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**Establishing professional role congruity
within the discipline of mental health
nursing**

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PhD

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**Establishing professional role
congruity within the discipline of
mental health nursing**

Thomas Anthony Machin

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of the requirements of the University of
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Abstract

Over the period of the last century in the United Kingdom mental health nursing roles have evolved and adapted in response to changes in mental health-related policy and associated changes in the ethos, structure and delivery of mental health services. The conceptual framework informing this thesis drew upon the theoretical perspective of symbolic interactionism underpinning a qualitative, grounded theory approach augmented with the use of situational analysis to explore the processes involved in the development and maintenance of professional role congruity. 'Role congruity' is defined as a functional balance between aspects of role adequacy, role legitimacy and role support. Nine student and ten registered mental health nurses were depth interviewed between 2012 and 2016. Analysis of data was conducted using grounded theory data analysis approaches, with the research context incorporated into analysis using the mapping processes of situational analysis. This analysis yielded the formulation of a grounded theory model entitled 'Establishing Role Congruity', capturing the processes involved in developing and maintaining professional role congruity for this group of mental health nurses. Situational analysis enriched this model by contextualising the captured processes within 'social worlds' and discourses evident within the mental health practice arena. On the basis of this analysis, a conceptual model of 'Role Congruity Alignment' is proposed together with recommendations for contemporary and future mental health nursing roles with regard to the balance between 'generic/eclectic' functions and roles specialising in terms of service user groups and/or therapeutic interventions. Attendant implications for the initial education and subsequent continuing professional development of mental health nurses are summarised.

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Tony Machin: July 2017

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Ethical clearance for the work presented in this thesis was sought from the Ethics Panel of the School of Health, Community and Education Studies at the University of Northumbria, and granted on 17th May 2012.

I declare that the word count of this thesis is 85,627

Signed:

Thomas Anthony Machin

Date: 30/7/17

Chapter 1: Introduction

The discipline of mental health nursing has been central to the delivery of mental health care services in the United Kingdom for over a century (Nolan, 1993). The discipline has evolved in tandem with and response to the evolution and development of mental health services, and the associated needs of users of these services, over this period of time (Norman & Ryrle, 2009). The focus of this thesis is upon mental health nursing as a professional discipline, and in particular upon the roles fulfilled by mental health nurses within mental health services and systems in the United Kingdom. Of central interest here are the aspects of role mental health nurses engage with in practice, rather than a direct focus upon the concept of 'identity', though this is related and will be afforded some attention. More specifically, this thesis is concerned with the concept of 'role congruity' in mental health nursing. This concept is derived from the notion of 'optimum role function', suggested by Machin and Stevenson (1997), and is defined here as a sense of having an agreed, consistent role (or aspects of role), appropriate to given context or contexts of practice and, conversely, an absence of role conflict. In this sense, I assert that the attainment and maintenance of role congruity for mental health nurses results in professional roles which are functional and valuable to the services within which they work and to the service users they work with, whilst also being acceptable and manageable to and for themselves.

I am a mental health nurse, and also an academic working within higher education at Northumbria University. I am employed within academic provision for professionals working within mental health practice contexts, with mental health nurses constituting the majority of those professionals. I have worked in higher education for over twenty years, prior to which I spent twelve years working as a mental health nurse in practice. My interest in this research area stems from having seen and experienced, during my own clinical working period as a mental health nurse in practice, the move from institutionally-based mental health care to a more community-based focus for mental health services. In my subsequent career in higher education, I have seen the on-going development of mental health services via the perspectives of students, both pre-registration and post-qualifying, as they have engaged with initial mental health nurse education and post-qualifying continuing professional development (CPD). This includes the ways in which mental health nurses engage with psychological interventions and the notion of 'evidence-based' practice, aspects which are central to the arguments developed within this thesis.

This introductory chapter provides a brief context for the thesis. Firstly, I briefly summarise the evolving context of mental health nursing in the UK. Secondly, the aims and objectives of the research informing this thesis are outlined, together with a brief summary of the specific research

approaches taken in addressing them. The chapter ends with an orientating summary of the chapter structure of this thesis.

The Evolving Context of Mental Health Nursing

The use of the term 'evolution' within this review of literature in relation to service and policy context is not meant to imply that services have progressively developed and improved in a linear fashion over history. Rather it is meant to capture the changes which have led to the current situations within which mental health nurses practice, and provide context for this thesis and the research which informs it.

Nolan (1993) outlined the origins of mental health nursing as a professional discipline within institutional provision for the management of people with mental health problems, created in the late 19th Century in the form of the Victorian 'Asylums' for the insane. Emerging from roles of 'attendants upon the insane' within the Asylum era to become a recognised branch of the profession of nursing in the early part of the 20th Century, mental health nursing has represented a consistent presence among the professions working within evolving systems of mental health care management and provision. Norman and Ryrie (2013) provide an overview of the contemporary practice context for mental health nursing as an 'art and science'. Within this overview, three key evolutionary strands of change relating to provision for mental health can be identified in the areas of: knowledge relating to mental health; 'technology' in the form of intervention approaches and; societal attitudes toward those with mental health problems. These factors have, arguably, interacted to result in the contemporary provision we now see for mental health in terms of systems and services.

The evolution of knowledge regarding the nature of mental health problems, together with societal concern regarding the nature of provision, contributed to the development of mental health policy and practice change. Together with more general health policy, this culminated in shifts in the nature of delivery systems for mental health care, with the relocation of sites of care delivery from large institutions, typified by Victorian Asylum buildings, through to an era of community-oriented care instigated in the latter part of the 20th Century (Jones, 1993). Caliminus (2013) outlined the proliferation of contexts for care interventions which have developed since that time, and within which necessary adaptive responses have been required of professionals within the disciplines working within mental health services, including mental health nurses. This evolution of services and care contexts has also influenced the balance of relations between professional disciplines, though it can be argued that the dominance of the discipline of medicine in the form of psychiatry remains, if subtler than in the early history of services.

This evolution in knowledge also manifests within the 'technology' strand of influence, including both the availability of pharmacological treatments for mental health problems, and also the increase in the number and types of other interventions available for mental health problems. Of particular relevance are psychologically-orientated interventions, the 'talking therapies', such as cognitive behavioural therapy (CBT). These approaches are not the exclusive domain of any particular existing group or professional discipline, indeed the ability to deliver some of these interventions has increasingly become considered as a marker of professional status as 'therapist' in its own right (Morrall, 2008). These developments have occurred in conjunction with policy drivers which have increased requirements and expectations within systems and services that intervention approaches be demonstrably based upon evidence of efficacy (Davies, Nuttley, & Smith, 2000).

Added to this evolution in systems and service provision, the profession of nursing itself has become more technically based since the 1980s in terms of academic, educational preparation (RCN, 1985). Building upon the formal move of educational programmes for nurses to delivery in higher education (HE) settings late in the last century, the preparation of nurses for practice is, as of 2015, now implemented on an 'all-graduate' basis.

It is thus apparent that when health and social care systems evolve in response to the contextual factors outlined above, the professional practitioners working within these systems are in turn subject to reorganisation and evolution with respect to their professional roles within services. With this evolution and these developments as a backdrop, mental health nurses now occupy myriad roles within services, working with a range of service users and presenting problems with mental health. These roles can be very different in terms of the balance of skills and capabilities required for them, which makes it difficult to succinctly articulate any overarching ethos for mental health nursing. It is these roles and this difficulty which are the focus of this thesis. The current review of educational provision for nurses (Willis-Commission, 2015) makes this thesis and associated research a timely analysis.

The developments and issues summarised here are explored more fully within the review of relevant literature in chapter two.

Aims, Objectives and Research Approach

I aimed to identify and clarify the factors which contribute to mental health nurses attaining and enacting 'professional role congruity'. In addressing this aim, this thesis presents the findings of research which I conducted between 2012 and 2016, which drew upon the experiences of both student mental health nurses during their initial preparation, and qualified/registered mental health nurses working within a range of roles within contemporary mental health services, and with a

variety of experience in terms of career history and progression. The definition of 'Professional role congruity' which I have formulated in relation to this thesis and research is:

"A sense of having an agreed, consistent role (or aspects of role), appropriate to given context or contexts of practice and, conversely, an absence of role conflict."

This notion of 'role congruity' itself derives from an earlier analysis (Machin & Stevenson, 1997) of mental health nursing roles which postulated the idea of 'optimum role function'.

My research was designed to capture and explore the dynamics of contemporary mental health nursing roles in terms of initial role preparation (student nurses selected at various stages over the 3-year period of initial education and preparation to initial roles as qualified practitioners) and on-going role development across a variety of mental health practice contexts (qualified practitioners in career development). More specifically, it was concerned with how mental health nurses perceive congruity within their roles.

The objectives of the research can thus be captured within two related research questions:

- 1) How do student mental health nurses develop role congruity within their pre-registration preparation for practice?
- 2) How do mental health nurses maintain role congruity within their ongoing professional practice?

A consideration of the focus upon perceptions of role congruity led me to conclude that a qualitative approach, in methodological terms, would be most appropriate. Within that stance, the focus upon capturing the 'processes' involved in the attainment of role congruity further invites a grounded theory approach (Strauss & Corbin, 1990). Further to this, the focus upon a very defined situation in terms of the context of mental health services led me to employ the variant/evolution of a grounded theory approach, 'situational analysis' (Clarke, 2005). The particular attraction of situational analysis for this study was its explicit stated intent to capture key aspects of the *situation of interest* as part of the analysis, in addition to the narratives and experience of the research participants. Given the focus of interest here upon mental health nurses and the nature of their professional roles, and the evolving practice context summarised above, the importance of explicitly capturing these aspects of context is very evident. The relationship between grounded theory and situational analysis is outlined in more detail within chapters three and four.

The data for the study was thus comprised of the outcome from situational analysis, together with qualitative, grounded theory analysis of 22 depth interviews from 19 research participants (three participants were re-interviewed).

An important point should be made here with regard to the employment of a qualitative approach in terms of the way in which 'reality' is perceived, or the stance taken with regard to how reality is 'socially constructed'. Bryant and Charmaz (2007) discuss three stances on this issue reflected in literature and studies. At one extreme in philosophy, it can be claimed that no external reality exists at all. A second position becomes bogged down (or even collapses) into relativism, whereby all versions of the world are afforded equal consideration/merit. A third position consists of acknowledging that there is a reality, but that the social 'actors' *understanding* of that reality is 'socially constructed'. It is this latter position which informs the research and analysis reported here.

Chapters three and four of this thesis elaborate the research approach taken in more technical and critical detail.

The Structure of This Thesis

Chapter two: Presents an overview and summary of relevant background literature. This is articulated within two key themes. The nature of mental health problems and responses to them are first explored, including a consideration of key policy initiatives up to the contemporary context. Attention then turns to professions and roles within mental health services, with a particular focus upon mental health nursing. This consideration includes a historical context, as well as consideration of contemporary research exploring mental health nursing roles. It should be noted that this review of literature is primarily concerned with setting the context for this thesis and associated research, rather than representing an in-depth critical review of social policy and associated service development and structure.

Chapter three: Presents the conceptual framework which frames the approach taken to the research informing this thesis. The theoretical perspective of symbolic interactionism and the methodological approach of grounded theory, as applied from a stance of situational analysis, are articulated as a conceptual framework guiding the study.

Chapter four: Outlines the actual design and methods employed in the execution of the research. Issues of sampling, data collection and the framework for data analysis are described, including the employment of the 'mapping' techniques related to situational analysis.

Chapter five: Presents the findings and initial discussion from analysis of the qualitative interviews and the situational analysis elements. These findings were derived from analysis post-conceptual framework. A situational map of the research context is presented, together with

mapping of the social worlds/arenas relevant to the research context. Analysis of the qualitative interview data is presented in the form of five theoretical categories interacting within a postulated grounded theory model, 'Establishing Role Congruity'. Analysis incorporates identifying positions relating to service structure, therapeutic interventions and discourse-related issues.

Chapter six: Builds upon the theoretical model of 'Establishing Role Congruity' presented in chapter five, and addresses the processes involved in attaining and maintaining professional role congruity. Again, this analysis was derived post-conceptual framework. A model of 'Role Congruity Alignment' is offered as a theoretical proposition. The importance and influence of social worlds is considered, together with possible positions relating to the use of therapeutic approaches. The chapter concludes with a discussion of implications for education and practice relating to mental health nursing.

Chapter seven: Considers the credibility of the research study informing this thesis in terms of strengths and weaknesses, and issues of reliability, validity and generality for qualitative research generally, and within this study in particular. It also presents a reflexive account of the author from the perspective of being a researcher for this study.

Chapter eight: Concludes the thesis by re-visiting the stated aims and summarising the key messages of findings for mental health nursing as a discipline. Potential avenues for further research are indicated and a brief discussion of wider potential applicability of findings concludes this chapter.

Conclusion

The complexity of contexts within which mental health nursing roles develop in terms of congruence is evident from the brief discussion in this introductory section. Drawing upon the study outlined here, this thesis will go on to develop discussion and knowledge about the factors contributing to initial and on-going development of professional role-congruence. The theoretical models derived from the research presented here will have potential relevance in contributing to:

- Informing the development of pre-registration curricula in the effective preparation of mental health nurses for initial professional roles.
- Informing the development of post-registration CPD curricula in effective development for ongoing, service-relevant role and career development.
- Exploration of how therapeutic intervention approaches can 'fit' with and be incorporated into the practice of mental health nursing.
- Wider aspects of self-reflection and clinical supervision issues in mental health nursing professional practice.

- An approach to consider strategic planning for the development of mental health nursing workforces, both more generally and specifically in relation to local services.

More tentatively, these models may offer relevance to other health and social care-related working roles.

This chapter has outlined the focus of this thesis, the research which informs it, the impetus for undertaking the study and the thesis structure in terms of how the key information and arguments will be presented. The following chapter will summarise background literature relating to the context of this thesis and research.

Chapter 2: Review and Summary of Relevant Background Literature

Introduction

This chapter will explore and summarise relevant literature engaged with throughout the execution of my research and the formation of this thesis. The function of this chapter is to set out the historical and contemporary context for mental health nursing practice. As such, a broad area of literature is covered and though some critique is offered in relation to key perspectives and commentators, it is not the function of this chapter to offer detailed critical debate around social policy and the direction which service developments have taken. Rather, the chapter is important in summarising the context in relation to the situational analysis component of the research informing this thesis.

The strategy utilised for searching and locating literature is first summarised. The substantive topic areas are then presented in summarised themes. These themes are grouped into two broad areas.

The first broad area addresses pertinent issues regarding the very nature of presenting mental health problems and issues, and responses to them in terms of treatment/interventions and policy are also outlined. This includes a brief summary of the historical development of psychiatric provision.

The second broad area addresses the professional groups which constitute helping agents for people with mental health problems. These professions are outlined and discussed in terms of; the nature of professional identity and role, inter-related professional roles working with service users within mental health service systems and the nature of evidence for practice. With this background set out, analysis and discussion then turns explicitly to the discipline of mental health nursing. The context of nursing more broadly is briefly set, before turning to the nature of mental health nursing, drawing upon historical and contemporary literature and research to trace key developments in the evolution of mental health nursing roles, ending with consideration of educational preparation of mental health nurses for initial practice and subsequent professional development.

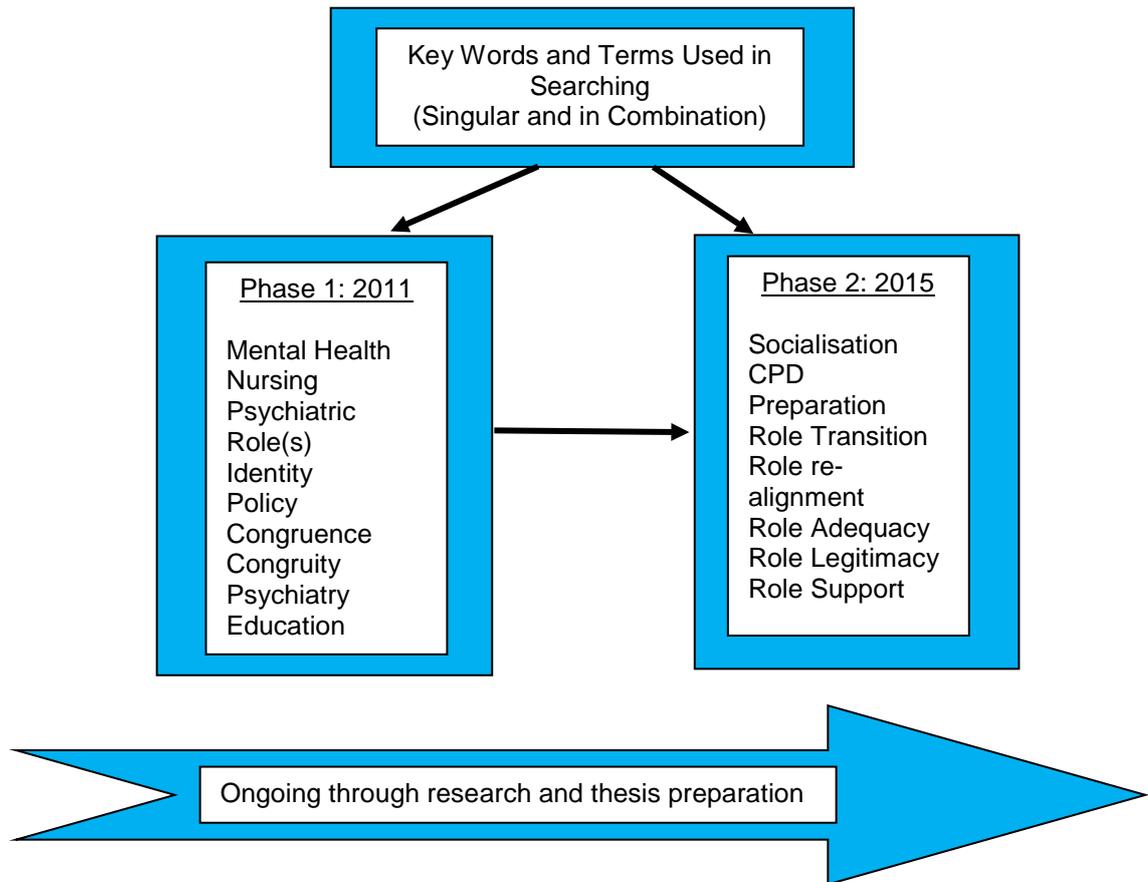
Finally, the key relevant issues from the literature are summarised in terms of relevance to the focus of this research study and thesis.

Strategy for Searching and Retrieving Literature

Bryant and Charmaz (2007) discuss the use of literature within grounded theory research approaches. At one extreme, some advocates advise entering the research domain with no preconceptions, including those potentially influenced by literature. Other experienced grounded theory researchers, notably Strauss and Corbin (1990), indicate that engagement with relevant literature can inform the 'theoretical sensitivity' of the researcher. Further to this, Ravitch and Riggan (2012) suggest that relevant literature is of value in formulating the 'conceptual framework' guiding a research study. Bryant and Charmaz (2007) conclude that in pragmatic research practice a balance arises between entering the research situation with pre-conceptions from literature, and having an understanding to provide some orientation for the researcher. It is the latter position which has been adopted within this research and thesis. The ways in which literature has informed the conceptual framework and theoretical sensitivity relating to this research and thesis are outlined in chapters three and four respectively. Chapter seven addresses my own reflexivity as a researcher, which also relates to the concept of theoretical sensitivity.

In an applied sense, an initial search of several databases, including CINAHL, MEDLINE, ASSIA and BIDS, was conducted at the outset of planning for the research informing this thesis. The initial time period encompassed 1990 to 2011 in terms of published research and literature concerned directly with mental health nursing. In terms of relevant theoretical perspectives, the University library catalogue search facility provided orientation to key texts relating to research methodology and social theory. A second phase of systematic searching was conducted in 2015, with additional words and terms added based on emergent analysis of research data and ongoing theorising. Ad-hoc updating and 'snowball' location of literature via references within located literature augmented the search process. The key words and terms involved are summarised in Figure 2:1 below.

Figure 2.1: Key Words and Terms Utilised in Literature Searching



Literature is presented within this chapter in what seemed the most relevant format during construction of the thesis itself.

Mental Health: Presenting Problems and Responses

In the first of the two broad areas of consideration, three themes are presented and summarised in terms of literature relating to presenting mental health problems and responses to them, though there are inevitable overlaps between each. Firstly, key perspectives regarding the very nature of mental health problems are outlined, since it is these presenting issues which are the focus of the work of the mental health nurse. Attention then turns to the responses which mental health services provide for presenting mental health problems, including physical and psychologically-focussed interventions. Relevant national policy relating to the provision of mental health services is then summarised. For each of these areas, a brief historical context is provided, identifying key developments.

