humorous. Jefferson (1984) has written about laughter in the talk of troubles-tellers, and how laughter can be interpreted differently depending on the nature of the troubles and the reactions of people present to the laughter. In the example with Amy, as the troubles teller she laughed first, then I as the troubles-recipient did not laugh, as the situation was a serious one and not funny. Amy's talk also demonstrated her awareness that there had been a number of missed opportunities for engagement in planning her care of which she was now aware.

In Amy's account of her experience of being part of the care and treatment planning process, she said "she [the CMHN] sort of rushed it a bit and, she just wanted to get it done and written out and put away" (lines 47-48). In Amy's account the process was not only described as "rushed", but she described her CMHN as seemingly having little time or value for such care planning activity. Bee, Price, Baker and Lovell (2015b) note that despite the political rhetoric promoting involvement, many users feel marginalised in the planning of their care. Five common antecedents were identified in relation to

involvement in user-led care planning: organisational influences, participatory decision-making, relational influences, meaningful information exchange and user/carer buy-in (Bee et al., 2015b). It not surprising that insufficient time dedicated to service users and high staff workloads are just two of the care planning barriers identified (Bee et al., 2015b). There is evidence from the implementation of the Measure that the administrative requirements of care and treatment planning do impact on time available for patient care (Welsh Government, 2012b).

In Wales, there has been literature freely available in both third sector organisations as well as mental health services that inform service users about the Mental Health (Wales) Measure and what individuals can expect from care and treatment planning (Hafal, 2012). It is reasonable to suggest that Amy had expectations about the care and treatment planning process, and maybe some pre-conceived ideas about what it might be like. Amy was interviewed for this study in February 2013, four months after the Measure was implemented in Wales. All mental health professional workers acting as care co-ordinators were tasked with completing care and treatment plans with service users on their caseload within a certain timeframe. This may explain Amy's account of the process feeling "rushed" and a sense of "get it done and written out".

Amy went on to describe her experience of the discussion of topics involved in the care planning process. She demonstrated awareness that the care and treatment planning was part of the Welsh Measure and had a number of sections, which needed to be discussed with every service user. The areas of care and treatment planning include finance and money, accommodation, personal care and physical well-being as well as social, cultural or spiritual issues. Amy stated that her CMHN "missed out a couple of sections as well which I didn't think she was supposed to do" (lines 50-51). In her talk Amy stated her knowledge about good practice as the Measure highlights 'Care Coordinators should agree outcomes in one or more of the eight areas', but it is recommended that all life areas are discussed (Hafal, 2012).

Furthermore, Amy's account highlighted not only the missing out of sections of the care and treatment plan, but she stated that the CMHN "said it wasn't relevant to me. But erm she was taking it very…rigidly" (lines 53-54). Amy went on to give an example of where her CMHN apparently suggested sections were not relevant. Amy stated "oh, we don't have any relationship problems at the moment, so we'll leave that". Amy's use of the words "we don't have any relationship problems", suggested she felt the nurse was making assumptions and denying Amy a voice. There are indications that although 90% of mental health service users in secondary care do have their own care and treatment plan, there is evidence of variability, with service users not always understanding their own plans (Welsh Government, 2015) indicating a lack of involvement.

The account Amy provided was indicative of someone who was trying to assert their views, but was not being heard. Amy gave more than one example of where she wanted a key area explored in more depth as part of her care and treatment plan. For example, Amy's account functioned to replicate the conversation she had with her CMHN. She said, first taking the part of the CMHN when they discussed the parenting or caring relationships section "you've got no…children or anything…anyone that you care for so we don't need to look at that bit either" (lines 59-60). Amy did not make it clear what her response was at the time to the CMHN, but did say in the research interview "which is true, I don't. But erm (3.0)". The "But" and a 3 second pause seem to indicate a sense of this not being finished or reconciled for Amy. As the researcher I made the observation that Amy appeared to want more from the care planning process. She then went on to emphasize why this was "because it…plans my treatment, doesn't it" which suggested that Amy saw value in the process. Amy displayed knowledge that all treatment plans have to be reviewed at least every six months. She then added further insight and stated that in her view this was "a bit silly anyway because things change more frequently than every six months" (lines 64-65).

This account by Amy, a mental health service user, highlighted her experience of involvement in the care and treatment planning process. She clearly had an expectation that service user involvement in care planning would be part of the activities of her

Community Mental Health Nurse, and appeared surprised and disappointed with her experience As a result of new mental health legislation, there is now policy in place that legally dictates requirements regarding user involvement in care planning (Welsh Government, 2015). Amy's account was contrary to this and she was critical of the process that she experienced.

5.5 "The place where it's most important for most people is involvement in your own care"

The next data extract is taken from a 1 hour 10 minute research interview with a mental health service user participant who I have named Brenda. I interviewed Brenda in her own home. She had met mental health nurses in both hospital and community settings in the past. During the research interview she narrated a story about some of her experiences of mental health services and what she had personally found helpful from mental health nurses. Brenda portrayed herself as a well-informed service user who had been involved on a range of committees and at a national level with various mental health projects. At this point in the interview I used a prompt to ask more broadly about user involvement in a number of settings.

JT: Any particular thoughts on how you would like to see service user involvement in nurse training, in people's care…?

Brenda: Ooooh (laughs). I've been very proactive, if you like, in this area for a long time, and er because of my own experience one of the things I've said is, okay, get involved in teaching, get involved in politics, get involved in policy development, blah, blah, blah. But the place where it's most important for most people is involvement in your own care.

JT: Yes

Brenda: Erm, but my…to some extent you know…to..erm…I think one of the problems is you're working in a culture which is very top down, the people at the top make decisions and you just have to co-operate with them. Erm, I don't think the nurses actually have much idea of what it's like to be involved in decisions about their own lives and, therefore, don't know how to involve the service users. So I think a lot of it is around the culture and you know I think you have to know what it feels like yourself really.

873 **JT**: Yes, yes. Mmm.

874 **Brenda**: (5.0) But, yeah, I think the first…the first thing I would like to see in terms of
875 involvement is communicate doesn't mean tell (laughs). It's about dialogue.

[Brenda, Mental health service user 3, lines 858-875]

Brenda began her response to my question about how she would like to see user involvement by accounting for her experience. Her initial response is "Ooooh (laughs). I've been very proactive (…) in this area for a long time" (lines 860-861). This talk did the work of accomplishing her identity as a person with extensive experience of being an involved service user. She used the words not just proactive but "very proactive", and adds "for a long time" to establish her credibility and experience.

In lines 861-863 Brenda went on to imply how she had recommended that others actively participate in involvement opportunities. Brenda said "because of my own experience one of the things I've said is, okay, get involved in teaching, get involved in politics, get involved in policy development, blah, blah, blah". It was not clear who Brenda had said this to, she used the words "in your own care", so there was a sense she had suggested this to other service users. Brenda was demonstrating a knowledge claim that service users can be involved in a range of different ways, but she did not elaborate on reactions to her statement. Many users may not be comfortable with all aspects of involvement, and not all are willing to participate as user representatives (Borg et al., 2009). Non-involvement may be for a variety of reasons, and Brenda went on to speak more about this.

In lines 866-868 Brenda accounted for the culture that professionals work in as she saw it. She described it as "a culture which is very top down, the people at the top make decisions and you just have to co-operate with them" (lines 867-868). It was not clear who the 'you' referred to, which could be nurses or service users, but Brenda was accounting for the culture of mental health services as being disempowering. Borg et al. (2009) suggests a useful question to examine the rhetoric-reality gap of user involvement might be 'how are mental health professionals as social agents of

knowledge involved in activities that reinforce the powerlessness of the users?' (Borg et al., 2009, p.291). There are a number of barriers in organisations that are considered barriers to involvement, such as hierarchies that exclude, jargon and atmospheres that are not user-friendly (Basset, Campbell & Anderson, 2006). Brenda's talk indicated that she was aware of these barriers and challenges.

Brenda then made a statement about nurses themselves and said "I don't think the nurses actually have much idea of what it's like to be involved in decisions about their own lives". Having talked about a "culture which is very top-down" (line 867), her talk then worked to portray the nurses as being passive, and certainly not as people who are decision-makers. Brenda was creating and sustaining an identity for mental health nurses that she has found to be the case from her experiences. Through her talk about nurses' traits Brenda's talk indicated identity-related activities about the mental health nurses that she had met.

Brenda went on say "and, therefore, [nurses] don't know how to involve the service users" (line 870). Brenda's talk here worked as a complaint. Brenda was accounting for the lack of involvement of service users being involved in their own care being due, at least in part, to the lack of knowledge and skills of mental health nurses. Whilst initially acknowledging competing tensions in the health service culture, Brenda was clear and her talk did the work of complaining that mental health nurses do not know how to involve service users.

In her next turn Brenda gave two reasons for nurses not involving service users in their care. She said it's "around the culture" (line 871) and that "I think you have to know what it feels like yourself really" (line 872). Brenda did not elaborate on this, but the suggestion is that nurses cannot know what it feels like to perhaps be a disempowered service user. Throughout the wider interview Brenda spoke about a number of occasions when she experienced unsatisfactory care, interventions and suggestions from mental health nurses about her care and treatment. According to McCauley, McKenna, Keeney

and McLaughlin (2017), co-constructing research tools with service users about recovery gives good insight into people's lived experience of mental distress, and relevant questions to explore. Brenda's experience suggested that nurses' knowledge about such painful experiences was limited.

At an earlier point in the interview Brenda had talked about her engagements with nurses and observed "I get the impression they're not terribly confident to be honest, erm in terms of feeling what they can do" (lines 42-43). Brenda was making a claim that mental health nurses have limited confidence, and suggested also that nurses have limited experience of decision making (lines 869-870), and therefore do not know how to encourage and involve service users in their care and care planning. It could be said that disempowered nurses and service users have much in common, and that nurses have real allies in service users in terms of identifying how the nursing profession can develop a culture that facilitates nurses to work in a more therapeutic way with users of mental health services (Rydon, 2005). Whilst some mental health workers are committed to developing a more equal culture and involving service users far more in care decisions, they are currently in the minority (Felton & Stickley, 2004). Brenda's talk implied a "culture which is very top-down", and that involvement is not commonplace is evident in the literature. For example, Rutter et al.'s (2004) study about two provider trusts in London reported that rather than true involvement, a more accurate description is that in reality patients are simply consulted and not fully involved in service change.

Brenda made the point in her narrative that the first thing she would like to see in terms of user involvement was that "communicate doesn't mean tell (…) It's about dialogue" (line 875). Brenda was asserting a claim that true involvement involves a dialogue between parties, and perhaps is not like the "very top down culture" she referred to (line 867). Brenda had given an account in the research interview that she had not been satisfied with many aspects of her care and treatment, particularly when she had made requests as part of her care plan which had not been met. Brenda's account did indicate similarities with both Mary's and Amy's accounts, that not only do some nurses not

involve service users in care planning, but that it can be rushed and not meet users' expectations. Brenda's account reinforced that "involvement in your own care" is most important, but acknowledges that nurses' skills in facilitating discussions and decision-making may be lacking. This supports the notion that service user involvement in care planning is not evident in the talk of, or about nurses, and therefore is not being considered as a dominant part of professional mental health nursing identities.

5.6 Conclusion

In this chapter I have used my findings to show that participants demonstrated awareness in their accounts about competing versions that arise in relation to service user involvement in nursing processes and care planning practices. This was accomplished in people's talk by participants providing narratives about their experiences in mental health care settings. Nursing student participants oriented towards perceptions that they had limited understandings of service user involvement, and had witnessed little of this activity whist on practice placements. Equally, student participants highlighted that service user involvement in care planning was not only good mental health nursing practice, but is now mandated as part of service users' care experience. Despite policy guidance and legislation, nurse participants highlighted that sometimes care planning was accomplished separately from service users. Scott and Lyman (1968) state that people include excuses in their talk, which are socially approved vocabularies for militating responsibility. Excuses about a lack of involvement were evident in nurses' talk, with mention of being busy and the perceived ill state of service users which functioned as a reason to develop care plans without involving service users.

The accounts provided by service user participants functioned to demonstrate that their experiences of involvement were often lacking or were unsatisfactory, with the notion that mental health nurses frequently had little idea how to involve service users in care decisions. This may suggest some lessons for those workers attempting to provide care

and treatment to people using mental health services. Equally this indicates that further work is required for those who educate and employ professional workers.

The stories told by participants in my study express a number of tensions which illustrate omissions and oversights in relation to service user involvement in nursing processes and care planning. People's accounts indicated an awareness of different reasons why service user involvement may be limited, and gave examples in their talk that functioned to justify low levels of involvement. How people talk about mental health nursing work has implications for service user involvement. If involvement is to be a tangible experience for users of mental health services, involving service users in their care would not just be an existent part of the mental health nursing role, but would be a recognised feature of their identity as mental health nurses.

The following chapter is the final findings chapter and explores mismatched expectations about mental health nursing. All participants in this study voiced expectations in relation to mental health nursing work, as well as expectations about approaches that nurses employed with service users.

Chapter 6: Mismatched expectations about mental health nursing

6.1 Introduction

In this chapter I present findings from participants' talk that relate to reported mismatches in their expectations about mental health nursing roles. These disparities often relate to workers' expectations of both ideal and actual nursing practice. How nurses perceive their roles will ultimately impact on how they engage with and work alongside mental health service users. The concept of roles is useful in understanding everyday dynamics, meanings, and complexities in people's organisational work roles, as this helps us to understand expected behaviour patterns and obligations attached to a specific status in a social structure or system (Biddle, 1986; Sargent, 1950). Social roles are about the performance or the way a part is played in social life, involving designated rights and responsibilities, with behaviour oriented to patterned expectations of others (Linton, 1936). Gross, Mason and McEachern (1958) suggest a role is also about how an individual performs a role in a given position, as distinct from how they are supposed to perform it, which concerns the areas of role performance versus expectations from others about the said role.

In this chapter I will build on my findings about mental health nursing in relation to the development of professional identities. Chapter 4 included findings about mental health nursing roles, and role-related activities. The findings in Chapter 4 highlighted that engagement with service users, often seen as central to mental health nursing work, can be time-limited by occupational demands. In Chapter 5 I explored participants' talk in my study about understandings and experiences of service user involvement in nursing processes. Talk included both service user accounts that highlighted barriers to involvement, along with narratives from nurses suggesting true service user involvement in practice was often sparse. I will explore elements of role theory in this chapter, such as role conflict and role ambiguity. However, no single perspective of role

theory can account for the complexity of how mental health nurses carry out their work, and understand their professional identities (Hercelinskyj, 2010). I will therefore explore talk about mental health nursing identities in further detail, particularly in relation to role expectations which is a central theme in this chapter.

In any social system a person's social status is not usually a single associated role, but an array of roles, which Merton, Reader and Kendall (1957) considered to be a role-set. Society will likely have expectations of these different roles. Job descriptions and work roles tend to prescribe employee behaviour, so that organisational aims will be achieved (Katz & Kahn, 1978). Norms or expectations can vary, and may reflect the organisation's demands or pressures from other groups. For example, if nurses in one team carry out a certain role, there may be expectations that nurses in a different team in the same geographical area act in the same fashion. So an individual in a given work role has a job description, a social status, and expectations placed on them by the organisation, other workers as well as their own expectations about how they will fulfil the said role. These role sets then act as a reference point by which we benchmark role behaviour, and develop expectations of the person fulfilling a particular role.

Organisational theory is complex because it relates to activity, people and links to wider environments, with dimensions of power and control posing different demands in line with cultural shifts and changes (Shafritz, Ott & Jang, 2016). Whilst my intention is not to focus on the structure of particular mental health organisations and management systems, there is relevance here for professional workers. Mental health nurses can be caught in the crossfire in terms of competing aims from organisations, government policies, healthcare guidelines, and service users' needs resulting in incompatible demands for staff. For example, policy has focussed increasingly on service users' physical health needs, as well as co-production of care plans and assessing carers' situations (Welsh Government, 2012a). Increasing demands from above and below can arise from various authorities, likely sending conflicting messages to mental health nurses about the nature and priority of their roles and work.

How an individual views themselves as a professional will be linked to the tasks they are expected to carry out, and how these expectations fit with their understanding of that role, as well as workplace factors that may impact upon the said role (Hercelinskyj, 2010). There are also expectations about the worker from the group that the role occupant interacts with. In this instance I am referring primarily to the expectations of mental health service users, but equally other members of the multi-disciplinary team who have expectations of other workers too. Social actors will have role expectations they are obliged to meet, with each role coming with its own responsibilities and authority to act. Certainly there are role expectations or norms which arise from professional, organisational and personal sources. These norms may be exerted by those external to the group, for example government and organisation policies regarding mental healthcare, and patients' rights. Role congruence results when expected activities within the role, as well as expectations from external organisations match with the individual (or profession). There is however potential for role incongruence, if additional activities are perceived as not matching the role (Hercelinskyj, 2010). External pressures to meet expectations can result in role stress. Any conflicting norms need to either be accommodated or competed against, with some cost to individual identities. Costs may result in role ambiguity; and role conflict (Hardy & Hardy, 1988). It is suggested that if employees do not know what they are expected to accomplish, or what they have authority to decide, they may hesitate to make decisions and rely on trial and error approaches (Husted & Husted, 2008; Rizzo, House & Lirtzman, 1970).

Conflicts in the roles of professional workers mean there is a discrepancy between either role expectations of a specific role, or individuals who have differing perceptions of how a role should be enacted. Hercelinskyj (2010) identifies the key feature of role conflict as a breakdown in communication in role expectations between two or more people. Role conflict can relate to time, resource and capability of the individual in relation to role behaviour. There may be conflicting expectations and demands from the organisation. Nurses do perceive mismatches between their actual and ideal nursing roles (Takase, Maude & Manias, 2006), and such differences in expectations were evident in participants' talk in my study. Disparities in the workplace can result in feelings of anxiety and ambiguity (Hart, Brannan & de Chesnay, 2014; Stacey & Hardy,

2011), particularly for neophytes who may struggle with the difference between their academic preparation and the real world of nursing practice.

I will show through my findings in participants' talk how this links with service user involvement in nursing processes (being one of many roles that mental health nurses have under their remit). Elements of nursing behaviours, include the contradictory mandate of care versus control, suggest further experiences of mismatched expectations for mental health nurses and will also be discussed in this chapter.

Throughout the course of my study participants repeatedly mentioned mismatched expectations they experienced in relation to mental health nursing, which was largely unprompted and became a noticeable pattern in the data. In my findings in this chapter I will delineate the descriptive devices employed about such inconsistencies. The data examples I have chosen include occasions where participants indicated awareness of mismatches they encountered both intrinsically within themselves, and extrinsically from other sources. Disparities of this nature have a bearing in relation to service user involvement and professional mental health nursing identities, as they may lead to uncertainties of role performance in this area.

In this chapter I will focus on how participants accounted for a mismatch of expectations regarding mental health nursing roles. In this first section I will focus in particular on disparities that arose in people's talk in relation to compliance behaviours and neophytes voicing a desire to fit in. I will argue that the mismatches that were present in mental health nurses' narratives and service user stories have relevance in terms of involvement practices and how nurses engage with service users.

6.2 "I've got to toughen up. I'm too caring": compliance and resistance

Nursing students' talk gathered as data in this study featured stories about resistance and compliance with existing cultures that were part of their socialisation journeys. Resistance is one response by members of occupational communities to organisational demands that attempt to influence their work (Van Manen, 2010). Compliance on the other hand relates to obeying or carrying out commands, and social influence in organisations that can play a large part in workers' compliance behaviours (Herath & Rao, 2009). Stories by nursing students in this section centre on disparities they experienced in relation to resistance and compliance.

In the following extract nursing student participants described their awareness of what I read as mismatched expectations in relation to their experiences in placement settings. Talk of disparities between their own expectations about mental health nursing work and those of others have relevance as to how students may construct their views about nursing roles and professional identities. This in turn may affect how they engage with and involve service users in their care. In their narratives nursing students spoke of their awareness of a strong imperative to comply with locally agreed cultures in order to fit in with staff teams. The students' expectations of nursing work versus the cultures in practice they were expected to comply with seemed at odds with each other. Narratives of resistance are discussed in this section, and can be read as a kind of defiance in this focus group towards clinical staff in placements, whom students considered to be more powerful than themselves (Mishler, 2005). However, in their accounts students presented the situation as being one where much more concrete compliance with locally agreed rules was preferred or placed ahead of what were seen as notional ideas of involvement.

A focus group with 6 third year mental health nursing students was held in a university setting familiar to them, and lasted for 1 hour and 8 minutes. During the focus group, student participants talked about challenges they had experienced whilst on practice placement, and their reactions to staff suggestions about how mental health nurses

might engage with service users. This extract follows on from a turn where student participants in this focus group were suggesting that the clinical staff they encountered on placement were more challenging than the patients, and in order to avoid tension students sometimes went along with staff views even if these were contrary to their own perspectives. One of the participants, Eve, reported seeing "students go sort of beyond what maybe they should be doing - they might feel like they really want to fit in" (lines 397-399). I discerned a struggle from what was said in the students' talk about how they wished to 'be' and competing versions about how to engage with or talk about service users.

Nursing student participants talked about experiences they had on placement where clinical staff suggested a need for these students to 'toughen up'. The idea that students should 'toughen up' appeared to challenge their notions of the values they deemed relevant for mental health nursing. Attempts to reconcile resulting feelings of conflict can be read in the follow data extract of the participants' focus group discussion.

Naomi: I've seen them agreeing, having similar attitudes, erm going along with what other nurses start saying to get on with them. And it is actually quite surprising how much a personality can affect you getting a job. Erm, if people like you, and you agree with what they say, then you're a better person for the job. If you've got a ..maybe a different, coming from a different viewpoint, then you get the impression that they don't think that you are going to be any good at the job and that you have a lot to learn. Just because you have a different viewpoint, or are coming from a different stance.

Helen: You get like 'oh you need to harden up', 'you need to toughen up'

? – I've had that

Helen: And you just think 'no I don't, I never want to be toughened up thank you'. [

Eve: Too sensitive]

?: I can't be like a wallflower. I've got to toughen up. I'm too caring.

Helen: That's what's so nice about you. Why change? Why chan - We've come into the profession with our attitudes which are, you know, we..we wanna be with patients and we you know, we've come in with compassion and loving people, 'cos that's really, you know, and then been told 'oh no (? Need to harden up) ..it's crazy innit. Why change?

Naomi: I can see that sometimes they're coming from where you don't want to get too emotionally involved,

418 **Helen**: Yeah

419 **Naomi**: And that you can get hurt, and I know some people have had some terrible
420 experiences where they've you know, tried to help people and things have gone awfully
421 wrong, and you can see how that might make someone quite negative you know about
422 things.

[Focus group 3, third year nursing students, lines 400-422]

During the focus group student participants talked about how they found it challenging working with existing staff in placement settings. Students voiced a desire to fit in; acknowledging that people who did not appear to fit in could have a difficult placement experience. In lines 400-401, Naomi stated that she had seen other students "going along with what other nurses start saying just to get on with them". Naomi referred to the getting of a "job" on three occasions in these few lines. Her talk suggested she was constructing a case for why some nursing students might go along with permanent staff's views. Students would be anxious to gain employment at the end of their training, and Naomi offered an explanation for student behaviours she considered untoward. Naomi used the notion of students "going along with what other nurses start saying just to get on with them" as an explanation for their behaviour. In this example Naomi judged what she had seen, "just to get on with them" in a critical way. Her account appears to be doing moral work. Her talk helped convey her as a moral person and one who's stance others may hope to identify with. Naomi highlighted that others change their behaviour in order to fit in, but she did not wish to be seen as changing her own behaviour to win acceptance from placement staff, was not so easily swayed and held true to her own beliefs and values.

The desire of nursing students to 'fit in' to a clinical environment is well documented in nursing literature (Chang, Hancock, Johnson, Daly & Jackson , 2005; Malouf & West, 2011), albeit more in adult nursing settings than in mental health areas. A wish to establish secure social bonds and fit in has been reported as an important part of nursing students' perceptions of their success (Malouf & West, 2011). Students in my study acknowledged this desire to belong. Belonging is recognised as a human motivational need, first identified by Maslow (1954), where social requirements (including a need to belong) are prioritised over needs for self-actualisation (such as learning and

accomplishment). In practice settings the desire to belong is reported as more important to students than the quality of care provided (Levett-Jones & Lathlean, 2009), and more desirable than adopting a critical stance about care witnessed in practice (Henderson, Cooke, Creedy & Walker, 2012). In this data extract awareness was demonstrated in participants' talk that students reported a desire to fit in and also that there could be consequences for students who chose to be different. Naomi appeared to be positioning herself as a student who did not always change her behaviour to fit in. She said "I've seen them agreeing" in line 400, which implied she was referring to students other than herself who were attempting to fit in, and in constructing her account this way her talk positioned her as different. Naomi's account works to position her as an astute observer of others. She also seems to be indicating that she, like others, was placed in the difficult position of having to choose between what she saw as right or correct, and therefore missing an opportunity for employment post-training, and adopting 'similar attitudes' to permanent staff. As they were third year nursing students their primary concern at this point in their training was to gain employment, which was a significant on-going concern for all participants in this focus group.

Additionally, there was an implication here in Naomi's talk of a process alluded to in which placement staff attempt to mould behaviours of nursing students in order that students comply with existing cultures. The effects of such compliance may be to reduce challenge and threat from institutional outsiders (in this case nursing students). Existing clinical staff may imply students have a knowledge or skill deficit, perhaps introducing doubt to students about their competence, who may then feel motivated to change, and therefore comply with existing ward or team cultures. Semmelhack et al. (2015) noted that a culture of obedience can exist in institutional settings, which may cultivate an unquestioned compliance with certain rules. The use of reward and punishment is used to encourage compliance, and this can apply to both staff and patients. In the interactional talk of students in this focus group there was certainly an indication that students were being encouraged to comply with existing cultures.