The Nature of Mental Health Problems

Early Conceptualisations

Scull (1981) charted the post-enlightenment development of Western psychiatry as a discipline from the Victorian era through to the latter part of the 1900s. He identified how from the early to mid 1700s in England, 'mad houses' evolved to become 'asylums'. At this time, however, even the medicine of physiology was somewhat rudimentary. In terms of the management of those with mental health and learning disability problems incarcerated within asylums, often brutal treatment and discipline was embedded within regimes of management. In the late 1700s a significant influence emerged in the form of William Tuke, a Quaker and layman. Tuke established 'the Retreat' in York, England in 1796, a facility which adopted his 'moral' principles and demonstrated better outcomes for those fortunate enough to find themselves there rather than the more usual asylum regimens. Scull (1981) suggested this challenge to medical management of 'madness' from Tuke's lay perspective ultimately resulted in the incorporation and absorption of these moral principles within the emergent branch of medicine which would become psychiatry. Within this absorption the asylum further evolved and would ultimately become the mental hospital, with a parallel definitional journey made by those with mental health problems from 'mad men/women' to 'mental patients'. An increasing role was taken by statutory state administrative and organisational systems in driving this evolution, with the asylum/mental hospital becoming the official approach to the management of mental health and/or learning disability problems. Jones (1993) acknowledged that the development of the asylum system and associated increased legislative safeguards for those with mental health problems represented an improvement in provision. She also suggested that the system of asylum provision itself became problematic by the second half of the 1800s, becoming over-bureaucratized and engendering overcrowding of facilities.

The Development of Diagnostic Categories

Ingleby (1981) identified an important point regarding the venture of psychiatry as a discipline in that it is as a branch of medicine fundamentally based upon the philosophical standpoint of positivism in terms of how mental health problems are understood and responded to. For Ingleby this has two forms, 'strong' and 'weak'. A strong positivist position is based around a disease or 'faulty machine' conception. What he terms a weak approach may seek to incorporate other factors, such as environmental and psychological, but remains positivist in that it seeks causal relationships and explanations.

This brings into focus the process and practice of psychiatric diagnosis. Jutel (2009) called for a 'sociology of diagnosis' as a sub-field of the sociology of medicine. She reviewed a range of sources in establishing some important issues relating to diagnosis generally. For Jutel, diagnosis presents a set of pre-existing categories agreed upon by the medical profession, but it also serves a number of other functions: it organises illness, identifies treatment options, predicts outcomes and contributes to explanatory frameworks; it serves administrative functions in enabling access to services, treatments and social entitlements; and it is integral to the system and profession of medicine and its contribution to the creation and maintenance of social order. Jutel also acknowledges that diagnosis can be value-laden and linked to culture and politics. Her final point concerns the distinction between illness and disease. Illness is defined in terms of the individual's experience of ill health, whereas disease focuses upon the biological, rather than personal, frame of reference. In this sense, illness is presented within the narrative of the individual presenting with symptoms, which is then reinterpreted by medical practitioners in the form of diagnosis.

Consistent systems for the diagnosis of morbidity and mortality are important in collating epidemiological data regarding the aetiology and course of conditions, and researching the efficacy of interventions for them. The principal diagnostic classification system utilised in Western psychiatry is the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA, 2013). The DSM was established in 1952, and since the third edition of the DSM in 1980 there has been a shift away from psychoanalytic influence in categorisation towards a more empirical underpinning in seeking to develop valid and reliable categories of diagnosis, which more accurately reflect the experience and presentation of those diagnosed. The fifth manifestation of this diagnostic tool, DSM V, published in 2013, replaced the fourth version published in 1994. In terms of the changes to the DSM classifications, Moller (2009) outlined arguments for a more radical re-organisation of the DSM system from a 'categorical' basis to a more 'syndromatological' basis, whereby combinations of certain symptoms can be accommodated when appearing together cumulatively, and allowing more flexibly for the consideration of 'co-morbidity'. In a very medical focus, Moller also indicated high expectations of

future advancements in knowledge regarding mental health problems emerging from the fields of neuroscience and genetics.

There is no shortage of criticism for diagnostic classification systems more generally in the form of the sociological perspective of the 'social construction of illness', well outlined by, for example, Brown (1995). This includes criticism for the DSM itself as a tool of 'social construction' via diagnosis, a noteworthy example of which being Kirk and Kutchins (1999).

It is thus apparent that the definition and consideration of mental health problems is itself a contested area which forms an important contextual factor. Historically, other key critical perspectives regarding 'medicalised' approaches to the classification and treatment/management of mental health problems have been evident. Foucault (1975) suggested that Western approaches to mental health problems were dominated by a medical discourse, in the guise of psychiatry. For Foucault, such a dominant discourse excludes competing/alternative discourses, and ultimately dictates societal response to presenting mental health problems via the establishment of norms and rules (even laws). The final link in this process is the 'subjection of the self', whereby people with mental health problems accept the dominant discourse, and subject themselves to the systems and processes created by it. Nettleton (1995) employed 'Foucauldian analyses' to explain why mental health care policy in the United Kingdom in the 1980s and 1990s had adopted an ideology of moving to community- rather than institutionally-based provision. She concluded that, though technological aspects in the shape of pharmacological treatments and therapeutic interventions were a factor, from a Foucauldian perspective the pervasion of professional power from institutional bases to community was also significant.

Szasz (1961) also criticised what he saw as the over-medicalised approach of psychiatry in the classification, treatment and control of individuals diagnosed with mental health problems. He did not deny the existence of what he referred to as 'problems of living', or that effective strategies can be developed to help individuals with such problems. Szasz was more concerned that the dominance of a medicalised approach to the classification and treatment of mental health problems is self-perpetuating, disempowering for people with problems and ultimately counter-productive. Szasz's ideas have drawn criticism from advocates of psychiatry. Shorter (2011) suggested that much of Szasz's critique of psychiatry was principally focussed upon psychodynamic approaches, such as those of Freud. Shorter also drew attention to the advances and discoveries made in the field of neuro-psychiatry, demonstrating substantive bases for diagnoses and treatments. Buchanan-Barker and Barker (2009) suggested that the influence and relevance of Szasz's challenge to psychiatric systems and his alternative views regarding mental ill health have, at the least, served to ensure that those administering psychiatric systems remain mindful of the power which they have over individuals, and have also served to help emphasise focus upon service users.

Diagnoses and Stigma

Another key aspect relating to mental health problems and their classification/diagnosis is that of the effects of labelling and stigma. Scambler (2009) summarised sociological theory related to the concept of health-related stigma, from the classic identification and theorising of the concept by Goffman (1963) through to the contemporary context. Goffman's original concept of stigma incorporated, for the stigmatised: exclusion, rejection, blame and devaluation. For society more generally, it was concerned with adverse social perception with regard to groups or individuals who are stigmatised. Bell (2008) provided a critical perspective on Goffman's concept of stigma, suggesting that the breadth of his definition leaves almost everyone stigmatised to some extent.

Scambler suggests that theoretical perspectives relating to stigma became, in the latter part of the 20th century, embroiled in the politics of disability movements advocating a more social model for considering disability. A social model of disability effectively re-locates responsibility for the effects of stigmatisation from those labelled to systems and their representatives who enact the labelling. Green (2009) differentiates between those conditions, such as substance misuse or HIV, where elements of blame can be seen as part of stigmatisation, and mental health problems where 'difference', rather than blame, underpin the stigmatisation. She sees all three conditions, however, as having the perception of 'danger' incorporated within stigma. In terms of strategies for tackling the negative effects of stigma, Green outlined three mechanisms. Technological mechanisms act so as to reduce any 'deficit' seen by others in terms of an individual's level of functioning, so the individual is no longer seen as 'inferior'. Personal mechanisms are concerned with individuals being personally empowered to see themselves as equal to others. Organisational mechanisms are concerned with challenging societal perception through lobbying for equal rights and justice against oppression.

In terms of actual levels of stigmatisation experienced by those with mental health problems, an annual 'mental health attitudes survey' is conducted in England on behalf of 'Time to Change', an alliance of mental health organisations committed to addressing issues of stigma for mental health service users. The last survey (Time-to-Change, 2015) was conducted in 2014. A sample of 1,736 adults were surveyed, and the results were compared with those of 2008, giving a six-year comparative time period. Attitudes overall show a more favourable view of mental health over this period in terms of greater understanding and tolerance. However, a particular sub-set of questions within the survey is concerned with mental illness in the community, and in terms of statistics represents the aspect with the lowest baseline in terms of negative attitudes. One particular aspect within the survey invites agreement/non-agreement with the statement: "People with mental illness are far less of a danger than most people suppose". Agreement with this statement rose from 57% in 2008 to 64% in 2014. Though this represents an improvement in perception between these

periods, it implies that 36% of respondents could not lend agreement to this statement in the 2014 survey. This perhaps demonstrates the enduring nature of the perceived dangerousness of those with mental health problems, though the potential methodological biases inherent in survey approaches should be borne in mind when interpreting results (Bryman, 2001).

Considerations of Risk

The notion of 'dangerousness' leads logically to the consideration of the assessment and management of 'risk' as a concept. Beck (1992), in an influential sociological analysis, suggested that Western societies were becoming increasingly preoccupied with notions of risk factors from environmental, social and health dimensions. People with mental health problems can be seen to present risks from the social and health aspects, and the development of the 'asylum' system can be seen as a societal response to this risk, within that era. In 1992 Christopher Clunis, a diagnosed paranoid schizophrenic, attacked and killed a complete stranger, Jonathan Zito, in the UK. This case, and others like it before and since, typifies the perceived actual and potential dangerousness of people with severe mental health problems living in community contexts. Concerns relating to high profile cases such as this became evident at a time when community care was translating into implementation in the UK. Scott (1998) neatly summed up the dilemma facing policymakers and mental health services in that to draw attention to the risks presented by those with mental health problems serves to increase public fear and stigmatisation, but to minimise risk concerns may serve to increase actual risks if the care of those with mental health problems in the community is not managed and delivered effectively. Thus, key policies relating to care in the community, such as the 'care programme approach' (DOH, 1990a), emphasised the need for effective communication and coordination with regard to people with mental health problems being discharged from residential facilities to live in community settings. Policy also explicitly addressed the issue of assessing and managing the risks that individuals with mental health problems posed. Langan and Lindow (2004) suggested that approaches to risk from mental health service users were, at that time, focussed upon defensive practice, namely assessment rather than management of risks, within a culture of blame and media hype. A more considered approach to assessing and managing risk developed from debate of this nature together with actual experience of assessing and managing risk, typified by 'best practice' guidelines formally issued by the Department of Health (DOH, 2007). This guidance stressed the need for positive risk management, in collaboration with service users, acknowledging and building upon their strengths and emphasising organisational, as well as individual professional, responsibilities in considering the assessment and management of risk. As a final consideration of risk, Power (2004) identified that, at an organisational level, 'systemic' or 'secondary' risks can become influential. Examples of such risks are the potential for litigation or the consequences of failing to achieve set targets.

The negative aspects of stigmatisation and risk need to be balanced against the beneficial outcomes of diagnosis. A diagnosis can engender understanding and empathy, certainly from professional quarters. It also facilitates treatment, intervention and avenues of support, and enables research to be conducted regarding the efficacy of approaches to interventions with specific groups (Jutel, 2009). In considering issues of risk, the very real (if infrequent) and sometimes catastrophic negative episodes relating to individuals with mental health diagnoses do need to be addressed by some means, preferably pro-actively.

Therapeutic Interventions for Mental Health Problems

Having explored the nature of presenting mental health problems, this review of literature now turns to examine the therapeutic approaches available in response to identified mental health problems.

Early Approaches to Practice in Mental Health

The term 'psychiatry' as a branch of medicine was introduced in Europe in 1808 (Marneras, 2008), though did not become prominent in the common language and organisation of roles within UK services until the early/mid 1900s. Shorter (2013) suggests that psychiatry, having established professional dominance in the treatment and management of mental health problems from the outset of its inception, has been subject to 'fads' and 'discontinuities' in terms of interventions over various periods in its developmental history. Shorter (1997) outlined how the 'biological psychiatry' of the late 1800s became influenced by the 'talking cure' emerging from the theory and practice of Sigmund Freud (1856-1939), with key ideas from Freud's psychoanalytical approach becoming incorporated into the practice of psychiatry. Shorter outlined how, by the 1970s, psychoanalytical influences within psychiatry had become marginalised as biological psychiatry, re-emerging since the 1950s with the discovery of neurotransmitters and more efficacious drugs for severe mental health conditions again became dominant. The previous section has outlined how, in the UK, from the 1800s through to the 1900s, asylums, reframed as mental hospitals, became the focus of mental health care provision. The notion that the very environment of the asylum/mental hospital was itself a therapeutic intervention is captured in the term 'therapeutic milieu'. Aiyegbusi and Norton (2013) point out that the many reported negative experiences of people in mental health-related residential care settings, both in remote but also very recent history, serve to underline that a therapeutic environment does not simply come into being, but needs to be actively created and maintained by those who structure and administer the environments and principles by which residents are managed and cared for. These authors draw upon the principles outlined by Gunderson (1978) for creating therapeutic milieus in psychiatry. These are: containment, ensuring safety of individuals and others; support, enabling individuals to attain alleviation from distress; structure, in terms of organisation and the effective use of time for therapeutic purposes;

involvement, encouraging attention to and participation within the social environment; and validation, affirming individuality. Prior to the proliferation of community-based services, mental health nurses played a lead role in the organisation of in-patient environments for the management and care of those with mental health problems. In the contemporary era of care, mental health nurses still perform this key function for in-patient and residential provision required for those presenting with acute mental health crisis, or in particular settings such as residential forensic facilities.

The Development and Evolution of Therapeutic Approaches

Though at least some of the drive toward community-based approaches to mental health can be attributed to more efficacious drug treatments, the development of other aspects of intervention for mental health-related problems have also been important. Morrall (2008) suggested that supportive psychological interventions which were not dominated and controlled by psychiatry effectively created a climate for practitioners not affiliated to psychiatry to practice in these areas. Carl Rogers typified this in his development of counselling as an humanistic, person-centred, non-directive therapeutic process, including the reframing of 'patient' as 'client' (Rogers, 1951). Such approaches, importantly, can be practiced without the prerequisite of experience and training in psychiatry. Psychotherapy thus became less the domain of psychiatry and more incorporated into the practice of psychologists and other emergent disciplines in the years following the second world war (Buchanan, 2003).

The term psychotherapy itself has come to constitute a wide variety of approaches. Reisman (1991) summarised the development of key schools of psychotherapeutic intervention over the last century. From Freud's original psychoanalytic approach developed 'Neo-Freudian' approaches, often established by immediate pupils of Freud. Other schools of psychological science also began to exert influence, with behaviourism building in influence between the 1920s and the 1950s. The first form of 'cognitive' therapeutic approach, rational emotive therapy was instigated by Albert Ellis during the 1950s. Cognitive therapy built upon this (Beck, 1975) and, since the 1980s, cognitive and behavioural approaches have re-combined as cognitive behavioural therapy (CBT), with variants such as dialectical behaviour therapy (DBT). Another therapeutic approach of note is that of family therapy or systemic practice. Becuar and Becuar (2008) trace the formal development of systemic approaches from their origins in social work movements in the 19th Century in the UK and USA, through to their more formal development as a theoretical and practical therapeutic approach during the 1940s and '50s, and ultimately to a recognised therapeutic approach of some years' standing, with a number of theoretical schools within the banner term of 'systemic interventions' and many practitioners drawing eclectically upon these schools in terms of their own practice.

The idea of being eclectic invites practitioners to draw upon several approaches relevant to the context within which they are working. One particular approach which lends some legitimacy to the idea of engaging with a level of knowledge and skills from several therapeutic approaches is that of psycho-social interventions (PSI). Recommended by the National Institute for Clinical Health Excellence since 2009 as an appropriate approach for individuals with severe and enduring mental health conditions, Butler, Begley, Parahoo, and Finn (2013) usefully summarise PSI as:

“...a broad suite of structured psychotherapeutic-based interventions underpinned by the stress-vulnerability model (SVM) and includes family interventions (FI) cognitive behaviour therapy for psychosis (CBTp), case management and a variety of therapeutic techniques including engagement, assessment, use of outcome measures, medication adherence, coping strategies and relapse prevention work” [P.867].

In terms of borrowing notions from particular intervention approaches, Crowe, Carlyle, and Farmer (2008) suggest that the concept of 'formulation' as a particular approach to assessment presents a useful alternative, or at least augmentation, to the process of diagnosis. Usually related to psychotherapeutic approaches such as CBT, formulation incorporates situational, psychological and social considerations into the consideration of presenting problems/issues and, crucially, is inclusive of the perspective of the individual with the issues. A further noteworthy example of an 'eclectic'-type approach is that of 'Motivational Interviewing'. Originally developed and postulated by American Psychologist William Miller (Miller, 1983) as an approach to building motivation for change with people with alcohol-related problems, the framework of the approach has since been applied to a range of negative health-related behaviours such as obesity and tobacco smoking. The key principles of Miller's approach were brought together under the banner of Motivational Interviewing, but were developed intuitively based upon his own practice-related experience, arguably a form of 'practice-based evidence'.

Considering the various 'schools' of therapeutic approach, Morrall (2008) suggests that, just as the professional disciplines of medicine and law developed their standing in societies historically as status groups, later emulated by such disciplines as psychology and nursing, therapists aligned to particular therapeutic approaches such as CBT or Systemic Practice are becoming similarly positioned and attaining associated increased status as professional groups.

The various psychotherapeutic approaches discussed so far are often referred to as 'talking therapies', as distinguished from other therapeutic approaches. Aside from physical interventions, such as Electro Convulsive therapy (ECT) and hospitalisation within the notion of therapeutic 'milieu' as discussed above, the other principle intervention mode available is the prescription of medication. Parker (2013) outlines a comprehensive list of medications commonly prescribed for

mental health conditions: antipsychotics, antidepressants, mood stabilisers, anxiolytics/hypnotics, medicines for dementia, medicines for attention deficit disorders, medicines for rapid tranquilisation and medicines for alcohol and opioid withdrawal and abstinence. Parker summarises how the first wave of antipsychotic drugs developed in the 1950s, though demonstrating efficacy in reducing the symptoms of psychosis, were accompanied by significant side effects, including weight gain, sedation and extrapyramidal movement disorders. Side effects are also evident relating to drugs from the other categories itemised above. Though the pharmaceutical industry has developed, researched and introduced new drugs at regular intervals, significant side effects are still evident with many of the drugs of first choice when prescribing for mental health problems. Distressing and uncomfortable side effects are a major factor affecting compliance with medication regimes for individuals with mental health problems (Gurney, 2013a). Medication side effects also bring into focus the notion of 'iatrogenesis' (Illich, 1975), a term which encompasses negative outcomes for individuals arising as a consequence of the very interventions meant to address their presenting problems. Another well documented iatrogenic effect from mental health provision historically relates to the negative effects of being resident within institutions, well documented by Goffman (1961), and arguably another driver which contributed to the move toward more community-oriented care in the latter part of the last century.

Mental health nurses have a central role with regard to medication in terms of monitoring compliance with and effects of prescribed medication. This may be working in conjunction with prescribers, or as 'non-medical prescribers'.

Regulation of and for Practice

This brings the discussion neatly to the nature of guidance and regulation for therapeutic interventions. The licensing and monitoring of the prescribing of drugs for mental health problems falls within strict guidelines and protocols defined by statute, and the 'core' mental health professions of medicine, psychology, nursing, occupational therapy and social work are regulated by the processes and status of professional registration. Morrall (2008) drew attention to the large number of individuals with membership of counselling/psychotherapy associations in the UK, estimated to be some 38,000 in 2006 (ten years ago now). Whilst some of these individuals would have concurrent registration as a core professional and thus be subject to regulation by statutory professional bodies, this would not be the case for all, meaning that individuals could establish themselves as psychotherapists without necessarily being subject to the rigorous background checks regarding character and good standing implied by professional registration. This could mean that practices which do not have an associated credible evidence base for efficacy might be available to people in potentially vulnerable personal situations relating to their mental health.

In 1999, the National Institute for Clinical Excellence (NICE) was established as a body with a mandate to provide guidance with regard to the evidence which underpins particular health-related interventions, including those for mental health problems. In 2005, this organisation became the National Institute for Health and Clinical Excellence (retaining the acronym NICE). The influence of NICE has grown over the years since its inception and, in 2012, its status as the primary organisation providing guidance on best practice in health care was enshrined in primary legislation as part of the 2012 Health and Social Care act (DOH, 2012c), with a further name change to The National Institute for Health and Care Excellence (again retaining the acronym NICE). At 1st April 2016, the NICE resource website contained 45 elements of 'advice', 513 of 'guidance' and 722 for 'pathways' relating to mental health (NICE, 2016), including indications of appropriate regimes of drug prescribing and, importantly, indications as to which forms of psychotherapeutic modalities/approaches have a sustainable evidence base in terms of effective outcomes for particular presenting mental health problems. Issues relating to the nature of evidence are revisited in relation to discussion of professional roles later in this section.

This consideration of the development of intervention approaches has important implications for mental health nursing roles. As services are driven by expectations to provide 'evidence-based' interventions, a key question arises regarding the extent to which mental health nurses can develop competence and expertise in the delivery of therapeutic interventions in an eclectic sense within an overarching ethos of mental health nursing. This question is an important one and will be returned to as discussion develops later in this thesis.

Policy Relating to Mental Health Service Delivery

In terms of the mental health service delivery context being an important part of the situation examined within this thesis and associated study, it is important to outline a clear summary of the influence of policy upon the development of services. It is stressed again at this point that the broadly chronological summarisation of policy presented here serves the primary function of framing the context for this thesis and associated research. It is not intended to suggest that the development of policy has represented incremental improvement to the strategy for the provision of mental health services.

A plethora of policy influencing provision for health and specifically mental health has been generated since UK governments began to actively legislate for the management of people with mental health problems. This section will summarise the policy context for this study by outlining the main thrusts of policy historically, and through to the present day. The section ends with a summary of the main themes in policy which have converged to create the contemporary context for mental health services.

Policy in the Early-Mid 20th Century

Early policy regarding mental health was driven, as discussed earlier, by post-enlightenment societal concern regarding provision for those with mental health problems. Nolan (1993) outlined how these concerns became manifest in governmental policy in the late 1800s, culminating in the provision of asylums. The early 20th century saw an increased concern for the standards of institutional provision, with policy introducing the status of 'voluntary' admission, precluding the need for 'certification' for all psychiatric patients. It also formalised asylums being reframed as mental hospitals. Norman and Ryrie (2009) point out that the two World Wars occurring in the first half of the 20th Century had an impact upon the asylum/mental hospital system of provision in terms of staff being enlisted in armed forces or redeployed, and the need for mental health-related provision for war veterans. The birth of the National Health Service (NHS) via the NHS act of 1948 marked a significant event in the history of provision of all aspects of health care within the UK, with free health care becoming a right of citizenship. This also created the role of consultant psychiatrist, the power of which would succeed the physician superintendent role from the pre-NHS institutional system (Norman & Ryrie, 2009). The 1950s saw an impetus, at least partly economic as well as ideological, to reduce numbers of in-patients within the UK mental health system. Jones (1993) suggests that three 'revolutions' interacted at this point in history. The first was pharmacological, with the development of more effective drug treatments for psychosis, through to the development of benzodiazepine anxiolytics/hypnotics following in the 1960s. The second was social/administrative, whereby the hospital setting became only one potential tool for interventions (other possibilities such as 'therapeutic communities' being introduced). The third was legislative, with the introduction of the Mental Health Act of 1959. This act built upon the notion of the 'voluntary' patient, with an emphasis upon the treatment of 'informal' patients, increasingly in a community setting, in effect encouraging changes to admission practices. Jones suggested the impetus toward community approaches to provision was driven in part by the financial implications of replacing the ageing asylum/institutional provision, but also by the ideologies being espoused by writers such as Szasz, Goffman and Foucault during the 1960s, fuelling condemnation of institutional approaches to provision.

Policy Driving Community Approaches

From the early 1960s, UK Government policy signalled the intent to replace 'Victorian asylums' with a 'modern' approach to mental health service provision. The scale of this task, taking into account the numbers of individuals who were institutionalised within this provision, meant it would be over twenty years before this stated intent began to be substantively realised. The intended replacement system was laid out formally in the Government 1975 White Paper 'Better services for the mentally ill' (DOH, 1975), and centred upon the development of comprehensive local services, with acute and day services linked to district hospital-based provision, and community mental

health teams (CMHTs) working in conjunction with Local Authority social services. In the early 1980s, the programme of closure of longer term provision for mental health was envisaged to take place over ten years (DOH, 1981), however in 1985 a government appointed Social Services Committee (DOH, 1985) urged caution in the pace at which longer-term hospital provision was being withdrawn, and that this pace should be matched by the development of appropriate community-based provision. At this time mental health nurses were, for the most part, institutionally based within mental health facilities, including the basis of their educational preparation. A specific post-qualifying programme of study was developed by the then English National Board for nurse education (ENB 811 'Community Psychiatric Nursing' course), to prepare mental health nurses to practice in community settings as community psychiatric nurses (CPNs). These courses, typically comprising a full-time year, were delivered across the country to prepare mental health nursing workforces for community roles from the early 1980s into the 1990s, by which time pre-registration programmes for mental health nurses had developed alongside services to reflect an appropriate balance of community-based experience.

Significant changes to the management of the NHS were implemented in 1983, with the implementation of recommendations from the 'Griffiths report' (Griffiths, Betts, Blyth, & Bailey, 1983). These changes saw a move to more accountable management structures, with 'unit management' replacing a system where a consensus approach was manifest across the professional disciplines in terms of day-to-day service management. Sir Roy Griffiths, chief author of the 1983 recommendations, was asked to examine community care structures and processes in 1987, and many of his recommendations became manifest in the NHS and Community Care Act of 1990 (DOH, 1990b). A key part of this act created the split between purchasers and providers of services for local populations, with NHS providers of health services enabled to become 'Trusts', and later 'Foundation Trusts' (with greater autonomy from the NHS managerial hierarchy). The operationalisation of this framework for providing community care for those with mental health problems was encapsulated in the 'Care Programme Approach' (CPA), a practical framework within which the requirements of health and social services to provide assessment of needs, written care plans and designated care coordinators was made explicit (DOH, 1990a). These fundamental structural changes impacted upon mental health nursing roles in terms of case management and coordination.

The 1990 act also formally called for the involvement of mental health service users in the planning of services, and most health policy since then has explicitly included the requirement for service user-involvement in service planning. The influence of service users had been growing since the 1960s and 70s, coinciding with the move toward community care but was, at least initially, often tokenistic rather than genuinely incorporative of the service user perspective (Bowl, 1996).

In 1992, the 'Health of the Nation' strategy (DOH, 1992) included mental illness as one of five key health targets to focus upon and re-affirmed commitment to closure of remaining mental hospitals and realignment of resources into community-based services, together with targets relating to the reduction of suicide rates. Following criticism regarding the degree of administrative burden for the case workers involved, the CPA was later adjusted to encompass 'standard' and 'enhanced' levels of consideration (DOH, 1999a). These organisational measures incorporated the emphasis upon the assessment and management of risk, discussed here earlier. This engendered the requirement for the discipline of mental health nursing to explicitly engage with the concept of risk, and its associated manifestation within practice.

Policy from the Late 20th Century to Early 21st Century

Davies et al. (2000) suggest that for a large part of the last century, a problem with policy in public services existed in that whilst targets were often set, the planned means of achieving goals were not always specific and underpinned by the best evidence in terms of efficacy of approaches and strategies employed to meet them. They recognised the increasing influence of 'evidence' in the form of research upon policy toward the end of the century. A flurry of health, and specifically mental health, policies which embody these principles were produced toward the end of the 1990s. 'The new NHS' (DOH, 1997) and 'A first class service' (DOH, 1998a) encompass the principles of evidence underpinning services and interventions in health generally, together with the principles of 'Clinical Governance' in quality assuring safe delivery of service standards and interventions. These policies were also instrumental in establishing the National Institute for Clinical Excellence (NICE), whose function and evolution is summarised in the previous section.

The government White Paper 'Modernising mental health services' (DOH, 1998b) aimed to raise standards and promote better partnership working between health and social services. It also heralded the implementation of the National Service Framework's (NSF) health-related conditions and service user groups between the late 1990s and the early part of the first decade of the current century. NSFs were 'standards based', with guidelines for implementation. The adult mental health framework (DOH, 1999b) identified seven key standards relating to; promoting mental health, primary care, 'severe' mental illness, carers needs and the reduction of suicide incidence. Associated policy guidance covered areas including; care coordination, 'talking therapies', 'assertive outreach', crisis resolution and 'early intervention in psychosis' (EIP).

Whilst initial and continuing professional development has always been an important issue for health and social care professionals, the move in policy development toward a more explicit evidence base in terms of interventions, in turn, made the focus of the initial and ongoing preparation of practitioners more explicit in terms of the skill base which they practice from. In

terms of delivering the standards relating to the 1999 NSF for mental health, there are some aspects which are more generic in terms of professional attitudinal and skill base for those working with people with mental health problems. A workforce action team was set up in relation to the NSF to advise on the likely workforce development needs for practitioners. 'The capable practitioner' document (Lindley, O'Halloran, & Juriansz, 2001) outlined a framework of capabilities required for case workers in mental health services, including; implementation of evidence-based interventions, decision making, ethical awareness and problem solving.

In considering the implementation of evidence-based interventions, specialist programmes of study aimed at preparing practitioners to develop skills in specific intervention approaches, such as CBT and systemic practice/family therapy, have been available for many years. In terms of a cohesive strategy for the development of mental health workforces in the delivery of these interventions, the 'Improving Access to Psychological Therapies' (IAPT) programme was initiated nationally in 2008 in England (DOH, 2008b). This sustainably-funded initiative aimed to increase the number of therapists, principally in CBT for anxiety and depression-related problems, in services across mental health services in England. By 2011, some 3,600 additional therapists had been trained across England, and evidence showed gains in levels of employment and reduction in dependency upon state benefits (Clark, 2011). By 2012, a million people had received interventions for anxiety and depression from IAPT-related services (DOH, 2012d). Many of these additional therapists were mental health nurses, which again raises the question of how expertise and competence within particular therapeutic approaches can be incorporated into the ethos of being a mental health nurse.

The 'new horizons' policy (DOH, 2009b) was designed as a cross government strategy for mental health in England, ten years on from the NSF. Two broad areas identified for priority were public health and well-being and the improvement of mental health services. The public health strand focussed upon the areas of children and young people, employment and housing and tackling stigma. The service improvement strand focussed upon improving quality and value for money, 'recovery' and personalisation, improving access for marginalised groups, early interventions, the improvement of transitions and the interface between physical and mental health. This latter aspect was brought more to the fore in the subsequent policy 'No health without mental health' (DOH, 2011), the focus of which was the mainstreaming of mental health as an issue across the life-course, and across the three governmental areas of public health, adult social care and the NHS. The issue of stigma was again given a firm focus, together with accessing psychological therapies, pointing to the achievements made within the ongoing IAPT initiative. The imperative to give 'parity of esteem' for mental health with physical health was also raised within this policy. This latter facet signals issues relating to the appreciation of physical health aspects for services and

professions focussing upon mental health, and conversely, of mental health issues for those focussing upon physical health.

In terms of structural reforms to the NHS, the health and social care act of 2012 (DOH, 2012b), heralded by the 2010 White Paper 'Equity and Excellence: Liberating the NHS' (DOH, 2010a), represented fundamental changes to the system of health care delivery in the UK. Behind this legislation lies the governmental conviction that fundamental reform of the NHS was necessary to ensure its affordability, and thus survival. This act marked the end for Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), and replaced their role in commissioning services with 'Clinical Commissioning Groups', heavily represented by General Practitioners (GPs). This act also created a number of 'arm's length' bodies which removed direct responsibility of the Government's Health Secretary. A new body overseeing public health, 'Public Health England', was established, and the 'Care Quality Commission' (CQC) created to address inspection of health-related services. 'Health Education England' (HEE) was created to oversee training of the health care workforce, and 'NHS England' was created to oversee commissioning for NHS services. Critics of the act, e.g. Delamothe and Godlee (2011), suggest that changes in commissioning arrangements invite 'privatisation through the backdoor', and fragmentation of health care. The 2012 act also enshrined in statute the role of NICE as arbiter of what constitutes 'evidence' for practice, and introduced into statute the stated intent for health services to aim to attain 'parity of esteem' between services for mental and physical health-related problems.

Policy Relating to Younger and Older People

Policy discussed up to this point has been generally related either to health services, 'adult' mental health or to mental health services more broadly. In the sense of a 'life course' consideration, though some policy explored has focussed upon the importance of transitions, there are two further specific agendas within this scope relevant to mental health, those relating to older people, and those relating to children and young people. These are important to summarise since older people and younger people comprise two important service user groups for which mental health services and provision are required. Mental health nurses represent an important professional group within these services.

In terms of the older person's agenda for mental health, a National Service Framework for older people was established in 2001 (DOH, 2001). One of the eight standards outlined was related specifically to the promotion of mental health for older people, and treatment and support for older people with dementia and depression. Some of the other more generic standards were also relevant to mental health services, in terms of equity of access and choice. In 2009 a national dementia strategy was launched (DOH, 2009a). This strategy set out an ambitious plan to approach the issue

of dementia in England, with far reaching proposals to enable early diagnosis and treatment, improved quality of care including in general hospitals and nursing homes, better community support services, better information and support for carers and better 'end of life' care. This policy outline of 2009 was followed up in 2010 with an update to bring the strategy into line with the new coalition plans for the NHS (DOH, 2010b), and the opportunity was taken to add the goal of reducing the amount of anti-psychotic medication inappropriately used in the treatment and management of dementia. An interim review (DOH, 2013a) indicated some positive achievements, but an ongoing agenda persists in further progressing these aims.

In terms of the children and young peoples' agenda, McCulloch and Ford (2009) suggested that Child and Adolescent Mental Health Services (CAMHS) were long considered to be a 'Cinderella within a Cinderella'. There was a National Service Framework for children, young people and maternity services (DOH, 2004) which included one specific standard relating to access to timely, appropriate mental health services. Other relevant standards were concerned with family support and the safeguarding of vulnerable children and young people. In 2008 the final report of a national CAMHS review was published (DOH, 2008a). This report was somewhat damning of existing CAMHS services in terms of; understanding of child development and mental health problems, 'child and family friendliness', accessibility, response time and thresholds for access to services. The report also noted large variability in service provision between areas of England. A large thrust of the response to these concerns was focussed within the Children and Young Peoples' Improving Access to Psychological Therapies (CYP-IAPT) initiative (DOH, 2012a). Like the 'Adult' IAPT initiative outlined earlier here, a key focus was upon improving access to psychological therapies such as CBT, parenting interventions and systemic practice. However, whereas the Adult IAPT was concerned with creating new services, the focus taken with the children and young peoples' IAPT was the transformation of existing services. The increase in availability of psychological therapists is being implemented by up-skilling the existing clinical workforces within services, together with a 'whole-systems' approach involving the whole workforce of services in the core principles of service user participation and the delivery of evidence-based interventions. Again, many of the therapists being up-skilled are mental health nurses. The 2015 report of the children and young people's mental health task force, 'Future in mind' (DOH, 2015), includes the ongoing implementation of the children and young people's IAPT programme in pursuing the stated goals of increasing public awareness, challenging stigma and improving access to timely, evidence-based interventions for children, young people, parents and families.

Legal Frameworks

An important aspect of policy legislation for all mental health services and practitioners, including mental health nurses, is the legal framework within which people with mental health problems are

considered. The Mental Health Act of 1959 was replaced, historically, by the Mental Health Act of 1983 (DOH, 1983). This act clarified aspects of compulsory treatment relating to people detained in mental health facilities. Importantly, it also enhanced the rights of people with mental health problems who were detained against their will. The role of 'approved social worker' was enshrined within the process of compulsory admission, and explicit appeal processes were stipulated. It created in statute the 'holding power' of mental health nurses, who could enact legal holding of patients, against their will, for a period of six hours. The 1983 Mental Health Act was amended in 2007. Williamson and Lawton-Smith (2013) summarised the key amendments, within which two new roles were created. The first is that of 'approved clinician', which expanded the role of 'approved social worker' within the 1983 Act to other disciplines than social work. The second is that of 'responsible clinician', which expanded the role of the 'responsible medical officer' to other disciplines. The 2007 amendments also included the provision for 'supervised community treatment' (SCT), whereby individuals living in community settings can be required to comply with treatment regimens and re-admitted for treatment if they fail to do so. A further important piece of mental health-related legislation relating to the amended mental health act and compulsory admission is the Mental Capacity Act of 2005 (DOH, 2005).

This brings into focus the role of practitioners in the mental health field, including mental health nurses, as 'agents of social control'. Barker and Buchanan-Barker (2012) discussed this in relation to administration of psychiatric drugs. They point out that nurses widely promote a range of social norms in relation to health (diet, exercise, smoking cessation), but only in psychiatric settings do they *enforce* social norms. Morrall and Muir-Cochrane (2002) draw upon the example of the use of seclusion within mental health settings as a means of addressing disruptive/challenging behaviour. They identify how mental health nurses become engaged with injunctions of thoughts and behaviour, in addition to acting as arbiters of risk and dangerousness, with the practice of seclusion representing a particularly 'naked' form of social control. Crowe and Carlyle (2008), in discussing the care of people diagnosed with personality disorder, identify how the use of psychiatric discourse can potentially limit the role of mental health nurses to medication dispensers and agents of social control in relation to service users whose behaviour becomes challenging. They call for a 'discursive' approach to managing distress in such individuals, working with them to connect and identify the nature of the distress and explore alternative avenues for its management. However, within the context of nursing roles as outlined here, these practices remain prescribed and embedded within systems of care and provision.

Current Policy

In 2014, the UK government produced a 'five year forward view' for the reorganisation of health services (DOH, 2014). Taking a lifespan approach for a 'seven day NHS' which considers mental and physical ill health with equal parity, the key thrusts of the proposals for the NHS are concerned with models of care for community, acute, and urgent/emergency care within localities. A mental health task force was charged with providing recommendations for mental health service provision within this five year plan, and reported in February 2016 (DOH, 2016). The key mental health-related areas identified for attention are; the support of people experiencing a mental health crisis, the physical health needs of people with severe and long term mental health problems, the need to continue with the programme improving services for children and young people (CYP-IAPT), improved standards of access to recognised care pathways, the location of acute and secure services as close to people's homes as possible, addressing inequalities in access and treatment for minority groups and supporting employment. Specific areas of care provision focussed upon are; peri-natal mental health, first episodes of psychosis and crisis care for children and young people. The report also calls for a clear workforce development strategy in pursuing these objectives, and includes a call for considerations of good occupational mental health in workplaces. Importantly, employing organisations of the mental health workforce itself are included here. As part of any service reorganisations involving delivery of general practitioner (GP) services, the report recommends core mental health training for GPs, with some GPs having extended scope of practice relating to mental health. There is also a call for improved standards for all health professionals who prescribe within mental health settings. The recommendations conclude at a more general level with a call for a cohesive ten-year research plan in the area of mental health.

As would be expected, the policy agenda as summarised here has influenced the development of mental health services significantly, together with the role of mental health nurses within these services. Services are increasingly required to demonstrate the availability and provision of identified evidence-based interventions for specified presenting problems. This has implications for the development of workforces within these services, including mental health nurses.

Having summarised issues relating to mental health in terms of presenting problems and broad responses to them, this review now turns to the second area of literature, exploration of professional roles which have developed within mental health services.

Professions and Roles within the Mental Health Arena

This second broad area of literature examines the nature of professional roles within the mental health arena within four key themes. Firstly, relevant theoretical perspectives regarding the nature of professional roles and identities are summarised. A brief overview of professional roles which have developed within mental health service provision is then presented, followed by consideration of knowledge and evidence in relation to the practice of mental health professions. Lastly, mental health nursing itself, as the focus of this research study and thesis, is explored more specifically within the final section in terms of the development of the role to date.

The Nature of Professional Identity and Role

In considering the concepts of 'identity' and 'self' in relation to society, Giddens (1991) refers to the 'reflexive project of the self' (p.9) which generates two programmes for individuals to pursue, those of actualisation (realising potential) and mastery (of knowledge skill and competence). More broadly, for Giddens, a person's identity concerns 'the capacity to keep a particular narrative going' (p.54). Central to the focus of this research study is the concept of 'professional role congruity', with particular reference to mental health nursing. This encompasses aspects of role function and also overlaps with the concept of identity. In social theoretical terms, this lies firmly within the perspective of symbolic interactionism.