In lines 402-403, Naomi stated "if people like you, and you agree with what they say", indicated this concept of power and compliance. The words 'if' and 'then' in Naomi's

turn suggested a consequence, in that there may be penalties for students who do not comply with existing cultures or views. This talk also did the work of suggesting that students' fitting into a clinical environment can be subjective in the eyes of the staff in each particular team. It could be said that people who give an impression that they share personalised opinions and beliefs of existing clinical staff would be more likely to fit into that setting. Students would be aware of local ward or team cultures, and may be keen to comply with these. This might include the use of jargon, abbreviations, and attitudes towards service users and team members. For example, the use of negative and labelling language by staff as discussed in Hamilton and Manias' (2006) paper 'She's manipulative and he's right off', where they stress nurses should look with a critical eye at the activities of power that can be intrinsic to nurses' language use. Naomi made a comparison between students who are considered favourably by clinical staff, and viewed to be "a better person for the job" (lines 403-404), versus other students who may be "coming from a different viewpoint" (line 404). There was a sense that being different, or coming from a different viewpoint might be quite challenging for such individual students and create tensions for them.

In the next turn the focus of conversation shifts to what students reported had been said to them by clinical staff. Helen said staff told her "you need to harden up', 'you need to toughen up" (line 407). This was swiftly followed by some consensus from other participants who reported similar experiences. No examples of how students are to "toughen up" are provided at this point in the focus group. However, earlier in the group discussion students spoke about times on placement when they had sought to be compliant with patients' requests, only to be met with rebuttals from other staff. For example, in lines 316-319 Helen recounted "I remember seeing this one nurse, and she was just taking every single amount of control off this patient possible. This patient just wanted something, and she was like 'she's not having it, she's not allowed it', and I was like 'well why can't she have it?' It's you know, it's no problem". Although the item requested by the service user is not named by Helen, her talk was doing work on a number of levels. Helen's account positioned some staff as controlling, and who may have a concern for power. In addition, Helen's account of her conversations with clinical staff was made meaningful by her claims of showing resistance. Resistance talk

is evident in this focus group in relation to student participants' encounters with more powerful professionals in practice settings.

Mishler (2005) describes stories told by people in marginalised positions as narratives of resistance. In general, I would consider nursing students to be a slightly less powerful group in comparison to existing qualified staff in clinical settings. Students are in the role of learners, and as such narratives from less powerful groups should not be dismissed, because as Stone-Mediatore (2003) suggests this type of disregard reinforces the disempowered position of these groups. Nursing students in my study can be seen to be attempting professional identity work as they negotiate how to do being a mental health nurse in practice. Negotiation can involve resistance to established ways of doing things. Vinthagen and Johansson (2013) state that everyday resistance is a practice entangled with power, that features overlapping or intersecting social identities and is contingent on changing contexts. In my example, the intersecting social identities relate to the nursing students and existing clinical staff. The resistance present in students' accounts shows construction of their professional identities as being a dynamic interaction as they seek to work out what sort of mental health nurse they want to be. Resistance narratives can help to accomplish identity claims, and the contrast created in student participants' talk is a necessary part of the identity they are creating.

Students' interactional talk in the focus group showed they had become aware that competing versions about mental health nursing identities existed in practice. During participants' talk several references made were attributed to other people, such as "you need to toughen up" (line 407). Talk that a speaker presents as belonging to other people can be considered as a second hand account, and is presented by the first speaker to do some particular work in their narrative. Gilovich (1987) suggests that second-hand accounts are often stripped of their situational context, and can result in more extreme evaluations. A lack of context for the listener means that the speaker can put such accounts to whatever use they choose. Second-hand accounts can be powerful, may work to convince listeners of the speaker's own viewpoint, and seek to show the speaker in a favourable light. In this extract student participants presented suggestions made to them that they "need to harden up", and "toughen up" (line 407). The listener

does not necessarily know why students were told to "toughen up", only that a number of them in this focus group reported this to be the case. Students' accounts can be heard as expressing resistance. Helen said "I never want to be toughened up thank you" (line 409). In terms of resistance, students positioned their talk for the purpose of presenting a different nursing identity than those they perceived in existing staff.

Helen's implication was that "our attitudes" referred to positive caring attributes. Her talk had elements of a complaint, as she highlighted that despite "our attitudes" that included "compassion and loving people" (line 414), students are being told "oh no". Helen's talk highlighted that students' approaches were apparently being challenged by clinical staff. There was interaction in the focus group extract to show support for Helen's position. In her talk Helen has constructed the others as caring, and this required their assent, which seemed to be forthcoming from other group members. For Helen's account to work she constructed these unnamed others in contrast to her own position, and it was the contrast that helped her account to work. The attributes Helen referred to are highlighted in the Nursing and Midwifery Code of Conduct (2015, p.4), which states nurses are to 'treat people with kindness, respect and compassion' (NMC, 2015). These attributes are expected by professional regulators, and this was highlighted by a student participant Michelle at a later point in this focus group. Michelle said "Your code of conduct does make your patient your first concern. First and foremost" (line 432). Michelle used these priorities as a resource to make the case for specific sets of attributes they know are expected of them as professionals. These attributes are then presented as desirable in the creation of what it means to be a mental health nurse. It does seem that from the students' talk that this was not straightforward for them, or for the other professionals they work with. Mental illness and behaviours that can arise from such conditions are difficult to care for (Watkins, 2001), require high level skills and can challenge the empathy of workers caring for the person and the sympathy from the wider public (Rogers & Pilgrim, 2014). Participant accounts provide examples of the tensions and dissonance that can arise for nursing students on their socialisation journey to becoming a nurse.

Helen's statement "we wanna be with patients" (lines 413) was a further claim that she was attempting to establish both herself and others present as wanting to be a nurse who helps people. The use of the word 'we' in people's talk has a distinct purpose. Saj (2012), explored the use of personal pronouns in discourse analysis, and noted that the word 'we' denotes reference to a common attitude, or that the presented information is frequently believed by general people. Helen's use of the word 'we' functioned to strengthen her claim. In the 'we' she was including (what she saw as) other like-minded students in the focus group by suggesting that they shared the same viewpoint that she did, in terms of being with patients.

There is perhaps a sense here of students as 'we' and other staff as 'them', as Helen portrayed both groups as having different viewpoints, although this is not explicit. In terms of the students' developing professional identities as mental health nurses, Helen spoke about attributes needed to be a mental health nurse, as she saw it, which related in the main to the therapeutic capacity of engaging with service users. It was as if students' perceptions were that they ought to behave in a certain way, and then being told 'oh no you need to harden up' (line 407). This indicated an area of conflict for the students. In the focus group talk students had been developing a claim that indicated existing staff they had met on placement were different to themselves. The suggestion being that perhaps the caring attitudes towards service users that students supported were possibly absent in clinical staff. In Naomi's next turn she indicated that there may be an underlying rationale for clinical staff's behaviour.

Naomi said "I can see that sometimes they're coming from where you don't want to get too emotionally involved" (lines 416-417). In her talk Naomi appeared to be making a justification for other staff suggesting a need to "toughen up". Naomi rationalised this with "I know some people have had some terrible experiences where they've you know, tried to help people and things have gone awfully wrong". She did not elaborate on this, although Naomi's consideration of another view served to explain perhaps why staff have suggested students 'toughen up'. Naomi suggested that such "terrible experiences" (lines 419-420) "might make someone quite negative you know about things" (lines 421-422). Naomi's account worked to provide an explanation as to why staff may

suggest that 'being toughened up' is the most appropriate course for students who are deemed "too caring". Naomi's talk did the work of highlighting to the others present that there may be explanations and motives for staff to promote this toughening up, and that she was aware of these. The other group members' responses did not appear to agree with Naomi's explanation of toughening up in certain situations, and went on to make suggestions that difficult situations could be managed in other ways. Shortly after Michelle stated "you should be able to be, hopefully in an environment where you can kind of support each other as well" (lines 436-438). Michelle's use of "hopefully" suggested such support cannot always be expected. In terms of disparities that nursing students may experience, these focus group participants have highlighted that in clinical settings there may be terrible experiences, and an amount of toughening up promoted by existing staff. The students have also suggested that team support cannot be relied upon. Narratives in this focus group reinforced the notion that nursing students experience a number of inconsistencies which impacts upon their engagement with service users.

The notion of toughening up or developing resilience, may refer to students becoming more hardy. Ouellette and DiPlacido (2001) suggest that developing hardiness is one method of promoting workers' coping strategies, as hardy individuals are reported to have a more optimistic view of the environment. Hardiness for nurses is indicated as a protective factor incorporating commitment, control and challenge that enables an individual to manage problematic situations (Klag & Bradley, 2004; Pengilly & Dowd, 2000). This controlling type of hardiness in this context is portrayed as an attribute, with Abdollahi, Abu Talib, Yaacob and Ismail (2014) describing hardiness as a mediator. In this respect hardiness would facilitate progress or a way forward. For example, this could include a nurse being clear about boundaries in their therapeutic relationship with a service user. In this extract, student participants initially indicated the suggestion of becoming 'toughened up' to be negative, (as Helen said "I don't ever want to be toughened up") implying that it could involve a lack of compassion.

The view from Naomi at the close of this extract suggested that the hardiness referred to by clinical staff may have been adopted into part of some mental health nurses' identity in order to avoid "terrible experiences". There is perhaps a sense here of the neophytes'

growing awareness that their mental health nurse identities were at a developmental stage, as they will encounter further experiences in their mental health nursing work. Student participants indirectly showed an awareness that during engagement with service users, nurses may need to draw on a range of mental mechanisms, which may include being more or less hardy. During their interactional talk, these student participants worked up what type of mental health nurse they wanted to be, and how they might go about constructing this.

As nursing student participants highlighted their expectations about mental health nursing, and what their roles might include, ambiguities about their experiences in practice were revealed in their talk. In the next section I will continue to explore my findings with further examples of mismatched expectations in relation to the development of professional mental health nursing identities. The focus will be on expectations about role performance and role blurring.

6.3 "You're everything in one role here": role ambiguities for mental health nurses

The concept of social roles refers to expected behaviour patterns and obligations attached to a specific status in a social structure or system (Parsons, 1951; Goffman, 1959). It therefore follows that others will have expectations of such positions (Biddle, 1986; Conway, 1988). The idea however that a role has a set of expected activities assumes agreement among the relevant people as to what these undertakings might be (Katz & Kahn, 1978). Orne's (1962) body of work about roles highlights that people have role expectations as to how a particular social actor will carry out a specific role. These expectations may be either confirmed, or denied if the person's actions are different from those presumed. Additionally expectations about a person's role may have consequences for subsequent social interactions.

Chapter 6: Mismatched expectations about mental health nursing

Expectations are about looking forward, and have been defined as real-time representations of future situations, or wishful enactments of a desired future (Borup, Brown, Konrad & Van Lent, 2006). Role expectations therefore refer to the position specific demands of the person occupying that role (Hardy & Hardy, 1988). Biddle (1986) states that groups and individuals have an awareness of role expectations and both know and communicate about what is expected. In relation to nursing, for example, role expectations may be communicated via professional, organizational and personal sources (Hercelinskyj, 2010). Equally some roles may be new or emergent; with expectations less certain as such roles would not yet be clearly defined.

People's knowledge and awareness about roles often comes from their background expectancies. Garfinkel (1967) first used the term 'background expectancies' to describe how things are perceived and defined in everyday life. Garfinkel examined the seen but unnoticed background features in society, and how people use these background expectancies as a scheme of interpretation. That is to say people have their own perceptions and expectations of a role or situations based on past experiences and use these as a device for understanding what is going on in social settings. Society's members in turn communicate their understanding of these expectations in their talk. In my study participants communicated their expectations about mental health nursing roles in their interactional talk in research interviews.

Nurses' perceptions of their roles may be subject to influence by a number of factors, such as government policies, service user needs, and regulators' requests (Brookes, Davidson, Daly & Halcomb, 2007). In addition nurses may be influenced by their own experiences of being a nurse and how these fit with their expectations of the role. If service users have particular expectations of a nurse's role, but find their experiences to the contrary, this could challenge previously held views and certainties about such roles. Background expectancies and perceptions may therefore be fulfilled or unfulfilled.

In this section I use my findings to show that uncertainties arise for some nurses where there is role conflict or ambiguity. Awareness can create mismatched expectations for

nurses, who may either internalize new role expectations or re-shape their role to fit with their sense of professional identity (Hercelinskyj, 2010). Perceived inconsistencies about nursing roles may affect everyday understandings of what it is to be a mental health nurse.

This section includes a data extract from a 58 minute research interview with a mental health nurse participant I have named Ben, who had been qualified for 4 years at the time of interview. He was working as a Community Mental Health Nurse and I interviewed him in the team building where he worked. In this section I show how Ben talked about multiple expectations and then cited a mismatch in role expectations and a concern about role blurring redefining his professional identity.

872 **JT**: What have your experiences been, both in the past and now, with changes of
873 service user involvement?

874 **Ben**: In - in what sense?

875 **JT**: In how you've - how you've seen it in practice or not.

876 **Ben**: Erm, from my experiences working in different, I mean I've worked in two
877 different trusts and I find every CMHT I've worked in, worked very differently with
878 clients. Erm, for example, when I was up in (local town) it was - it was -you were very
879 much erm you know doing a lot for patients, one patient asked me to dig a hole in his
880 garden for him because that's what the last CPN did, and I went, no, I'm sorry, that's not
881 my role. Erm, so I find there's a - and down here there's a lot of newer nurses. You
882 know, they're very social service led down here as opposed to nurse led up in (local
883 town) and you're more of the care co coordinator, care manager down here whilst you're
884 a social worker, OT, nurse, you're everything in one role here. Whilst in (local town) I
885 found I was the nurse/support worker, but here you're the actual care - although you
886 were the care co ordinator in (local town) but here you are - you are everything in a
887 sense. Social workers will deliver medication, but we'll do housing

888 **JT**: Right

889 **Ben**: There's no, we refer to the social worker, because as care co coordinators we do
890 that. And I find - I find that limits our nursing role massively and I think this - the one
891 thing I've said in one of my essays for my Masters is that this care co coordinator role
892 has had a massive impact on erm how we are as nurses in the community. You know, if
893 we didn't have to do all these housings and referrals and everything like that then we'd

be able to actually do the nursing with the patient which to be honest with you I rarely do.

JT: Yes

Ben: You know I can assess and engage, I can do all that, but you know spending more than an hour with a patient is – is -.hardly ever happens unless they're in crisis.

JT: Yes

Ben: So I think the role of the care co coordinator has had a massive impact on how we function as - as CPNs.

[Ben, Mental health nurse participant 10, lines 872-901]

Ben indicated his experience near the start of this section with the statement "I mean I've worked in two different trusts" (lines 876-877), which functioned to do the work of positioning him as an authority, in order to establish the authenticity of his account. Ben did this by positioning himself as a nurse with experience. Interestingly, in this section (and the wider interview), Ben commented little about service user involvement in response to my questions. It may be heard by the listener that Ben therefore had little to say about his experiences of service user involvement. Discourse is a resource for demonstrating understanding and how such understandings are constructed in verbal interaction (Cameron, 2001). Speakers are known to assert their authority to speak and refer to their experience when they have few resources to draw upon on a particular subject (Antaki & Widdecombe, 1998). In Ben's case, a question about service user involvement would be an area relevant to his specialist role and on which he might be expected to hold a view. However, rather than answering directly, his response was to assert his authority, and therefore it was his lack of a direct answer that aroused questions for me as a researcher about his dearth of verbal resources about user involvement.

In his next turn, Ben highlighted that "every CMHT I've worked in, worked very differently with clients" (lines 877-878). Ben then made a comparison about his nursing role in both respective Community Mental Health Teams (CMHTs) in the two different Health Boards where he had worked. In line 885 Ben indicated that in one team he felt he "was the nurse/support worker", a role he seems to align with "doing a lot for

patients" (line 879). In Ben's example as to what this might involve, he made reference to a service user who "asked me to dig a hole in his garden for him because that's what the last CPN did" (lines 879-880). Ben's example of digging holes did the work of providing an extreme example of non-nursing work that is convincing and persuasive. It was a long way from any expectation of nursing, and as an extreme it reinforced his argument that things have somehow gone too far, and as a nurse he cannot justifiably be expected to do such an activity. In discourse, extreme examples can be a poor form of argument as they obscure the realities of situations and almost simplify complex concepts (Brecht, 1993). Although Ben's extreme talk closed down further discussion and debate, it was effective in persuasively communicating his point.

When recounting this story, Ben indicated his response, "no, I'm sorry that's not my role" (line 880-8811). There is a sense here that "doing a lot for patients" may have its limits, certainly for some nurses like Ben, and that nurses may enforce boundaries regarding work they consider inappropriate. Ben's talk functioned to show challenges about nursing roles, and differing expectations about nursing work. His example about digging holes indicated that his expectations about the CMHN role were certainly different to the service user he mentions. Ben attempted to establish a position in relation to roles and mismatched expectations about such roles.

Ben's comment "that's not my role" (line 880-881) functioned to assert his claim that there are different types of mental health nursing roles, and his positioning of himself as a particular type of nurse. Ben reported that service users may have certain expectations about activities that a mental health nurse might engage in which they have developed over time based on previous experiences of others working in those roles. Background expectancies held by service users of what a community mental health nurse will do were challenged by Ben who portrayed his view about roles differently. These differences highlighted that such roles may not only be interpreted differently by service users in terms of expectations, but be interpreted differently by nurses themselves. Mismatched expectations about a nurse's role will likely have consequences for the therapeutic relationship, as if a service user is expecting a particular type of support or input that is not on offer, this could result in a lack of trust and difficulties with

engagement. Repper, Ford and Cooke (1994) emphasise that mental health nurses need to find ways to develop effective relationships with people in order to offer a service which the user is not only willing to engage in, but takes an active part in, thus allowing nurses to derive satisfaction from their work.

In interactional talk speakers provide talk for the purposes at hand. Talk may be provided in the context of the audience, in this case Ben's audience was me, a mental health nurse academic. Ben may have considered me to be someone with shared understandings of what it is to be a mental health nurse. He may also have considered me as someone with this understanding observing from a more external position, working in a university and not in the local Health Board, and that I might have a more critical lens to what is being said. In such circumstances speakers then work hard to convince the listener of their claims. Ben made his case using an extreme example but then did no further work to add to his alternative category. So having been clear that nursing was not about digging holes, he did not say what his version of nursing would involve, or why his version of nursing was preferable.

In his next turn Ben described his current role in a CMHT, and began to highlight role differences with his job in a previous team. He used descriptors such as "up in" (lines 878 & 882) (referring to the previous team) and "down here" (line 881 & 882) for his current team. These geographical references served to provide clarity for the listener about which team he is referring to. In terms of Ben's account, the team difference he highlighted served to reinforce variances between teams, and therefore disparities in nursing work. Ben began to elaborate on the culture of these teams. He stated his current CMHT was "very social service led" (line 882), which differed from his impression of the previous team being "nurse-led". Ben then accounted for how his current role as a CMHN was far more blurred compared to his previous team. In lines 883-885, he said "you're more of the care co coordinator, care manager down here whilst you're a social worker, OT, nurse, you're everything in one role here". In his account Ben expressed a preference for his previous team, which did things more to his liking and fitted with his personal construction of what a nursing team should be doing.

Ben then made a repair in his talk. He said "here you're the actual care - although you were the care co-ordinator in (local town) but here you are - you are everything" (lines 885-887). Schegloff, Jefferson and Sacks (1977) described a conversational repair as a mechanism people use to deal with trouble when speaking or understanding. Ben's self-initiated repair did the work of showing that he is sought to clarify the situation regarding care co-ordination and not to contradict himself. Ben knew his role in the previous team included being a care co-ordinator, but his talk emphasised that he saw his present role as a care co-ordinator meant doing "everything in a sense" (lines 886-887). Ben's implication was that in the new team the care co-ordinator role was more comprehensive, which was closer to that envisaged by legislation and policy. However, Ben's version appeared at odds with this, and his talk suggested an argument that as a result of the care co-ordinator role, the consequence was that nursing was being re-shaped by policy. Ben neglected to say the policy has been around for over thirty years. Guidance in England and Wales designates that each service user in secondary mental health services must have a care co-ordinator. During the past three decades in the UK, there have been formal arrangements for both care co-ordination and care planning in mental health services. In the early 1990s two mental healthcare delivery systems were introduced: local authority-led care management (Department of Health, 1989) and the health-led care programme approach (CPA) (Department of Health, 1990b). Both care systems were intended as mechanisms for co-ordinating complex care plans and organising the efforts of workers in a range of organisations who would deliver such care (Hannigan, 2006). In Wales this care co-ordination has now been replaced by a legislative framework, the Mental Health (Wales) Measure, which ensures care and treatment plans (CTPs) and care co-ordination are now statutory (Welsh Government, 2012b).

Care co-ordination roles can be undertaken by a range of professionals, including social workers and mental health nurses. The introduction of the care co-ordinator role has been considered an important shift in the delivery of mental health services, with the keyworker role thought to be paramount in ensuring the success of care (Simpson, 2004; Simpson et al., 2016a). However, care co-ordination work has led to much role

blurring and the erosion of professional boundaries, which not all mental health professionals find desirable (Hannigan, 2006). Ben's statement "you're everything in one role here" (lines 886-887) served as a complaint. Forster (2001) questions too whether it was intentional that mental health nurses adopt a hybrid role in response to policy directives. Yet the Care Services Improvement Partnership (2007) *New Ways of Working* Policy was clear that workers, regardless of discipline, move towards working flexibly to best meet the needs of people using services. Ben was replaying an argument for a singular disciplinary identity, and appears to be against a system need for workers to broaden their skill base.

Attempts have been made to demonstrate the uniqueness of the mental health nurse's role, with suggestions that it is the 'being with and caring with' that distinguishes nurses from other professions (Barker, 1997, p.660). Service users have reported that they place a high value on their case manager/care co-ordinator being accessible, approachable and engaged, regardless of their professional background (Simpson, Miller & Bowers, 2003). What Ben appeared to be making relevant in his talk was that he saw a blurring of roles with other professional workers. Role blurring may not have been what Ben expected in relation to his nursing role. The mismatch of expectations for Ben may function as a complaint about how he saw what his nursing work and role have become.

In his next turn Ben continued his complaint about a sense of role blurring. He said "you are everything in a sense. Social workers will deliver medication, but we'll do housing" (lines 886-887). Ben then indicated a consequence for nurses. In line 890, he said "I find that limits our nursing role massively. In Ben's view "this care coordinator role has had a massive impact on erm how we are as nurses in the community" (891-892). Also that if nurses "didn't have to do all these housings and referrals and everything like that then we'd be able to actually do the nursing with the patient" (893-894). His talk added to his complaint about current arrangements in practice regarding his role. Ben's talk worked to show he had his own version of mental health nursing in mind, which could be considered a uni-professional version of nursing. Uni-professional versions of a role may be rather insular and rigid, and not take into account

how roles are viewed from a wider perspective. However, Ben did not actually say what he meant by his version of nursing, which made his case less convincing. His talk reinforced that his expectations about his nursing role in practice are at times mismatched with the views he held previously.

Role blurring suggests ambiguities about what a particular role entails, and that there is overlap with the work of other professionals. It is reported that whilst role blurring has been encouraged in practice, it can result in practitioners being more likely to defend their jurisdictional claims (Brown et al., 2000; Hannigan, 2006). Ben has made a claim here that as a direct result of having to undertake the care co-ordinator role or tasks that traditionally were not performed by nurses, that he now does not have the time to "do the nursing with the patient". In line 894 Ben claimed he no longer undertakes the nursing work that he expected to with service users. The change in his role activities he attributed to being a care co-ordinator. Again, this is an example of a mismatch in Ben's expectations about his nursing role. These mismatched expectations are further problematized for Ben by the discrepancy between what he expects and what service users expect. Ben's talk suggested that articulating a nursing identity is difficult for him in the face of modernising policy for community mental health care. His account could be read as an example of external pressures that are brought to bear on the nursing role. Service user involvement in nursing processes could be considered another such external pressure that requires changes to the ways that nurses work. Some mental health nurses are already fundamentally challenged by counter expectations of their roles and service user involvement could be considered by them to be in a similar category and something to be cautious about.

Ben's claims about the impact of care co-ordination on his nursing role are evident in mental health nursing literature. For example, in his thesis Simpson (2004) emphasised the notion of 'limited nursing', which refers to CMHNs being frustrated by the restricted face-to-face contact they have with service users, and the reduced opportunity then to engage in evidence based psychosocial interventions. Simpson suggested that when nurses act as care co-ordinators and administrators that they are at risk of becoming non-therapeutic, and are no longer doing nursing. Although in the data Ben

did not suggest how the care co-ordination role limited his nursing work, he implied this was very much the case. What is interesting is that Ben did not articulate specifically what this doing "the nursing with the patient" (lines 894) referred to. Ben did however highlight that "spending more than an hour with a patient" (line 897-898) occured seldom "unless they're [the service user is] in crisis" (line 898). Ben's account suggested that now he considered time to be more limited, that less nursing activity occured, with the implication that this was due to the blurring of roles in the multi-disciplinary team. Temporality is the term used to describe the experience of time, and it is a central element of people's experience of the world (Reddy, Dourish & Pratt, 2006). Zerubavel (2003) highlighted that people orient to particular temporal conventions. In Ben's case, he indicated that nursing involves time and by default the more comprehensive care co-ordination role reduces this time for nursing until a crisis arises and then presumably nursing is re-prioritised. Ben seemed to be orienting towards some convention (that is perhaps unspoken in practice settings) which might be time for nursing is not needed until nursing is needed. Ben's account and indeed his nursing identity appeared to be bound up with doing for, as opposed to being with. His mention of crisis suggested some role clarity, as this is when he is needed for his nursing skills (the doing for), but otherwise he might be any professional worker who is available for the 'being with'.