At a theoretical level, classic symbolic interactionist perspectives (Blumer, 1969; Mead, 1934) provide a theoretical framework for understanding the processes of identity formation and socialisation into roles. Berger and Luckman (1967), building upon early interactionist theories in their seminal text concerning the sociology of knowledge, explore both objective and subjective aspects of society, with a particular emphasis upon the interaction between individuals and institutions in society during primary and secondary socialisation processes. These processes, they argue, result in the internalisation of social structures in terms of 'symbolic universes' and outline processes by which these 'universes' are maintained both at a given point, but also generationally over time. In the context of this study, this includes professional roles within systems and, importantly, the way in which individuals become socialised within professional groups. This includes consideration of the ways in which particular areas and aspects of knowledge become the domain of particular professional groups. There are criticisms of the perspective of symbolic interactionism, chiefly that it is fundamentally theoretical, rooted in the perception of individuals, and thus fails to account for society at the level of social structures (Giddens & Sutton, 2013). Nevertheless, symbolic interactionism remains a significant 'school of thought' in relation to things social. There are classic symbolic interactionist theorists who focus specifically upon identity (e.g. Goffman, 1959; Strauss, 1959, 1997). Strauss (1978a) outlined a theory of 'negotiated order',

exploring the way in which cooperative structures are built and maintained through negotiations between the 'social actors' involved in given situations. Strauss (1978b) also identified the importance of 'social worlds', groups of social actors with shared commitments to particular activities and ideologies. This notion of social worlds will be returned to as a central aspect of the conceptual framework and applied methodology for the research informing this thesis, outlined in chapters three and four.

There are several social theoretical considerations of professions in terms of identifying the 'traits' which differentiate a profession from an occupation. These are summarised by Macdonald (1995) as: making a positive, ethical contribution to society; autonomy to direct the nature of their own work; control of professional regulation of education and practice; and control of a discreet body of knowledge. A professional, regulatory body is usually evident (the NMC in the case of nursing) in implementing and monitoring these characteristics, via explicit codes, ethical conduct relating to practice and explicit criteria for educational preparation and admission to the profession and ongoing professional development. Significantly, Macdonald suggests that the difficulty in identifying a cogent and unique knowledge and theory base for nursing leads to difficulties in asserting full professional status. For McKeown and White (2015) the fact that important decisions regarding the future of nursing education and career structures are being reviewed by an 'independent' task group (Willis-Commission, 2015) illustrates the limited autonomy the profession has in comparison to that of medicine. This aspect of identifying a unique, underpinning theoretical perspective is an important one, and will be returned to later in discussion.

In terms of theoretical perspectives derived from applied research, Collier (2001) explored the process of role identity acquisition within a sample of 140 college students in America. He found that acquisition of role identity is rooted in the experiences of group members, and that shared meanings relating to a specific role can facilitate individuals from different backgrounds in recognising the role. He also found that individuals occupying similar roles may agree upon meanings and characteristics of the role, but might disagree with regard to the relative priorities of component parts. Within the UK context, Machin, Machin and Pearson (2012) reported on a qualitative, grounded theory study of health visitors' perceptions of the changing professional practice context. 17 health visitors from the north of England were interviewed, with four inter-linked categories emerging from analysis: professional role identity (core category); professional role in action; inter-professional working; and local micro-systems for practice. These categories interact within a process of 'role identity equilibrium', whereby health visitors maintain their individual, collective and public 'identity equilibrium' via interaction and feedback at levels of: referent group (fellow health visitors); other referent groups (inter-professional context); role parameters within practice; policy parameters (as interpreted for practice). This study concluded

that equilibrium and consistency in identity for these health care professionals was of central importance. Though not related to mental health nurses directly, and subject to the criticism that they were localised, small-scale qualitative research approaches, these findings are of relevance in terms of relating to professional groups which strive to maintain identity whilst undergoing major change within the context of defined practice arenas. The concept of 'referent group' is particularly resonant when considered in relation to social worlds.

Professions with roles which operate within the same arenas as other professional groups often need to navigate the political landscape within a given arena of practice. Castels (1997) provided a useful concept of 'political identity', of central importance among and between professional groups. He proposed three aspects relating to political identity:

- 1) Legitimising identity: relating to the perpetuation of order and social structures from the dominant social structures which generate this identity. Policy generated from institutional structures such as the Department of Health can be suggested to reflect this kind of identity in terms of its acknowledgement of the role of professional groups in implementation.
- 2) Resistance identity: the active resistance to dominant oppressive forces presenting a threat to a profession. This threat may be to undermine or redefine aspects of practice for a given profession, and carries a danger of fragmentation of a professional group.
- 3) Project identity: entailing the consciously-planned transformational building of identity. This aspect is employed when a professional group sets out to manage a change in their position in society. Social movements such as those concerned with 'gay rights' illustrate this kind of identity. In the context of professional groups, it can be seen in their historical development.

As a final theoretical perspective of relevance, Machin and Stevenson (1997) drew upon research carried out by Shaw, Cartwright, Sprately, and Harwin (1978), the focus of which was to explore why some general practitioners, probation officers, social workers and other 'agents' within helping professions/agencies were prepared to offer help to individuals they encountered who had problematic alcohol use, whilst some shrank from the task. This research was fairly robust, as the 1978 publication was based upon eight research studies involving survey and qualitative interviewing approaches carried out in two phases between 1973 and 1977. Based on their analysis, these researchers developed a model outlining 'role security' and 'role insecurity' cycles, whereby when the three elements of role adequacy (knowledge and skills relating to the role), role legitimacy (the sense that the role was a valid one to engage with) and role support (being

supported in the role) were present, and a positive cycle of role security was fostered within which the agents would offer help. In a theoretical discussion, Machin and Stevenson (1997) applied the three elements of role adequacy, role legitimacy and role support to the analysis of facets of mental health nursing roles, suggesting that when the three elements were present 'optimum role function' would result. The idea of optimum role function can be suggested to relate closely to 'role congruity', the fundamental concept which this research and thesis addresses.

Professional Roles Within Mental Health Services

It is important to locate mental health nursing among the range of professional roles operating within the context of mental health services and service users. There are five key 'core professions': psychiatry, psychology, occupational therapy, social work and mental health nursing.

The formation of psychiatry as a specific branch of medicine in the 1800s has been outlined earlier in this review, together with its established dominance in the developing asylum and then mental hospital systems. The neuro-biological approach of psychiatry remains as a dominant focus in practice, and the discipline of psychiatry has retained dominant influence upon the way mental health services are configured around diagnostic groupings of service users. Psychiatrists are initially prepared as medical doctors, before pursuing further development in the specialism of psychiatry.

Psychology as a discipline has its roots in the late 1800s, with the discipline of clinical psychology emerging in the early part of the 20th century. The original focus of the discipline was around psychological assessment, including considerations of intelligence, personality and behaviour. Following the Second World War, clinical psychologists became more involved with psychotherapeutic interventions within various schools of psychotherapy, as they became more divorced from medical control and influence (Shorter, 1997). Modern clinical psychologists are prepared via a three-year Doctoral programme which they enter as graduates of the academic discipline of psychology. One of the key approaches which delineates clinical psychology from psychiatry as a discipline is a focus upon 'formulation' rather than 'diagnosis' as a basis of assessment (Cheshire & Pilgrim, 2004). Formulation is more explicitly concerned with how an individual's mental health issues have arisen and are maintained in context (thus informing strategies for addressing them), whereas diagnosis is more about categorising individuals, with presenting problems informing the diagnosis.

Occupational therapy (OT) as a discipline emerged in the late 19th/early 20th century, with a focus upon meaningful occupation as being therapeutic. 'Occupation' in this sense can be seen to form a fit with the way in which mental health institutions in the early to mid-20th century developed

programmes of activity for those resident within them (Reed & Sanderson, 1999). In the context of modern occupational therapy practice, the College of Occupational Therapists (COT) in the UK describe the role of occupational therapy as follows:

'Occupational Therapy provides practical support to enable people to facilitate recovery and overcome and barriers that prevent them from doing the activities (occupations) that matter to them. This helps to increase people's independence and satisfaction in all aspects of life' (COT, 2016).

The relevance of this description of OT practice and focus is very evident in considering the rehabilitation of individuals with mental health problems.

Like occupational therapy, the discipline of social work also emerged from the late 19th century, from an original emphasis upon philanthropy, and like clinical psychology, evolved a more therapeutic orientation following the Second World War (Home, 2009). The British Association of Social Workers (BASW) summarise the role of social worker as follows:

'Social Workers work with individuals and families to help improve outcomes in their lives. This may be helping to protect vulnerable people from harm or abuse or supporting people to live independently. Social Workers support people, act as advocates and direct people to the services they may require. Social Workers often work in multi-disciplinary teams alongside health and education professionals.' (BASW, 2016).

The need for social work for people with mental health problems is, again, very evident when issues of housing, resettlement and help with independent living are considered. When the era of community care was instigated in the latter part of the last century, a notable increase in the workforce of social workers was required (Nolan, 1993).

Nolan outlines how, in the context of the UK, the origin of mental health nursing as a discipline is linked with the history of mental health provision, as outlined earlier. He describes how 'keepers' in 'mad-houses' came to have their role re-defined as 'attendants' in 'asylums', the latter term relating to a more caring than custodial role in semantic terms at least. It was not until 1923 that 'mental health nursing' was placed upon the register of the, by then, General Nursing Council (GNC). The development of the discipline of mental health nursing since that time has continued to be related to the development of mental health service provision. The transition from hospital to community care, outlined earlier in both history and policy, brought about the role of the 'community psychiatric nurse' (CPN). Norman and Ryrie (2013) described how this role evolved from early beginnings as 'outpatient' and 'after care' nurses in the 1950s and '60s, and the CPN role became synonymous with community mental health services as they expanded through the 1980s and the 1990s, through to the present day. Within that time period, mental health nursing roles have

evolved from hospital-based functions dealing with people admitted with acute episodes of mental ill health or people with more enduring and disabling conditions in need of 'rehabilitation' or daily support, to a context involving a variety of specialist areas in terms of presenting problems and therapeutic interventions.

The mental health professions summarised here do not work in isolation. Whether in hospital or Community-based roles, these professional groups have a remit to work together as a team in order to address the needs of people with mental health problems. Onyet (2009) made the point that simply labelling a group of practitioners a 'team' does not necessarily result in an effectively functioning one. He outlined several requirements which characterise effective team working, among which are: a clear vision from the host organisation; shared objectives; diverse, differentiated and clear roles and; clear leadership.

Discussion so far has focussed in particular upon the 'core' professional roles working within the mental health arena. Other important roles exist, not least of which is that of the 'care assistant' or nursing assistant. Care assistants, under a variety of role titles, carry out much of the day-to-day 'hands on' care as directed by qualified nurses, and other core professions have similar 'assistant' roles. Many of these individuals secure qualifications relating to health and social care, and a significant number seek to attain the qualification threshold to enter into pre-registration preparation to become registered practitioners. Other roles of note include therapists not allied to a core professional role in the mainstream sense, for example 'art therapists' and 'play therapists' in young people's services. There are also a significant number of roles exclusively termed 'psychotherapist', or 'therapist', which relate to the therapeutic modalities such as cognitive behavioural therapist or family therapist discussed in the previous section. Complexity arises where these roles and associated knowledge, perspectives and competence co-reside in individuals who are also from the core mental health professions, including mental health nursing.

Considering the context of mental health services as outlined so far, and descriptions of the focus of practice for mental health professionals as summarised above, it is evident that there is considerable potential for overlap and competition around specific aspects of role. Nancarrow and Borthwick (2005) proposed a useful framework for considering how these dynamic boundaries between health care professionals manifest in practice. They outlined four pathways which professions can take in terms of changing boundaries of practice. The first two are framed as 'intra-disciplinary', whereby professions may diversify or specialise. Diversification involves practice expanding into a new area of activity for that discipline alone. This may involve new markets, new settings, new ways of providing services, new therapeutic approaches, new techniques or new philosophies of care. The diversification of mental health nurses into community roles might fall

into this category. The specialisation avenue involves an increase in the level of expertise pertaining to a specific area and may be adopted by a specific group within a profession, with a specific title and involving post-registration training/education leading to a role with greater autonomy (and often greater financial remuneration). The role of health visitor might be seen in this light, as a specific, specialist role with a pre-requisite requirement of nursing as an initial registration. The second two pathways for practice role boundary changes are 'inter-disciplinary', whereby vertical or horizontal substitution may occur. Vertical substitution involves the delegation (and adoption) of areas of activity which have hitherto been the realm of another, often more prestigious profession. This typically occurs without the substituting profession being remunerated at the same level as the profession from which the role is substituted. Examples of this can be seen in the granting of powers of non-medical prescribing to professions other than medicine, or the creation of assistant or 'associate practitioner' roles, whereby individuals deliver components or aspects of a role usually or historically related to a specific profession, often under supervision of a practitioner of that profession. Horizontal substitution occurs in situations where professions of similar levels of training and expertise, but differing disciplinary backgrounds, undertake roles usually associated with another discipline. This represents the 'nitty gritty' of practice scenarios, with examples including the 'mobilisation' of people during rehabilitation, whereby OTs, physiotherapists and nurses might all be involved with specific aspects of rehabilitative mobilisation. Nancarrow and Borthwick (2005) suggested that the potential for horizontal substitution is increased where roles and tasks are less well defined, though this is limited by regulatory aspects, legal indemnity, and the potential for protectionism within and between professions.

Knowledge and Evidence for Practice in Mental Health

Discussion earlier has outlined the increasing importance of 'evidence' underpinning practice in all aspects of health care. This has translated into policy directives at organisational levels, and also into the ethos of professional practice, as will be discussed specifically in relation to mental health nursing later in this review of literature.

In terms of evidence-based interventions, the National Institute for Health and Care Excellence (NICE), the principal advisory body to health care services regarding effective interventions, established a 'hierarchy' of approaches to research into efficacy of interventions. Davies et al. (2000) summarised this hierarchy as:

I-1: Systematic reviews and meta-analysis of two or more double-blind randomised control trials.

I-2: One or more large double-blind randomised control trials.

II-1: One or more well conducted cohort studies.

II-2: One or more well conducted case-control studies.

II-3: A dramatic uncontrolled experiment.

III: Expert committee sitting in review; peer leader opinion.

IV: Personal experience.

Davies et al., whilst accepting the value of approaches such as the random controlled trial (RCT) in 'objectively' evaluating the efficacy of an intervention, point out that such approaches, though demonstrating that beneficial outcomes have occurred, do not explain why these outcomes have occurred. When interventions are complex or 'bundled', such as the input of several professionals and approaches with people with mental health problems, it can be difficult to disentangle the relative impact of differing aspects of input. It may also be unethical to design a research study which precludes some aspects of intervention in order to attempt to establish the relative importance of others. McCrae (2012) draws attention to the way in which such evidence can be perceived and applied in a distorted way. This can occur, he suggests, in adopting a stance of naive empiricism (in applying experimental principles to the complex human social world), distorting the applicability of findings (either by seeing applicability beyond that indicated within study parameters, or detracting from the size of any beneficial effects) or overlooking cultural issues in terms of application of findings.

However, the hierarchy outlined above remains the dominant consideration in evaluating the efficacy of interventions. Whilst some psychotherapeutic interventions which are delivered over a defined timescale and structure (such as CBT and family therapy) can employ RCTs in evaluating specific outcomes, other approaches with less standardisation or defined structure find difficulty. Fonagy (2003) summarised the problems in evaluating establishing the evidence base for psychotherapeutic interventions of the more 'analytic' type in terms of difficulty in using the 'gold standard' of the RCT. In 2013, the UK Government (DOH, 2013b) responded to a Parliamentary Select Committee established to examine the effectiveness of the role of NICE in providing guidance to services, commissioners and professionals. The British Association for Counselling and Psychotherapy (BACP, 2013) presented a submission to the health select committee in relation to this review suggesting that, whilst the NICE process is robust, there are two major disadvantages to maintaining the rigid hierarchy favouring the RCT. Firstly, since mental health research has limited funding and though some approaches such as CBT have been evaluated across a range of conditions, many established psychotherapeutic approaches remain unevaluated by RCT. This means NICE guidelines are based on a valid but quite narrow evidence base. Secondly, the downgrading of other types of research, such as case studies, which can also assess how an approach works in practice, potentially disadvantages approaches which are currently employed in practice and evaluated successfully via these means, but not by RCTs. The Government response to

the issues raised by the select committee was generally in favour of the established approach employed by NICE. The response did indicate that, as NICE had assumed a central role on guidance for social as well as health aspects in relation to people with complex and co-morbid needs, consultation with appropriate stakeholders would be required. On their part, NICE established social care guidance (NICE, 2013) which does indicate the need to recognise a range of evidence sources in relation to complex scenarios involving health and social aspects of care. However, in relation to specific, defined presenting mental health diagnoses, specific NICE guidance continues to follow the hierarchy of evidence for efficacy.

Mental Health Nursing Roles

The Nature of Nursing

Sommerfeldt (2013) discussed the difficulty of articulating what nursing actually is, and suggested (somewhat tautologically) that the ability to explain nursing knowledge, skills and roles to others is a nursing competency in its own right in being able to identify the 'unique selling point' for nursing roles. In terms of classic attempts to articulate nursing as a discipline, two often-cited theorists relating to nursing knowledge, theory and practice in a wider sense are Patricia Benner and Barbara Carper. Benner (1984) described the development of nurses in their competence from 'novice' to 'expert' in terms of their clinical practice. In making this transition, she postulated that nurses passed through the categories of 'advanced beginner', 'competent' and 'proficient', before attaining 'expert' status. The characteristics which differentiated expert status from that of novice are concerned with the development, through experience and learning, of 'intuitive' or 'tacit' knowledge to inform practice. Carper (1978) outlined 'patterns of knowing' within the practice of nursing within four categories: empirics (the 'science' of nursing); aesthetics (the 'art' of nursing); ethics (the 'moral' aspects of nursing); and personal (the intuitive/tacit 'sum' of the patterns). Paniagua (2004) suggested that defining nursing via concepts of 'art' and 'intuition' is problematic, since art is itself an obscure concept to define and categorise, and intuition is given low value as a concept in Western (particularly scientific) understanding. Nevertheless, individual nurses, and indeed textbooks and educational programmes for nursing in both pre-registration and post-registration curricula, continue to espouse the virtues of the 'art' of nursing. McCrae (2011) draws attention to various 'models of nursing' expounded in the 1970s and '80s in the UK, which have broadly fallen out of use since then. He suggested various reasons why these attempts to capture and define a theory of nursing were abandoned; that nursing eludes definition, that models did not translate into understandable daily practice and became a documentation exercise, and that such models were incompatible with evidence-based practice. McCrae countered each of these arguments against the development of a theoretical framework for nursing practice, and calls for development of a theoretical basis for nursing as a science and an art, with pragmatism as a

philosophical underpinning, combining the pursuit and application of empirical evidence for practice with theory-based practice. This perspective, as will be seen, has resonance with the focus of this thesis.

In terms of the day-to-day prescribed range of competencies for nursing practice, including regulation of standards in the UK context, the Nursing and Midwifery Council (NMC, 2010) outline specific standards of competency required for all registered nurses. These competencies cover all 'fields' of nursing in the UK, that is: adult, children's, learning disabilities and mental health. These competencies encompass domains of: professional values, communication and interpersonal skills, nursing practice and decision making and leadership, management and team working. These four domains incorporate competency standards which apply 'generically' across all four fields, and standards which are specific to each field. The NMC also prescribe a code of professional practice (NMC, 2015a), which applies to all registered nurses.

The Nature of Mental Health Nursing

Turning more specifically to mental health nursing, the earlier outline of the origin of the profession demonstrates that, up until the latter two decades of the last century, the major focus of practice and intervention with people with mental health problems occurred in institutional/residential settings, heavily influenced by the medical model and associated approaches. As mental health nurses increasingly moved to formal ascribed roles working in community settings during the latter part of the last century, psycho-social models of consideration became more influential (Simmons & Brooker, 1990).

Norman and Ryrrie (2013) suggest that two broad contrasting traditions can be seen to have contributed to the contemporary mental health nursing ethos. The first concerns the rise of evidence-based health care which has influenced all health care professions in terms of pursuing therapeutic approaches which have been verified as efficacious, and mental health nurses are no exception to this. Norman and Ryrrie identify the second tradition as the 'inter-personal relations' tradition typified by the approach of Peplau.