6.4 Identity talk about service user involvement in nursing processes and mental health nursing roles

It is through interactional talk that people position descriptions of themselves. Identity talk shows how people construct and negotiate personal identities (Snow & Anderson, 1987). Identity is something that is used in talk as part of the fine detail of everyday interaction (Antaki & Widdecombe, 1998, p.1). In my study, how mental health nurse participants talked about their roles said much about their everyday understandings of their nursing work. It was notable that there was little focus in participants' talk as to how nurses accounted for service user involvement in nursing processes as part of their nursing roles and professional identities. The focus of mental health nurses' talk was about getting the work done, and centred on the tasks at hand. By this I mean the focus

of talk was on accomplishing identities that emphasised a task-oriented focus. I suggest there has been an emphasis on the 'what' aspects of mental health nursing work, namely the duties and responsibilities. This is markedly different from the 'how' and 'why' aspects of nursing, which would include far more nuanced skills and knowledge than a job and finish type approach. The focus of talk about nursing work frequently emphasised busyness and the completion of tasks, indicating active nurses and perhaps by default passive patients.

Task-oriented nursing has been evident since Florence Nightingale (1859) proposed that nurses should be managers of their environment. However, contemporary nursing principles suggest nurses allocate their time to establish therapeutic nurse patient relationships in order to maximise patient outcomes (Foster & Hawkins, 2005). In order to understand mental health nursing therefore, it is suggested that knowing not only what nurses do, but how they do it will help clarify the meaning of mental health nursing (Jones, 2010). For the past two decades the focus in mental health nursing literature and policy guidance has been on a recovery focused approach which seeks to put service users in primary control over decisions about their own care (Repper & Perkins, 2003; Slade, 2009). The importance of nurses engaging with mental health service users in the development and delivery of mental healthcare services is being increasingly valued, with a shift towards a more consumerist ethos (Bee et al., 2008). Ensuring patient satisfaction and people-centred services helps contribute to the quality assurance agenda (NHS Executive, 2000), in order that people's actual involvement is clearly visible. There is a drive from academics that service user involvement is very much a part of the mental health nurses' role (Happell, Cowin, Roper, Lakeman & Cox, 2013; Perry, Watkins, Gilbert & Rawlinson, 2013; Terry, 2012). However, whilst authors such as Santangelo, Proctor and Fassett (2017) claim that the very identity of mental health nursing is recovery-focused; participants in my study gave rather mixed reports.

In relation to my study for example, a number of mental health nurse participants spoke about recovery focused practice, but very few described related actions in their day to day work that bore this out. Argyris and Schon (1974) suggest there is a difference

between professionals' conscious and unconscious reasoning, and highlight the distinction between espoused theory and theory-in-use. Espoused theory refers to values that individuals believe guide their behaviours, whereas theory-in-use is the values reflected in behaviours that actually drive people's actions. People therefore may espouse or advocate certain approaches as being ideal, but in practice may act or behave in a different way. Mismatches about recovery focused practice and service user involvement in nursing processes featured in participants' identity talk in my study.

6.5 "She didn't use any of the ought words": different expectations of mental health nursing roles

In previous sections in this chapter I showed how nursing students voiced concerns about existing staff with perceived expectations that students would toughen up and comply with workers' behaviours in institutionalised cultures. I also showed how the talk of Ben, a CMHN, worked to show multiple expectations of him in his nursing role. In this section I will show how service user talk indicated an awareness of power differences, and how this can lead to mental health service users having treatment imposed on them by professional workers. I will show how a service user demonstrated and handled talk about mismatched expectations in relation to mental health nursing roles, which indicated a consciousness around expectations about ways mental health nurses might engage with service users.

Historically, mental health services, their staff hierarchies and treatment approaches have been associated with power (Goffman, 1968; Szasz, 2007). Service users have reported their experiences in terms of fear in relation to power and control (Chorlton, Smith & Jones, 2015; Sweeney, Gillard, Wykes & Rose, 2015). Fears might include enforced treatment, such as medication given against people's will, limited choice of designated workers assigned to co-ordinate care, and limited freedoms under Mental Health Act regulations. Concerns may feature as background expectancies that service users have about mental health nurses and the nature of care relationships with those nurses. Expectations will be specific to individuals, as some service users may expect

time to talk with nursing staff (Stenhouse, 2011), whilst others' expectations may relate to staff having power and control (Baker, Lovell, Easton & Harris, 2006). Expectations of this type may influence how service users engage with mental health nurses.

The following two extracts presented in this final section of the chapter are from a research interview with a service user I have named Judy. The interview lasted for 1 hour and 36 minutes, and took place in a hospital education setting. From the beginning of the interview Judy reflected on a time when she had been discharged from an acute admission unit. The first extract starts at the point where she begins to talk about Karen, the Community Mental Health Nurse (CMHN) who had been allocated to Judy to support her in the community. In this section I show how expectations about mental health nurses were a feature of Judy's talk. I will also show how her account functioned to show that professional workers can value the lived experience of mental illness.

JT: So you first met her when she came to your home?

Judy: That's right, she came to er introduce herself on one visit, I was a little taken aback because she was so young, compared to myself and a good bit younger than my own daughters, which I think was er, (? disconcerting), but she very soon put me at ease, erm explaining that she wasn't there to impose anything on me, erm, how much of this was due to her being a student and still in a learning situation, I don't know. But she took the attitude that we were working together on my recovery, and that she was learning as she went along. Now I found this exceedingly helpful

JT: Right

Judy: Because it made me take the initiative in some places, it immediately made me feel that she was telling me I possibly had more experience of my illness

JT: Yes

Judy: Than she had, which when [4.0] when you're someone like myself who has always felt very much in control of their lives

JT: Mmm

Judy: And what they've done, it was very very hard suddenly to have no control

JT: Mmm

[Judy, Mental health service user participant 2, lines 32-48]

In this extract Judy's initial talk worked to show her reaction upon meeting Karen, her newly allocated CMHN, for the first time. Judy said "I was a little taken aback because she was so young" (lines 33-34). In terms of expectations Judy's talk functioned to show she was expecting a nurse much older. Judy emphasised her expectations by making age comparisons with herself (line 34) as well as that she perceived Karen to be "a good bit younger than my own daughters" (lines 34-35). Judy appeared to find Karen's youth "disconcerting", although this word was difficult to hear on the audio file.

In her next turn Judy continued to highlight her surprise about Karen, whom she stated "wasn't there to impose anything on me" (lines 36-37). Judy's talk worked to show that her expectations about mental health nurses were mismatched or being challenged. She seemed to show awareness of other possible ways of working for mental health nurses. Judy may have experienced these previously and could be sensitised to the need to be ready to resist or reject treatment suggestions. She showed that she may be sensitive to attempts to impose things upon her. Her account showed her awareness that treatment decisions can be imposed, therefore highlighting her concern about control and the possibility that such control might be removed.

Judy highlighted in her talk not only Karen's youth, but her inexperience. In lines 37-38, Judy referred to Karen "being a student and still in a learning situation". After discussion with Judy, I surmised that Karen was either a third year pre-registration nursing student on a community placement, or that she was undertaking a Post-registration programme in Community Mental Health Nursing. Judy's talk functioned to show that although she may have expected a nurse who was much older and more experienced, she actually found Karen's approach to be "exceedingly helpful" (line 39). Judy's expectations were exceeded as she further engaged with Karen, and are described in detail throughout the research interview.

I did not ask Judy about recovery per se in the research interview, as this was not a focus of my study. Although when I considered elements of Judy's talk, she appeared

conversant with recovery principles. In lines 37-38, Judy said "she [Karen] took the attitude that we were working together on my recovery". The way that Judy talked about her interactions with Karen portrayed an experience that was congruent with a recovery approach. For example, during the research interview Judy talked about choice, hope and how she as the service user dictated the pace of her treatment. Early attempts to define recovery suggest a process where people accept the challenge of being socially disabled by mental distress and aim to recover a new sense of self, with a focus on developing new meaning and purpose (Anthony, 1993; Deegan, 1988) Judy's talk functioned to show how she felt enabled by this unexpected approach from her new CMHN. Judy described how Karen's approach made her "take the initiative in some places". During the wider interview there are many examples, such as in line 41, where Judy talked about feeling empowered, although she voiced that she had not expected this to occur.

In her next turn Judy said "[Karen] made me feel that she was telling me I possibly had more experience of my illness (…) than she had" (lines 41-44). Judy's talk functioned to show that she recognised the value of her own lived experience of mental illness. This valuing of lived experience is reported in mental health literature as a form of expertise (Borg et al., 2011; Hurley et al., 2017). Service users recognise that sharing lived experience of mental distress can mean that others know more about how to help. Equally, the value placed on sharing lived experience can have a positive effect on the development of trust in helping relationships. Judy acknowledged that she was the one with "more experience" of mental illness in comparison to Karen. The use of "possibly" (line 42) implied tentatively, that Judy may be used to deferring to professionals and their knowledge, and so "possibly" leaves open the possibility to being challenged here. Judy may well know more, but she also indicated she was ready to accept that she may not.

As Judy said it was "very very hard suddenly to have no control" (line 47), such talk functioned to show her vulnerability as a person with mental distress. The World Health Organisation (2013) states that people with mental illness have a range of vulnerabilities which may include stigma, discrimination, and social exclusion. In her account Judy

was clear that having previously felt in control, the experience of mental illness had led to her increased vulnerability, which impacted upon her assurances. Judy's account highlighted that she wanted control and seemed to value it and therefore she prioritised this in her account. This prioritising suggested that her experiences and expectations of mental health nurses were such that some form of struggle for this control was not uncommon.

Judy had not expected a subtle shift regarding power, or perhaps more scope for evenness, in the relationship between herself and her CMHN. Power differentials have been acknowledged between service users and professionals (Speers & Lathlean, 2015), with service users noting that workers usually have the final say (Bee et al., 2015a). Ultimately professionals hold a very powerful card that service users are only too aware of, with one example being the use of compulsory powers under the Mental Health Act. Judy's talk indicated that she saw Karen's status as helpful in that the weight of experience and knowledge was more evenly distributed between them. Judy reported Karen's approach as putting her at ease and being there to work together on her recovery. Judy's experience of such an approach was a positive one, although did not match with her expectations of a mental health nurse.

The extract provided below follows on from Judy's talk about her expectations of mental health nurses. In this part of Judy's account I show how Judy talked about becoming more collaboratively involved in her own care and treatment. During the wider research interview Judy talked about how, following discharge home from hospital, she lived mostly in one room at the back of the bungalow she shared with her husband. Judy described how over time she had begun to gain confidence and started to make progress towards going out again. Therapeutic approaches for people who are anxious sometimes include a step by step approach with increased exposure to a stimulus that triggers anxiety (Pijpers, Oudejans, Holsheimer & Bakker, 2003). The idea being that with support the service user is gradually able to increase their confidence, which may be similar to what Judy is describing below.

Judy: Karen actually sort of opened a small window right from the beginning. She erm just came for a few weeks, she put no pressure on me to do anything, when I expressed a small amount of concern at this, it was quite unusual to have erm, a member of the medical team actually coming for an hour, and not, even very subtly suggesting I might be doing more than I was doing

JT: Yes

Judy: erm, which I'm not knocking as an approach because the problem is with mental illness, I think from what I've seen, everyone is completely different, and needs completely different approaches to recover from seemingly the same illness

JT: very true, very true

Judy: yeah, erm I think it must have been perhaps on the third or fourth visit that Karen began to talk to ask me about what would I like to be able to do, and again she was, I thought she was excellent for someone who was starting out because she didn't say, er she didn't use any of the ought words

[Judy, Mental health service user participant 2, lines 74-87]

It is noted that values and attitudes of mental health service staff are vitally important to the promotion of recovery (Buchanan-Barker & Barker, 2008; Slade et al., 2014). Professional workers can build on notions of recovery by using mutually acceptable language that encompasses hope and therapeutic optimism (Lester & Gask, 2006). During the research interview with Judy, there were a number of occasions where she commented on Karen's approach. In line 74 Judy said "Karen actually sort of opened a small window right from the beginning". My reading of this is that the metaphorical window opening suggests hope. It has been highlighted in the recovery literature that professional workers need to be hope inspiring (Roberts, 2008). Hope is a positive emotion that allows people to believe good things can happen, which can influence physical and mental well-being. The notion that recovery from mental distress is possible gives people renewed reason to hope. Although, according to Niebieszczanski, Dent and McGowan (2016), little is known about how mental health nurses might go about such an activity. Judy does not specifically state how Karen imparted hope and optimism, but her interview talk about Karen's approach does much to describe a thoughtful and deliberate attempt at building the relationship with Judy. Relationship building is a fundamental focus of mental health nursing (Newman et al., 2015; Peplau, 1952; Scanlon, 2006). I cannot know what Karen was thinking when she worked with Judy, as this information is not available to me through the interview data I have

collected. However, I can say that the way that Judy described her experience suggests that she appreciated Karen's approach.

Judy expressed concern in lines 75-76 that "she [Karen] put no pressure on me to do anything". Judy contextualises this further by saying how it was "quite unusual" (line 76) to have a professional worker visiting and not prescribing an intervention. In her talk, Judy described that Karen was "not, even very subtly suggesting", which indicated Judy had background expectancies of a rather different approach. According to Hugman (1991), patients are socially constructed as objects of an occupation or defined in relation to a profession, nursing for example. This type of social construction can result in patients being viewed through a professional definition of needs. Mental health service users can therefore be marginalised within the organisation and practice of caring professions, and contextualised as subordinate (Croft & Beresford, 1986). Judy's talk showed she was sensitive to any approach that sought to position her in a particular way, for example as a passive recipient to be manipulated or cajoled into accepting specific types of services.

In her next turn, Judy said "from what I've seen" (line 81), in relation to mental illness, which is an example of a speaker saying 'I have licence to talk on these matters'. Judy implied that not only has she experienced mental illness, but that she has also seen others experience it. In the wider interview Judy reflected on her time in hospital with fellow inpatients, as well as about people she had met in third sector community groups. Judy then highlighted people's individuality and stressed a need for "completely different approaches" (line 82). It is important for the researcher to indicate the characteristics of speech delivery when reproducing participants' talk (Hutchby & Wooffitt, 1998). Judy stressed the work "completely", with the underline indicating her emphasis. The weighting of Judy's words prioritised the need for very individual approaches to treatment. Judy seemed to be highlighting that Karen's approach to her was very different and not expected, and that in Judy's view there was certainly room for different approaches, including those like Karen's.

As Judy talked further about Karen's approach towards her, she highlighted the introduction of choice with the words "Karen began (…) to ask me about what would I like to be able to do" (line 85). Choice firmly places treatment options with the service user (Samele, Lawton-Smith, Warner & Mariathasan, 2007; Slade, 2009). Judy indicated again how "excellent" she thought this approach was. Clearly though Karen's approach was a mismatch with Judy's expectations. Judy said "she didn't use any of the ought words" (line 87), suggesting that she had expected a more authoritarian approach where professional workers used words like "you ought to be doing this or that". In the wider interview, Judy spoke about staff approaches in the hospital setting that were more prescriptive and how service users spoke of a "them and us" (line 971) atmosphere, as other service user participants did in my study. McKeown, Wright and Mercer (2017) stress that 'them and us' cultures contribute to poor patient experiences in alienating environments, which further feeds a notion that overly coercive approaches from staff still remain. In order to build effective relationships, it is often necessary for professionals to relinquish some of their power (Warne & McAndrew, 2007). This re-distribution of power can be enabling for service users, and encourage people to grow in confidence.

At a later point in Judy's interview she says of Karen:

449 **Judy**: she never adopted an authoritative point of view even though she was in
450 the authoritative position to me

[Judy, Mental health service user participant 2, lines 449-450]

Perkins, Repper, Rinaldi and Brown (2012) suggests that therapeutic relationships can actually maintain power imbalances, with problems defined and types of therapy chosen by the professional 'expert'. Certainly issues of power and powerlessness are recognised in the mental health system by nurses (Fisher & Freshwater, 2014; Pieranunzi, 1997). In recent years however there is a greater drive for workers and service users to reach consensus with service users about treatment goals in order to reduce distress, and for service users to gain a greater sense of control (Coffey et al., 2016). The example provided by Judy indicated that she appreciated a greater sense of control, although this was a mismatch with her expectations. Judy made relevant what she saw as Karen's status. She appeared to position this as an opportunity for her to

show her experience and to jointly learn from each other. Karen's status as a learner is therefore relevant and makes it possible to interact in a new and perhaps unexpected way.

Despite increasing guidance promoting service user involvement approaches in healthcare generally (Department of Health, 2012; NICE, 2015), professional workers need to consider how this translates into practice. Service users who are informed about recovery may be at the metaphorical steering wheel and driving the involvement agenda by calling the shots, although this may be illusory. However, many individuals may be simply offered an occasional turn in the driving seat (Fudge et al., 2008; Terry et al., 2018), with the main direction of travel being dictated by professionals. Patton's (2013) study about inpatient mental health nurses indicated that nurses viewed service users as privileged to be involved in their care plans, and that nurses were heroic in such activities. These reports imply any suggestion of involvement is actually rather limited and tokenistic. If service users are not expecting to be involved in their care and treatment, they may need to be prepared for these activities by having the opportunity to discuss potential merits, as well as what may be required. The ethical need to respect service users' autonomy and to respond to consumer demand with increased involvement in decision making is becoming more recognised (Elwyn, Edwards, Kinnersley & Grol, 2000). For example, the Picker Institute (2013), an international charity dedicated to improving health and social care, stress that indicators of quality and safety from a patient perspective include respect for patients' values, preferences, and expressed needs. Equally it is important that service users have varying desires for autonomy in terms of shared decision making. When an individual has limited desire for agency in such processes, Barry and Edgman-Levitan (2012) suggest that healthcare experiences be considered more though patients' eyes, so that clinicians may be more responsive to patients' needs. Although without some level of shared decision making there is a danger of making assumptions on the patient's behalf.

When I put it to Judy in the research interview that it sounded as if she had been involved in her care and treatment, she replied:

441 **Judy**: well it was Karen who brought me in to being involved in it. I feel that
442 suited me as a personality, but [3.0] I felt I needed it because the very worst
443 thing for me was to have lost control

[Judy, Mental health service user participant 2, lines 441-443]

Judy indicated several times in her account that she had not expected the opportunity to engage in her treatment. Elwyn et al. (2000) suggest that patients are made aware that they will be expected to take an active role in decisions about their care. I am not proposing that all service users want equal control. Certainly there is evidence in the shared decision-making literature to suggest that this is not the case (Légaré, Stacey, Forest & Coutu, 2011). However, as autonomy centres on the capacity to be one's own person, it is people's value systems that determine what matters most to them in relation to the self. According to Stiggelbout et al. (2012), shared decision making should be the norm in most healthcare situations because of the principles of biomedical ethics, which include respecting autonomy (enabling individuals to make reasoned informed choices), and the need for beneficence (balancing benefits of treatment against the risks and costs). Judy's expression "for me" (line 443) functioned as a tentative claim for her as an individual, as she would not logically claim something on behalf of others. This "for me" talk reinforced that it was important for Judy to be valued and treated as an individual, and her story suggested this took place.

My findings shows that in making relevant the junior position of the nurse, Judy elevated her own experience as being of value to the process of her recovery. Her concern with control and the potential for this to be grasped by others dominated her account. Background expectancies of how mental health nurses operate and the mismatch between previous controlling services and her experience with Karen was presented as a critical juncture in her care trajectory (Hannigan & Evans, 2013). Critical junctures refer to a pivotal moment or turning point that alerts a person to plausible alternatives. Hannigan and Evans highlight that such junctures can have enduring consequences, and can create opportunities to try new things in the pursuit of improvement and change. I cannot assume Judy's journey following her interactions

with Karen, but her account implied Judy's increased awareness and knowledge about possibilities and alternative approaches in mental health care.

In the wider context of the provision of mental health services, Judy's account can be read as evidence of an increasing awareness and sensitivity of people using services to controlling or coercive practice of nursing staff. In attempting to reassert her own experience Judy's account can be seen to work towards righting a long-standing epistemic injustice (Fricker, 2007) in the ways which mental health service users' knowledge of their own experiences has been downplayed or devalued.

Indeed Judy's was one of the few narratives from the service user participants in my study who gave an account describing satisfaction about how they were involved in their care and treatment. Although Judy spoke encouragingly about her experiences with her CMHN, she highlighted a mismatch in her expectations. Judy voiced awareness about issues relating to authority and power, a lack of control and a 'them and us' mentality as part of her background expectancies. Restrictive practices remain evident as part of service users' experiences, and many participants alluded to these in my study.

6.6 Conclusion

In this chapter I have demonstrated how mismatched expectations about mental health nursing are handled in research interview talk from multiple perspectives. Discussions may provide an insight into expectations about mental health nursing roles in other social settings. Nursing students' interactional talk highlighted examples where they reported expectations from qualified staff that they, as students, would comply and fit in to existing cultures. Students' narratives included stories of resistance, which functioned to show that issues of power exist for students and for service users in mental health care environments. These examples of power and power struggles did not match students' expectations.

In a number of examples in this study participants showed mismatched expectations about mental health nursing roles. For example, Ben, a mental health nurse, whose talk about role blurring and role ambiguity highlighted that there are many versions of, and ways of being a mental health nurse. Ben's story indicated that service users have certain expectations of nursing roles, and may voice dissatisfaction when such expectations are not met.

In participants' accounts they gave examples in their talk about how meaningful service user involvement in nursing processes may be either existent or virtually absent. One mental health service user participant, Judy, indicated her background expectancies about mental health nurses, which included her expectations of a 'them and us' style approach in terms of power and authority. Contrary to such expectations, Judy's narrative included her experiences of meeting a mental health nurse who promoted choice and hope, which Judy highlighted as empowering.

These mismatched expectations from multiple perspectives about mental health nursing suggest that there is much at stake for all parties. Nursing students in their pre-registration training have awareness they are about to enter a profession that includes a number of tensions in practice settings, with challenges expected from both staff and service users. Equally nurses themselves have on-going concerns about teams they work in, other multi-disciplinary professionals they work with, as well as an awareness of the expectations service users have of mental health nurses.

In the next chapter I expand upon my findings from the data that I have examined in Chapters 4, 5, and 6 with the aim of exploring relevance in relation to both mental health nursing roles and identities and the applicability to service user involvement. I provide further discussion about professional identity talk about mental health nursing roles and work, particularly in relation to the engagement and involvement of mental health service users.

Chapter 7: Discussion: Exploring mental health nurses' and services users' talk about mental health nursing

7.1 Introduction

In the previous chapters I have examined people's talk about mental health nursing roles and professional identities in relation to service user involvement in nursing processes from multiple perspectives. A multiple perspectives approach to my study was valuable as different participants had distinct viewpoints about the topic under study (Chong, Aslani & Chen, 2013), which included both similar and contrasting accounts. Research involving multiple perspectives can provide an integrative approach that inter-relates differing forms of knowledge in order to contribute to a more satisfactory evidence base (Rose et al., 2006, p.112), than asking singular groups. My study aimed to explore participants' talk about mental health nursing, and experiences of service user involvement in nursing processes. Perspectives of mental health nursing students, qualified mental health nurses and mental health service users were sought, in order to explore this phenomenon from a variety of perspectives. Allowing differing views to sit alongside each other, without attempting a consensus, ensures a range of voices are included, rather than restricting views to a limited perspective.

In this chapter I will provide a discussion based on my findings in previous chapters, about how nursing work was mostly referred to as task-oriented, with limited emphasis on skills employed when working with people who use services, to emphasise the separateness and inadequate engagements that do not encourage involvement practices. This will be followed by a section on tensions around service user involvement in care planning, in which I explore the powerlessness reported by service users and limited scope perceived for collaborative working. I will follow on with a section about mismatched expectations about mental health nursing, in order to show frustrations perceived with existing cultures, that people do not know what to expect from mental

health nursing, and that this all adds to a culture of service user involvement being limited.

Mental health nursing work has been described as invisible and misunderstood (Dryden, 2010; Jackson & Stevenson, 2000; Mann & Cowburn, 2005; Michael, 1994). In my study people's accounts have shown awareness of different versions of mental health nursing, including caring and controlling elements and how participants were aware of different approaches from different nurses that they met in the course of their care. One might expect that through the nurse-patient relationship there are prime opportunities for engagement and involvement, yet competing accounts about the veracity of such involvement were evident in participants' talk in my study. My intention was to explore how people talked about mental health nursing in order to explore displays of understanding about mental health nursing roles particularly in relation to service user involvement.

Meaningful service user involvement is about active engagement from individuals who use health and social care services, to ensure people' s voices are heard in order to make real, sustainable changes, both to their own care and to services generally (Terry et al., 2018). Service user involvement exists in many forms, with a variety of terms used. Patient involvement in decision-making ensures people have a voice about care decisions (Godolphin, 2009), whilst patient participation in decision making is more about access to information, so people can obtain answers about the problem being addressed (Brownlea, 1987). In addition, the opportunities for patient choice, for people to have increased control of circumstances and to achieve desired goals (Anthony & Crawford, 2000) are also major elements of service user involvement in nursing processes.

One increasing aspect of professionals' work in healthcare environments has been to engage in partnership discussions with patients, to encourage and enable people to be involved in their care and treatment decisions. There have been moves to increase such service user involvement in healthcare (Department of Health, 1991, 2003, 2012). This

type of involvement has now been firmly established in legislation (National Assembly for Wales, 2010), yet a lack of service user involvement in care has been reported (Coffey, 2006; Simpson et al., 2016b). Whilst mental health nurses have often described their role and purpose under the banner of the therapeutic relationship (Browne et al., 2012), it does not transpire that they have necessarily taken on the principles and practice of collaborative working and a true sense of service user involvement. It is not known whether mental health nurses have taken on board service user involvement as a fundamental part of their role and professional identity. Equally it is difficult to suggest what such an identity might look like. My study provided the opportunity to explore how mental health nurses account for service user involvement as part of their roles and professional identities.

Although a growing body of research into service user involvement is evident in the mental health nursing literature in relation to education, practice and research (Bee et al., 2015a; Newman et al., 2015; Terry, 2013), it was service user involvement in relation to people's care experiences that I was particularly interested to hear about in people's accounts. Service user involvement in care planning activities has been a legal requirement in Wales since 2012, but such activity has generally been under-reported in nursing literature to date. When I asked service user participants about involvement, they reported mixed experiences. Not every patient wants to be involved in their own care, and by the very nature for which this is legislated, suggests a further form of control from services. Therefore one more aspect that service users are expected to comply with, along with taking prescribed medication and attending various appointments. In their accounts service users showed mismatched expectations in relation to experiences of service user involvement. For example, some service users gave accounts of expecting and hoping to be involved in discussions about their care but reported this to be unsatisfactory. Whilst others, when provided with the opportunity to work collaboratively in their care and treatment, expressed surprise at the notion of being involved.

7.2 Nursing work: task focused and time-limited

The findings of this study show how mental health nursing is rhetorically constructed by participants in the justifications, explanations and accounts of what mental health nurses do. I identified in my findings that participants spoke about mental health nursing work in a task-focused manner, with frequent reference to nurses operating separately from service users. I am going to argue that mental health nurses need to increase their awareness of what their roles involve and what this means for service users, in order that they can articulate a professional role that is effective and of value to people who use and work in mental health services. I will go on to argue that:

1. the therapeutic relationship is central to mental health nurses' roles
2. nurses themselves seem to lack confidence and competence in how to undertake service user involvement in nursing processes
3. nurses work in a mental health service climate associated with coercion, power and control.

Role theory suggests there are expectations attached to certain social roles, although it is stated that mental health nursing is difficult to define (Happell, 2011, Happell et al., 2012; Rungapadiarchy et al., 2004). These difficulties are attributed to the nature of mental health nursing practice, and the complex and dynamic landscape in which it exists. For example, I suggest there are both formal and informal constructions of mental health nursing, which would include what is written down versus what an individual might experience. The profession's regulator, the Nursing and Midwifery Council (2016b) sets standards of education, training, conduct and performance with the intention that nurses and midwives deliver high quality healthcare consistently. Informal constructions of nursing however may be far more dynamic and idiosyncratic, and vary from person to person and from one experience to another. Informal constructions can however be long-lasting, and if someone has a negative experience of mental health nursing care it may stay with that person regardless of what the formal versions say. In this sense formal and informal versions of nursing have currency which may have differential value depending on the individuals who encounter and experience such versions. Whilst there are formal and informal versions of mental health nursing, the

work is also influenced by a range of stakeholders both internal and external to the profession itself. For example, mental health nursing work continues to be influenced by educators, policy makers, regulators, service users and nurses themselves.

For a person to have a specific identity, Antaki and Widdecombe (1998) suggest that the descriptions used about an individual result in them being cast into a category of associated features and characteristics. For example, a mental health nurse's talk is the means by which professional identity is performed, which includes what they say about their nursing work. The successful achievement of identity is a process. Erikson (1950) highlighted how from birth individuals realise their own uniqueness and acquire a personal identity. At a later point, people become more aware of their social identity in relation to their membership of various groups, including those that may be ethnic and occupational. These group identities satisfy a need for belonging and help people to define themselves in their own eyes and those of others. As people actively construct their social identities, they then communicate them, display them and publicly perform them (Sjoblom & Aronsson, 2013). Those working in mental health nursing may assume a taken-for-granted character (Rawls, 2006, p.23). This does not mean that such identity remains fixed, indeed Foucault (1981) suggested that the self is defined by a continuing discourse through a shifting communication of oneself to others. Nurses, like other individuals, will have a range of learning experiences across their careers (academic learning, practice learning, non-professional learning) which we might expect to influence how they see their roles, and themselves within those roles. It is to be expected then that what they say about their work, and themselves in the context of this work, is likely to be constantly renewed and refreshed. It is also possible that individuals seek to embody a particular version or set of practices as a nurse and find themselves doing something that is not congruent with those values and therefore experience dissonance with their roles and work. Being clear about one's role, in relation to accomplishing identity, is therefore important as this ensures clarity and congruence, and may help when articulating that role to others.

Rather than the profession seeking to define its distinctiveness and therefore its professional identity on a unique concept or singular point of difference, Hurley (2009)

suggests that the mental health nurse role might best be understood from identifying a cluster of capabilities. Hurley suggests such capabilities include having a service user focus, the nurse utilising their personal self, using talk-based therapies, and transferable skills. It has been suggested by Cleary (2004) that as mental health nurses deliver a variety of services to patients, that this breadth of their work is unique to the profession. Breadth may be disadvantageous and can result in a definition of mental health nursing being elusive. The notion that the role is broad and non-specific can suggest an 'all things to all people' identity (Brown et al., 2000). This expansiveness may be a drawback for those in the role compared to other professional mental health workers whose roles and boundaries appear more defined. A lack of role clarity can therefore lead to mental health nurses experiencing difficulties meeting expectations placed on them, resulting in role overload and a conflict of priorities (Hercelinskyj, 2010). If mental health nurses are unsure of their roles and jurisdictions, they may be at the mercy of other professionals who delegate increasing work to nursing staff. Evident in nursing literature is a notion that mental health nurses are at risk of being seen as a 'Jack of all Trades, and Master of none' (Clarke, 2011; Clarke, 2013). The 'Jack of all Trades' notion may be seen positively, but the 'Master of none' element is very negative. This concept was highlighted as a possibility by two nurse participants in my study, Emma and Angela, in Chapter 4. In their interactional talk they reported identifying more as being specialists rather than generalists, which supports Hurley's position:

> "the stance of MHN [mental health nurses] occupying specialist status due to their generic capabilities is also an important contribution, attracting professional worth to MHN's versatility rather than merely 'tradesman's-like' recognition."
>
> (Hurley, 2009, p.388)

It is unsurprising that mental health nurse participants would prefer to be considered as specialists rather than generalists, and I suggest that those in more specialist roles find it easier to articulate what they do. Emma worked as a ward manager in a forensic facility, and Angela had a specialist lead role in an early intervention service. Both participants spoke about their roles in relation to other team members, service users and other services. In my view, whilst mental health nursing roles have flexibility and can encompass a broad scope of tasks, the more generic a particular nursing role, the greater difficulty a nurse may have in describing it.

In this section so far I have considered that people will have role expectations of mental health nurses, and that roles and professional identities involve a level of flexibility. I noted that identifying a cluster of capabilities for the profession would provide a useful baseline, as a lack of role clarity brings some danger of mental health nurses being seen generically. I believe these notions were borne out when the Nursing and Midwifery Council (2017b) produced their draft proficiencies with mental health nurses highlighting that despite early consultation the NMC's apparent understanding of mental health nursing work was clearly limited. This was evident through the limited descriptions about what mental health nursing work involves. I will move on to discuss further notions of mental health nursing work being both busy as well as misunderstood.

The work of mental health nurses was portrayed by multiple participants in my study as being demanding and hectic. People referred to 'busy wards', 'busy units' and 'busy environments'. In today's world being busy has become akin to a badge of honour, almost a status symbol (Bellezza, Paharia & Keinan, 2017). A feature of professional groups when called to discuss their work is to highlight their busyness as a sort of proxy measure of their worth. This talk seeks to do the work of stressing how clearly valued their services are, and that they are required by others. In terms of criticality, exploring busyness is worthwhile, as there may be more to activities than there first appears.

> "Being busy does not always mean real work. The object of all work is production or accomplishment and to either of these ends there must be forethought, system, planning, intelligence, and honest purpose, as well as perspiration. Seeming to do is not doing"
>
> (Edison, 1912)

Participants in my study talked about the busyness of nurses and how people viewed such busyness as having an impact upon them. When referring to nurses who worked in community settings, staff caseloads were often referred to as sizeable, with participants showing awareness of staff workloads associated with such roles. For example, Emlyn talked about the size of his CMHN's caseload and Sian showed her awareness that her CMHN had many other patients to see. Service user accounts included several

references to mental health nurses who were 'too busy', which is echoed in other studies about mental health nursing (Cleary & Edwards, 1999; Stenhouse, 2011), reinforcing the notion that nurses' one to one time spent with patients was limited.

It may be that nurses describing their work as busy is a professional defence for the purposes of delaying or distracting potential negative evaluations that can arise when work is poorly understood or is not widely valued. In Chapter 4 I highlighted how Simon stressed that although the nurses appeared busy and rushing about, he had little idea what they were actually doing:

445 "They seemed to walk up and down a lot, I don't know what they're doing
446 (laughing)".

[Simon, Mental health service user 10, lines 445-446]

There is no notion in Simon's account of nurses busying themselves with one to one interactions designed to help people feel safe and supported. Nor to understand what is going on with individual service users, such as engaging them in ward activities or care planning meetings, which is echoed in other studies (Simpson et al., 2017; Stenhouse, 2011). Given the claim that mental health nursing identity is all about the interpersonal relationships with service users, this begs the question why mental health nurses are seemingly avoiding this part of the role in favour of other elements. In his talk about inpatient experiences Simon reported what he saw which is nurses leaving little time for one to one work with individuals. Certainly the nurses may be engaged in others tasks that require their attention but take them away from doing meaningful one to one work. One element of people's talk that arose frequently was nurses spending time away from service users, and being located for long periods in the ward office.

Mary highlighted "I sit in the office most of the time", and I discussed her account in Chapter 4. I do not wish to give the impression that this 'office focus' was entirely related to nursing tasks that needed completion, or that nurses in my study were necessarily aware of separating themselves for potentially protective reasons. There was

however a sense from participants about a separateness that was felt by nurses being in the office, which added to the 'them and us' feelings service users experienced. This talk did not always relate to ward nurses either. Service user participants such as Emlyn and Jack referred to the office base of their CMHNs, and how they had a sense of the nurses doing "heaps of work" in their offices, and that was a central point where nurses were located.

Participants' talk in my study included phrases such as: "so much time in the office", "busy running the office", and "won't come out of the office". This is not so much about the office as a location, but more about a distancing tactic, and nurses removing themselves from public areas of the ward space, into an area less accessible to service users. This distance that nurses are seeking, is almost the opposite of what is required in service user involvement in nursing processes, therefore a close proximity to service users. McKeown et al., (2017) stress that nurses are deceiving themselves if they try to justify excessive time needed for office paperwork at the expense of direct care. These apparently rational practices in which nurses engage, including copious documentation and risk assessments, recommended in policy documents, seemingly motivated by ideals about care, actually function to destroy the very essence of what it might mean to be a caring professional worker. One argument suggested by McKeown et al. (2017) suggest this is the opposite of what services intended to achieve, and compare this to a confidence trick. Mental health nurses may or may not be pulling the wool over their own eyes, but are complicit in persuading people into a game, which distracts people from the very real issues of structural problems in the health service and limited resources.

Nurse participants in my study did not mention one to one work with patients in their accounts, so this seems to feature less as a form of professional identity claim about what it is to be a mental health nurse. Ideas of being with, active listening skills, counselling support, psycho-education and help with managing symptoms are perhaps curiously absent from the nursing work being described. This appears to be different from the priorities that service users say they want and even mental health nurses themselves argue for, but feel distanced from by the nature and demands of their work

in certain settings. By and large the talk about busyness and task-related nursing work related mostly to those working in inpatient settings.

Participants' talk about busyness and being in the office often related to descriptions about task-related work. Although participants did not use the word tasks, my understanding of the accounts provided was that a task oriented approach to nursing was often being verbalised. For example, Mary stressed that she used to "work through the diary" (Mental health nurse participant 1), as highlighted in Chapter 4. The context in which Mary spoke about this task was that it was under the jurisdiction of the ward nurses. Jurisdiction refers to the link between a profession and its work (Abbott, 1988). According to Hannigan and Allen (2011) professional workers frequently work to control tasks and activities against claims from others, and seek to protect or control such aspects of their work. This indicates that nurses may be invested in continuing with these task-based activities. In the absence of higher status work that may not fall within their remit, nurses therefore lay claim to more menial tasks. However, Abbott (1988), building on Freidson's work, states that in terms of a professionalisation agenda if workers identify higher status work they could lay claim to, they are likely to take on more of this desired work in order to advance both themselves and perhaps their status.

There is some sense here that nurses may not only remain in the office to complete tasks, but that they may be attempting to cope with the demands of the role. The nature of mental health nursing work involves much emotional labour, which is the effort workers put into regulating their emotions as they attempt to meet the organisational expectations of their role (Hochschild, 1983), as discussed in Chapters 2 and 4. The on-going requirement to perform emotional labour is said to have negative effects on people's health (Mann & Cowburn, 2005). Studies of stress and burnout frequently advocate the need for improved support of nurses within their work environments (Laker et al., 2012). Social supports may be formal taking the shape of clinical supervision, which involves individuals and organisations committing to this activity as a means for developing and maintaining awareness. Clinical supervision is also a potential container for anxieties and stresses for those engaging in the complex and difficult practice of interactional mental health nursing. Other informal supports also

exist, and include support from colleagues in the office or family and friends (Coffey & Coleman, 2001). It is true to say there was far more talk about busyness from participants in relation to nursing work, than references to stress. This showed that nursing staff advanced this claim of being busy, and that service users too were aware of the busyness, which impacted negatively on their needs in a sense of less direct nursing input.

There is a sense here that nurses have both limited coping and limited confidence.

> "The main cause of this 'burnout' appeared to arise from limited internal coping skills and from the need for staff to protect themselves emotionally from the complexities of individual service users in their care"
>
> (Rose, Evans, Laker & Wykes, 2015, p.4)

The notion of nurses having limited coping skills is comparable with further critique of nurses. Benner et al. (2009) suggested an increased focus on developing an individual's understanding of the self and their own identity formation would assist the formation of a professional nursing identity. This increased self-understanding may well increase assurance, confidence and encourage nurses to develop alternative habits that do not include so much office-based time.

The suggestion that nurses may have limited confidence featured in participants' talk in my study. People spoke about: "lacking confidence", "building confidence" and "growing confidence", and that confidence could be knocked in some way. Limited confidence from nurses is evident is studies such as Coffey and Hewitt's (2008) '*We don't talk about the voices'* study, where nurses said they shied away from discussing voice hearing experiences, and encouraging emotions and distress they then could not manage. In my study it was a service user participant (Brenda) who suggested she found nurses to be "not terribly confident" (line 42). I suggest that this lack of confidence is disadvantageous for mental health nurses in terms of how they consider their roles and professional identities. In her research interview, Brenda went further in her critique of mental health nurses:

> **Brenda**: When I've been having a hard time the nurses who are supportive and helpful are – erm (4.0) erm maybe I've just been unlucky but it's felt like they're the minority not the majority. And the…Almost the most common response I've got has been sort of 'well, what do you expect us to do, you know there's …it's

> kind of up to you' and erm 'you're the one who's got to do the work'. Erm, 'There's nothing I can do' is a common one and there's this kind of professional helplessness comes across quite strongly which is a bit scary when you're going through a scary erm experience. Those nurses who feel they can't do anything and say that, are actually, erm…it's not very helpful, let's put it that way.
>
> [Brenda, Mental health service user 3, lines 63-71]

Brenda's comments about professional helplessness may not be without substance, and resonate with the difficulties mental health nurses have in articulating their roles and their work. Dryden (2010) suggested that low confidence in mental health nurses may relate to the low visibility interpersonal skills they have that are considered central to efficient and effective working. Low visibility skills, like developing therapeutic relationships, may be unfamiliar to those outside mental health settings, and therefore result in a limited understanding of mental health nursing roles and professional identities. Whilst the role of mental health nurses has been to support people living with mental distress, nurses have attempted to develop a theory of the profession under the notion of the therapeutic relationship. Even if educators, academics and practice staff all emphasize the importance of this said relationship, it does not translate that nursing students are properly prepared for the complex work involved in mental health nursing, particularly how to develop and engage confidently in therapeutic relationships.

There is little evidence about the amount of time spent in skill rehearsal as a core element of current mental health nurse preparation, or indeed about its effectiveness. In a literature review of neophytes' interpersonal skills training that involved service users, it was attitudes, empathy, and skills (in terms of paying attention, having a therapeutic approach and flexibility) that were identified as vital interpersonal skills (Perry et al., 2013). It may be that lecture experiences simply involve talk about what is needed with limited practice or rehearsal elements. If students have not had the opportunity to practice skills in safe neutral learning environments, they are unlikely to have the confidence or ability to try them out in real practice situations. According to the new forthcoming standards for nurse education it is stipulated that up to 300 hours can be spent on simulation activities (NMC, 2017a). There is an opportunity here for education providers to increase the amount of classroom time spent developing practical skills and

knowledge around building and maintaining therapeutic relationships. The literature on simulation approaches in mental health nursing education is developing (Felton & Wright, 2017; Williams, Reddy, Marshall, Beovich & McKarney, 2017), with findings suggesting benefits in a variety of approaches, although actual benefits on patient outcomes in practices are not yet known. Equally, I suggest that with 50% of pre-registration hours spent in practice, it is also in clinical settings that nursing students should be improving their one-to-one patient skills.

The origins of the therapeutic relationship can be traced to attendants' interpersonal practices in the asylum era (O'Brien, 2001), with a large body of literature promoting such alliances as crucial to positive outcomes for service users' mental health (Wright & Hacking, 2012). The forefather of advocating a focus on the therapeutic relationship is said to be Carl Rogers (1951), who identified essential attributes of respect, empathy and genuineness (Rolfe, 1990). Others have stressed important elements that need to be present like trust, familiarity, and friendliness (Forchuk et al. 1998). Following the work of Peplau, Altschul, Barker and others, the therapeutic relationship is considered the fundamental core and essence of the role of the mental health nurse (Scanlon, 2006). However, Dziopa and Ahern (2009) raised concerns that whilst the therapeutic relationship has been considered essential to therapeutic patient outcomes in mental health, the actual construct of the nurse patient relationship, and relevant attributes required, has remained elusive. So, although nurse theorists have continued to name relevant constructs of the said relationship, including conveying understanding, accepting individuality, providing support, being there/being available, promoting equality, maintaining clear boundaries, and having self-awareness (Dziopa & Ahern, 2009); it can still be said to lack clarity. O'Brien (2001) suggests that the therapeutic relationship continues to play a fundamental role in mental health nurses' professional identity, and how it is articulated in the future will determine the meaning of the therapeutic relationship for future generations of mental health nurses. In my study mental health nurse participants talked about forming, building and maintaining relationships with service users but not with description or clarity, except perhaps a sense that it needed to be worked at. This is evident in an extract from Sally's research interview.

Sally: There's two patients on the ward, and it took them quite a while to warm to me, they were very erm…very cautious but now they're telling me about their history of substance misuse and the other gentleman's got history of gambling. But it's just making…you know make sure you do make the effort to make the therapeutic relationship.

[Sally, Mental health nurse participant 13, lines 1065-1069]

So whilst nurses believe the therapeutic relationship to be an important part of their practice, defining its exact nature has remained a challenge (Fourie et al., 2005). Browne et al., (2012, p.839) suggest that 'because of the diversity of the way [nurses] work, and the notion that their work is not easily categorised, this [therapeutic relationship] theory becomes too unwieldy to use' as an all-encompassing definition of the mental health nursing role. Hewitt and Coffey (2005) argue that whilst Rogers' core conditions are known and indeed necessary to form therapeutic relationships; the relationship alone is not sufficient to improve service user mental health. This implies to me that whilst the very nature of the therapeutic relationship is definable; its effectiveness may not easily be quantifiably measurable. Although research is this area is slowly developing, for example with Chambers et al. (2016) therapeutic engagement questionnaire, it may seek to answer a question that has been unfathomable to date. My study included talk from participants that implied they saw therapeutic relationships with service users as fundamental. This extract from Emma highlighted her concerns when she felt nursing students were not confident about such engagements, and that change was required.

JT: What are some of the things you need to see be different and changed?

Emma: Well, interaction with the patients for a start, you know that's fundamental in forming a relationship with the patients on the ward. I've had students here that won't come out of the office, and then when we've explored it it's not because they're scared which you very much think, well, maybe they're scared, maybe it's the risk. You know, but, no, there's no self direction

[Emma, Mental health nurse participant 14, lines 1036-1041]

I believe that without extensive time, input and skills practice at a pre-registration education level that the concept of the therapeutic relationship will continue to remain vague to some extent. Certainly some nurses' levels of confidence and competence will

vary, with service users continuing to have mixed experiences of engagements with nursing staff.

Happell (2011) notes nurses need to identify the things they do in order to clearly articulate their contributions. I would go further and suggest that mental health nurses need further training and guidance in order to better articulate their professional identities regarding the therapeutic relationship. Pre-registration nurse education in the UK has adopted a more generic focus, with less time spent than in previous programmes learning about mental health nursing roles and professional identities. In my study, whilst mental health nurse participants spoke about the relationship they had with service users, indicating its importance to their work, there was limited talk about how participants quantified the nuances of those relationships. It follows that if the therapeutic relationship is core and central to the identity of mental health nurses then one could assume that nurse education would start from that point, and make the subject of relationship central to everything students are taught and expected to learn.

Expectations from service users about time to talk with nurses, like Simon (Chapter 4) and Brenda (Chapter 5), were apparent in my study. Simon spoke about expectations of ward nurses spending one to one time with him, and Brenda highlighted that talking directly with nurses about coping strategies was something she found supportive and was therefore important to her. There is a sense here that both nurses and service users have mismatched expectations about interactions. While on the one hand service users noted a lack of time spent with nurses, on the other hand nurses claimed a need to attend to practical tasks of managing the environment of care. Dryden's (2010) thesis on making mental health nursing skills visible stressed the importance of placing unseen practices alongside evidence based knowledge in order to better articulate skilful mental health nursing. Service users on the other hand may be expecting a more tangible input or intervention that can be articulated by the nurse. However, such an approach militates against collaborative working. The very essence of service user involvement in nursing processes is that there are on-going conversations between service users and professional workers about people's care and treatment that include choice and discussion (NICE, 2011). Approaches of this type also have low visibility, and it may

take an experienced and confident nurse to begin and maintain these flexible conversations.

> "It's much more a two-way process. But you have to leave your comfort zone, it's messy and scary. [I ask her what she means by 'messy and scary'.] Well, it's like letting them know that you don't know and also, yeah actually ... you don't know where you are going to go"
>
> (Dryden, 2010, p.119-120)

Dryden goes on to say that these collaborative approaches involve not only a loss of control for the nurse, but also a need to exude confidence in order to instil assurance in the service user. It is my argument based on findings from my data collected for this study that in terms of expectations, service users want support and advice that is tangible. Nurses on the other hand, with their sense of busyness, limited confidence and poorly articulated skills tend to fall back on task oriented activities which may be more easily articulated than risking collaborative conversations that may increase service user involvement in nursing processes and promote a truer sense of working together.

The breadth of their roles, lack of role clarity and uncertainty about jurisdiction is evident in nursing talk. Equally, notions of busyness and leanings towards task-oriented work seem to drive a culture in staff that frequently separates themselves from service users. Separateness of this nature may aim to manage workers' own stress and well-being, or may occur due to staff having limited coping skills to manage the demands of nursing work. Spending extended periods of time with service users in any mental health setting is regarded as the mainstay of the profession. A focus on partnership working with service users in policy, guidance and education standards suggests nurses may be keen to adopt such approaches. Yet the stories told by participants in my study suggest otherwise. In the next section I explore tensions about service user involvement in care planning, and people's expectations in relation to this, to show that service user involvement in care planning varies, with awareness that users' positions have limited power.

7.3 "A lot of them are not involved in their care plan to the extent what I am": tensions around service user involvement in care planning

In the 20th century professional workers' approaches to mental illness and its treatment exuded power, with dictated treatments and limited input or say from users of services (Busfield, 1986). During the last three decades there has been a growth in service user movements and more accepted ideas of working collaboratively with service users and of service user expertise (Bee et al., 2015a). Whether this means that service users actually have more power, or whether professional workers have shifted to less obvious forms of control is open to debate. How evident actual collaborative working is in reality is a question not easily answered. Principles for working with people as equal care partners are clearly visible in the World Health Organization's Mental Health Action Plan (2013), and other policy guidance (DoH, 2003, 2008, 2011, 2013b). However, whilst policy content may show awareness of involvement and its potential benefits, the transfer of policy statements to on the ground changes in service provision is not simple, linear or straightforward; even if was assumed that people were aware of such policy content. Wells (1997, p.333) highlights that professional workers attempt to balance tensions between political and policy imperatives, local management agendas, professional and peer cultures, as well as perceived personal advantage. Wells suggests that managers themselves may have a vested interest in not examining staff implementation of policy too vigorously as a way of deflecting responsibility for its consequences. Examination therefore of the actual interpretation and implementation of service user involvement in practice is under reported.

My study was concerned with how participants talked about service user involvement in relation to the mental health nurses' role. I was curious to explore how mental health nurses viewed user involvement as part of their role, and how service users talked about their experiences of involvement. Increasingly research evidence suggests that involving service users in their care and care planning is beneficial (Bee et al., 2015a, Brooks et al., 2015). Involvement can help to promote service user satisfaction with services and can maximize the effectiveness of care strategies (Beech & Norman 1995; Rogers & Dunne, 2013; Valimaki & Leino-Kilpi, 1998). By service users being more actively involved, people may choose their own recovery goals, and be more invested in

treatment approaches; and therefore more engaged in improving their well-being. However, this all rather depends on service users being involved in their care in the first place.