Hildegard Peplau (1909 – 1999) proposed ways in which mental health nurses establish and progress therapeutic relationships with their clients/service users. Building on her original 1952 propositions regarding 'interpersonal relations', Peplau (1991) outlined the therapeutic stages of orientation (meeting), relationship establishment (identification), exploration and use of skills and resources (exploitation), with the ultimate goal of pursuing 'wellness' (resolution). A more contemporary model of approach to mental health is the 'Tidal Model of Mental Health Recovery and Reclamation' (Barker & Buchanan-Barker, 2005). This approach shares Peplau's fundamental

focus upon the therapeutic relationship. The tidal metaphor is based upon the notion of change often 'ebbing and flowing', and emphasises consideration of interaction between self, world and others in facilitating the move toward recovery.

The concept of 'recovery' has become mainstream in the consideration of policy and service delivery over recent years. Perkins and Repper (2013) summarise the principles of recovery in the context of mental health problems as moving beyond 'cure', focussing upon lives rather than symptoms. Recovery is personal rather than clinical in this focus, making the most of life and having a focus upon the individual within their life context, rather than the 'patient' within services.

These aspects of mental health nursing which focus upon the 'interpersonal' dimensions of care, and notions of 'therapeutic relationship' and esoteric concepts such as 'recovery', remain open to criticism in not being directly 'evidence-based' in any sense which would be amenable to an organisation such as NICE.

These considerations of evidence-based practice focus upon therapeutic relationships, psychosocial aspects and recovery which, whilst valuable principles for practice, are not exclusive to the practice of mental health nursing. Clarke (2014) suggests that, whilst service users commonly indicate satisfaction with the service and input from mental health nurses, and the nature of the therapeutic relationships mental health nurses form with service users are contributory to that, 'being satisfied' does not necessarily translate to better outcomes. He suggests that the therapeutic relationship should be framed as a 'therapeutic alliance' and seen as a launch-pad for the delivery of more structured interventions such as CBT. This brings the focus back to the question of how mental health nurses can incorporate therapeutic approaches within an ethos of mental health nursing.

In terms of defining mental health nursing, Nolan (1993) noted that several attempts were made to outline the role and work of mental health nurses during the mid part of the last century, concluding that the role was difficult to define due to the 'multiplicity of components'. Like nursing more broadly, this difficulty in articulation and definition of mental health nursing has endured, if not increased, within the contemporary context. Clarke (2006) discussed the problematic nature of defining professional identity for mental health nurses. Individual roles differ across employment grades and the many varied clinical contexts within which mental health nurses practice. These contexts, in turn, evolve with changing service climate and policy drivers. Historically, perhaps the most significant changes in recent history constitute the move from institutional provision for people with mental health problems to community-based provision in the latter part of the last century, and the move in the early part of this century to a more service-user centred 'recovery'

focus. The picture is further complicated by an increasingly inter-professional context of practice within health and social care, engendering role overlap and role boundary issues (Wackerhausen, 2009). Browne, Cashin, and Graham (2012) echoed the problematic nature of defining mental health nursing identity. They suggested that the role of the mental health nurse has always been to support people with mental illness to strive for a meaningful, dignified life. In doing so they assert that mental health nurses offer a variety of psychotherapies, not just 'on the couch', but in day-to-day contexts such as supermarkets, kitchens or seclusion rooms. They suggest that, because of the divergent contexts of practice, it is unwieldy to attempt a definition of mental health nursing based upon the notion of the therapeutic relationship, indeed they recognise a danger in focussing upon this at the expense of what is done within the relationship. For these authors, mental health nurses need to articulate and evaluate their actual day-to-day activities more explicitly in terms of value to service-user recovery. Happell (2011) underlined the importance of mental health nurses tangibly demonstrating their value in making a difference to the lives of people with mental health problems, suggesting that it may be reductionist to attempt to encompass all that mental health nurses do across differing settings with different presenting problems into a concise definitional statement.

A further important point regarding the professional identity of mental health nursing is that of the professional name attached to the role. Historically, the term 'psychiatric nurse' has commonly been interchangeable with the term 'mental health nurse' (for example, a significant journal over the last 20 years, referenced significantly within this thesis, is 'the Journal of Psychiatric and Mental Health Nursing'). In terms of the nursing register, the term 'psychiatric' has never been part of the title, which has always used the term 'mental'. Barker (2011) noted the favouring of the term 'mental health nursing' over recent decades, and suggests that the political implications implied in the associated emphasis upon person-centred, recovery-focussed care may need to involve a formal separation of the discipline from the traditional 'psychiatric family'.

Hurley, Mears, and Ramsay (2008) discussed the difficulties and dangers of defining/constructing what they term a modernist mental health nursing identity based within competency/capability frameworks/inventories. A key danger they identify, also echoed elsewhere (Hurley & Ramsay, 2008) is the argument for a 'generic nurse', gaining momentum in some quarters at that time (NMC, 2007). Again, the key issue these authors identify is the diverse arenas and contexts within which mental health nurses practice. They draw attention to the 'jack of all trades' professional orientation potentially negating from deep engagement with any singular key identifiable role or approach. They further call for a post-modern response constructing an identity from within the profession, acting as a counter-narrative to dominant, positivistic constructs of mental health roles and identity imposed by the prevailing health care governance systems. They also raise the

prospect of mental health nurses drawing upon the concept of a 'double agent' (Danaher, Coombes, Simpson, Harreveld, & Danaher, 2002) whereby mental health nurses, with 'bi-lingual abilities', on the one hand comply with the bureaucratic system of mental health care, whilst also using the same system to ensure that the needs of service users are met.

The discussion above illustrates that, historically, as the demands upon mental health-related services change, the roles of mental health nurses evolve. The development and proliferation of the role of the 'community psychiatric nurse' (or 'community mental health nurse') in the latter part of the last century provides an illustrative example of this.

New Roles

Hurley and Rankin (2008) itemised a number of facets of expansion of roles and responsibilities for mental health nurses: community working; proliferation of specialities; increased user/carer expectations; legal aspects and the assessment of risk; crisis resolution; increases in the availability of psychological therapies. In the context of their analysis, they argue for an increase in explicit 'emotional intelligence' competencies to be incorporated within pre-registration educational programmes for mental health nurses, thus sensitising affective capabilities for future careers within mental health nursing.

In terms of expansion of roles and responsibilities, Coffey and Hannigan (2013) cited the example of mental health nurses in England and Wales adopting new roles as 'approved mental health professionals' following amendments to the 1983 Mental Health Act in 2007. This role, following appropriate preparation and training, brings responsibilities related to the statutory detention of people with 'mental disorder'. Mental health nurses who choose to adopt this statutory role will find themselves encroaching upon professional territory which was, prior to 2007, the exclusive domain of social workers. The role also brings with it dilemmas in balancing biomedical perspectives from psychiatry, with the independent 'social perspective' required from the approved practitioner. In terms of medical roles, the 2007 amendment to the Mental Health Act also created the opportunity to assume the role of 'responsible clinician'. Another example of expansion of roles and responsibilities relates to the development of 'non-medical prescribing' and 'advanced nurse practitioners' (ANPs). Gilfedder, Barron, and Docherty (2010) outlined the development of the ANP role in mental health in a Scottish context, where mental health nursing roles were developed as 'advanced nurse practitioners' in order to replace the role of junior psychiatric doctors in out-of-hours' time periods. Interestingly, in this example, the mental health ANPs were also required to cover 'general' wards alongside general ANPs. The key issue here is whether it is deemed appropriate to assume such roles because of workforce shortage and the imperative to provide

'cover', or if assuming such roles is in the interests of the profession of mental health nursing in a wider context.

Gurney (2013b) suggested that advanced practice remains unclear as a concept and engenders confusion around titles and roles. Terminology is not consistent around the roles of specialist, therapist, consultant and advanced in terms of actual practice. Rolfe (2014), addressing this issue in nursing more generally, argued against advanced practice being seen as the adoption of 'medical' skills and roles, and for advanced nursing practice to be rooted in the advancement of the core skills, values and attitudes of nursing itself. The National Leadership and Innovation Agency for healthcare in Wales (NLIA, 2010) offered a useful analytical perspective concerning the concept of 'advanced practice'. The terms 'advanced' and 'specialist' are separated in definition, with 'advanced' being part of a continuum from 'novice to expert' (Benner, 1984), and 'specialist' being framed within a continuum from 'generalist' to 'specialist'. A specialist setting within this framework could be a service user group, a skill set or an organisational context. It is thus possible to become an 'advanced generalist'. This, as will be seen in later discussion, is a potentially useful way to consider and value developed expertise which is not specialist in the sense of a specific therapeutic modality.

A further point to make with regard to the establishment of new roles is that it is not exclusively mental health nursing roles which are evolving within the mental health workforce. Pearson et al. (2010) evaluated a programme in the north of England which had introduced new working roles within the mental health workforce, including: 'support, time and recovery workers', 'community development workers', 'carer support workers', 'gateway workers' and 'psychology associates'. Many of these roles encroach upon territory perhaps historically associated with mental health nurses, and in many cases the level of qualifications and associated status and financial remuneration is at a lesser level than professionally registered mental health nurses. Potential development of the health care assistant role is discussed in the section below concerned with knowledge and education for mental health nurses.

Research Related to Mental Health Nursing Roles

Wilson and Crowe (2008) employed a qualitative, grounded theory approach to exploring factors relating to job satisfaction for community mental health nurses in the New Zealand context. Depth interviews were conducted with 12 community mental health nurses. In terms of job satisfaction, the most significant source of satisfaction emerging from analysis was that of 'the therapeutic relationship', with three sub-categories: being therapeutic; knowing oneself; and knowing how. However, these three factors were mediated by three properties associated with role performance: working for the organisation; belonging to a team; and maintaining a personal life. The concept of

‘equilibrium’ and balance/counter-balance in ‘role performance’ emerges as a central theme from analysis.

Deacon and Fairhurst (2008) employed an ethnographic approach including activity sampling to explore mental health nursing role activities in the context of an acute in-patient mental health facility in the United Kingdom context. They took as their starting point eight interrelated 'bundles' of activity established by Allen (2004) in an earlier synthesis of several studies of nursing activity. As Allen's original analysis had not included mental health nursing settings, Deacon and Fairhurst thus aimed to establish the relevance of Allen's findings to the acute mental health in-patient setting. Allen's original analysis highlighted the role of the nurse as 'health-care intermediary', with eight associated 'bundles' of activity:

- 1) Managing multiple agendas
- 2) Circulating patients
- 3) Bringing the individual into the organisation
- 4) Managing the work of others
- 5) Mediating occupational boundaries
- 6) Obtaining, fabricating, interpreting and communicating information
- 7) Maintaining a record
- 8) Prioritising care and rationing resources

They found that, of these eight 'bundles', all but one constituted a 'fit' when explored as activities in the context of an acute mental health nursing environment. This was the category of 'obtaining, fabricating, interpreting and communicating information'. The particular elements of 'fabricating' and 'interpreting' information were felt to be influenced by the uncertainty of the knowledge base relating to psychiatry, and the lack of invasive physical diagnostic tools applicable in Allen's original analysis. They also suggested an additional category pertinent to the mental health setting, and not present in Allen's original bundles, relating to the use of specific, in-context nursing skills and interventions.

Hurley (2009) employed a social constructionist, qualitative methodology to explore the perceptions of 25 United Kingdom-based mental health nurses regarding their professional roles. In relation to the issue of what mental health nurses can bring to 'talk-based' therapies, respondents in this research saw the mental health nurse as: a 'generic specialist'; having a service-user focus; positioning and utilising personal self; spending time with the service user; delivering talk-based therapies in versatile ways; having an 'everyday' attitude; and having transferable skills. In terms of identity, Hurley suggested that the key findings from this study centre on what mental health

nurses can uniquely bring to talk-based therapies within the breadth of roles they already occupy. He also raises the issue that generic capabilities within versatile roles are not necessarily a barrier to specialist status.

Hurley and Lakeman (2011) employed a phenomenological approach in exploring how a purposive sample of 24 mental health nurses in the United Kingdom had reached their current identities. All 24 participants were qualified mental health nurses who were engaged in the delivery of talk-based therapies. Four themes were derived from data analysis:

- 1) Identity journeys through direct and vicarious work-based experiences with service users. This included watching experienced clinicians in earlier career development, their own direct experience and those of peers.
- 2) Identity journeys through non-work-based education and training. Education and training away from the workplace, particularly activity which was perceived as enhancing capabilities with service users.
- 3) Identity journeys through assuming new job titles and roles. This included role titles which were non-nursing (e.g. CBT therapist).
- 4) Exit journeys. Whereby new clinical roles and titles might be seen as having moved on from being a mental health nurse.

The notion of leaving, or exiting the profession of mental health nursing to 'become' something else is noteworthy here. It may be that becoming a therapist is attached to a more defined social world and referent group, with less conflicted identity compared to the less easily articulated generic mental health nursing role. McCrae, Askey-Jones, and Laker (2014) conducted a qualitative study with ten postgraduate nursing students undertaking a Master's level accelerated education programme for mental health nursing. They found that, whilst such programmes could attract talented graduates, several students saw the qualification as a springboard to other career opportunities. They postulated that such trainees can feel uncomfortable with 'nursing culture', and professional identification can be inhibited by the shortened nature of such programmes.

Crawford, Brown, and Majomi (2008) applied a qualitative, thematic analysis to the study of a sample of 34 UK community mental health nurses regarding their perceptions of professional role and working lives. Four major themes emerged: client focus (the public service identity of the profession); not being a profession (scepticism, doubt and uncertainty); growing out of the role (professional development as exit strategy); and waiting to be discovered (the search for recognition). A central theme emerging from their analysis concerned the balance between specialist and generic roles. Within specialist roles, professional identity was more specifically

defined in terms of role function. However, many of the nurses within the study had more generic roles, which they found more difficult to articulate.

In terms of student nurses' perceptions of the role of the mental health nurse, Rungapadiachy, Madhill, and Gough (2004) utilised a qualitative approach based upon grounded theory to elicit the perceptions of 14 pre-registration students of mental health nursing in the United Kingdom context. All were interviewed within the last 6 months of their three-year programme of study, when facing transition from student nurse to qualified mental health nurse. Six themes were elicited from analysis, with students typifying the mental health nurse as: administrator; agent of physical interventions, both clinical and non-clinical; administrator of drugs; agent of psychological interventions; teacher; and agent of non-therapeutic interventions, either through malpractice, non-involvement, lack of skill or negative approach. Though this research took place some time ago, some areas of interest were identified and are worthy of note. Student nurses had expected to conduct more psychologically-based interventions and related that an emphasis on drug administration could lead to conflicts of interest with an advocacy role with patients, and finally students were exposed to some poor role models within placements, which can have a negative influence upon how student nurses perceive future roles.

The studies summarised above are open to the general criticism of qualitative research findings in that 'generality' of findings can be seen as problematic given the specific location in time and place and small sample numbers involved. However, the notion of 'moderatum generality' proposed by Williams (2000), also used here later in exploring the value of my own research, emphasises the case-by-case appreciation of the 'transferability' and resonance of such findings in alternative contexts.

Knowledge and Education for Mental Health Nursing

As a profession, the discipline of mental health nursing should, according to criteria suggested by sociologists such as Macdonald (1995), be able to articulate a body of knowledge unique to the discipline. Historically, Nolan (1993) points out that up until 1923, the main text for the preparation of mental health nurses was still based upon the original 1885 'handbook for the instruction of attendants on the insane', commonly known as the 'red handbook', produced by the forerunner to the Royal College of Psychiatrists, the Medico-Psychological Association (MPA, 1885). This represented the first attempt to introduce a national training scheme for those with roles as 'attendants' working within the asylum system (Nolan, 1993). With a focus upon duties, tasks and work, it was renamed as 'the handbook for mental nurses' in the 1923 seventh edition (MPA, 1923). The ninth edition in 1964 became an edited collection of chapters written by specialists (RMPA, 1964). Regularly expanded and updated, it was not re-commissioned after the late 1970s, by which

time the Medico-Psychological Association (which had become the Royal Medico-Psychological Association in 1926) had become the Royal College of Psychiatrists (in 1971). In terms of the curriculum for mental health nurses, the 1950s saw the introduction of psychology and sociology into the programme of education, and the curriculum was reviewed and updated periodically. Writing in 1993, Nolan suggested that the introduction of the 1982 syllabus for mental health nurse education represented an important shift towards a skills focus, with a consideration of application of skills in a variety of settings (including the community), and increased emphasis on the promotion of health. This was also the first curriculum for mental health nursing which was formulated without consultation and approval from the Royal College of Psychiatrists.

In 1985, the Judge Commission on nursing education (RCN, 1985) recommended that the education of nurses should be broadened in knowledge base to 'educate' rather than 'train', with the intent that the bringing together of practice and theory could be better facilitated. The position of student nurses as employees of the organisations within which they would ultimately work was also questioned. In 1986, the then United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, now replaced by the NMC), clearly formalised the intent to move forward the recommendations of the Judge Commission and increase the status of nursing as a profession with the publication of 'Project 2000' (UKCC, 1986). This involved raising the baseline qualification level of nursing to diploma level, with those in pre-registration preparation having the status of students in higher education rather than employees of the NHS. Since its implementation, nursing curricula have gradually moved beyond diploma level, since 2015, all programmes for the preparation of nurses in the UK are at full graduate level. All nursing curricula are designed with NMC approval to prepare nurses to the required level of competency as summarised earlier (NMC, 2010).

The future of education for nurses was more recently called into question following several identified cases of poor standards in health care in the UK over recent years, perhaps the most high profile case concerning the Mid-Staffordshire NHS Foundation Trust, published as a public inquiry (Francis, 2013). One issue emerging from these cases of failure in care standards questioned whether the academic direction taken by the nursing profession over recent years had resulted in a less compassionate nursing workforce. In 2012, Lord Willis was commissioned by the Royal College of Nursing to establish the current state of nurse education with a view to future recommendations. The report (Willis-Commission, 2012) found the hypothesis that graduate preparation has resulted in producing less compassionate nurses was not a valid nor causative factor in cases of failure in care organisations. Lord Willis was further commissioned by Health Education England (HEE) and the NMC to provide more detailed recommendations with regard to tangible proposals for the future shape and scope of educational preparation of the nursing

workforce. The key thrusts of the report recommendations (Willis-Commission, 2015) can be summarised as follows:

- The work of care assistants should be consistent in title, role and preparation, including career progression and the opportunity to progress to become a registered nurse within a system of 'widened access' to higher education.
- The structure of pre-registration nursing programmes should retain the four existing 'fields', and potentially incorporate a new field of 'community'.
- Consideration of a four-year programme for pre-registration preparation, whereby the first two years comprise a shared 'whole person' core, the third year is set within the chosen specialist field leading to initial registration, and the fourth year is comprised of 'preceptorship' working within field-related practice.
- Post-graduate/registration development for nurses would be grouped around specialism into areas of 'shared care', 'self-care' and 'restorative' care.

These proposals are currently subject to consultation from relevant stakeholders, and hold potentially radical implications for the initial preparation of registered nurses, their ongoing career pathway and professional development, and also the preparation and role of health care assistants. Hemmingway, Clifton, and Edward (2016) pointed to experience within Australia and New Zealand systems for educating mental health nurses, whereby moving to a generic preparation focus led to a fall in the number of people interested in pursuing careers in mental health nursing, and perceived deficits in preparedness for those who did.

Any system of educational preparation is, of course, bound up with knowledge and theory. The concept of knowledge is, in turn, synonymous with that of theory. Rolfe, Freshwater, and Jasper (2001) defined theory as a way of ordering knowledge into an explanatory framework. This review of literature has, earlier, considered issues relating to knowledge and theory for mental health practice more generally. A key problem for the discipline of nursing, and specifically mental health nursing, is the difficulty in clearly articulating the role of a mental health nurse. This is very evidently demonstrated in the discussion of literature here.

Susser, Watson and Hooper (1985) distinguish between what they term sociology 'of' health and medicine, and sociology 'for' health and medicine. Machin and Stevenson (1997) adapted this distinction in terms of theory and professions, specifically applying the notion to mental health nursing. They suggested 'theory of' a profession attempts to define the very nature of a particular profession in terms of knowledge and theory. 'Theory for' a profession defines knowledge and theory which may not be specific to a particular profession, but is subsumed into the practice of a

profession. This distinction provides a useful means of considering the complex roles which co-exist within the discipline of mental health nursing, and between related disciplines working in the mental health practice arena. This will be revisited within discussion relating to the findings of this research in chapter six.

Summary

Throughout the historical developments and key perspectives summarised in this review, the continued dominance of the medical approach to mental health problems, in the form of psychiatry and with diagnostic categories rooted within the DSM, has been and continues to be the main influence upon the way in which mental health problems are viewed. Mental health nurses represent one of a number of professional groups within the mental health arena who are required to engage with this dominance of psychiatry in their day-to-day work with service users.