The central focus of my study is how people talk about mental health nursing in the context of service user involvement. If mental health nurses were expected to assimilate lessons learnt from service user involvement practices (whatever these might be), one could assume that nurses would be challenging and disrupting the status quo of the cultures they create and work in. However, nurses do not appear to be doing this, and one might question why that is. Service user participants clearly indicated that they were not happy with attempts by nurses at involvement activities in their care (see Amy and Brenda in Chapter 5). Whether service user involvement in nursing processes is considered to be an aspiration to be achieved at some future point, is being actively rejected or is not sufficiently valued or powered to have an effect is possible. Equally nurses themselves may not feel confident to have such conversations that will likely involve new ways of talking and working in order to increase the quality and amount of service user involvement in practice settings. I have highlighted the notion that nurses may lack confidence and competence in this chapter already, and this was raised by Brenda (Chapter 5). Looking at the data corpus the notion of confidence occurred frequently in talk mostly from mental health nurses, and this related to limited confidence, and confidence being knocked and related to talk about their roles and work generally. Talk of this nature reinforces that nurses in my study did not show confidence in their talk about their roles and nursing work.

So nurses may lack confidence in some of their general engagement abilities, and perhaps also lack competence when it comes to how to involve service users in their care. It may be that nurses feel disabled and disempowered by a system they see as more powerful than themselves.

1055 **Laura**: The problem comes back to the same thing, the system that you have dictates
1056 that if you're suffering from certain things you have to do certain things.

1057 **JT**: Mmm, hm

1058 **Laura**: So that pushes the service user out and it says, well, it doesn't really matter what
1059 you think or what you want to get involved in, this is kind of what we have to do. And I
1060 think there are limited resources for them anyway to use certainly in hospital. There's
1061 nothing for them to do even if they wanted to

1062 **JT**: Yes, yes

1063 **Laura**: So their involvement in their own care is kind of limited really.

[Laura, Mental health nurse participant 11, lines 1055-1063]

The sense here is that service user involvement in nursing processes may be limited anyway. There may be a range of views about care responsibilities and user involvement practices, with mental health nurses expected to implement involvement strategies as part of their day to day work (Department of Health, 2006; Welsh Government, 2012). There are service users and their supporters, who view involvement in terms of partnership, democracy and justice, and such ideologies may be aligned with nurses' personal values (Mckeown, Jones & Spandler, 2014; Wright & Jones, 2012). However, despite increased guidance and legislation promoting user involvement, it is reported that user involvement levels in mental healthcare could be significantly improved (Grundy et al., 2016; Simpson et al., 2016b). Bee et al. (2015a) highlight that policy imperatives about involvement remain inconsistently implemented, and can be contested or diluted by more procedural or traditional practices.

Service user talk in my study varied about experiences of involvement. I asked one service user, Emlyn, a man I met at a third sector organization; whether he thought people were being more involved in their care plans nowadays.

811 **Emlyn**: Er…(5.0) They should be, but (3.0) a lot of them (4.0) are not involved
812 in their care plan to the extent what I am.

813 **JT**: Right. You're quite involved?

814 **Emlyn**: I am quite involved. If I want somebody there I tell them I want
815 somebody there, and they say you can't and I tell anybody who the bleeding hell
816 I have at my meeting.

[Emlyn, Service user participant 5, lines 811-816]

I had a sense from Emlyn, that he was talking about his care and treatment plan review meetings. It was also apparent from Emlyn's talk, and from Amy's and Brenda's narratives (Chapter 5), that some service users are more informed than others about service user involvement generally. All three of these service users spoke about going to information events and workshops about the Mental Health Measure. Service users being informed and knowing their rights potentially put people in a more enabled position. I asked Emlyn whether he thought lots of service users were like him in this respect, and he replied:

830 **Emlyn**: A lot of them have gone into hospital in the dark old days (…) and have
831 had the crap kicked out of them, haven't got the er…(4.0) forethought to say
832 enough is enough

[Emlyn, Service user participant 5, lines 830-832]

Historical concerns about mental health care have been reported by service users (Campbell, 2005; Taylor, 2015), and have similarities with Emyln's stance. Powerful cultures in traditional mental health systems often denied people a say in their care and treatment (Beresford & Wallcraft, 1997; Gilburt et al., 2008). Emlyn is referring to service users he knows who have experienced treatment with little choice, and although his reference to the 'dark old days' indirectly implies that things may have improved, his account is still one where he emphasizes that as a service user you have to fight your corner. A key element in user involvement is choice (Deegan & Drake, 2006; Elwyn et al., 2000). Yet choices about treatment and care are often situated within the context of politics and power relations, meaning that choices can be limited by particular contexts (Mckeown & Mercer, 2010). Bee et al. (2015a, 2015b) reported that user involved care planning was considered difficult to realize in practice, with extremely engrained nursing behaviours sustained through top-down, risk averse cultures which prevent meaningful engagement and are directly opposed to service user notions of hope and recovery. It is reported that service users often feel marginalised in the care planning process and are dissatisfied with care planning involvement (Grundy et al., 2016).

Equally, some service users have reported confusion about involvement in their care, with little notion of what this might actually mean for them (Storm & Davidson, 2010). Again, this has negative implications for mental health nurses working in a powerful system that may limit choice and involvement for service users.

In the next section I will draw comparisons with what participants said in research interviews in this study, and the wider literature on mental health care, to explore some potential explanations for limited involvement of service users in their care.

In Chapter 5 I reported how a nurse participant, Mary, said many nursing staff "won't really have an in-depth discussion with the patient" (Mental health nurse participant 1, line 767), and write care plans separately. Her rationale for this was:

771 **Mary**: when you know that they're that unwell, you kind of think, well, sitting
772 down and talking to me about a care plan was the last thing that they need

[Mary, Mental health nurse participant 1, lines 771-772]

Mary appeared to be arguing for making choices for the person without their involvement. Whilst there would be occasions when service users may be deemed too unwell to engage in meaningful discussions about their care, there are also too many examples of services users being excluded from these conversations (Coffey et al., 2017; Grundy et al., 2016; Simpson et al., 2016b). I also note Mary's continued use of 'they' which implies othering, a 'them and us' mentality, which perhaps reinforces the sense of a lack of partnership working.

Narratives about limited service user involvement were also apparent in nursing students' focus group talk, as students commented that "you don't see much of that" (Ruth, focus group 2 participant, line 1193). Students indicated their understanding about service user involvement was narrow, and that they had seen few examples of this

in practice. Inadequate staff knowledge and awareness on a topic usually indicates a training need. Limited evidence exists on the effectiveness of training programmes about improving service user involvement in care planning. One initiative has been a research partnership between the University of Manchester, the University of Nottingham and local NHS trusts who have developed EQUIP: Enhancing the quality and purpose of care planning in mental health services. EQUIP is a training resource for mental health professionals, delivered collaboratively with service users (Bee et al., 2015a; Bower et al., 2015). Emerging findings indicate that service user trainers, when asked to report imagined implementation of care planning from newly trained staff, perceived that success could be eroded by attempts at practice standardisation and service cultures (Brooks et al., 2015). These results suggest there is awareness in the service user community that despite increased staff training, powerful organisational cultures exist that can work against increased service user involvement in care planning (Fraser, Grundy, Meade, Callaghan & Lovell, 2017). More is required in terms of interventions to activate service users, a kind of preparation for participation, so that people can be fully prepared, discuss their expectations, and then acquire knowledge about how to be involved in their own care, if they wish to.

Whilst new legislation in Wales has promoted change in care and treatment planning, this does not mean that those changes will be enacted by staff responsible for making those adjustments. For example, according to the Code of Practice for parts 2 and 3 of the Mental Health Wales Measure, care co-ordinators are required to work collaboratively:

> "with the relevant patient and the relevant patient's mental health service providers with a view to agreeing the outcomes which the provision of mental health services are designed to achieve; ensuring that a care and treatment plan is developed and written"
>
> (Welsh Government 2012b, p.14)

Despite legislation and further supportive guidance, like Hafal's (2012) care and treatment planning information, it is apparent that service users' experiences of care planning vary; which was echoed in participant narratives in my study. Other studies,

such as Cusack et al., (2017) highlight that policy seems to be ahead of research. Cusack et al show that less than half their sample adopted a recovery approach six years after policy implementation that promoted these approaches.

Changing priorities and demands from policy drivers or service changes can result in nurses having many complex roles due to the high number of systems and types of work that they engage in (Hercelinskyj, 2010). Staff roles often change over time, with stakeholders having different expectations. For example, lay people may appraise professional performance in terms of outcome, whilst professionals tend to judge performance in terms of what was accomplished. Bittner (1965) recognised that there is a complex relationship between the members of an organisation, its rules and structures and practical action. Bittner's suggestion was that staff workers engage in their work or craft, and tend to employ a certain amount of flexibility in the process. For a worker there may be some reconsideration of meaning in terms of how work and jobs are applied and carried out. My understanding is that professional workers interpret directives in their own way and within the resources they perceive available to them to carry out their work in meaningful ways. Bittner calls this the gambit of compliance and suggests staff engage in some manoeuvrability in how they carry out their work. I am not suggesting this implies rule bending as such, I propose this is more about interpretation, and that staff will seek to carry out work that complies, or appears to comply, with organisational expectations, whilst at the same time suiting both themselves and complying with other aspects of organisational and professional rules. The relevance here for professional mental health nursing identities is that workers see themselves bound to targets and performance-related measures, and in this way may find themselves some distance from engaging relationally with people in order to support their well-being.

The Welsh Government set targets for all Health Boards in Wales that require valid care and treatment plans to be written within a set time period, with audits in place to measure the completion of CTPs, as well as service user satisfaction. In the Welsh Government's Duty to Review final report, it was stated that:

> "Initial service user satisfaction surveys reveal a significant majority of those receiving secondary mental health services are now aware of their entitlement to a CTP and a care coordinator and are more satisfied with the quality of their CTPs"
>
> (Welsh Government, 2015, p.4)

In my study I found that service users' experiences of CTPs were mixed and often less than positive, which is reflected in other studies (Coffey et al., 2017; Simpson et al., 2016b). Clinicians may find that they become focused on measures and targets for completing CTPs at the cost of fully involving people in care planning. Goodhart's law is worth noting in a situation such as this, in terms of something not measuring what it was meant to measure. Goodhart (1975) claimed that when a measure becomes a target, it ceases to be a good measure, which rather negates the notion that health service targets are there to improve care (Chrystal & Mizen, 2003). If staff are focussing on achieving targets it does not follow that the service experience is necessarily improved for service users. My interest lies in what this might mean for mental health nurses. If as neophytes individuals had idealistic views about working closely in therapeutic partnerships in a role that espoused a humanistic values-base, they may be disappointed to find themselves in a role laden with targets that are difficult to achieve. Ultimately if nurses find targets limit the humanistic interactions they imagined were part of the role, they may find themselves confused and dissatisfied.

Kelman and Friedman (2009) highlight that performance measures can result in unintended dysfunctional consequences. Dysfunctional consequences might include effort substitution (like reducing effort on non-measured work), or gaming (by making effort on the work measured appear better than it may be). For example, care co-ordinators may make efforts to ensure that all service users on their caseload have a signed CTP, but it does not necessarily follow that the service user has been fully involved in a collaborative discussion about their treatment. Brenda, in Chapter 5, emphasised that "communicate doesn't mean tell. It's about dialogue" (Mental health service user 3, line 876). It has been noted by Barrett and Linsley (2017) that care planning has become overly focussed on managing problems, with staff concerned with risk-averse practices, and limited time on collaborative dialogue.

Bradley (2015) proposes that professional workers take a more radical approach involving service users as active agents, with workers relinquishing power and control and focussing on a more facilitative role. With several authors encouraging a partnership approach (Barker, 2008; Grundy et al., 2016), it raises the question why professional staff appear to be steering away from this. Simpson et al. (2016b, p.13) reported that some care coordinators said they had 'always worked in a recovery-focused way, and what hindered them were organisational targets and issues such as adversity to risk, documentation, limited resources, and 'firefighting' (i.e. responding to emergent priorities)'. There seems to be a notion that whilst one thing needs fixing in one part of a service, that attention paid to that can throw up a problem somewhere else. So as policies direct front-line workers to adhere to targets, so their work focus moves to accommodate that, resulting in further role and work changes. Continual shifts are not helpful to the overall patient experience or indeed to the workers' sense of job satisfaction. Equally role shifts may add further confusion to mental health nursing identities as what individuals imagined the role might involve may be very different in reality. One mental health nurse participant, Laura, voiced her views and dissatisfaction about what she perceived the nursing role had become, and how this contrasted with her expectations.

592 **Laura**: we can't do anything (laughs), because everything we do, we're just like
593 a - a coordinator really of everybody else (…) Occupational therapists,
594 physiotherapists, doctors, social workers. They're the ones that have the kind of
595 proper roles and it seems to me the nurse in the middle just kind of (3.0)
596 coordinates it. (…) Which is like an administration role (…) It's strange to me,
597 to have gone through university for three years to be in that kind of position.

[Laura, Mental health nurse participant 11, lines 592-597]

During the research interview with Laura, she situated her professional identity as a nurse quite negatively, voicing that the role was not what she thought, and how she was actively engaged in pursing a different career outside of nursing. My findings here are similar to a study by McCrae et al., (2014) who reported dissonance verbalised by nurses that they saw the profession as having relatively low status. Nurses said they felt socially and intellectually incompatible with the nursing culture, and their image of the

profession was tainted by contact with nurses lacking in morale or motivation (McCrae et al., 2014). Laura's interview talk had similarities to McCrae's participants, in that due to her negative experiences of mental health nursing, she was keen to distance herself from the role, and was seeking another work identity.

If nurses, such as Laura, consider the nursing role to be more about administration and coordination, this suggests limited scope for working collaboratively with service users. I have already stressed how nurses spend much time apart from service users to complete administrative aspects of their work, regardless of whether this is a need for solace in the office. In her interview talk Laura did not consider mental health nurses to have much independence or power of their own. When considering the literature about service user involvement, much is written about the concept of power (Felton & Stickley, 2004; Hodge, 2005). Inequity of power is evident between service users and professional workers in terms of language, jargon and accessibility. For example, service users do not have access to systems, policies and the workings of the healthcare establishment. Therefore service user involvement in nursing processes may be limited for many reasons. My findings from what nurses and service users said about mental health care indicates that social systems are implicated as responsible for tensions in the delivery of truly involved and user focused services.

Collaborating with service users involves workers sharing or giving away some of their power (Stenhouse, 2013; Stickley, 2006). If nurses are to engage service users in true involvement, they will need to consider the transfer of power to service users. Nurse participants in my study showed awareness that they had power in relation to service users, and that this was a flexible commodity where they had influence. Hui and Stickley (2007) highlight that service user involvement has implications for the role of the mental health nurse, and suggest nurses need to be aware of potential conflicts in managing their practice. For example, service user involvement in nursing processes may occur by invitation, by coercion or through encouragement and informed choice. I suggest that service user involvement activities are subject to the whims and agency of professional workers who may promote such pursuits, or equally who may limit them. Several participants in my study talked about power, an example from my data would

be from Amy, Mental health service user participant 8, who talked about nurses "pushing power on us" and an "over exertion of power", which is evident in her narrative about experiences in both hospital and community settings. Certainly nurses can be considered to have power by service users. However, when comparing nurses' power, perceived by Laura as rather limited, I am unsure whether nurses consider their power to be of value, and whether it is sufficient enough to transfer and share with service users in the first place. If nurses see their own power as limited, they may be unwilling to part with it.

Sines (1994) suggests that few managers and nursing leaders have appreciated the complexity of the task involved in moving from a professional led service to one that is based on a true sharing of power between service users and professional workers. Although there have been two decades of user involvement activity, many obstacles to real participation still remain, such as the use of jargon, hierarchies and a lack of support (Basset et al., 2006; Tee, 2012). The participants in my study who prioritised service user involvement as a topic in their talk were generally the services users rather than the nurses. Being involved in their care decisions was presented in service users' talk as being important to them. Some service users like Amy and Brenda who were aware of their rights around care and treatment planning in Wales, had expectations around involvement in care plan discussions. Others, like Judy (Mental health service user participant 2), had no expectations about being involved, but voiced satisfaction at working collaboratively and having a say in her plan of care.

The mental health system exudes a history of power and control, and with policy initiatives increasingly promoting a shift in power to consumers this creates a tension for those providing and receiving services (Busfield, 1986; Campbell, 2005). I sought to explore how mental health nurses viewed service user involvement as part of their roles and professional identities, and found their talk on this was limited. Greater involvement by service users suggests they will need to take increased responsibility for their own health and well-being, and that nurses may need to work more democratically, rather than trying to exert power over service users. Literature has indicated that the quality of user involvement in care planning could be significantly improved (Fraser et

al., 2017; Grundy et al., 2016), despite legislation and guidance promoting these activities. Complexities in social systems like healthcare, and the agency of street level bureaucrats are factors in the actual business of involvement and how and whether it is implemented and experienced as a real commodity by service users. Performance measurement and target setting do not necessarily capture the reality of service user involvement on the ground, as staff may work to pursue goals that do not relate to the actual service user experience of collaborative conversations about their care. Service users being involved in their care unsurprisingly seems to be more of a priority to the users of services that those working in such services. In the next section I will explore my findings from Chapter 6 about mismatched expectations in relation to mental health nursing and service user involvement, to highlight powerful cultures that exist in practice, and mixed messages about what mental health nursing work might involve.

7.4 "I just thought I'd be more with patients, and that's what I hoped": mismatched expectations about mental health nursing

In this section I will explore mismatched expectations that were reported by participants in my study. I identified in my findings that mental health nursing students had expectations of what the nursing role would be like, only to find frustrations and disappointment with existing powerful health service cultures. I also found that mental health environments that promote control and compliance militate against involvement practices. I am going to argue that this means mental health nurses have rather been set up to fail, as the principles of involvement are polar opposite to practices that include coercion, power and control.

According to Weimer (1975), issues relating to inference and expectations relate to learning and knowledge, and people's understanding is therefore positioned within the psychological sciences (for example, cognitive, social and health psychology). Weimer suggests that in order to understand expectations, that we learn more about the organism (or person) that does the perceiving, in order to understand how they acquired their knowledge. Meaning is created in the mind (Resnick, 1983) as a result of interaction

with the world (Saunders, 1992) which can be used as the basis of future expectations. I have shown from my findings in talk of participants in this study that expectations appear frequently in peoples stories. In relation to this study I was interested in hearing what people said about mental health nursing, including their expectations in relation to this.

Mantere (2008) states that role concepts are defined by the totality of expectations directed by others towards an individual (Linton, 1936; Turner, 1978) within a social structure (Katz & Kahn, 1978). In the research I have conducted for this thesis service users reported expectations of what they expected from those in mental health nursing roles, and mental health nurses also had expectations about what to expect from the role and work they were cast into. Mantere (2008) argues that role expectations have the potential to both enable and constrain strategic agency of individuals, and participants across my study highlighted this in their talk, which I will discuss further in this section.

I have shown how nursing student narratives of their experiences on placement did not meet with their expectations of the mental health nursing role. For example, nursing students spoke particularly about the direct contact they had with service users on placement being the most satisfying aspect of their work, which indicates their values centred on compassion and care. These findings are similar to Nolan, Haque and Doran (2007), who added that administration was the least satisfying aspect of the role. In the third year focus group, one participant did state: "I just thought I'd be more with patients, and that's what I hoped" (Helen, participant 4, focus group 1, line 119). Helen's talk implied that other aspects of nursing work have come to intrude on time spent in the company of patients. In terms of professional identity performance, Helen's talk implied that she would rather be a nurse who spends lots of time with service users, and this was her expectation at the start of her nurse education. I suggest that many nursing students as they enter the socialisation process experience similar views, only to find that as they become second and third years and move through the socialisation process, that they realise far more what is involved in mental health nursing work. The same could be said of neophytes entering any profession. Indeed it was the third year nursing students who spoke most about power out of the three focus groups, and their

growing awareness that existing cultures that promoted coercion and control were evident in the mental health nursing cultures they experienced on placement.

Concerns raised by these student participants were that they perceived a powerful institutionalized nursing culture with which they said they were expected to comply. The pressure to comply, also highlighted by Semmelhack et al. (2015), seemed to focus on the need to get a job. However, these institutional cultures are highly conservative and resistant to change. Existing staff are highly attuned to likely effects of outsiders and engage in routines and rituals designed to socialise and assimilate threatening outsiders. Workers in these systems act as the boundary managers, or 'moral entrepreneurs', according to Becker (1963). The incentive of fitting in to secure a job is a powerful one in most cases, and sufficient to gain compliance from the majority. Nursing student participants construct mental health services as environments which respond with hostility to potential challenges from external sources. These responses are not confined to students however and even newly qualified nurses who fail to assimilate are the subject of strong coercive powers such that there is a sense in which they lose sight of their personal identities in an attempt to fit in.

In Chapter 3 I highlighted a comment from one service user in a third sector organisation who remarked about nursing students:

> 'It's like taking all that enthusiasm and dropping it into a pond full of apathy'.
>
> (Anon)

His talk implied that students were likely to have negative experiences of existing nursing cultures. Hercelinskyj (2010) suggested there is a reported mismatch between contemporary role expectations placed on mental health nurses and their own personal and professional role expectations, which can negatively impact upon their workplace experiences. For example workplace conflicts, implementation of rules, and expanding roles. As nursing students would not have worked as mental health nurses before, I surmise that their role expectations were based on information gleaned in university settings, acquired during previous placement experiences and/or their exposure to media influences. If nursing students have limited knowledge of the role they are training for,

or being socialised into, it is likely they will experience some surprises if they are unaware of the work involved. There is work here for universities and service organisations in terms of promoting accurate and appealing examples of mental health nursing that feature positive role models and inspiring stories to encourage applications to study nursing.

The socialisation journey for nursing students is significant as they start with expectations of spending direct one to one time with service users, but voice an awareness of powerful existing cultures they feel bound to comply with. This was evident not only in nursing students' talk in my study, but also from mental health nurse participants. For example, Ann, who had been qualified for 11 years at the time she was interviewed, reflected on her early days as a qualified nurse:

> **Ann**: they [other ward staff] could make life very, very difficult for you, erm and that's very hard to …it's very hard to hold on to who you are in that environment because you desperately…when you're newly qualified you want to fit in

[Ann, Mental health nurse participant 2, lines 660-663]

Nursing staff, like Ann, showed an awareness of a covert curriculum in practice settings. Neophytes are encouraged to engage in the status quo, 'the way we've always done it', acutely aware that fitting in is easier that being different. Institutionalised cultures such as these may inhibit a new graduate's development toward a more holistic, individualized, patient-oriented philosophy of nursing care. Tensions of this nature are likely to shape nursing students' socialization into the nursing profession, and result in a mismatch of their initial expectations about what mental health nursing might involve.

Mismatched expectations were also apparent in Ben's story, as he described comparing his role as a CMHN in two different CMHTs. Ben highlighted service users' expectations sometimes related to the way in which previous nurses had engaged, with the example that one service user hoped Ben would dig a hole in his garden because "that's what the last CPN did" (line 880). Other mental health nurses in my study

highlighted their experiences too in that people generally had limited knowledge about the work that mental health nursing might involve.

> **Ann**: I've seen perceptions that other people have of mental health nursing. You know mental health nurses sort of hang around and have a chat with the patients and play pool with the patients, don't really do anything beyond that which is kind of erm bizarre really.
>
> [Ann, Mental health nurse participant 2, lines 58-61]

These comments are an interesting contrast with the service user accounts saying nurses are too busy to spend time with them. Nurses' perceptions of their roles and how others experience that may be at odds with each other. The professional identity talk of nurses in my study worked as a means to establish their version of a mental health nurse identity. Ann is presenting this category as an alternative candidate category of what it is to be a mental health nurse, but only to then reject it. This acts as a powerful rhetorical device because it shows her as the speaker to be aware of other versions, and that she is then able to reject them. Her declaration of what it is to be a mental health nurse can then be seen to be a much stronger one as she has shown she has considered alternatives and rejected them in favour of her own more thoughtful version. Yet service users' expectations about mental health nursing work are perhaps more in line with this version, in that spending one to one time with people on an equal footing is exactly what service users want.

Mental health nurses as a group need to be more vociferous about their roles to better inform the public about their work. Such activities would raise awareness about what mental health nurses do. A recent review in England of the mental health nursing profession stated that 'nurses must be more resolute when it comes to shaping their own future through active engagement in policy' (Butterworth & Shaw, 2017, p.23). Reasons for nurses to be more active relate not only to an uninformed public, but also a concerns about potential recruitment into the profession. Unfilled nursing vacancies remain at 13% (National Quality Board, 2017), and there are marked changes to the financing of pre-registration nurse education, with students in England now self-funding, as opposed

to having the opportunity to access commissioned places. There is a real danger here that there will simply not be enough nurses to meet service users' needs, which would put considerable pressure on those currently working in these roles.