In relation to professions and roles within the mental health practice arena, key theoretical perspectives in symbolic interactionism and the social construction of reality have been identified and briefly outlined. These perspectives are relevant not only to any consideration of socialisation into professional roles, but also inform the conceptual framework for this present research study, outlined in the following chapter. The analytical framework of role adequacy, legitimacy and support (Machin & Stevenson, 1997) offers a useful sensitising concept for consideration of role congruity, in relation to the research focus here. The relevance of these theoretical perspectives becomes evident when considering the formation and maintenance of a professional discipline, such as mental health nursing, and its related spheres of knowledge and activity, within an evolving practice arena populated with other professional groups, including the emergence of the therapist role in its own right. The increased emphasis upon evidence-based approaches places the use of particular approaches in a central light in terms of the expectations upon services to provide them. The way in which the discipline of mental health nursing engages with these therapeutic approaches, and with the demonstration of evidence for mental health nursing practice more generally, will be of fundamental importance to future mental health nursing roles, and is a central consideration which will be returned to within analysis and discussion later within this thesis.

The difficulties inherent in articulating the role of a nurse, and particularly a mental health nurse, have been identified within this review. Relying upon the idea that a therapeutic relationship drawing upon the art and intuition of practice as a defining characteristic of mental health nursing is not unproblematic in a climate which values evidence of efficacy and outcomes. In this sense, the therapeutic relationship can be argued to be a necessary but not sufficient factor within mental health nursing roles which have become myriad and complex within the context of the direction of

development of mental health services. The historical development of educational provision for mental health nurses has been led by, but often lagged behind, service developments.

The framework for role analysis proposed by Machin and Stevenson (1997) provides a useful means to summarise the key focal issues within this review of literature in terms of mental health nursing roles.

Role adequacy is concerned with the knowledge and competency related to practice roles. This is implicit in much of the debate above in the sense that, for example, particular knowledge and skills are related to particular specialist roles, whereas a different balance of knowledge and skills are required in more generic roles. This aspect is related to *theory/knowledge for* mental health nursing.

Role legitimacy is concerned with what are seen as appropriate aspects of practice for mental health nurses to engage in. The debate around generic/specialist roles, 'advanced practice' and specific arenas of role activity can be seen reflected here. This aspect relates to *theory/knowledge of* mental health nursing.

Role support is the potential sources of role support which can be identified from different aspects and levels, for example: the general public; service users/carers; other professional disciplines; commissioners and managers of mental health services. Though clarity of role identity is important, a clear understanding of what value mental health nurses bring to mental health services in terms of positive outcomes is essential in attracting role support from these aspects.

These three elements overlap in the sense that if any one of them is deficient, then there can be problems with the other two.

In terms of the aspects of 'political identity' proposed by Castels (1997), it would seem that at present there is no clear agreement across the diversity of mental health nursing roles of what could be construed as a stable 'legitimising identity'. There are debates and positions being taken within the literature which indicate 'resistance identity' (e.g. resisting the notion of a generic nurse role within educational preparation). In terms of 'project identity', perhaps mental health nursing first requires the project to be clarified. The status of nursing as a graduate profession, with the critical and analytic skill base that this implies, together with the current proposals of the Willis commission for fundamental re-organisation of the way in which nurses are prepared for practice, make this study and analysis timely.

Conclusion

This review has covered a range of aspects relevant to the focus of this research study and thesis, the development and maintenance of professional role congruity within mental health nurses. It has been, necessarily, broad in terms of covering the relevant areas in order to set the context. Most of the areas covered could have been debated in more critical depth, but the principal purpose within the context of this thesis has been to appreciate the arena of mental health practice generally, including an appreciation of its development, in order to identify the contextual and historical influences upon the role congruence of contemporary mental health nurses.

Two broad areas have been presented. The first, concerned with the nature of presenting mental health problems and the organisation of responses to them, demonstrates that policy and services have evolved in relation to developments in knowledge and associated technologies of intervention, together with shifts in societal attitudes toward mental health issues. The second broad area is concerned with the way in which the roles of professional groups working within the mental health arena have developed in relation to this evolving service context. Particular emphasis has been placed upon the way in which mental health nursing roles have developed to date from their original roots in institutional/custodial functions in the early part of the 20th century, through to roles as therapeutic agents and from institutional settings, to a range of settings within an ethos of community care in the latter part of the last century.

The next chapter will present the conceptual framework and related methodology which guided the research which informs this thesis.

Chapter 3: Conceptual Framework and Methodology

Introduction

This chapter provides a critical overview of the approach employed by this research in terms of the underpinning conceptual framework. The importance of developing a conceptual framework for a research study is discussed first. The theoretical perspective of symbolic interactionism is then outlined in terms of key tenets, principles and relevance to the focus of this study. This is followed by a discussion of the use of grounded theory as an approach within this research. Since grounded theory methodology has, over the four decades since its original inception, come to embody several variants in application, this discussion will make explicit the ways in which grounded theory methodology is interpreted and applied within this study, specifically outlining the more recent variant of situational analysis. Discussion will focus upon the assertion that grounded theory as an approach, in the form developed by Anselm Strauss, has its roots in the perspective of symbolic interactionism. The way in which situational analysis extends and augments a grounded theory approach will then be outlined. These elements will then be drawn together with key relevant theoretical perspectives from reviewed literature, within a summary of the conceptual framework for this study as it has evolved and emerged during the process of conducting the research.

The Importance of a Conceptual Framework for Research

Ravitch and Riggan (2012) outlined several key reasons why a research study should be guided by an explicit conceptual framework as ‘guide and ballast’ to the research process. They suggest that conceptual frameworks identify presumed relationships among key factors and constructs to be studied and that these factors may emerge from a variety of sources, including the researcher’s own previous experience or tentative theories, as well as established theories/empirical work. They also see a conceptual framework as a tool for, but also reflexively informed by, the researcher’s learning and suggest that it can constitute an argument for the importance of a study, justifying research both substantively and methodologically. Taking these factors together, Ravitch and Riggan (2012) assert that a conceptual framework:

“Is a guide for research; it serves to situate the research questions and the methods for exploring them within the broader context of existing knowledge about a topic, even as the researcher seeks to generate new knowledge about that topic” (P. 136).

Leshem and Trafford (2007) examine the utility of conceptual frameworks as a useful underpinning for academic research, and draw similar conclusions. They see a twofold role for a conceptual framework in guiding research. Firstly, an explicit conceptual framework can bring theoretical

clarification in terms of what is being investigated. Secondly, it can help researchers to clearly articulate the aims and focus of research, and how research aims will be achieved. In addressing these two aspects, Leshem and Trafford (2007) argued that that a conceptual framework can act as a catalyst which raises the level of the researcher's thinking from being descriptive, in terms of analysing and presenting data, to conceptualising the research process itself. Ravitch and Riggan (2012) further indicated that conceptual frameworks evolve alongside research studies as they unfold, that they are constructed rather than found. In this sense, they argue, conceptual frameworks originate from three primary elements. First are the personal interests of the researcher: these encompass curiosity, biases, ideological commitments, theories of action, epistemological assumptions, institutional position, social location and position within the research itself. Secondly comes topical research, previous research which has focused upon or is relevant to the area of interest, including an appreciation of research approaches which have been used previously. Thirdly is a theoretical framework, which constitutes theoretical stances which inform or 'frame' the focus of the research in terms of explaining inter-relationships between elements present within the research focus.

These positive aspects of utilising a conceptual framework should be balanced against potential pitfalls. The principle potential drawback relates to the danger of entering the research situation with pre-conceived ideas, rather than truly allowing what exists in the situation to emerge during the study, or be 'discovered'. This also relates to the wider engagement with literature relating to the research situation. Lempert (2007) identifies this tension, and outlines the need for a pragmatic approach whereby some understanding is needed in order to recognise gaps in theorising and potentially new phenomena of interest emerging from the research analysis. My own approach to the use of literature and the conceptual framework outlined here relates to this pragmatism, tempered by an awareness of the need to be reflexive. My own reflexivity as a researcher is discussed in chapter seven of this thesis.

It is useful to re-state the research questions of this study at this point:

- 1) How do student mental health nurses develop role congruity within their pre-registration preparation for practice?
- 2) How do mental health nurses maintain role congruity within their ongoing professional practice?

Several key factors can be summarised in relation to this research focus:

- It is concerned with a specific professional group, that of mental health nurses.
- It is concerned with the professional practice of this group within the context of mental health.
- It is concerned with the personal and professional development of mental health nurses.
- It is thus concerned with professional role development at the individual level in terms of learning and development.
- It is also concerned at the level of the profession of mental health nursing in terms of the evolution of practice within the broader context of mental health services.
- It is thus concerned with capturing dynamic processes in a complex, interacting and changing environment.

It follows that the conceptual framework must effectively and coherently address all of these factors in clearly articulating the nature of the focus of study, and the research design in addressing the stated aims.

Symbolic Interactionism as a Theoretical Perspective

Symbolic interactionism has its roots within ‘pragmatism’ in the early and mid-decades of the last century. Blumer (1969) draws and builds upon Mead (1934) in outlining three key tenets of a symbolic interactionist approach.

Firstly, human beings act towards things on the basis of meanings they have for those things. ‘Things’ can be physical objects, social (other human beings) or abstract (ideas), which individuals encounter in daily life. Secondly, the meanings held for these things arise out of and are derived from social interaction with others. Thirdly, as individuals, human beings deal with and modify these meanings as necessary through an ongoing process of interpretation. Considering these principles with regard to this study focus, mental health nursing roles and their associated meanings are at the very centre of interest. Participants within the study were encouraged to relate the ways in which they approach their roles in practice. The ‘things’ which mental health nurses deal with include the physical environment within which their roles are enacted, service users presenting with mental health problems, other mental health nurses and other professional groups working within mental health settings. The ongoing processes of interpretation and negotiation around existing and potential roles is also very evidently in focus, including the ways in which student mental health nurses come to internalise these factors.

Blumer (1969) distinguishes the symbolic interactionist position with respect to ‘meaning’ from a realist position, where meaning is seen as intrinsic to the object viewed (i.e. it ‘exists’ independently of interpretation), and also from a position where meaning for an object is constructed by the individual. Blumer emphasizes that symbolic interactionism sees meaning relating to an object

arising from interaction between people. Meanings are social products defined by people who engage in defining activities during their interactions. This research is fundamentally concerned with the ways in which mental health nurses and other 'social actors' interpret and define situations during their interactions, and learn to do so in the first instance. Chapter two has set out the ways in which nursing roles have been influenced by developments in knowledge and technology with regard to how mental health problems are understood and responded to. These changes in mental health nursing roles and practices have involved interactively re-negotiating roles at the level of both individual and profession.

Blumer goes on to identify several 'root images' with which symbolic interactionist study is concerned. Firstly, in terms of the nature of human society, a fundamental tenet is that what we perceive as social structure and culture arise from individual and collective human action. This is the converse to a functional view, whereby societal structure is seen as the pre-requisite for interaction. It then follows that the nature of social interaction is viewed as an interaction between social actors and not between factors attributed to them. Social interaction is seen as forming human conduct, not simply acting as a setting where it is expressed. A distinction is made between non-symbolic interactions which are responses without interpretation involved (routine, reflexive, automatic responses), and symbolic interactions where interpretation is involved. Blumer uses the analogue of a boxer responding instinctively (non-symbolic) to an opponent's blow, or perceiving it as a 'feint' and responding differently (symbolic, involving interpretation). With regard to this research study, a key focus is the way in which mental health nurses approach their roles in helping relationships with service users. This involves responding intentionally and strategically, having interpreted the presenting situation symbolically, and learning to do so in the first instance.

In examining an interaction, Blumer highlighted three elements as evident in terms of gestures. Firstly, a gesture instigated by one individual towards another signifies what that individual expects in response from the other. Secondly, the gesture also indicates what the gesturer plans to do in terms of action. Thirdly, the gesture also signifies the joint action that arises via both (initial gesture and response). Again, in relation to this research, mental health nurses execute their roles (or learn to do so) in various defined contexts or situations with specific interactional intentions. This is arguably particularly the case when a defined therapeutic strategy such as CBT is being employed.

For Blumer the significance of considering an interaction thus indicates the requirement that each involved party necessarily must be able to take the perspective of each other's roles in order to understand intentions. In considering the human being as an acting organism, the central issue here for Blumer is the notion of the self as an object, with human beings having the ability to see the self from an external perspective and engage in self-talk. This links to the nature of human action in that, from a symbolic interactionist perspective, human beings are constantly constructing and

guiding action based upon interpretation and not just simply responding. This applies to both individual and collective action. These last two aspects highlight very specific issues with regard to the practice of mental health nursing. These are the ability to empathise with service users, as part of the development of a therapeutic relationship, and the need for self-awareness within the therapeutic use of self. These aspects are foundational to the development and maintenance of a therapeutic relationship, and at the heart of theories and frameworks for mental health nursing practice such as those espoused by Peplau (1991), discussed earlier in chapter two.

This brings discussion to the last of Blumer's root images, that of the inter-linkage of action. Since meaning is created via social interaction, group membership and action constitute a particularly important focus of analysis for symbolic interactionism. Fundamentally, human group life is seen as comprising 'lines of action' between group members, with joint action comprising the social organization of actions and behaviour by and among group participants. Though joint action of a group is an inter-linkage of separate acts of the participants, joint action, importantly, is seen as more than the aggregation of individual actions, having a character in its own right in terms of the collectivity of group action. Blumer points out that collective group action must still undergo a process of formation, within which participants still guide their acts via the formation and interpretation of meanings. Blumer makes three key points regarding joint action.

Firstly, in instances of joint action that are repetitive and stable existing in the form of recurrent patterns of collaborative joint action, there is a tendency to see regularity in the form of 'norms' and 'social order'. He points out that even within such regularized patterns, new situations and problems inevitably arise, are not catered for by existing rules and need to be dealt with. It is also the case that, even with established patterns of joint action, each instance still needs to be formed via designation and interpretation. In this sense norms, values and social roles are still subject to processes of social interaction. From the perspective of symbolic interactionism, social processes within group life create and uphold rules, rather than rules creating and upholding group social processes. Also, group life is characterized by extended connections of actions within complex networks involving division of labour/functions. A symbolic interactionist perspective retains a focus upon the participants within networks rather than seeing the systems and networks themselves as primary and self-operating entities. Networks and systems are seen as functioning because of the interaction of individuals in terms of how they define and interpret situations and act. The focus is upon the sets of meanings that lead participants to act as they do within their positions within organisations/networks in terms of how meanings are formed, sustained or may change via social interaction. The final point Blumer makes regarding joint action is that, whether long established or new patterns of joint action are considered, all arise against the background of previous actions. Participants bring their existing world view (objects, meanings and interpretations) to the formation of joint actions. This gives a linkage to previous joint action for

the respective participants. This latter aspect of symbolic interactionism relates to this research in widening consideration to the collective profession of mental health nursing, including debates around what future roles should or might entail within the changing context of mental health service delivery.

This overview of symbolic interactionism as a perspective serves to illustrate the relevance of this theoretical perspective to the substantive area of focus for this research study. The ways in which mental health nurses initially engage with their role(s) and subsequently manage their role(s) within the context of their practice can be seen to be fundamentally captured within the tenets of symbolic interactionism.

The relevance of symbolic interaction to the research approach itself will now be shown in discussion of the application of grounded theory/situational analysis approaches to research, and in particular to the study informing this thesis.

Grounded Theory as an Approach to Research

Since the original conceptualisation of the grounded theory as an approach to research in 1967 by Glaser and Strauss, there has been much debate regarding the interpretation and application of the key elements of the approach. Charmaz (2006) summarises grounded theory method as a systematic, inductive and comparative approach to qualitative research which has the aim of constructing theory, involving data collection and analysis proceeding simultaneously and iteratively.

Following their original collaboration (Glaser & Strauss, 1967), Barney Glaser and Anselm Strauss, the two originators of the grounded theory approach, subsequently disagreed over some fundamental applications and interpretations of the approach. Glaser (1992) suggested that Strauss, in his later outline of a grounded theory approach (Strauss & Corbin, 1990), had taken an increasingly divergent approach from the original tenets and had arrived at an approach which was 'forcing' emergent analysis from data rather than allowing a theory to 'emerge'. Glaser would advocate approaching a research context without pre-conceptions informed by reviewing literature, whereas Strauss saw literature as informing 'theoretical sensitivity'. Glaser (2007) further distinguished between 'formal grounded theory' and 'substantive grounded theory'. For Glaser, substantive theories relate very specifically to the substantive area which they have emerged from in a descriptive way, whereas formal theories are truer to his original view of grounded theory and can have conceptual application beyond the substantive area studied.

Charmaz (2000) suggested that grounded theory, in the years since its original conception by Glaser and Strauss, had become increasingly deployed in a way which aligned with a

‘constructivist’ perspective, whereby the nature of a phenomenon under study is accepted to be a ‘construction’ of the participants of research rather than an explicit claim to represent the objective ‘reality’ under study. Bryant and Charmaz (2007) usefully distinguish between the use of the term grounded theory as; a) a research approach/method and b) the product of a research study. In this sense, they suggest that there are studies which claim to employ a grounded theory approach which do not follow the process through to the development of theory. Interestingly, they also suggest that studies can be identified which, whilst not purporting to use a grounded theory approach, nevertheless result in a theory which is ‘grounded’ in the study data.

Bryant and Charmaz (2007) present an overview of the ways in which grounded theory as an approach has been adapted, developed and enhanced by researchers in many differing contexts and applications over some forty years since its original inception, suggesting that many of the early tenets of the grounded theory approach were in need of extrication from what had become an outdated epistemological stance, perceived as leaning towards positivism and empiricism. In this respect, they suggest that grounded theory methodology has become a ‘contested concept’. A key question here is whether different approaches to the use of a grounded theory approach are simply variations on a theme, or have come to constitute distinct approaches. They propose three broad interpretations or versions of a grounded theory approach which can be distinguished as follows:

- 1) A ‘Glaserian’ position/version: observing the tenets and underpinnings of Barney Glaser’s interpretation, as outlined above.
- 2) A position/version aligned with the iteration of a grounded theory approach as espoused by Strauss and Corbin (1990).
- 3) A ‘constructivist’ position/version.

For Bryant and Charmaz, a ‘constructivist’ version of grounded theory emphasizes how data, analysis and methodological strategies, together with research contexts and researcher position, perspectives, priorities and interactions, all become ‘constructed’ within the research context.

It is useful to make an important clarification at this point. Andrews (2012) points out that the terms ‘constructivist’ and ‘constructionist’ are often used inter-changeably, and that the term ‘constructivist’ is itself often used as an overarching term for both. Constructivism is a theoretical perspective concerned with how people ‘construct’ the reality in which they participate, with the acknowledgement that the interpretation is itself a construction. Social constructionism is a theoretical perspective which assumes that people create social reality, and is concerned with how this is accomplished. Social constructionism is thus strongly associated with the theoretical perspective of symbolic interactionism. Constructivism is more concerned with individual

cognitive mental constructs whereas social constructionism has a social rather than individual focus. Andrews (2012) suggested that Charmaz used the term 'constructivist' in the over-arching sense of subsuming 'social constructionist', which makes much more sense as we turn later to consider the advent of situational analysis as a development within the evolution of grounded theory as a research approach.

At the level of conducting a grounded theory study, Strauss and Corbin (1990) outlined the key procedures and approaches, namely: establishing the research problem and question(s); the notion of 'theoretical sensitivity'; theoretical sampling/data coding and analysis processes; and the use of a 'conditional matrix'. These aspects are now briefly summarised, and are more clearly articulated within the context of this study in chapter four.

The research questions relating to this study have been clearly laid out and are concerned with the attainment and maintenance of 'professional role congruity' among pre-registration and post-registration mental health nurses. The use of research questions identifies the phenomenon to be studied and also serves to help the researcher keep focused upon the research aims and objectives when dealing with complex situations and contexts.

Theoretical sensitivity is defined by Strauss and Corbin (1990) thus:

“Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't.” (P. 42).