Whilst my study has sought to examine the taken-for-granted aspects of mental health nursing roles by using an ethnomethodological lens, participants spoke vociferously about mismatched expectations in their narratives. I am suggesting that for all parties involved in the delivery and receipt of mental health services that information and clarity need much attention. Mental health services have been shrouded in mystery for many years, evident by an uninformed general public who have limited knowledge about mental health generally. If people do not know what to expect from services and from the professionals who work in those services, this indicates that service users are in a weak and uninformed position with limited power at the outset. Equally those entering the profession of mental health nursing often do so with limited knowledge of what the role might involve. Entrants can then be subject to powerful institutionalised cultures that seek to grow and nurture neophytes into the same mould as themselves, thus reducing the threat of change and maintaining existing power structures leaving service users at the bottom of the pile. Service users themselves have experienced 'them and us' cultures and often do not expect anything other than more of the same. Even the implementation of policy and legislation that promotes involvement has had limited effect on care experiences. One service user, Judy, had negative expectations of mental health nurses. She had expected to be on the receiving end of nursing interventions that were prescriptive and controlling. Her story, presented in Chapter 6, described how a new CMHN facilitated interventions that Judy found enabling and which encouraged her as the service user to take the lead, which Judy found "exceedingly helpful" (line 39). These stories are refreshing, but generally are in the minority as service users' stories in my study frequently stressed how they wished to be more involved in their care, and were concerned by nursing attitudes that prevented them having a voice.

In terms of expectations, we might expect the majority of service users to be interested in being involved in their care, and certainly for that care to be of a high quality with visible interventions and regular time with staff. In terms of saving face, as Goffman

(1959) would suggest, we might expect that nurses would say they seek greater collaborations with service users, but are limited by time, tasks and a pressure to meet organisational targets that detract from meaningful engagements with service users. Nurses therefore can say and do different things and by pointing at organisations is a useful way of avoiding personal accountability for minimal service user involvement in nursing processes.

As nurses meet service users in their subjective worlds, it may be unsettling for nurses who thrive in personal and professional paradigms that are characterised by feelings of competence and being in control (Reynolds, 2002). There are a number of reasons then that work against nurses engaging service users in collaborative care partnerships. Service users' frames of reference are generally experiential, and unless well informed about rights and choices about involvement, service users tend to be isolated from one another, and are therefore subject to the explanations and guidance of workers who have powerful individual agency (Lipsky, 1980). Street level bureaucrats, Lipsky argued, may adjust their work habits by processing people in a routine manner within their corrupted world of service. Professional workers are said to find work situations uncertain, as they struggle with inadequate time to meet limitless needs (Hill & Hupe, 2014). Workers are often subject to oppressive social systems, and in the face of such adversity can only hope to achieve best work under the circumstances (Lipsky, 1980). This absolves the responsibility of workers to change the status quo, which suggests levels of service user involvement may not change any time soon.

7.5 Conclusion

Mental health nurses as a group may feel that their professional identity is under threat, in that the collective they belong to has struggled to articulate and evidence their contribution and effectiveness to mental healthcare. In this way mental health nurses can be considered a group of workers whose identity can be threatened and devalued (Emerson & Murphy, 2014). This study explored talk about mental health nursing, in a policy and practice climate that promotes service user involvement. Mental health

service delivery has been linked with coercion, power and control (Foucault & Howard, 1967; Goffman, 1968; Szasz, 2007). Opposition to the notions of coercion and control can be found in practices that promote recovery and service user involvement (Molkenthin, 2016). However, the extent to which true service user involvement is workable in a system that promotes detention and compliance is challenging. It is important that mental health nurses consider the imbalanced power relationships that exist in mental health environments in order to develop their confidence and competence in involvement practices.

Nurses themselves talked about being trained to work in a system that expects compliance, is bound by organisational targets, and has a focus on safety and risk. With the medical model and task-oriented approaches still a force to be reckoned with, engineering change may prove to be an uphill struggle. From participants' talk in my study, in the main service user involvement in nursing processes does not appear to be a compelling part of nurses' identity. Whilst there are certainly pockets of good practice in terms of how mental health nurses work in partnership with service users, even with legislation it does not translate into everyday talk about established working practices. Attempts to measure service user involvement, certainly in care planning, appear to be failing as there is little evidence of research into actual collaborative ways that care actually occurs. Evidence shows that ticking boxes and meeting targets are still the order of the day, which in turn leads to service users expecting little else from professional workers. Ways to instigate real change would be to raise awareness about what mental health nurses can offer to people who use mental health services, and for service users and nurses to work together more collectively.

Nurses and service users talked about nursing work often being task-focused, resulting in limited time spent by nurses directly with people using mental health services. Nursing staff can be influenced by powerful existing cultures, as well as the pressure to meet targets and quality standards. Pressures of this nature may result in a re-focussing of mental health nursing work. Nursing students voiced limited knowledge and experience of how nurses engage in involvement activities in practice. Equally, service

users reported unsatisfactory experiences of involvement and reported dissatisfaction when their expectations of mental health nurses were not met.

Service user narratives have reported time and again that they want more time with nursing staff, yet nurses seem unable or unprepared to give this. Nurses have appeared unconfident and distant to service users, separating themselves from the needs of those they serve. If nurses are unprepared for their role and how to work both therapeutically and in partnership with service users, this rather points a finger to educational settings and how nurses are prepared for their roles. Equally, practice settings that maintain engrained routines and strong powerful cultures resistant to change need to re-focus their work in order to benefit both service users and staff alike.

I have argued that the performed identities of mental health nurses show evidence of how mental health nursing roles and professional identities are handled in peoples' talk. It is important that nurses can more confidently articulate their roles to demonstrate their contributions to service users' care. These vocalisations may assist mental health nurses in strengthening their professional identity and in turn impact upon challenges relating to recruitment, multi-disciplinary working and confidence. However, it appears there is some way to go before service user involvement in nursing processes is talked about, and is realised as a central part of mental health nursing practice.

Chapter 8: Conclusions

8.1 Introduction

In this final chapter I begin by providing a summary of the study. I argue that mental health nursing practice is largely task-focused with nurses spending limited direct time with service users, that an imbalance of power exists in nurse patient relationships, and that there is a separateness between nurses and service users, with little evidence of user involvement practices occurring. I then follow this with the contributions of this thesis in relation to knowledge, and mental health nursing and service user involvement literature. I then discuss limitations of this study and follow this with implications for education, practice, and further research. Finally I reflect on the benefits and challenges experienced during my doctoral student journey before concluding.

8.2 Summary of the study

Taking an ethnomethodological approach to this study has helped me to explore the meaning making in talk about mental health nursing and what this says about service user involvement in nursing processes from multiple perspectives. Mental health nurses' professional identities are personalised in the language that nurses use in how they describe, explain and account for who and what they are in the world of healthcare (Leishman, 2003). Nurses have reportedly had difficulty articulating their roles (McCrae et al., 2014; Rungapadiarchy et al., 2004), which may have impacted on their professional standing in multi-disciplinary teams, as well as public expectations about nursing roles. Mental health nursing work includes activities that are both visible and invisible, and the more nuanced of these, such as 'how' mental health nursing is accomplished, may be a challenge to convey to both service users, team members and the wider public. Policy changes require professional workers to involve service users collaboratively in their care, which involves revising previous working practices whereby professionals were considered to be in a more powerful position to service users. Service user involvement in care involves collaborative conversations with

people using mental health services, usually achieved through the therapeutic relationships that nurses have developed with service users over time, based on empathy, respect and trust. Service user involvement in care planning is legislated in Wales, so it is a reasonable expectation that service users can assume increasingly collaborative approaches from mental health nurses who are assigned to their care. The agency of patients has changed over time, with service user movements and policy directives meaning that patients now have increased agency and power. Service users will have background expectancies of mental health nurses (Garfinkel, 1967), and such expectations may relate to how service users can expect to partner nurses in care discussions. For example, service users may expect mental health nurses to spend regular one-to-one time talking with them. However, nurses are subject to organisational pressures and targets set by the very Government who have written service user approaches into statute. Despite the mandatory nature of service user involvement in care planning, nurses themselves may find this is just one area of practice along with a tranche of other requirements on which they are expected to deliver.

The study on which this thesis reports is about how mental health nurses and the people they work with talk about mental health nursing professional identities and what this says about service user involvement in nursing processes. Service user involvement in mental health care planning is often reported to be at low levels in the literature (Grundy et al., 2016; Simpson et al., 2016b); with service users reporting low satisfaction and limited engagement in the process. Service users in my study echoed such findings, and highlighted in their talk that their voice was often not acknowledged. Equally mental health nurses themselves spoke little about service user involvement, and, based on their talk, involvement seemed to be a negligible part of their role.

In this thesis an account of the research approach and governance arrangements have been presented. A rationale for an interview study of accounts was discussed, which included my intention to explore the meaning making in people's talk from multiple perspectives about mental health nursing. Findings from 30 audio-recorded and transcribed individual interviews and 3 focus groups were described.

My findings make visible that mental health nursing in inpatient settings is reportedly largely task-focussed with nurses spending limited direct time with service users. Nursing students, as social actors in mental health care environments, voiced limited knowledge and exposure about how nurses engage in service user involvement activities in practice. Having indicated their limited experience of involvement, they stressed feeling compelled to go along with practices that appeared to work in opposition to this. Displays of understanding in participants' talk about mental health nursing work indicated the existence of powerful nursing cultures that included distance and separateness from service users and perpetuated limited service user involvement in nursing processes.

In the three data-based findings chapters the professional identity of mental health nurses was examined. My findings were presented with notions of mental health nursing work, followed by the context of service user involvement and finally mismatched expectations about mental health nursing. People's talk functioned to show that strong institutionalised cultures continue to exist in practice, which maintains a status quo of often powerful staff, working against collaborative working practices in which service users might have an increased voice and involvement in their care. This final chapter focuses on the original contributions of this thesis, as well as implications for mental health nursing education, practice, and further research.

8.3 Contributions of this thesis

The findings provide a detailed picture about mental health nursing roles and nursing work. A distinct feature of this study has been the inclusion of talk from multiple perspectives. Accounts from mental health nurses, nursing students and service users have been made visible and enabled the study of competing versions of accounts from different stakeholder groups. People's narratives are positioned to do work for each speaker. As I examined the meaning making in participants' talk I was able to consider

how it is that different participant groups experience mental health nursing practice, what maintains it, and how challenging it may be.

The findings contribute to a body of research into mental health nursing and service user involvement in nursing processes. Research studies in mental health nursing to date have examined what service users want from mental health nurses (Bee et al., 2008; Stenhouse, 2009), what the roles are within mental health nursing (Brown et al., 2000; Fourie et al., 2005), and how involved service users are in their care and treatment planning (Grundy et al., 2016; Simpson et al., 2016b). However, there has not been specific research into how mental health nurses account for service user involvement as part of their roles and professional identities. As such, this study provides additional insights into aspects of mental health nursing, as well as notions and practices about service user involvement.

The talk of mental health nurses was concerned with busyness and task-orientated work. In terms of how people talk about their work, it has been through the medium of participants' narratives in my study that I have been able to examine professional identity-relevant talk and the function it is put to by speakers. Nurses indicated separateness from service users in inpatient settings, with mentions of extended time spent in the office. Nurses ascribed to identities of being task completers and care co-ordinators, but spoke little about involving service users in care and treatment approaches.

The findings of this study indicate a mismatch in the perceived expectations of participant groups in my study. Nursing students expected to learn in placement settings with caring staff, but reported a climate of powerful existing cultures, and expectations that they comply with existing practices in order to fit in. Service users expected to spend one to one time with nursing staff, and for their voices to be heard, but found their expectations of nursing staff were frequently not met. Nurses themselves did not appear to recognise that service user expectations were not met, and were concerned with tasks at hand and meeting targets. The limited mention of service user involvement

in nursing processes indicated that this notion and practice was not particularly important to nursing staff. However, there were examples from service users of stories where they were more involved in their care, which they found unexpected and welcome in terms of their recovery.

These findings suggest that mental health nursing work needs to focus increasingly on engagements with service users, by spending time with people and involving them more in their care and treatment. These notions are not new and other studies have highlighted similar concerns (Peplau, 1988; Stenhouse, 2009). It is perhaps the changes in nursing work and the increasing attention on risk that has led to a shift in focus. In the main it was nurse participants in my study who spoke about risk assessment and safety, as they indicated awareness of their responsibilities in this regard. Similar findings about a risk focus have been reported previously (Coffey et al., 2017; Godin, 2004), with organisations focusing more on safety and control rather than the consumer experience of care.

Professional identity may be regarded as a process through which an individual comes to have a sense of themselves (Wiles, 2013). As with other professional roles, the notion of identity stresses dynamic aspects, some of which may centre on 'who I am' and 'what I stand for'. This begs the question whether those becoming mental health nurses have the opportunity to really explore their values and developing sense of identity during nurse preparation.

An increasing number of studies have identified low levels of service user involvement in care planning by mental health nurses (Coffey et al., 2017; Grundy et al., 2016; Simpson et al., 2016a; Simpson et al., 2017). Little attention has been paid to mental health nursing identity in this context. If nurses have limited notions about the values and practices of involvement, they are unlikely to create a mental health nursing philosophy of involvement (Hui & Stickley, 2007), or assimilate such approaches into their professional identity. Nurses need to have increased understanding about the contentions within their roles in terms of caring and controlling aspects, and more

awareness about power differentials and practices that can ameliorate against collaborative working.

This study has shown for the first time that the notion of service user involvement in nursing processes does not feature highly in professional identity talk of mental health nurses. The everyday practices of mental health nurses tend to focus on a demonstration of getting their work done and completing tasks and targets. Service users highlighted that this seemed to be at the expense of time spent with those requiring nursing care. Nursing students showed limited understanding about user involvement, but had awareness that there were limited role models available for them to witness and learn about such practices first-hand. There was also an indication that nursing students and newly qualified nurses with enthusiasm for involvement approaches may be at risk of being negatively influenced by existing powerful cultures with pressure to conform to, and to maintain the status quo.

8.4 Limitations

During the course of this study I have become aware of a number of limitations. In this section I focus on three limitations that relate to the authenticity of accounts, geographical context and my own part as the researcher.

First, I am aware that talk produced for the purposes of research interviews (and focus groups) is just that, and whilst interactional, cannot be considered as naturally occurring conversation. People tell their stories for a particular reason and, according to Reissman (1993), seek to engage the listener, as they are pulled in to the teller's point of view. Some caution is needed then as narratives need to be viewed as people articulating a particular version of themselves and events, and experiences that the narrator orientates towards. In terms of authenticity, I could have considered an approach that included elements of ethnography, such as participant observation in the field under study. However, I was concerned that studying naturally occurring talk for this study may be

difficult to achieve. Attempting to observe mental health nurses 'doing' involvement or having collaborative conversations may have been difficult to observe in terms of timing and would also have been ethically intrusive for service users, with myself as an outsider present. Not all involvement conversations are planned, and if they do occur, may occur spontaneously, so if I had spent observation time in a ward or community setting it would have been difficult to know if and when involvement activities or conversations were likely to happen. Equally, it can be difficult for researchers to know when activity is being performed for their benefit, in that observed nurses may have performed involvement practices in ways they do not usually do so.

During this research I have studied how people talk about mental health nursing and what this says about involvement. I have achieved this by exploring the meaning making in participants' talk. I am aware that what function talk achieves and the background context are important, rather than stories being taken at face value with the bigger picture ignored. Therefore rather than considering the findings from such talk as a way of unearthing people's understandings, this interactional talk needs to be viewed as situated and produced for the purposes at hand (Antaki, Condor & Levine, 1996). This however does not devalue how people talked about the subject in question.

Second, in terms of location it could be argued that the study was carried out within one small region of the UK, which may reflect bias in terms of culture and local context. If I had asked different individuals or included other regions of the UK potentially participants' talk about the subject may have been different. However, previous studies about mental health nursing roles (Crawford et al., 2008; Stenhouse, 2009) and service user involvement in care planning (Grundy et al., 2016; Simpson et al., 2016b) which have been conducted in different geographical areas, have reported findings that resonate with this study in terms of service users having limited time with nurses and reduced opportunities for involvement in their care.

Third, as the researcher I have played my own part in the interactional occurrences of talk in this study. I was conscious of my dual role at times not only as researcher, but as

lecturer and link tutor, and that I was known to a number of participants. My own words, pauses and body language would no doubt have influenced the talk of others, but it is impossible to disentangle my impact on the narratives that were created. I have therefore included some of my own talk in the presentation of data, although it is impossible to make my presence fully visible to the reader. Furthermore it is a challenge to avoid my own biases and prejudices from entering into my analysis, although I sought to minimise these with regular supervision and by engaging in my research log writing and reflections.

8.5 Implications for education

The findings of this study indicate that nursing students had limited knowledge about service user involvement principles and had witnessed few examples of how to 'do' service user involvement in practice. Equally they indicated few ideologies about involvement in their emergent professional mental health nursing identities, and at times leaned towards notions of othering, reinforcing a sense of them and us. These findings indicate there is much work to do in nurse education settings in both the classroom and practice areas, in order to challenge students' views, encourage a growth in self - awareness and reflective activities, as well as a need to develop skills to enable increased partnership working.

Increased focus on service user involvement in nursing processes throughout pre-registration nursing curricula will go some way in increasing nursing students' knowledge about the principles and practice of involvement. Whilst universities may already demonstrate examples of such initiatives, these can often be pockets of good practice rather that involvement as an embedded culture in education programmes.

Education providers are required by regulators to demonstrate how they are doing service user involvement in programmes from student selection, programme planning and delivery through to evaluation. Universities may have examples of involvement that

students have evaluated well, but frequently opportunities to engage in and experience involvement are generally limited. Regulatory bodies and commissioners give little guidance about involvement practices, which is one reason why the growth of user involvement in education has been slow.

Greater focus on increasing students' awareness about involvement in practice is vital, so ensuring involvement in university settings first would set a strong precedent. This can be achieved through the regular involvement of service users across modules, in classroom teaching and across a range of educational activities. Service user participants in this study suggested service users be regular visitors to classrooms and be involved routinely in student learning. Activities such as practising how to have involvement conversations with people who use services and hearing from people about how they want to be involved in care and treatment planning would go some way in developing students' knowledge, as well as positive attitudes towards collaborative working.

Equally some existing educators themselves may have limited understanding about involvement, and may be anxious or unwilling to share educational activities with service users. Similar to practice, such sharing would involve the re-distribution of power, with educators needing to relinquish some of their own power.

Furthermore students themselves need to be prepared for involvement to ensure their own participation and engagement. Preparation activities at a foundation stage, in terms of what is required from a mental health nurse with strong collaborative skills, would go some way in increasing awareness about the development of professional mental health nursing identities. Students also would need increased self-awareness and to develop resilience mechanisms to manage themselves in practice settings where institutionalised practices exist.

Students need exposure to notions about practice pressures, policy directives, and competing versions of how to be a mental health nurse. Educators and practice staff

may need to draw attention to these for students, as they attempt to learn how to balance the requirements placed on them. The advantage of including the priorities of service users into curricula as an on-going theme means it is more likely that students will continue with such practices in placement settings and beyond. The Nursing and Midwifery Council included little focus on service user involvement in their proposed standards for nurse education (NMC, 2017a). However it will be for each education provider to determine how they address service user involvement in education settings. This suggests that how service user involvement occurs in nursing education will continue to occur in an arbitrary fashion.

8.6 Implications for practice

Currently half of nursing students' pre-registration programme time is spent in clinical practice settings. If students encounter role models who see involvement as a significant part of their role, and can articulate this work to students, this may go some way in demonstrating and communicating the importance of involvement. Opportunities to practice involvement in care planning under supervision would be a beneficial learning experience. Whilst some practice staff already include such opportunities, there is evidence that such practices are tokenistic (Simpson et al., 2016b). Feedback from service users to students about their experiences would increase student learning about what is wanted. Feedback from mentors would inform students of organizational requirements as well, so students can gauge a balanced approach and seek to involve service users in meaningful ways, and not just tick a box that indicates user involvement has occurred, albeit in a tokenistic fashion.

Despite training initiatives to improve user involvement practice in care planning, such as those developed with EQUIP (Bee et al.., 2015a) which have involved service users in their delivery, there is limited evidence of improvement. Therefore to suggest further training seems rather simplistic, when it comes at a point when clinicians have well established practices and may be resistive to practice change. Equally nursing staff already voice concerns about heavy workloads, achieving targets and meeting service

users' needs with often limited resources. Including involvement practices in legislation in Wales appears to have made little difference to the ways that nurses work with service users around care planning. This suggests that practice staff may benefit from increased awareness about their own part and agency in social systems, as well as being cognizant that they have the power to influence change.

It is cultural change in mental healthcare settings that appears to be needed most. Only by continuous direction to staff about users' expectations and by increasing awareness about involvement with service users can we expect to see significant practice change in how service user involvement in nursing processes occurs. Equally this is not about nurses 'allowing' service users to be involved, this is about genuinely working alongside people so they can steer the direction of their own care. Change can only be achieved with nurses and other professional staff working in new and innovative ways with a range of individuals and agencies, by being increasingly political about the importance of service user involvement, and by increasingly advocating for involvement.

8.7 Implications for research

This study will be of interest to mental health nurses, educators, service users and the wider mental health community. Further research is required into service user involvement in practice and education settings in order that people understand how to do involvement well. At times it can be difficult to see how and why involvement practices are so limited, yet being aware of challenges and solutions can significantly help those involved to increase the quality of involvement for all.

Focused studies that examine the impact of true service user involvement might go some way in identifying how these practices are achievable. It is crucially important for mental health nurses to develop their skills and knowledge around involvement in order

to discuss these activities and practices with service users and their families, students and wider staff networks.

An increasing focus on inspections and audits often reveals both positive practice as well as areas of concern. The methodology used is likely to be key. I suggest approaches that clearly document how user involvement occurred may be more reliable than a tick box approach. Further research around inspection and audit may reveal not only a picture about involvement in practice, but also the effectiveness of such practices, and whether changes are maintained over time.

Researchers and professional workers are aware of the ever-powerful health, social care and political structures in which care takes place. Just as the old asylums stood large and dominant, still now many imbalances of power are evident. It is these practices that need further investigation in terms of what maintains them, such as why staff may be reluctant to give up tasks over working in partnership with service users. Changing climates would involve dismantling risk adverse cultures and long-standing powerful constructs of mental health services built on notions of coercion and control. These ideologies conflict with service user hopes of recovery, and those who want to accompany service users on their journeys towards increased well-being.

This study offers new knowledge and understanding about mental health nursing and service user involvement. The findings suggest further exploration of mental health care environments and nursing practice are required in order to consider reasons for the maintenance of approaches that perpetuate an imbalance of power in relationships with service users. Further insights into mental health nursing cultures and practice would provide the opportunity to explore solutions as to how approaches that promote service user involvement might be developed and sustained.

8.8 Benefits and challenges during my doctoral journey

I have found the process of PhD study to be inspiring and challenging. The variety of activities involved in research requires the development of a plethora of skills and as a novice researcher I have enjoyed engaging in a range of opportunities that improved my learning. Early insights from individuals in local service user groups as well as people I met during my Florence Nightingale Travel Scholarship were invaluable in developing my initial thinking about this study. Having the opportunity to engage in a long term research study on a topic relevant to my day to day work role has been extremely pertinent, and has helped me to reflect on involvement practices along the way.

I have benefitted from study opportunities that have improved my research skills and knowledge. The qualitative research training at the University of Oxford was extremely helpful in learning how to start working with data. Equally the Ethnomethodology and Conversation Analysis Doctoral Students' Network assisted my understanding about ethnomethods and the meaning making in people's talk as I engaged in the sharing and discussion of anonymised student data. I have found the opportunity to present and discuss emerging findings from my study both locally and nationally extremely helpful. I have presented preliminary findings at the then Network for Psychiatric Nursing Research conference in 2016 and the Mental Health Nursing Research conference in 2017, where I presented ideas from Chapters 5 and 6. These opportunities allowed me to engage in discussions about my study with other mental health nurses, service users and nursing students.

The main challenge has been the nature of part-time study, and the sense that the PhD was one journey alongside all the other paths that needed to be travelled at the same time. I have endeavoured to overcome feelings of discontinuity and disjointedness by regularly writing in my research log and planning out my PhD activities quite methodically, which helped enormously. I have learned much about the challenges of recruiting participants, and the time and effort required to ensure this is successful. On reflection, the areas where I have learned most relate to analysis and writing. My early

attempts at exploring my findings were superficial, and it was only with time, practice, reading and supervision that I came to realize what was required from a qualitative researcher at doctoral level study. Gradually I understood that I could only report on what the data allowed according to my approach, and not to go beyond that and make wild claims. My learning will impact on approaches I take with future research studies, in terms of considering research questions, and exploring relevant methods. There has been significant learning in terms of the development of my academic writing. This has improved mostly with practice, and with the support of my supervisors. The challenge of bringing a whole research study into one final cohesive report was daunting at times, and finally bringing all chapters together into one document was very satisfying and manageable in terms of keeping a focus.

Further challenges have related to my own learning journey, and coping with intermittent doubts about my ability as a researcher and writer. My self-awareness has increased, as has my stamina for long-term projects. The hare and tortoise analogy I referred to in the acknowledgements section has remained pertinent throughout my studies, and I have discussed this with many people. Going forwards I am able to take my increased knowledge into future research studies and writing projects, simply because I have learned so much during my doctoral experience.

8.9 Conclusion

In this chapter I have provided an overview of the study's findings, and discussed the contributions of this thesis. I have highlighted that it is important for mental health nurses to consider imbalanced power relationships that exist in mental health environments and to challenge cultures that discourage collaborative working with service users, otherwise values and practice around involvement are unlikely to progress. I have considered the limitations of this study, and then discussed a range of implications relating to education, practice and research. Finally I reflected on the benefits and challenges I have experienced during this study and how the learning achieved will take me forward in my academic and research career.

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Appendices

Appendix 1: Organisation and sequencing of PhD journey

2011-2018

Month	**Progress**
January & February 2011	• Early reading and beginnings of literature gathering • PhD experience conference – University of Hull • MSc Qualitative research methods module – Swansea University
March 2011	• Feedback from National Research Ethics Service – deemed study as educational evaluation • Initial approval from College of Human & Health Science gatekeeper re student participation
April 2011	• NVIVO 8 training day • Endnote workshop • Submitted article to Journal of Psychiatric & Mental Health Nursing re Service user involvement in pre-registration mental health nurse education classroom settings
May & June 2011	• Met with gatekeepers in Local Health Board re former student participants • Met with gatekeepers who are local points of contact re service user participants, group helped to develop participant information sheet • Florence Nightingale Travel Scholarship 4 week study tour to 15 universities in the UK and Ireland exploring excellence in user involvement in nurse education
July & August 2011	• Continued development of paper on professional socialisation of mental health nurses • Completed Florence Nightingale Travel Scholarship report • Submitted abstracts to present findings of travel scholarship to: - Network of Psychiatric Nursing Research conference Sept 11 - International Nursing Research conference RCN - International Nurse Education Today conference • Met with gatekeeper in Local Health Board re former student participants
September 2011	• Approval to proceed with study received from College of Human & Health Sciences Research & Ethics committee • 4 user involvement events in the College to recruit new users and to train staff in good practice in user involvement • Introduction to qualitative interviewing course - University of Oxford • Presentation of travel scholarship findings at Network for Psychiatric Nursing Research conference, Oxford

October 2011	• Revisions submitted to JPMHN re literature review article on user involvement in classroom settings • Meetings arranged to deliver short presentation about study to invite former service user participants through local points of contact
November 2011	• Training - Analysing qualitative interviews – University of Oxford • Conference presentations to 150 people re travel scholarship findings at Wales Centre for Practice Innovation conference • Conducted first 2 interviews with former service user participants • Poster presentation accepted for International Nursing Research conference April 2012
December 2011	• Literature review paper re user involvement in pre-reg nurse education accepted by JPMHN
January & February 2012	• Finished transcribing first 2 former service user interviews • Invitation sent to former students to participate – 16 respondents • Training - attended Introduction to focus groups – Bournemouth University • Submitted revisions of NEP article re FN travel scholarship
March & April 2012	• Interviewed 5 former students to date, with a further 2 booked in • Poster presentation of User involvement travel scholarship at RCN International Nursing Research Conference • Core theme paper re User involvement travel scholarship findings accepted for Nurse Education Today Conference in September 2012
May – July 2012	• Completed 3 further former student interviews • Attended NVIVO 8 training, started uploading data files to NVIVO project • Focus group interviews completed, first years and third years
August & September 2012	• Transcribing of all focus groups completed • Presented Core paper re User involvement travel scholarship at International Nurse Education Today conference • Article re travel scholarship accepted for publication by *Nurse Education in Practice*
October – December 2012	• Probation presentation of study at Research interest group • Presentations (oral and poster) at Conversazione 2012, Swansea University • Further interviews with former students and service users

January – March 2013	• Second invitation to participate to former students to increase sample • Further interviews with former students and service users • Writing first draft of Methods chapter
April – July 2013	• Further presentations at voluntary sector agencies to invite service user participants • Draft Methods chapter sent to supervisors and feedback discussed • Further interviews with former students and service users
August – October 2013	• Revisions of Methods chapter • Further recruitment of service users
November & December 2013	• Completion of data collection, final interviews with service users
January – May 2014	• Early data analysis work: reading and re-reading of transcripts and initial manual coding
June – August 2014	• Further manual coding of all 3 datasets, coding all 30 individual and 3 focus group transcripts on QSR NVIVO 10. • Sabbatical leave application approved for March – May 2015
September & October 2014	• Revisions of Literature review chapter and sent to supervisors • Ethnomethodology and conversation analysis (EMCA) doctoral network Autumn workshop, Kings College, London.
November & December 2014	• Data analysis work • Review of draft Literature review chapter
January & February 2015	• Review of draft Methods chapter • Writing up your qualitative data study day • Completing the thesis and surviving the viva study day
March – May 2015	• Sabbatical leave – writing draft findings chapters • First Mental health nurse to be awarded NICE Fellowship (major strand of work – service user involvement)
June – November 2015	• Further development of Findings chapters
December 2015 7 January 2016	• Revisions of Findings- chapter 4
February – July 2016	• Revisions of Findings- chapter 5 • Abstract submitted and accepted re Network for Psychiatric Nursing Research conference Sept 2016 of early findings

July – December 2016	• Revisions of Findings- chapters 4- 6 • Presentation of early findings from Chapter 4 at Network for Psychiatric Nursing Research conference, Nottingham and Swansea University Post Graduate Research Student Conference 13th & 14th September 2016
January – April 2017	• Early drafts of Discussion chapter • Abstract submitted to Mental Health Nursing Research conference Sept 2017 of early findings
May - August 2017	• First draft of Discussion chapter sent to supervisors • Revisions of Discussion chapter • Development of Introduction, Conclusions and Summary • First draft of thesis sent to supervisors
September – December 2017	• Presentation of findings in Chapter 6 "One patient asked me to dig a hole in his garden": expectations of mental health nurses' roles. 23rd International Mental Health Nursing Research Conference, 14th-15th September 2017, Cardiff. • Revisions of thesis draft
January 2018	• Final read through and submission of thesis

Appendix 2: Publications and Conference presentations.

During my PhD journey I have had the opportunity to publish some background work related to this field of practice and to present my ideas at international, national and local conferences and seminars, which are listed below.

Publications

Terry, J. & the Service user and carer involvement group for Health programmes at Swansea University (2018). Meaningful service user involvement. In K. Wright & M. McKeown (eds) *Essentials of Mental health nursing*. London: Sage

Terry, J., Raithby, M., Cutter, J., Murphy, F. (2015). A menu for learning: a World Café approach for user involvement and inter-professional learning on mental health, *Social Work Education*: *The International Journal.* doi: 10.1080/02615479.2015.1031651

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Terry, J. (2010). Ethics of involving service users in forensic nursing education. In M. Coffey & R. Byrt (eds) *Forensic Mental Health Nursing*. London: Quay Books

Conference presentations

September 2017 - "One patient asked me to dig a hole in his garden": expectations of mental health nurses' roles. 23rd International Mental Health Nursing Research Conference, 14th-15th September 2017, Cardiff.

September 2016 - "She sort of rushed it a bit": Adult mental health service users' experiences of being involved in care and treatment planning. 22nd International Network for Psychiatric Nursing Research conference, 15th-16th September 2016 Nottingham.

September 2016 - "She sort of rushed it a bit": Adult mental health service users' experiences of being involved in care and treatment planning. Post Graduate Research Conference, Swansea University, Café West.

November 2015 - Establishing a Student Award for Best Practice in Service User and Carer Involvement 2nd International Conference: Where's the Patient's Voice in Health Professional Education 10 Years On? November 12-14, 2015, Coast Plaza Hotel & Suites, Vancouver, BC

November 2015 - It Matters to Me: A Participatory Approach Engaging Nursing and Social Work Students and Service Users to Promote Good Mental Health Practice 2nd International Conference: Where's the Patient's Voice in Health Professional Education 10 Years On? November 12-14, 2015, Coast Plaza Hotel & Suites, Vancouver, BC

September 2015 – Being a NICE Fellow: a first for mental health nursing. Network for Psychiatric Nursing conference, Manchester. Poster – first prize.

October 2013 - It matters to me: a participatory approach engaging nursing and social work students and service users to promote good mental health practice. Conversazione, Swansea University

September 2013 –It matters to me: a participatory approach engaging nursing and social work students and service users to promote good mental health practice. International Network for Psychiatric Nursing Research conference, Warwick

June 2013 - It matters to me: a participatory approach engaging nursing and social work students and service users to promote good mental health practice. SALT Teaching and Learning Conference, Swansea University

November 2012 - Development and evaluation of an educational module for mental health nurses regarding the physical health of mental health service users. Wales Centre for Practice Innovation conference. Swansea: Swansea University

September 2012 - Development and evaluation of an educational module for mental health nurses regarding the physical health of mental health service users. International Network for Psychiatric Nursing Research conference, Oxford.

September 2012 - Terry, J. (2012) The pursuit of excellence in user involvement in nurse education. 23rd International Networking for Healthcare Education conference. Cambridge: 4th September 2012, p.19

November 2011- Terry, J. (2011) The pursuit of excellence in user involvement in nurse education. Wales Centre for Practice Innovation conference. Swansea: Swansea University

September 2011 – The pursuit of excellence in user involvement in nurse education. International Network for Psychiatric Nursing Research (NPNR), Oxford

Appendix 3: Summary of findings of studies included in review

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Anthony & Crawford (2000)	Qualified mental health nurses from 3 acute wards in 1 NHS Trust in England, including different grades of staff	n = 9	Semi-structured interviews	Quotes organised into theme clusters. Colaizzi's procedural framework informed analysis as meanings were sought, use of preconceived framework of questions linked to research objectives	Findings identified as 6 Some consensus in part concept of user involve of a greater move towar • service users v care planning • care plan is ba expressed nee • patient agreem information is • patient choice, views/opinion • involving user significant co involvement • there is some health nurses' what user invo

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Rise, Solbjor, Lara, Westerlund, Grimstad & Steinsbekk (2011)	20 patients, 13 public representatives, 44 health service providers/managers from hospital trusts in Central Norway	33 patients & public representatives, & 44 health service providers	Semi-structured interviews	Use of a grounded theory approach, until theoretical saturation (when no new topics emerged). Use of QSR NVIVO 8.0. Further analysis conducted using basic code list, inspected by all	A common definition o involvement emerged, v core aspects: respect, di decision making. Differ groups however gave th values & emphasis. Bot that the other party wan Definition of involveme individual & system lev
Cusack, Killoury & Nugent (2017)	Population sample of mental health nurses, nurse educators, clinical nurse specialists, advanced nurse practitioners & nurse directors in Ireland	n = 1017 completed survey (response rate of 17%) 22 focus groups held (n = 204), plus 28 written submissions	Exploratory mixed methods design: survey to establish professional role of mental health nurse & to identify barriers to role development. Focus groups & written submissions sought to identify skills, competencies required by nurses to respond to '*A vision for change*' (Dept of Health & Children, 2006)	Survey methods software used. Thematic content analysis. After open coding final themes reviewed by research team	Survey indicated how o specific areas in assessm employment & coping s their service had adopte approach. Most commo (80%) was goal setting (75%). Most frequent m professional developme newsletters (68%), furth Knowledge, motivation facilitate nursing role, & organisation culture i Documentation in medi implementation of reco requires multitude of st

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Gunasekara, Pentland, Rodgers & Patterson (2014)	People with lived experience of inpatient care	n = 20 service users, n = 6 consumer/ carer reps, n = 6 mental health nurses (Australia)	Initial analysis of feedback from suggestion boxes on wards led to question 'What makes an excellent mental health nurse?'. Interviews & telephone interviews	Consumer reference group themed data, further layer added re carers' concerns. Early results then shared with nurse participants for discussion, findings of groups synthesised	Excellent mental health a 'complex construct'. Personal qualities, inter resources & environme delivery & experience c Recovery oriented appr empathy, respect and fr Suggests nurses need so oriented practice

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Jönsson, Schon, Rosenberg, Sandlund & Svedberg (2015)	Service users with experience of serious mental illness in 2 regions of Sweden	n = 20	Individual interviews (n=2) & focus groups (n=5)	Constructivist grounded theory used to explore users' experiences of participation in decision making. Initial then focused coding, findings evaluated with team discussion & rough model of core categories developed	Service users said they perceived as a competer Also identified being th controlled and being on conditions to promote p identified as personal su knowledge, having a di about responsibilities

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Laker, Rose, Flach, Csipke, McCrone, Craig, Kelland & Wykes (2012)	n = 376 stakeholders involved in Views of Therapeutic Environment (VOTE) Inpatient nursing staff in 1 London Mental health trust	n = 376 involved: n = 48 initial focus groups n = 40 feasibility group n = 43 test/retest group n = 245 trial group (with 200 who completed VOTE tool)	20 item measure generated through thematic analysis of initial focus group data (stakeholder involvement). Led to development of a psychometrically sound measure to capture staff perceptions of daily pressures on acute wards using Likert scale. Index of work satisfaction & Maslach burnout inventory also included. Nurses then engaged in VOTE measure. Quality of care model explored re pressures of burnout	Statistical analysis described with test-retest reliability assessed during development stage. t-test used to examine how VOTE related to Index of work satisfaction & Maslach burnout inventory, then Pearson's correlation coefficient to explore relationship across all 3 measure	Staff had more positive job than other studies, b levels of burnout. Perce pressures of working on significantly predict bu burned out than younge likely to have higher lev non-qualified staff and Only significant demog was country of birth, th showed more positive p daily pressures.

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Lloyd & Carson (2012)	30 people from voluntary groups, organised by service users & carers	n = 30 in 5 different focus groups	Group interviews – narrative research re what 'authentic involvement means to service users'	Short discussion of deconstruction of narrative with term 'critical conversation' applied. Service users said to be engaged in critical dialogue with ethnomethodological orientation	Universality in genuine consistent relationships recovery. Diversity requ accept people's differen identified in terms of ho Suggested that this meti applied in learning envi
Patton (2013)	Staff nurses in acute admission units in Ireland (part of larger mixed methods study, first stage - survey, this paper reports on 2nd stage - interviews	n = 18	Semi-structured telephone interviews with 11 questions developed from first stage survey responses	Attride-Stirling's (2001) framework used as conceptual guide to code categories & produce themes	Stories of 'heroic nursin involving users in their referred to nursing mod Involvement expected f Suggestion that users w involved in their care pl nurses have high level c competency, often unst superficial

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Stenhouse (2011)	Individuals who were inpatients on acute wards in Scotland	n = 13	Unstructured interviews to gather narratives	Main narrative themes drawn out with summary sent to participant, which formed basis of 2nd interview, then use of Gee's (1991) theory of narrative structure used	Service users reported t nurses to come and talk that they observed the n to do this. In order to fi users supported each ot was a sense of camarad some users supporting e felt vulnerable without networks
Storm & Davidson (2010)	20 semi-structured interviews with inpatients (wider study -14 log reports from providers 16 sets of staff minutes, from 2 centres in Western Norway	n = 20 (13 women, 7 men)		Content analysis, themes discussed by both authors	Service users found it d took part in planning th clear to people what inv Providers were describe understanding & suppo not feel seen and heard Providers aware of limi increase involvement. I providers' perspectives different. Confusion for meaning of being invol

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Storm, Hausken & Mikkelsen (2010)	2 groups of mental health professionals in focus groups from 1 mental health centre in Western Norway Development of 30 item instrument, & testing & validation of instrument to measure involvement in inpatient settings from professional perspective	n = 12 in focus groups n = 98 completed empirical testing of instrument	Focus groups to develop domains for tool, Self- report questionnaires to operationalize service user involvement	Summary of focus group interview with extracted meaning units discussed at subsequent groups Using SPSS software features of instrument were explored using descriptive analysis, exploratory factor analysis & reliability analysis	Measurement of profess of involvement in devel reasonable level of cons reliability

Author	Sample type	Sample size	Data collection	Data analysis	Study findings
Tee, Lathlean, Herbert, Coldham, East & Johnson (2007)	Service users and nursing students in a co-operative enquiry group to identify factors that enable user involvement in clinical decisions	n = 8 service users, n = 8 nursing students in 2nd or 3rd year (1 facilitator)	Reflective group discussions were recorded using audio, flipchart & email during & between groups	Emerging themes from group discussions shared for challenge & feedback. Thematic analysis used (Burnard, 1991)	Factors that enable invo kindness, genuineness, Students voiced paterna nursing, rather than valu appreciating potential, u too often medicalize ex Stigmatizing attitudes & care processes that excl disempower. Nurses ne balance between depen Continuum of shared cl making developed

Appendix 4: Participant Information Sheets

– Focus group - Student nurses

Part 1

Study title

Mental health nursing and service user involvement: multiple perspectives on roles

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- *Part 1 tells you the purpose of this study and what will happen to you if you take part.*
- *Part 2 gives you more detailed information about the conduct of the study.*

Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore understandings and assumptions that may exist about mental health nursing, in the context of service user involvement. The study will use interviews and focus groups with mental health student nurses, former mental health service users and former students. The perspectives of these three different groups of people will provide information regarding similarities and/or differences between the groups. This research will be conducted as a PhD study.

Why have I been chosen?

You have been chosen because you are a pre-registration mental health student nurse, and have experienced at least one mental health practice learning experience (placement). You will be one of around 15 student nurses to be involved. Your thoughts, feelings and perceptions as a pre-registration mental health student nurse will greatly inform the contributions you can make to this study.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be asked to participate in a focus group with other mental health student nurses to explore your views on and experiences of mental health nursing, in the context of service user involvement. When we meet the discussion itself may last for approximately one hour, and will be held in the College of Human and Health Science. With your full consent, the focus group interview will be digitally audio-recorded and transcribed. Some verbatim quotations from the interview may be included in future publications and public reports from the study. All quotations used will be anonymised to maintain the anonymity of participants.

If you decide to take part in the focus group interview, you may be contacted at a later point in your programme and be invited to participate in an individual interview, which would also take place in a mutually convenient venue.

What do I have to do?

You would need to agree to give your own time in order to attend the focus group, which as far as possible would be a timetabled event, so as not to disrupt your studies. There will be no unacceptable financial costs to you being involved.

If you decide to participate you will need to complete the reply slip.

What are the disadvantages and risks of taking part?

No substantial risks are identified. It can be cathartic and beneficial to reflect on experiences, and sometimes these may raise issues, but this is not anticipated. All the information you provide will be treated as confidential.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people taking part in the study, it is hoped that the findings will inform the future content and delivery of mental health

nursing education and service user involvement in both education programmes and local mental health services.

What if there is a problem?

Any complaint about the way in which you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept strictly confidential.

Contact Details

Further information about the study is available from: Julia Terry, College of Human and Health Sciences, Swansea University, Building 3, St. David's Park, Carmarthen, Carmarthenshire SA31 3HB Tel: 01792 513801. E:[redacted]

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

As a participant in this study, you retain the right at any stage of the research to decide if you do not wish to continue. The information from the focus group interview will be analysed with other participants' contributions and used in the dissemination of the findings. The information you give will be securely stored and destroyed on completion of the study. If you decide to withdraw from the study, your data from the focus group will still be retained as it would be difficult to take out or remove individual data from that of the group.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak with the researcher's supervisors who will do their best to answer your question.

Dr. Michael Coffey – email - [redacted]

Dr. Aled Jones – email - [redacted]

And are based at: College of Human and Health Science, Swansea University, Singleton Park, Swansea. SA2 8PP. [redacted]

If you remain unhappy and wish to complain formally you can do this through the College of Human and Health Sciences. Your complaint will be dealt with by a member of the College's senior management team. Details are available from the College.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. Digital audio files and transcripts from the interviews will be securely stored in the College of Human and Health Science. Individual names will be removed from the transcripts.

The information you provide in the focus group interview will be analysed, and the results from the overall study will be reported in academic papers, conferences presentations and workshops. No individuals will be identified, and any verbatim quotations from the interviews which are used will be anonymised. At the end of the

study, original digital recordings will be deleted, and only anonymised transcripts will be retained for ongoing analysis and publication of results.

Who is organising and funding the research?

The research project is being sponsored by Swansea University, and is funded through a part-time PhD studentship.

Who has reviewed the study?

(when approved this section would read)

This study has been reviewed and approved by the College of Human and Health Sciences Research and Ethics Committee.

Thank you for taking the time to read this information sheet

Julia Terry Mental Health Nurse Tutor [redacted]

If you would be interested in participating in this study, please complete reply slip.

Reply slip

I would like to participate in the following research study:

Mental health nursing and service user involvement: multiple perspectives on roles

Name:

Address:

Tel. No:

Email:

Student cohort:

Please hand to the facilitator who will collect reply slips

Participant Information Sheet – Interview – Service users

Part 1

Study title

Mental health nursing and service user involvement: multiple perspectives on roles

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- *Part 1 tells you the purpose of this study and what will happen to you if you take part.*
- *Part 2 gives you more detailed information about the conduct of the study.*

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore understandings and assumptions that may exist about mental health nursing, in the context of service user involvement. The study will use interviews and focus groups with mental health student nurses, mental health service users and former students. The perspectives of these three different groups of people will provide information regarding similarities and/or differences between the groups. This research will be conducted as a PhD study.

Why have I been chosen?

You have been chosen because you have had contact with mental health services in the South Wales area, which is covered by the University. You have been contacted through a local individual or group who is acting as a point of contact, and you will be one of around 15 service users to be involved. Your thoughts, feelings and perceptions as a service user will greatly inform the contributions you can make to this study. The terms of the study ask that you are currently in a stage of recovery, and/or are experiencing a period of mental health. Also, that during the contact you

had with mental health services, you met student mental health nurses within a hospital or community setting (within the last ten years).

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be asked to participate in an interview to explore your views on and experiences of mental health nursing and service user involvement. When we meet the discussion itself may last for approximately one hour, and will be held at a mutually convenient venue. With your full consent, the interview will be digitally audio-recorded and transcribed. Some verbatim quotations from the interview may be included in future publications and public reports from the study. All quotations used will be anonymised to maintain the anonymity of participants.

What do I have to do?

You would need to agree to give your own time in order to be interviewed and to travel to meet at a convenient venue. There will be no unacceptable financial costs to you being involved.

If you decide to participate you will need to complete the reply slip or contact me by email at [redacted],and I will contact you to agree a suitable time and location for the interview.

What are the disadvantages and risks of taking part?

No substantial risks are identified. It can be cathartic and beneficial to reflect on experiences, and sometimes these may raise issues, but this is not anticipated. All the information you provide will be treated as confidential.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people taking part in the study, it is hoped that the findings will inform the future content and delivery of mental health nursing education and service user involvement in both education programmes and local mental health services.

What if there is a problem?

Any complaint about the way in which you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept strictly confidential.

Contact Details

Further information about the study is available from: Julia Terry, College of Human and Health Sciences, Swansea University, Building 3, St. David's Park, Carmarthen, Carmarthenshire SA31 3HB Tel: 01792 513801. E: [redacted]

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

As a participant in this study, you retain the right at any stage of the research to decide if you do not wish to continue. The information from your interview will be analysed with other participants' contributions and used in the dissemination of the findings. The information you give will be securely stored and original digital recordings will be destroyed on completion of the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak with the researcher's supervisors who will do their best to answer your question.

Dr. Michael Coffey – [redacted] tel: 01792 518570

And are based at: College of Human and Health Science, Swansea University, Singleton Park, Swansea. SA2 8PP. Tel. 01792 518572.

If you remain unhappy and wish to complain formally you can do this through the College of Human and Health Sciences. Your complaint will be dealt with by a member of the College's senior management team. Details are available from the College.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. Digital audio files and transcripts from the interviews will be securely stored in the College of Human and Health Science. Individual names will be removed from the transcripts.

The information you provide in the interview will be analysed, and the results from the overall study will be reported in academic papers, conferences presentations and workshops. No individuals will be identified, and any verbatim quotations from the interviews which are used will be anonymised. At the end of the study, original digital recordings will be deleted, and only anonymised transcripts will be retained for ongoing analysis and publication of results.

Who is organising and funding the research?

The research project is being sponsored by Swansea University, and is funded through a part-time PhD studentship.

Who has reviewed the study?

(when approved this section would read)

This study has been reviewed and approved by the College of Human and Health Sciences Research and Ethics Committee.

Thank you for taking the time to read this information sheet

Julia Terry Mental Health Nurse Tutor [redacted]

If you would be interested in participating in this study, please complete reply slip.

Reply slip

I would like to participate in the following research study:

Mental health nursing and service user involvement: multiple perspectives on roles

Name:

Address:

Tel. No:

Email:

Please either email these details to me ([redacted] , or post them in the stamped addressed envelope provided.

Participant Information Sheet – Interview – Former students

Part 1

Study title

Mental health nursing and service user involvement: multiple perspectives on roles

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- *Part 1 tells you the purpose of this study and what will happen to you if you take part.*
- *Part 2 gives you more detailed information about the conduct of the study.*

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to explore understandings and assumptions that may exist about mental health nursing, in the context of service user involvement. The study will use interviews and focus groups with mental health student nurses, former mental health service users and former students. The perspectives of these three different groups of people will provide information regarding similarities and/or differences between the groups. This research will be conducted as a PhD study.

Why have I been chosen?

You have been chosen because you are a former student who previously studied with the College of Human and Health Sciences at Swansea University, and are now working as a qualified mental health nurse; and for the purposes of this study are regarded as a former student.

You will be one of around 15 former students to be involved. Former students may be newly qualified mental health nurses or have been qualified for a number of

years. Your thoughts, feelings and perceptions as a mental health nurse will greatly inform the contributions you can make to this study.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be asked to participate in an interview to explore your views on and experiences of mental health nursing and service user involvement. When we meet the discussion itself may last for approximately one hour, and will be held at a mutually convenient venue. With your full consent, the interview will be digitally audio-recorded and transcribed. Some verbatim quotations from the interview may be included in future publications and public reports from the study. All quotations used will be anonymised to maintain the anonymity of participants.

What do I have to do?

You would need to agree to give your own time in order to be interviewed at a convenient venue. There will be no unacceptable financial costs to you being involved.

If you decide to participate you will need to complete the reply slip or contact me by email at [redacted], and I will contact you to agree a suitable time and location for the interview.

What are the disadvantages and risks of taking part?

No substantial risks are identified. It can be cathartic and beneficial to reflect on experiences, and sometimes these may raise issues, but this is not anticipated. All the information you provide will be treated as confidential.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people taking part in the study, it is hoped that the findings will inform the future content and delivery of mental health nursing education and service user involvement in both education programmes and local mental health services.

What if there is a problem?

Any complaint about the way in which you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept strictly confidential.