Three sources of theoretical sensitivity are itemised as literature, professional experience and personal experience. Strauss and Corbin also suggest that, in addition to these background factors, theoretical sensitivity is enhanced through interaction with the data during the analytical process itself, whilst maintaining a balance between creativity and 'science'. This balance, it is suggested, is achieved by periodically 'stepping back' from the data during the process, maintaining an attitude of scepticism, and by following the research procedures. Kelle (2007) drew upon Blumer (1954) to make an important point regarding the use of pre-existing theoretical concepts whilst conducting research. Blumer distinguished between 'definitive concepts', which provide descriptions of *what to see* in a given situation, and 'sensitising concepts' which *suggest directions along which to look*. In relation to this research, theoretical sensitivity draws upon all three aspects of literature, personal and professional experience. Aspects of my own personal reflexivity are explicitly discussed in chapter seven of this thesis. In terms of 'sensitising concepts', the framework for role analysis suggested by Machin and Stevenson (1997) introduces the idea of 'optimum role function' in terms of the three elements of role adequacy, role legitimacy and role

support. This can be firmly related to the concept of role congruity in the context of this thesis, and the framework provides a heuristic device which frames the concept.

Another central tenet of a grounded theory approach is that of 'theoretical sampling'. It is a common for qualitative research approaches to adopt a sampling approach whereby participants are selected on the basis of their relevance to the research questions in terms of demographic characteristics and appropriate experiences or narratives. Theoretical sampling involves an additional aspect of selection on the basis of relevance to the emergent data analysis. The construction of the sample for this research is outlined in more detail in chapter four of this thesis.

Strauss and Corbin (1990) outlined the processes and stages of data coding within their interpretation of grounded theory in considerable detail. They emphasised that the purpose of data coding/analysis within a grounded theory approach is to go beyond establishing 'themes' within data, to build theory which is 'grounded' within the data. They stipulate three types of coding processes; open coding, axial coding and selective coding. These three phases of coding can be summarised as a process whereby analysis begins with open coding, where the data is fractured into concepts and combined into categories, proceeds to 'axial' coding where the categories are developed with more conceptual density, and then to selective coding where the categories are inter-related in a way which captures the central focus of the research around a 'core category' in a theoretical, conceptual way which addresses the research question and is grounded from and within the study data. Two important processes are employed within grounded theory coding and analysis. The first is the making of comparisons. This is a central feature of a grounded theory approach, 'the constant comparative method of analysis' which remains intact from the original description of the approach (Glaser & Strauss, 1967). It consists of constantly comparing instances within the data for similarities and differences, and grouping data together or apart based on this process. The second process involved is that of asking questions of the data. This entails examining each named component or concept and asking what it is and what it represents. At a practical level, the use of 'memos' in the form of notes and diagrams is also a central analytic aid throughout all phases of the data coding and analysis process. Chapter four of this thesis outlines the coding and analysis strategy employed with the interview data within this study in more specific detail, with illustrative examples drawn from the actual process in action.

The final component of the grounded theory approach specified by Strauss and Corbin (1990) is the 'conditional matrix', which they define as:

"An analytic aid, a diagram, useful for considering the wide range of conditions and consequences related to the phenomenon under study" (p. 158).

Strauss and Corbin further define a conditional matrix as a 'transactional system' composed of interacting and interrelated levels of conditions, from broad to specific, relating to the focus of the research. It is the employment of a conditional matrix as part of the grounded theory analysis process which is particularly criticised by Clarke (2005) in her proposal of situational analysis, summarised in the following section, as an expansion of grounded theory.

Situational Analysis

Clarke (2005) built upon the ideas proposed by Charmaz (2000) that grounded theory approaches in practice often implicitly, if not explicitly, accept a constructivist/constructionist underpinning. She suggests that grounded theory and symbolic interactionism concord as a 'theory/methods package' in relation to research and enquiry. Clarke pursued this further by suggesting that, even accepting the move to constructionist/constructionist underpinning, grounded theory approaches still maintained a modernist world view in several ways. Whilst not dismissing all processes and techniques as outlined by Strauss and Corbin (1990), Clarke called for grounded theory approaches to be enlarged to more accurately reflect the complexity of the context of study. In doing this, her stated intent was to locate grounded theory explicitly within the 'postmodern turn' she suggests has taken place over recent decades and now influences academic disciplines within social sciences, humanities and professional practice contexts of research and enquiry.

Since the term postmodern has many interpretations, Clarke sets out the principles of the postmodernist position which she relates to her approach. Whereas modernism emphasises generality, universality, simplification, stability, permanence, wholeness, rationality, regularity and homogeneity, postmodernism emphasises partialities, positionality, complication, instability, irregularity, contradictions, heterogeneity, 'situatedness' and fragmentation. A postmodern stance, for Clarke, thus entails complexity. She argues that, since this postmodern turn, knowledge is understood as *situated*, which is to say is produced and consumed by particular groups located in history and geography. Clarke's principal criticisms of traditional grounded theory are: that it lacks reflexivity regarding research processes and also products; that it oversimplifies via emphasis upon commonalities and aims to establish coherence; that it oversimplifies by looking for single rather than multiple social processes within situations; that it interprets data variation as 'negative' cases; and that it searches for purity in generated theory.

Situational analysis as an 'enlargement' of grounded theory aims to address these issues. It incorporates analytical approaches which acknowledge and emphasise the situatedness of the theory generated from analysis. Clarke strongly suggests that the Straussian version of grounded theory outlined by Strauss and Corbin (1990) draws upon Strauss' symbolic interactionist/constructionist leanings, and in this sense was already substantively moved around the 'postmodern turn'. For Clarke, the additional elements added within a situational analysis

approach complete this move. Three key new roots within which situational analysis frames a grounded theory approach are outlined below.

First is the bringing together of the social world of research participants with an acknowledgment of the importance of how power relations are captured within analysis. It is here that Clarke incorporates the notion of 'discourse' as proposed by Foucault (1972) and subsequently developed to include the notion of 'discipline' (Foucault, 1973). A discourse is defined as a way of viewing, classifying and representing a particular phenomenon, for instance the way in which the discourse of medicine represents illness. 'Discipline' relates to the ways in which mechanisms of power regulate the behaviour of individuals. Discursive practice flows from allegiance to a particular discourse. Some discourses become dominant above others, and perpetuate through the process of 'disciplining practices' through which contradictory discourses are contained and individuals conform. Clarke's situational analysis also draws explicitly upon Strauss's work relating to social worlds, arenas and negotiations (Strauss, 1978a) in outlining the importance of the social worlds inherent within the research situation. For Clarke, both Foucault and Strauss are, as theorists, viewing social situations through different lenses. In relation to this research, the very nature of mental health problems and how they are defined has been discussed in chapter two as contentious. Furthermore, the way in which mental health problems are viewed fundamentally affects or even dictates the responses to these presenting issues at both individual practitioner and service organisational levels.

Secondly, situational analysis very explicitly takes into account the non-human elements or 'materialities' within a situation, the ways in which they interact with the social network elements and they are themselves constructed in terms of meanings and importance. This includes the notion of 'hybrid' objects, in the sense that the category of human/non-human is itself a grey area when considering, for example, discourses as non-human elements within a situation. Within the literature reviewed in chapter two of this thesis, the context of practice has been shown to be of central importance. This context includes the ways in which services and protocols for practice are designed and enacted, which itself can be shown to relate to discourses.

Thirdly, situational analysis incorporates the use of mapping approaches to assist analysis of the situation under investigation, replacing the traditional grounded theory focus upon basic or key social processes by mapping the complexities of the situation. Three kinds of maps are employed in constructing the situation of enquiry. Firstly, situational maps outline the major human, non-human, discursive, historical, symbolic, cultural and political elements of the situation under analysis. The complexities of the situation are captured here. Secondly, social worlds/arenas maps outline the collective 'actors' within the situation, and the non-human elements and arenas of commitment within which they are embroiled in social organisational discourse and negotiations.

Finally, positional maps outline the positions taken (and not taken) within the data, including axes of variation and difference. This includes focus upon controversy and contradiction. These maps seek to outline the range of discursive positions on relevant issues.

The use of these mapping techniques encourages the explicit asking of 'situational questions' about the focus of enquiry. Centrally, Clarke (2005) traces the development of Strauss' notion of the 'conditional matrix' (Strauss & Corbin, 1990) as a means of incorporating and specifying structural conditions within analysis. For Clarke, however, the conditional matrix as an analytical approach remains outside of the situation of enquiry, as a contextualising device in analysis. She emphasised that:

*"The conditions of the situation are **in** the situation. There is no such thing as context. The conditional elements of the situation need to be specified in the analysis of the situation itself as *they are constitutive of it*, not merely surrounding it or framing it or contributing to it. They *are* it." (P.71, original emphasis).*

Clarke (2005) emphasised that these mapping techniques are an aid to analysis, rather than a replacement for the analysis and coding processes described by Strauss and Corbin (1990). The maps themselves may, or may not, become part of the final findings of the research process. Constructing these maps can assist in arriving at more detailed consideration of the bigger picture of the situation of interest, particularly when used in conjunction with the use of memos as advocated within grounded theory approaches. The research context, for Clarke, is illuminated in more relevant specific detail to that context than that afforded by constructing a conditional matrix and some elements of the 'axial' coding process outlined above. In relation to my research, the complexities to be captured are those relating to the ways in which mental health nurses engage with their roles in the first instance, and how they subsequently maintain engagement with their roles in the various arenas within which they practice.

Situational analysis thus expands/enlarges a grounded theory approach in several key ways. Through an explicit linkage to postmodern underpinnings, the relativistic nature of findings in context are acknowledged. Through the same underpinnings, reflexivity between the researcher and the research situation is explicitly acknowledged. Explicit interactionist, constructionist and relativist roots move grounded theory away from entanglement with notions of positivism and 'objective' science. The explicit focus upon power relations via the requirement to consider discourses present in the situation enriches analysis. The importance of the non-human or material within situations is acknowledged and incorporated explicitly within analysis, and there is an explicit move towards accepting and capturing complexity within situations, rather than reducing complexity as theory is built.

Assembling the Conceptual Framework for this Research

This chapter began by outlining the importance of making explicit a conceptual framework for a research study, as articulated by Ravitch and Riggan (2012), driven by the three elements of the personal interests of the researcher, topical research and theoretical framework(s). In assembling the conceptual framework for this research, these three elements are now briefly articulated in turn.

From a personal perspective, I have long held an interest in professional roles in health care, both more generally, including inter-professional collaboration, and specifically in relation to mental health nursing roles. I am a mental health nurse, having worked in both practice and educational settings for some years. The increasing complexity of mental health nursing roles and the difficulty in articulating a unique mental health nursing perspective has been a particular ongoing interest, including academic publication in this area. The execution of this research study presents as a valuable opportunity to contribute to an important debate at an important time. Chapter seven of this thesis incorporates a more expansive consideration of my personal reflexivity relating to the research informing this thesis.

Turning to literature, previous research into roles within health care, mental health care and mental health nursing specifically has served only to underline the complexity involved. The elements of continually changing contexts of practice and the difficulty in articulating clear nursing and mental health nursing roles previously discussed within the literature review serve to underline this complexity. Situational analysis explicitly aims to capture complexity, and is thus commensurate as an approach to this research focus. The specific framework for role analysis proposed by Machin and Stevenson (1997), concerned with aspects of role adequacy, role legitimacy and role support, presents as a valuable sensitising concept in providing a means to, in turn, define 'role congruity', the central focus of this research. For this reason, the framework of role adequacy, role legitimacy and role support is incorporated into the conceptual framework for this research in terms of providing a heuristic device via which role congruity as an outcome can be made explicit.

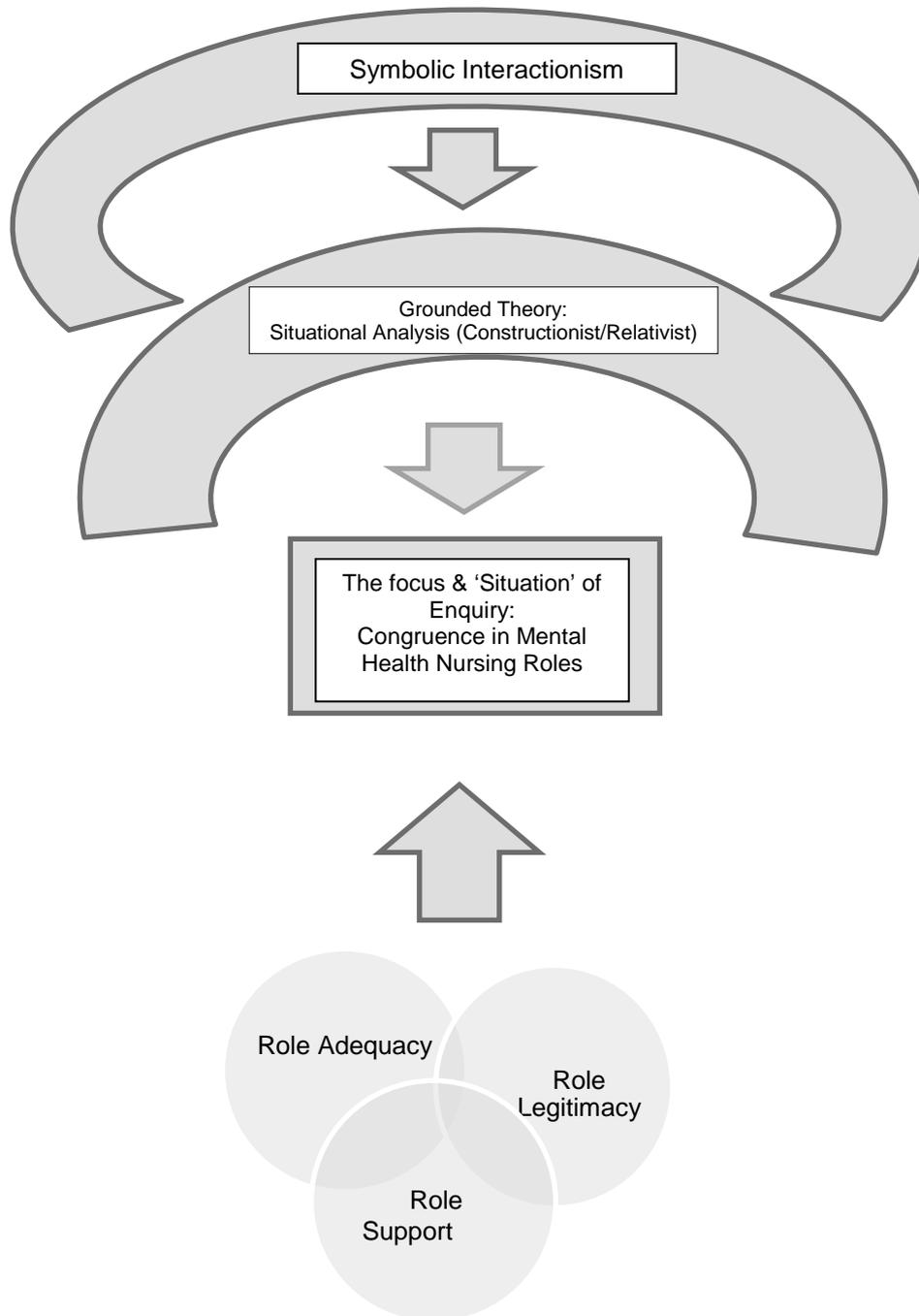
In terms of a theoretical framework, much time has been spent within this chapter outlining the tenets of symbolic interactionism as a perspective. This is important not only to the underpinning of the research approach articulated here, but also to the focus upon professional roles for mental health nurses and to the very nature of mental health/ill health itself. Symbolic interactionism can be seen to frame:

- Interaction between mental health nurses and service users.
- Interaction between mental health nurses and the organisational systems within which their roles are manifest.

- Specific interactions between mental health nurses and other professional groups, within health care more generally and mental health care specifically. This includes power relations between professional groups.
- The very process of engaging with the role of the mental health nurse in the sense of becoming socialised into the profession.
- The ongoing process of professional development and professionalisation.

The research approaches of grounded theory and situational analysis have also been summarised in some depth here. Given the evolution of grounded theory as an approach since its conception in 1967, it is important to clearly articulate the underpinning assumptions inherent in this research study. The processes of grounded theory, as articulated by Strauss and Corbin (1990), have been shown to have strong roots in symbolic interactionist principles. The move from the original, more positivist, principles inherent in the Glaserian stance to explicit engagement with a constructionist underpinning proposed by Charmaz (2000) has been outlined as a precursor to Clarke's expansion of grounded theory with the relativist position taken within situational analysis. Taken together, these elements construct the conceptual framework underpinning this research, expressed in Figure 3:1 below.

Figure 3.1: Conceptual Framework for the Research



Conclusion

This chapter has outlined the conceptual framework for this research. The importance and utility of setting out an explicit conceptual framework for any research study has been argued, with the three key elements of; personal interest of the researcher, previous research/literature and theoretical framework made explicit to the focus area of ‘the development and maintenance of professional role congruity within mental health nursing roles’. My personal interest as researcher has been outlined in terms of my own narrative experience within the discipline of mental health nursing. Drawing upon literature, the role analysis framework comprising the three elements of role adequacy, role legitimacy and role support brings a useful, systematic consideration for specific aspects of mental health nursing roles.

Considerable focus has been given in this section to the way in which the theoretical perspective of symbolic interactionism relates to a grounded theory methodology and, in turn, how this relates to the more recent grounded theory variant of situational analysis. This has been essential to undertake as part of the articulation of the conceptual framework, since grounded theory as a research approach has been subject to much re-interpretation and application over the period of almost forty years since its original inception in 1967. It is thus, in turn, important to make very explicit on what terms the approach is being utilised within a given research study.

In terms of theoretical frameworks, the inter-relationship between symbolic interactionism as a fundamental underpinning to a grounded theory approach, incorporating the development of situational analysis within a ‘constructionist/relativist’ position has been outlined. The framework of role adequacy, legitimacy and support has also been justifiably incorporated into the conceptual framework as a heuristic device or sensitising concept.

Though key elements of a grounded theory/situational analysis approach have been outlined within this chapter, the next chapter goes on to outline and discuss the actual application of these elements in the specific context of this study in terms of design, methodology and methods.

Chapter 4: Applied Methodology, Research Design and Methods

Introduction

The conceptual framework for this research outlined within the previous chapter of this thesis outlines the ontological, epistemological and methodological assumptions underpinning the research approach taken. This has identified that the version of grounded theory employed within this study adopts the constructionist/relativist stance encapsulated within situational analysis as outlined by Clarke (2005). This chapter of the thesis outlines in explicit detail the research approach taken at the level of actual design, methodology and methods. The issue of evaluating qualitative research approaches, and this study in particular, are not directly addressed in this chapter, but are specifically discussed together with issues of my own reflexivity as a researcher in chapter seven of this thesis.

The research approach is first summarised in terms of the applied principles of grounded theory/situational analysis specifically deployed. The approach taken to sampling is then described, this being particularly relevant in terms of the principles of theoretical sampling espoused within a grounded theory approach. Following a summary of ethical issues, the data collection strategy of qualitative, depth interviewing is then outlined in terms of its employment within this study. Finally, the strategies of data analysis are then set out, making explicit the way in which the mapping approaches of situational analysis were employed in relation to the data coding and analysis techniques of grounded theory.

Methodology

Situational Analysis (Clarke, 2005) sits within the broader methodology of 'grounded theory' originally proposed by Glaser and Strauss (1967), and subsequently elaborated by Strauss and Corbin (1990), though it does stipulate notable variations in underpinning assumptions as an approach in its own right. These have been outlined in chapter three of this thesis.

The inherent strengths of grounded theory in capturing social processes are augmented by the emphasis of situational analysis which moves beyond social processes to more fully and integrally incorporate contextual/situational aspects via the use of cartographical or mapping approaches. The use of these, for Clarke, re-situate grounded theory in a variety of ways which enable researchers to encapsulate the discursive as well as the action-orientated complexity of social life within situations of enquiry. Importantly, this includes the influence of broader situational factors including political and economic influences. This is often implicit in the sense that the situational

position of research participants is clearly influenced by such factors, but not necessarily allured to explicitly within the narratives of participants. It was also not a primary goal of the research informing this thesis to explicitly and directly explore these aspects.

Firstly, situational maps make explicit human and non-human elements within the situation. This includes discursive elements, which are practices and other elements directly related to particular discourses (specific ways of viewing the world and its aspects, medical discourse being a notable example) manifest within the situation, and material elements within the research context. Secondly, social world/arenas maps focus upon the collective human actors in the research situation, and their arenas of commitment. Thirdly, positional maps are concerned with discourses and positions taken/not taken by participants within the situation of enquiry. The use of these mapping techniques is outlined in more detail within the outline of analysis, below.

Theoretical Sampling

The nature of sampling within qualitative, grounded theory/situational analysis is, fundamentally, flexible and related reflexively to on-going analysis (purposive/theoretical sampling). In that sense, the initial proposed sampling strategy needs to necessarily involve the potential to 'follow' the emergent data analysis (Strauss & Corbin, 1990). Morse (2007) echoes this flexible approach to sampling as central to a grounded theory approach, even though initial sampling may be based upon a degree of convenience. Theoretical sampling purposively seeks out participants who are relevant to the emergent analysis, either in confirming emergent themes, or because alternative situations are being sought in the spirit of constant comparative analysis.