Contact Details

Further information about the study is available from: Julia Terry, College of Human and Health Sciences, Swansea University, Building 3, St. David's Park, Carmarthen, Carmarthenshire SA31 3HB Tel: [redacted]

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

As a participant in this study, you retain the right at any stage of the research to decide if you do not wish to continue. The information from your interview will be analysed with other participants' contributions and used in the dissemination of the findings. The information you give will be securely stored and original digital recordings will be destroyed on completion of the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak with the researcher's supervisors who will do their best to answer your question.

Dr. Michael Coffey – email - [redacted]

Dr. Aled Jones – email - [redacted]

And are based at: College of Human and Health Science, Swansea University, Singleton Park, Swansea. SA2 8PP. Tel. 01792 518572.

If you remain unhappy and wish to complain formally you can do this through the College of Human and Health Sciences. Your complaint will be dealt with by a member of the College's senior management team. Details are available from the College.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. Digital audio files and transcripts from the interviews will be securely stored in the College of Human and Health Science. Individual names will be removed from the transcripts.

The information you provide in the interview will be analysed, and the results from the overall study will be reported in academic papers, conferences presentations and workshops. No individuals will be identified, and any verbatim quotations from the interviews which are used will be anonymised. At the end of the study, original digital

recordings will be deleted, and only anonymised transcripts will be retained for ongoing analysis and publication of results.

Who is organising and funding the research?

The research project is being sponsored by Swansea University, and is funded through a part-time PhD studentship.

Who has reviewed the study?

(when approved this section would read)

This study has been reviewed and approved by the College of Human and Health Sciences Research and Ethics Committee. Additionally, the Research and Development Departments for Abertawe Bro Morgannwg University Health Board and Hywel Dda Health Board are aware of this study, and Directors in Mental health nursing have given agreement for this study.

Thank you for taking the time to read this information sheet

Julia Terry Mental Health Nurse Tutor [redacted]

If you would be interested in participating in this study, please complete reply slip

Reply slip - I would like to participate in the following research study:

Mental health nursing and service user involvement: multiple perspectives on roles

Name:

Work or Home Address: Tel. No:

Email:

Please email these details to me ([redacted])

Appendix 5: Consent form

Title of Study: Mental health nursing and service user involvement: multiple perspectives on roles

Name of Researcher: Julia Terry

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that the interview that I participate in will be digitally audio-recorded and transcribed. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

4. I give my permission for the researcher to use suitably anonymised verbatim quotations from the interview in which I am taking part. ☐

5. (Focus groups only) I understand that if I choose to withdraw from the study, any data I have contributed will remain, as this may be difficult to take out from the group's discussion ☐

5. I agree to take part in the above study. ☐

Name of participant _____

Signature _____

Date _____

Researcher _____

Signature _____

Date _____

When completed, 1 for participant; 1 for researcher

Appendix 6: Communications with neighbouring Health Boards' Research and Development Departments and National Research and Ethics Committee

Communication with Health Boards

Dear [redacted]

Just to confirm, in response to your email, I have consulted with managers in [redacted] the relevant areas who are aware of the evaluation study. I also have removed the word 'research' from the documentation.

I have now started recruitment for this evaluation, and am informing you to update your records. I enclose a short summary for information

regards

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

Team Lead for Mental Health Nursing/ Arweinydd Tîm dros Nyrsio Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

Tel: 01792 513801 / Fon: 01792 513801

e: [redacted]

[redacted]

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Sent: 21 July 2011 14:24
To: Terry, Julia
Subject: RE: Keen to talk to you re study

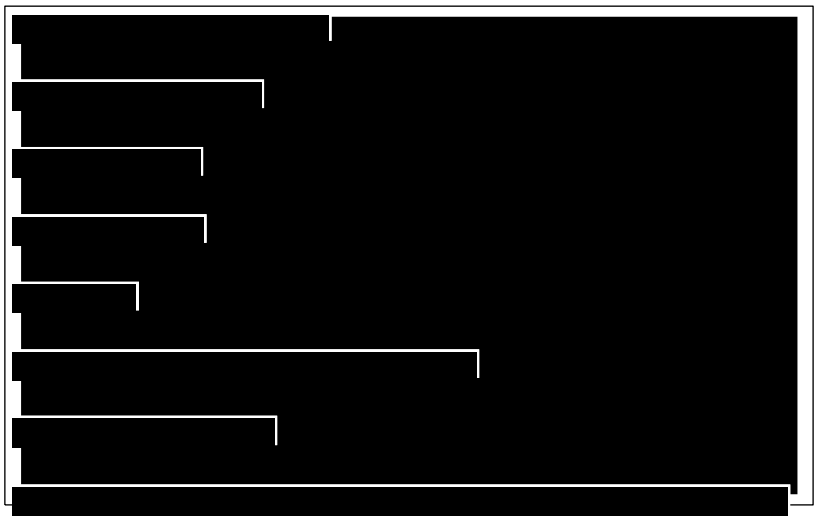
Julia,

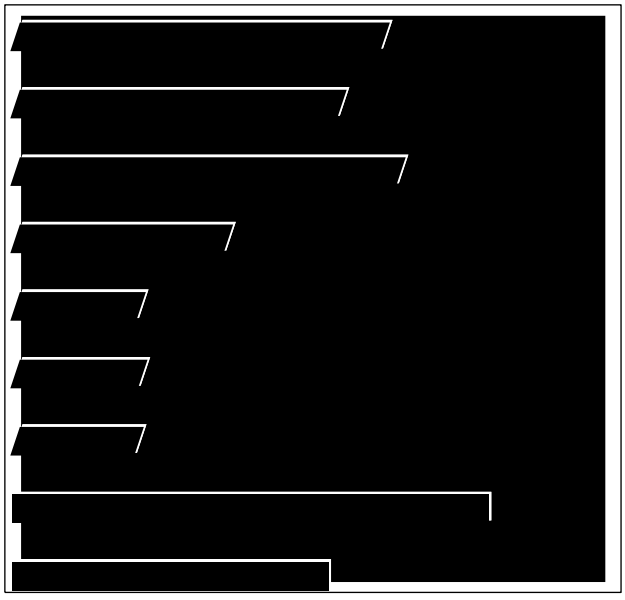
Sorry its been so hard to get in touch with me,

I note from your correspondence with the ethics service that they consider this piece of work not to be research, but instead an evaluation.

We will accept this decision, however, please ensure you have agreement from the various areas of the Health Board (local management agreement) before you proceed in those areas. Please also remove any mention of 'research' from the documentation. This email should not however be considered as our agreement to the project, just that R&D agreement is not required.

[redacted]





From: Terry, Julia [mailto:J.Terry@swansea.ac.uk]
Sent: 21 July 2011 12:37
To: [redacted]

Hi [redacted]

I am keen to talk to you regarding advice for my proposed study. [redacted] suggested as this was postgrad area, you were best person in [redacted] (please see email below)

I'm seeing [redacted] nursing directorate, so it would be useful to have an R & D opinion from you, so I can include that in our discussions.

My mobile is [redacted] you can get me on my office tel from 9am tomorrow 01792 513801. Hope to talk to you soon,

regards

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

Tel: 01792 513801 / Fon: 01792 513801

e: j.terry@swansea.ac.uk

From: Terry, Julia
Sent: 07 July 2011 14:56
To: [redacted]

Hi [redacted]

I'm not sure whether you received an email on the following, so I thought I'd get in touch. Please scroll down to my email below.

In a nutshell I have a proposed study which will go before our College of Human & Health Sciences Research and Ethics Committee, and the National Research Ethics committee have

As the Research and Development manager, it' s appropriate to contact you as well (n.b. [redacted] they would just keep a note of the study on file), I am meeting with [redacted] later this month to discuss the study out of courtesy,

I've attached the information I sent to NRES, I look forward to your reply

Best wishes,

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

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Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

Tel: [redacted] / Fon: [redacted]

e: [redacted]

From: [redacted] Research [redacted]
Sent: 09 May 2011 09:05
To: Terry, Julia
Subject: RE: Proposed educational study

Good Morning Julia

[redacted]

deals with higher degrees so I am passing your request on to him. I am sure he will be in touch asap.

Best wishes

[redacted]

Rheolwr Ymchwil a Datblygu/Research & Development Manager

Bwrdd Iechyd Hywel Dda/Hywel Dda Health Board

Management Offices

[redacted]

[redacted] Terry, Julia [mailto:J.Terry@swansea.ac.uk]
Sent: 06 May 2011 14:26
[redacted]
Admin Block)
Subject: [redacted]

I'd like to ask you about a proposed study relating to my PhD. As you can see from the email below I've had a response from NRES who view this as an educational evaluation. I've attached a resume of the project. It involves 3 types of participants: current student nurses, ex-service users (recruited through local points of contact, voluntary sector) and ex-students.

The ex-students would be contacted through our student records, and would be working as qualified nurses, possibly in [redacted] Health Board (hence my reason for contacting you). I'm planning to meet with [redacted] Director of Mental Health Nursing to discuss the project out of courtesy.

I wanted to seek your advice initially, I'm assuming I would need to inform you about the study and adhere to any procedures that you have in the R & D Dept. Naturally I shall be seeking ethical approval through the College of Human and Health Sciences Research and Ethics Committee.

Any further pointers you can give would be welcome.

(For information, I have also approached [redacted] R & D Dept, and their response was that they would wish to keep a record of the study on file).

Best wishes,

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

Tel: [redacted]

e: [redacted]

Response from National Research and Ethics Committee

From: NRES Queries Line [mailto:queries@nres.npsa.nhs.uk]
Sent: 11 March 2011 17:08
To: Terry, Julia
Subject: RE: Enquiry from NRES website: is my project reseach?

Thank you for your enquiry.

Your query was reviewed by our Queries Line Advisers.

Our leaflet “Defining Research”, which explains how we differentiate research from other activities, is published at:

http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee.

I agree that this is an educational evaluation and would not require REC review.

If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.

This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless specifically revised by that REC. Should you wish to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service

National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

The NRES Queries Line is an email based service that provides advice from NRES senior management including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with accurate written response. It also enables us to monitor the quality and timeliness of the advice given by NRES to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Website: www.nres.npsa.nhs.uk
Email: queries@nres.npsa.nhs.uk

Ref: 04/31

Streamline your research application process with IRAS (Integrated Research Application System). To view IRAS and for further information visit: www.myresearchproject.org.uk

Help save paper - do you need to print this email?

From: Terry, Julia [redacted]
Sent: 09 March 2011 22:20
To: NRES Queries Line
Subject: Enquiry from NRES website: is my project reseach?

Hi

I should be grateful of your advice concerning the attached research proposal. Given that the participants who are ex-students may be working as qualified mental health nurses and may be NHS staff, I believe that due to the nature of the research question and proposed aims, this is more akin to service evaluation. I shall be seeking ethical approval through the College of Human and Health Science Research and Ethics Committee regarding the other participants.

I would appreciate your advice concerning this proposal, and the appropriateness of a full IRAS application. I would like to ask whether this study requires a submission to my local REC, or if it is more appropriate to seek clearance through the University.

Many thanks,

regards

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

[redacted]

[redacted]

Editorial Board Member of The Journal of Mental Health Training, Education and Practice http://pierprofessional.metapress.com/content/121412

Communication with other Health Board

Dear [redacted]

Just to confirm, in response to your email, I have consulted with managers in [redacted] the relevant areas who are aware of the evaluation study.

I have now started recruitment for this evaluation, and am informing you to update your records. I enclose a short summary for information

regards

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

Team Lead for Mental Health Nursing/ Arweinydd Tîm dros Nyrsio Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

Tel: [redacted]

[redacted]

Editorial Board Member of The Journal of Mental Health Training, Education and Practice http://pierprofessional.metapress.com/content/121412

From: [redacted]- Research & Development)
[mailto:[redacted]]
Sent: 01 April 2011 16:49

To: Terry, Julia
Subject: RE: Query regarding a proposed study

Hi Julia

As this hasn't been classified as research, we wouldn't need submission through R&D, we will keep details on file and as long as there are no objections from directorate, there shouldn't be a problem

Kind regards

[redacted]

From: Terry, Julia [J.Terry@swansea.ac.uk]
Sent: 01 April 2011 10:01
To: [redacted]
Research & Development)
Subject: Query regarding a proposed study

Hi [redacted]

I'd like to ask you about a proposed study relating to my PhD. As you can see from the email below I've had a response from NRES who view this as an educational evaluation. I've attached a resume of the project. It involves 3 types of participants: current student nurses, ex-service users (recruited through local points of contact, voluntary sector) and ex-students.

The ex-students would be contacted through our student records, and would be working as qualified nurses, possibly in [redacted] hence my reason for contacting you). I'm meeting with [redacted] on Tues 5th to discuss the project.

I wanted to seek your advice initially, I'm assuming I would need to inform you about the study and adhere to any procedures that you have in the R & D Dept. Naturally I shall be seeking ethical approval through the College Research and Ethics Committee,

Any further pointers you can give would be welcome

Many thanks

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

[redacted]

e: [redacted]

Attachment sent to both Health Boards in 10th January 2012 emails above:

Mental health nursing and service user involvement: multiple perspectives on roles

This proposal is about a study to investigate how student nurses develop into the role of professional mental health nurses throughout their University education.

Study aim: this study aims to explore people's understanding of the developing role of mental health nurses, in the context of service user involvement. It is useful to look at this from a variety of perspectives, and the views of mental health student nurses, former service users and former student mental health nurses are sought, in order to explore this phenomenon from a variety of perspectives.

Methods: the study will involve qualitative interviews and focus groups where participants will be invited to talk about mental health nursing and how different perspectives contribute to this professional identity.

The sample will feature 15 pre-registration mental health nursing students, which involves speaking to them at different points in their journey towards becoming qualified. I am also seeking other perspectives, which would be 15 former students who may be working in the NHS and 15 former service users accessed through voluntary groups on the changing roles of mental health nurses. I have received ethical approval through the College of Human and Health Science Research and Ethics Committee to start this study.

Study objectives

- To explore mental health student nurses', former service users' and former students' talk about mental health nursing, and to provide an analysis of meaning making from multiple perspectives
- to critically explore similarities/differences between the participants, with a view of enhancing the understanding of how mental health nurses become socialised into the profession
- to critically explore how mental health nursing is socially constructed in Higher Education, and how this may relate to practice

- to critically explore the provision of mental health nursing education from the perspective of ex-service users
- to construct a better understanding of how the professional socialisation of mental health nurses is practically addressed within Higher Education;
- to critically explore assumptions that exist about mental health nursing in the context of an increasing focus on service user involvement

Appendix 7: Response from College Research and Ethics Committee

From: [redacted]
Sent: 12 September 2011 12:45
To: Terry, Julia
Cc: [redacted]
Subject: RE: re application to CHHS REc

12/9/11

Dear Julia, thanks for your responses and for the email regarding the CRB check. Re point 1, 2-3 hours is fine. Re point 2, removing Aled's name is fine. Re point 3 the information from personnel will suffice. Re point 4, thank you for the additional information.

The application is now formally approved. Good luck with your research,

Regards

[redacted]

[redacted]

From: Terry, Julia
Sent: 12 September 2011 11:52
To: [redacted]
Subject: FW: re application to CHHS REc

Hi Steve,

In response to the feedback from the Committee, I have attached an updated version of my application, with amendments highlighted in yellow.

1. With regard to recruitment of the student group, can you clarify how much time they will have to decide about whether or not to participate, once they hear your presentation and/or receive the information sheet? – I note the need to state a 'time to think' period. I would prefer to ask the students to respond, after 2-3 hours (i.e. a couple of lessons later), if they're interested on the same day, as wonder that if there is a time lapse they will have received information on so many other issues in the University they may forget all about the invitation to participate (however, am flexible to suggestions).

2. Since [redacted] has now left, can you update the forms? – I have taken Aled's name off, and will be seeking a second supervisor, however would prefer to discuss this with my supervisor first.

3. Can you send a copy of your CRB check? - I have information from Human Resources in a separate email, which will follow this one.

4. On p.7 (para 2, last line) you refer to individuals who will "review recruitment" – can you explain what is meant by this? – more detail provided on application

Please let me know if further revisions are needed,

Best wishes,.

Julia Terry

Mental Health Nurse Tutor/ Nyrs Tiwtor Iechyd Meddwl

Team Lead for Mental Health Nursing/ Arweinydd Tîm dros Nyrsio Iechyd Meddwl

College of Human and Health Sciences/ Coleg y Gwyddorau Dynol ac Iechyd

Swansea University/ Prifysgol Abertawe

Building 3, St. David's Park/ Adeulad 3, Parc Dewi Sant

Carmarthen / Caerfyrddin

Carmarthenshire SA31 3HB / Sir Gaerfyddin SA31 3HB

Tel: [redacted]

[redacted]

Editorial Board Member of The Journal of Mental Health Training, Education and Practice
http://pierprofessional.metapress.com/content/121412

From: [redacted]
Sent: 09 September 2011 12:52
To: [redacted]
[redacted]
Subject: re application to CHHS REc

9/9/11

Dear Julia,

Your application was considered at the above committee yesterday and can be approved subject to your attending to the following points:

5. With regard to recruitment of the student group, can you clarify how much time they will have to decide about whether or not to participate, once they hear your presentation and/or receive the information sheet?
6. Since A[redacted] has now left, can you update the forms?
7. Can you send a copy of your CRB check?
8. On p.7 (para 2, last line) you refer to individuals who will "review recruitment" – can you explain what is meant by this?

Can you respond to the above points, and send me a revised version of the application in light of them?

Good luck with your research,

best wishes

[redacted]

[redacted]

Prifysgol Abertawe/Swansea University

SA2 8PP

UK

Appendix 8: Letter to Local Health Boards

Written after approval received from College's Research and Ethics Committee

FAO

[redacted] Board

Address

Date

Dear ,

Re: Educational evaluation study involving students from the College of Human & Health Sciences, Swansea University

I am writing to you regarding our meeting on ……. when we discussed the following study:

Mental health nursing and service user involvement: multiple perspectives on roles.

I have now received ethical approval from the College of Human & Health Sciences Research and Ethics Committee to go ahead with the study, and confirm this will be in the context of an educational evaluation. I shall be recruiting from current and former student groups from the College, and shall be inviting them to participate in interviews to give their views and experiences about mental health nursing and the student nurse's journey to professional socialization.

I am contacting you out of courtesy, to raise awareness that this study is now starting. If you or colleagues have any further questions about the study, please do not hesitate to contact me.

Yours sincerely,

Julia Terry, Researcher, Mental Health Nurse Tutor

Appendix 9: Focus group and Interview topic guide

- being a mental health nurse (e.g. role, duties, responsibilities)
- becoming a mental health nurse (the journey to professional socialization)
- the process to becoming a qualified mental health nurse
- mental health nurses working in partnership with service users
- student nurses working in partnership with mental health service users
- mental health service users' perspectives of mental health nurses
- mental health service users' perspectives of mental health nurse education
- do/how do mental health nurses undertake service user involvement?
- Mental health service users' experiences of mental health nurses in a climate of increasing involvement
- Issues that assist or promote students' socialization into the nursing profession
- Issues that hinder or challenge students' socialization into the nursing profession

Appendix 10: Focus Group ground rules

1. One person speaks at a time
2. Speak for yourself, using “I” statements
3. Participate in both talking and listening
4. Be critical of ideas but respect different points of view and different perspectives
5. Stay on the topic and don’t digress too much
6. Maintain the confidentiality of opinions expressed in this discussion
7. Focus on issues that need to be discussed and not individuals
8. Wait for one person to finish speaking and don’t interrupt others

Appendix 11: Initial free nodes – all participants

Initial 57 free nodes

Name	Sources	References
1. being a student	1	1
2. being ill	2	3
3. Being labelled	1	1
4. Burnout	4	7*
5. changing once qualified	2	3
6. Changing roles of mental health nurses	3	3
7. changing services	2	9*
8. difference between hospital & community	2	3
9. differences between professionals	1	3
10. empowering users	2	4
11. Experience of mental health care	11	99*
12. flexibility	1	1
13. getting the right students	7	14*
14. giving hope	3	3
15. Good nurses go to the community	3	3
16. great ideas can't be implemented	1	1
17. Humour	1	1
18. impact of user involvement	1	3
19. in the office	3	3
20. increasing student awareness of involvement	1	1
21. like young or female nurses	2	4
22. making progress	1	2
23. management of resources	1	1
24. more user involvement	4	12*

25. not knowing about services	3	3
26. not rushing users	1	1
27. nurse education	5	10*
28. Nurse patient relationship	4	23*
29. observations about general hospitals	1	1
30. Perceptions of mental health nurses	11	109*
31. positive characteristics	6	23*
32. power & control	2	2
33. quality	7	32*
34. Responding to user's needs	5	6
35. Responsiveness	2	4
36. role	10	37*
37. role in recovery	5	8
38. sensitivity	1	1
39. setting goals	1	1
40. skill	3	4
41. stigma	2	2
42. student enthusiasm	2	3
43. supporting nurses	2	2
44. talking with nurses	5	8
45. them and us culture	6	25*
46. time	3	7
47. user as expert	2	10
48. user involvement in care	5	9*
49. user steering direction of care	4	8
50. users and students interacting	5	11*
51. users support each other	4	8
52. valuing nurses	1	1
53. wanting to achieve to please nurses	1	1

54. what needs to change	4	11*
55. what users value about third sector	3	11*
56. What users want	9	35*
57. working collaboratively	3	7

Parent tree nodes for all participants

After 57 initial free nodes, condensed into 16 categories
1. Background starting out 2. Experience of mental health care 3. Interviewing candidates 4. mental health specialities 5. more user involvement 6. Newly qualified 7. nurse education 8. Nurse patient relationship 9. Perceptions of mental health nurses 10. power or them and us 11. Qualities & skills 12. the aspirations 13. The challenges 14. the role and the work 15. What helps 16. What users want

16 free nodes with descriptors

	Name	Description	Sources	References
1	Background starting out	How students/nurses came into mental health nursing in the first place (e.g. family influences, voluntary work, family with mental health problems)	20	55
2	Experience of mental health care	Service users' experiences both positive and negative of mental health services, both inpatient and community	11	99
	being ill	What it's like being ill, experiencing symptoms	2	3
	Being labelled	The stigma of labelling	1	1
	observations general hospitals	General hospital staff with poor communication skills	1	1
3	Interviewing candidates	Interviewing candidates for mental health nursing:	8	11
	getting the right students	Qualities to look for in candidates applying for mental health nursing	7	14
4	mental health specialties	Different mental health areas, client groups, particular issues	17	51
5	more user involvement	Wanting to see more user involvement	4	12
	user as expert	Recognizing the user as expert	2	10
	user involvement in care	How users are involved in their own care	5	9
	empowering users	How users can be more empowered	2	4
	user steering direction of care	Users being in the driving seat	4	8
6	Newly qualified	Newly qualified mental health nurses, issues relating to	12	34
	changing once qualified	Nurses change one they have qualified	2	3
7	nurse education	Nurse education: experiences in university and on placement	24	120
	being a student	Experience of being a student	1	1
	student enthusiasm	Student enthusiasm	2	3
	users and students interacting	Benefits of user involvement for students	5	11
8	Nurse patient relationship	The therapeutic nurse patient relationship	23	109
	making progress	User making progress re goals	1	2
	supporting nurses	Users are supportive to mental health nurses	2	2

	talking with nurses	Finding talking with nurses beneficial	5	8
	time	Issues of time with nurses:	3	7
	valuing nurses	Finding value in nurses	1	1
	wanting to achieve to please nurses	Wanting to achieve to increase nurse's job satisfaction	1	1
	working collaboratively	Working together in the nurse patient relationship	3	7
9	Perceptions of mental health nurses	Perceptions of mental health nurses	11	109
10	power or them and us	Issues of power observed by users, noticing differences between us and them	9	30
	stigma	Stigma	2	2
11	Qualities & skills	Qualities and skills required by mental health nurses	20	54
	giving hope	Giving hope	3	3
	Humour	Humour	1	1
	like young or female nurses	Male users like female nurses	2	4
	not rushing users	Not being rushed	1	1
	positive characteristics	Positive characteristics of mental health nurses	6	23
	quality	Qualities	7	32
	Responding to user's needs	Responsiveness	5	6
	Responsiveness	Responsiveness	2	4
	sensivitivy	Being sensitive	1	1
	setting goals	Setting goals	1	1
	skill	Skills needed	3	4
12	the aspirations	Aspirations and career plans	16	59
13	The challenges	Challenges	19	168
	Burnout	Burnout and stress	4	7
	changing services	Continual change to services	2	9
	differences between professionals	Professional differences	1	3
	great ideas can't be implemented	Difficult to implement new ideas	1	1
	impact of involvement	Impact of user involvement	1	3
	in the office	Mental health nurses spend too much time in the office	3	3
	management resources	How resources are managed	1	1
	not knowing services	Not having enough information about available services	3	3
	what needs to change	What needs to change	4	11

	the questions	The key questions for mental health nurses	1	1
	Good nurses go to the community	Why do the good nurses leave inpatient care and go and work in the community	3	3
14	the role and the work	The mental health nurse's role and the work involved	20	151
	Changing roles of mental health nurses	Changes to the mental health nurse's role	3	3
	difference between hospital & community	Difference between mental health nursing roles in the hospital compared to community	2	3
	role	role focus	10	37
	role in recovery	Mental health nurse's role in recovery	5	8
15	What helps	What helps nurses ? (e.g. supervision)	15	40
	users support each other	Users find value in support from other users/peer support	4	8
16	What users want	What users want from mental health nurses	9	35
	what users value third sector	What users value about the voluntary sector compared to statutory services	3	11

Appendix 12: Word Clouds – phrases and concepts from Findings chapters

Word cloud from Chapter 4

Word cloud from Chapter 5

Word cloud from Chapter 6