Strauss and Corbin (1990) define theoretical sampling as 'sampling on the basis of proven theoretical relevance' (P. 176). Proven theoretical relevance is related to concepts that are of interest because they are repeatedly present (or notably absent) within the process of analysis. The process of theoretical sampling is broken into three phases, mirroring the three stages of data coding. *Open sampling* relates to the analysis phase of open coding and may be purposive, systematic or fortuitous. *Relational and variational sampling* builds upon this in seeking variation and comparison to inform the unfolding analysis, aiming to explore variations within identified dimensions within analysis. *Discriminate sampling* relates to selective coding and is concerned with verification of the emergent storyline, relationships between categories and substantiating less well-defined and illustrated categories. The relationship between sampling and data analysis is thus reflexive and emergent as the study progresses.

The sampling intent for this research broadly followed this pattern. 19 participants were ultimately involved, with three of them re-interviewed one year following their initial interview, resulting in 22 episodes of data collection.

The sample thus, ultimately, captured a range of participants from pre-registration programmes (n=9), through to qualified/registered mental health nurses (n=10) working in a variety of practice settings, with a range of expertise and competency in the delivery of therapeutic modalities ranging from 'interest', to accreditation.

Depth interviews were conducted within University premises, or within the participant's workplace, lasted for between 1 hour to 1.5 hours and were digitally recorded and transcribed.

Ethical Considerations

As service users were not directly involved in the proposed research, full IRAS (Integrated Research Application System) ethical approval was not required. Since the focus was upon pre-registration student nurses and post-registration nurses currently studying within the Faculty of Health and Life Sciences, Northumbria University, and the researcher was a member of faculty staff, a proposal to Northumbria University ethics process was required, submitted and approved in May 2012 (Northumbria ethics committee ref: RE-13-01-12567).

The main aspects of ethics relating to participants are those of preservation of confidentiality and correct consent processes, all of which were assured and affirmed via submission of the proposal for ethical scrutiny and approval. *Appendix (i)* to this thesis contains the confirmation of ethical approval, information given to prospective participants, and the consent forms used for those who agreed to participate. This includes clear indications that participants may withdraw from the study at any time without prejudice, which is an important consideration where participants are students, and the researcher a representative of the educational system within which they are engaged in study. In terms of confidentiality, participants were assured that they would not be identifiable within the writing up and reporting of data, and that recordings, transcripts and any identifiable information regarding participation (such as signed consent forms) would be stored securely, either digitally or physically, by the researcher.

No participants withdrew from the study on any ethical grounds, though one participant was discontinued from their programme of study and another participant changed field of nursing from 'mental health' to 'adult'. No ethical dilemmas or issues have been encountered within the conduct of the research.

Data Collection Method

The method of choice was that of depth, qualitative interviewing, with periodic re-interviews for selected individuals, based (in the spirit of grounded theory) on emergent data analysis. Wengraff (2001) provides a comprehensive overview of the processes of qualitative interviewing. With regard to 'depth' interviewing, he outlines two key strengths of the approach. Firstly, it can provide more detailed knowledge about the phenomenon of interest. Secondly, it can facilitate an uncovering of issues 'underneath the surface'. The focus upon 'surface appearances vs. depth realities' fits very well with the use of the mapping techniques of situational analysis in relation to this research focus.

Bowling (2002) points out that researchers employing depth interviews should be mindful of potential disadvantages. Firstly they are time consuming in terms of data collection and analysis, which typically leads to there being smaller sample numbers involved and associated issues in claiming any representativeness from the data more widely. This issue is discussed explicitly in chapter seven of this thesis. Secondly, there are greater opportunities for researcher bias to become an issue. This aspect relates to the need for ongoing reflexivity as a researcher, also discussed in chapter seven.

Interviews were conducted either within University premises or, in some cases, within the respondent's workplace, by appointment. Interviews lasted between 50 minutes and 1.5 hours, were digitally recorded and then later transcribed for analysis. The interview agendas focussed upon the respondents' narratives regarding their professional development as mental health nurses, from initial role preparation (the pre-registration part of the sample) through to ongoing professional development (the post-qualifying part of the sample). In the spirit of grounded theory, the data collection was concurrent with analysis and theoretical sampling, and the interview agenda did evolve in relation to emergent analysis. *Appendix (ii)* to this thesis contains the outline interview schedules utilised for pre-registration and post-registration participants. For participants who were re-interviewed, the interview agendas were annotated with relevant notes from the original interview transcripts.

Mapping Approaches to the Situation of Study

Situational analysis mapping techniques (Clarke, 2005) enrich emergent theory in several ways. There are three distinct mapping typologies:

- Situational maps: which make explicit human, non-human, discursive and material elements within the research context.
- Social worlds/arenas maps: concerned with the collective human actors in the research situation, and their arenas of commitment.
- Positional maps: concerned with discourses, and positions taken/not taken.

Given the discussion in chapter two outlining the complex practice contexts within which mental health nursing identity develops and evolves, the relevance and focus of these mapping techniques is clear, encompassing these dimensions of complexity. Typically, each type of map begins with a messy version, before it becomes more ordered.

Situational Maps

Situational maps have the actual situation of interest as their focus. Clarke (2005) outlined three fundamental questions for a situational map. Firstly ‘who and what are in this situation?’, secondly ‘who and what matters in this situation?’ and finally ‘what elements make a difference in this situation?’ The elements of a situational map typically encompass:

- Individual human elements/actors: Significant people in the situation.
- Collective human elements/actors: Organised groups of individuals.
- Discursive constructions of individual and/or collective human actors: The ways in which key issues relevant to the focus are constructed/understood.
- Political/economic elements: The State, non-State organisations, local/regional/national/global levels as relevant, politicised issues. This includes wider political and economic influences such as government ideology and economic conditions.
- Temporal elements: Historical, seasonal, crisis, trajectory aspects.
- Major issues/debates: Current contested issues in relation to the area under investigation.
- Non-human elements/actants: Technologies, material infrastructures, specialised knowledge/information, material things.
- Implicated/silent actors/actants: People or things within the situation which are not fully acknowledged.
- Discursive construction of non-human actants: The assumptions attached to or underlying non-human elements.

- Sociocultural/symbolic elements: Religion, race, sexuality/gender, icons/logos, visual or aural symbols of relevance to the situation.
- Spatial elements: Spaces in the situation, geographical aspects, local/regional/national/global levels.
- Related discourses (historical, narrative, and//or visual): Normative expectations of actors/actants, moral/ethical elements, media and other popular cultural discourses, situation specific discourses.

Once identified and itemised, these elements within the situational map are then subject to ‘relational analysis’, whereby each element is examined in relation to the other elements. The grounded theory technique of ‘memo writing’ (Strauss & Corbin, 1990) is useful during this process, as key though not immediately apparent issues to explore within the data can become evident. Chapter five presents the situational map constructed in relation to the research informing this thesis, together with an outline of the key considerations which emerged from the process of mapping the situation.

Social Worlds/Arenas Maps

For Clarke (2005), the social worlds/arenas aspect of situational analysis is explicitly related to symbolic interactionism, discussed within the conceptual framework chapter of this thesis. The interactionist emphasis upon the ways in which collective social groups create meanings and act collectively is central to mapping social worlds, arenas and discourses as part of the analytical process of situational analysis. The term ‘social worlds’ originates from Strauss (1978a), who also defined social worlds in terms of ‘universes of discourse’, which bring the issue of power explicitly into consideration. A key tension concerns how groups organise themselves within structural situations where other social groups are also exerting influence with discourses playing important roles within these dynamics. Social worlds/arenas maps, with an attendant focus upon discourses within the situation aim to capture these complexities. In doing this, social worlds/arenas mapping identifies the social worlds of groups and their organisation in terms of sub-worlds and segments, boundaries, and the negotiations and arrangements which are made between groups within these worlds. There are several key issues to be made explicit within this analysis. Fundamentally, the way in which social worlds gain social legitimacy in the first instance is central. The way in which boundaries are established and maintained between social worlds is also of concern. Within social worlds, individual social actors become framed as representatives of particular social worlds or sub-worlds insofar as they are collective identities, though this is also often balanced against personal interests within situations. Key questions which regarding the arena itself are:

- The focus of the arena.

- The social worlds present and active.
- Social worlds present and implicated, or not present and implicated.
- Worlds absent which might be expected.
- Contested topics/issues or controversies within the arena's discourses.
- 'Silences' in the discourse.
- Other specific important issues within the arena/situation.

The data which informs this analysis is inherent, of course, within a given research study design. In the case of this study, this comprised of depth interviews with mental health nurses in preparation and on-going career development. However, many of the issues inherent within the social worlds in question are also inherent in other historical and organisational documents and information, which are matters of accessible record, previous research and literature.

Once the social worlds involved in an arena are identified, as with situational maps, key issues to explore are:

- The 'work' of each world.
- The commitments of each world.
- How participants believe commitments should be fulfilled.
- How worlds present/describe themselves in discourse.
- How given worlds describe/consider others in the same arena.
- Actions taken in the past, currently and potential future actions.
- How the agendas of social worlds are organised and furthered.
- Technologies involved/implicated.
- Consideration of particular sites where action is organised.
- Other specific things of relevance/importance.

In systematically considering these issues, as with situational maps, the grounded theory technique of using 'memos' is a valuable tool. Two key overlapping social worlds/arenas were identified in relation to the research informing this thesis, those of the mental health practice arena and the higher education institute arena. Chapter five of this thesis presents the social worlds/arenas maps constructed, together with an outline of the key considerations which emerged from the process.

Positional Maps

Situational maps and social worlds/arenas maps capture important elements in the situation in terms of human, non-human, environment and social organisational elements. Positional maps

relate to these maps, but also to emergent data coding in terms of categories as they develop. The intent is to portray the positions taken within the data with reference to major discursive issues of relevance. Possible positions within relevant discourses may be identified, and research participants can be located within those positions. Importantly, this can include positions not taken by research participants, as part of the analysis. Positional maps are often constructed on two or more axes, with each representing either a dimensional range from lower to higher, or specific discrete positions. These axes are used to map relevant discursive positions relative to each other, resulting in the identification of the range of possible positions which could be taken. Those positions present and not present within the data are identified as such. A number of such maps are typically made within a situational analysis, and those most relevant to the research focus can be a particularly illuminating aspect of data analysis.

Data Coding and Analysis Approaches

Strauss and Corbin (1990) outlined the processes and stages of data coding within their interpretation of grounded theory in considerable detail. They emphasise that the purpose of data coding/analysis within a grounded theory approach is to go beyond establishing themes within data, but to build theory which is grounded within the data. They stipulate three types of coding processes: open coding, axial coding and selective coding.

Open coding consists of identifying *concepts* within the data. During this phase of coding, data are reduced to discrete parts and examined in close detail. Between the processes of comparing and questioning, phenomena become grouped as concepts, which are given names, or ‘conceptual labels’. These concepts are, in turn, grouped into *categories*. As open coding proceeds, categories become identified, named and populated with examples from data. The process of open coding thus ‘unlocks’ the data by fracturing it and identifying categories, in an analytical sense.

In a grounded theory study, following the processes outlined by Strauss and Corbin (1990), axial coding continues the analytical process of developing categories identified during open coding. Data are reconstituted in new ways by the establishment of connections between categories and their constituent parts (concepts or sub-categories). Categories are developed and described in terms of contextual issues, constituting what Strauss and Corbin (1990) refer to as ‘the paradigm model’, within which categories are related to their components or sub-categories within a set of relationships. In the context of this study, connections between categories were developed at this stage, but much of the focus of the paradigm model, like that of the conditional matrix, is addressed via the employment of situational analysis.

Selective coding, as outlined by Strauss and Corbin (1990), builds upon initial coding in bringing the analysis together as a coherent theory. Through this process, a 'core category' is identified to which the other categories can be systematically related and ordered. Connections are made and relationships identified analytically and verified within the data.

Grounded theory coding, as outlined by Strauss and Corbin (1990), can thus be summarized as a process whereby analysis begins with the data fractured into concepts and combined into categories. These are then developed with more conceptual density, and ultimately inter-related in a way which captures the central focus of the research in a theoretical conceptual way which addresses the research question and is grounded from and within the study data. At a practical level, the use of 'memos' in the form of notes and diagrams is also a central analytic aid throughout all phases of the data coding and analysis process. *Appendix (iii)* to this thesis contains scanned examples of open coding in the form of annotated transcripts from the analysis process. *Appendix (iv)* contains scanned examples of coding memos, indicating various stages in the process of conceptualising categories during analysis.

In the context of this study, all interview transcripts were line-numbered as word-processor documents and saved as files in that format so that particular data elements could be rapidly re-located or made reference to during analysis if necessary. The analysis itself began with line-by-line analysis of transcripts, and through the process of constant comparative analysis and open coding data examples were initially given conceptual labels. These concepts were then grouped into categories and sub-categories with appropriate names and definitions outlining on what basis data examples were appropriate to be thus categorised. As analysis progressed, a 'core' category was identified, which linked the categories together meaningfully in relation to the research aim and questions.

Conclusion

This chapter has built upon the preceding chapter concerned with the conceptual framework for this research. It has done so by outlining the principles, guided by the conceptual framework involved, of the research design. Issues of sampling, ethics, data collection and data analysis have been summarised. Data collection and analysis have also been outlined in terms of the level of research practice. Issues of evaluating a qualitative study of this nature have not been directly addressed within this chapter, as they are explicitly addressed together with the issue of my own reflexivity as a researcher in chapter seven of this thesis.

The next chapter will present the research findings related to analysis of the interview data, and the analysis of the situation of study following the processes of situational analysis.

Chapter 5: Presentation of Findings and Initial Discussion

Introduction

Chapters three and four of this thesis have outlined the research approach taken in terms of conceptual framework, design and methodology, outlining the inter-connection of symbolic interactionism as a theoretical stance underpinning the grounded theory/situational analysis approach to the research informing this thesis.

This chapter will present the insights and perspectives which emerged from the situational analysis of the research context, together with findings derived from analysis of data from the depth interviews conducted with participants. Since it is difficult to present essentially qualitative findings without engaging in discussion, this chapter title indicates that initial discussion occurs within the presentation of findings, with chapter six offering further, more summative discussion.

I considered several formats for the presentation of findings in terms of the balance between the elements from situational analysis and the qualitative data analysis. The format for presentation which makes most sense to me is captured in diagram form in Figure 5:1 below.

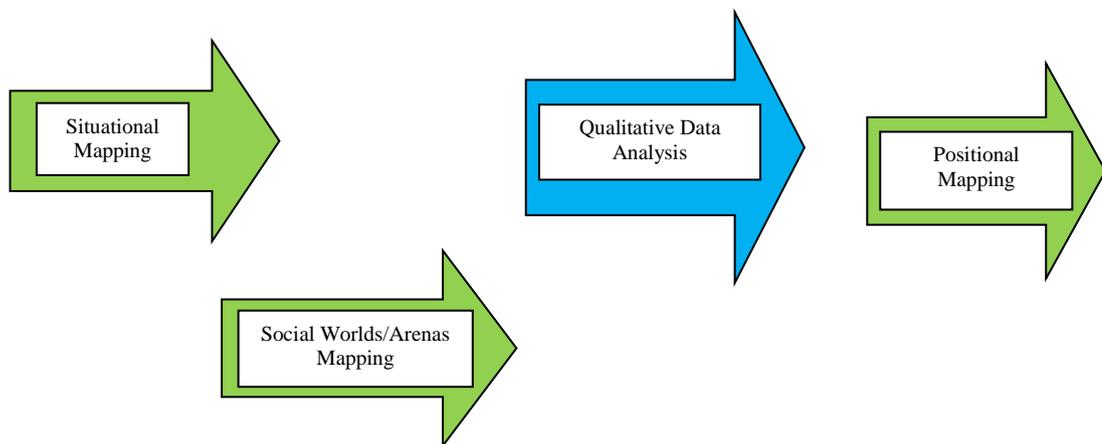


Figure 5.1: Sequence of Presentation of Findings

The first two elements of the situational analysis are initially outlined, beginning with the process and outcome of situational mapping, followed by consideration of the social worlds/arenas maps pertaining to the situation. The third mapping process in situational analysis, that of positional mapping, is only briefly summarised at this point, as it links more explicitly with the qualitative

data analysis, and is elaborated and incorporated more meaningfully later in this chapter, and within discussion in chapter six. Attention then turns to the presentation of findings from the qualitative depth interviews with the study participants in the form of inter-related categories which are presented and built sequentially to form a grounded theory model entitled 'Establishing Role Congruity'. Discussion then moves on to outline key positions relating to positional mapping, before concluding by drawing together and summarising both the grounded theory model and the situational analysis explicitly in terms of the way in which it illuminates the focus of this research. Chapter six will build upon the initial discussion instigated within this chapter, in explicitly relating these findings to the development and maintenance of professional role congruity for the discipline of mental health nursing.

The Research Participants

Table 5:2 below presents a summary of the characteristics of the research participants. A total of 19 individuals were interviewed, with three being re-interviewed one year after their initial interviews. The working locations and type of work with which they are engaged relates to the outline of the situation of analysis, as identified within the situational mapping process outlined in the following section.

Table 5.2: Summary of Participant Demographics

Participant	Gender	Age	Brief Relevant Biographical Details
1	F	24	Pre-Reg: Sept 11 (1 Year into course). Worked in administration in an addiction centre prior to course.
2	F	37	Pre-Reg: Sept 11 (1 year into course). Team manager in call centre prior to course.
3	F	25	Pre-Reg: Sept 11: First interview 1 year into course; 2nd Interview 2 years into course. Worked as 'housekeeper' on CAMH wards prior to course.
4	M	30	Pre-Reg: Sept 10 (2.5 years into course). Worked in motor trade prior to course. 2nd Interview 1 year post qualifying.
5	F	28	Pre-Reg: Sept-10 (2.5 years into course). Former admin/secretarial work prior to course. Mother LD nurse.
6	F	22	Pre-Reg: Sept 10 (2.5 years into course). Some voluntary work with 'troubled' children prior to course. Mother is Mental Health nurse.
7	M	31	Pre-Reg: March 13 (Prior to commencement). African by birth. Accountant prior to course. Suspended studies in 2014 for financial reasons.
8	F	28	Pre-Reg: March 13 (Prior to commencement). Former airline cabin crew prior to course. Father Mental Health Nurse, mother General Nurse. Changed nursing field to adult after year 1.
9	F	40	Post Qual: Completed degree. Qualified 20 years. Older person's mental health setting.
10	M	42	Post Qual: Completed degree. Qualified 10 years. Former prison work and computer systems prior to nursing. CAMH practice context.
11	F	34	Post Qual: 5 years Qualified (2009). Former Army (not Nursing). Crisis team practice context (3rd Role).
12	F	26	Child Nurse first. Qualified 2008. CAMH interest. Moved into CAMH ASAP when opportunity presented. Undertaking CAMH as CPD degree.
13	F	50	Initially LD. Converted to RMN. Vast experience as ward/senior manager. Completing PhD at time of interview.
14	F	46	Initially General Nurse. Converted to RMN. Team Manager in MH Trust. CAMH & Accredited Systemic Practitioner (Master's level).
15	F	51	RMN. Team Manager in MH Trust (CAMH). Accredited Systemic practitioner (Master's level).
16	M	23	Student Undertaking 'M Nurse'. Graduate Criminology and Voluntary Work Prior to entry.
17	M	55	HEI role teaching CBT and other therapeutic skills. 30 + years' experience in practice, the latter 10 as an Accredited CBT practitioner (Master's level).
18	M	53	HEI Teaching role in pre-registration MH. Practice career of 25+ years. Particular focus upon PSI for people with severe and enduring MH issues (psychosis). Completing PhD at time of interview.
19	M	49	29 years' experience, 16 years as care assistant, 3 years as student, 10 years working in Forensic services. More recently at interview Neuro-Psychiatry/Rehab specialist Unit.

Situational Analysis of the Research Context

Situational Map of the Research Context

Chapters three and four have outlined the rationale and key features of 'situational maps' within a grounded theory approach incorporating situational analysis. To re-iterate, Clarke (2005) describes the analytic function of situational maps as laying out the major human, non-human and discursive elements within the situation of interest. These elements are then examined in terms of the relations between them in so far as they influence the situation.

Figure 5:3 below summarises in schematic diagram form the key elements which a situational map incorporates. In the context of this research, mental health nursing is placed centrally.

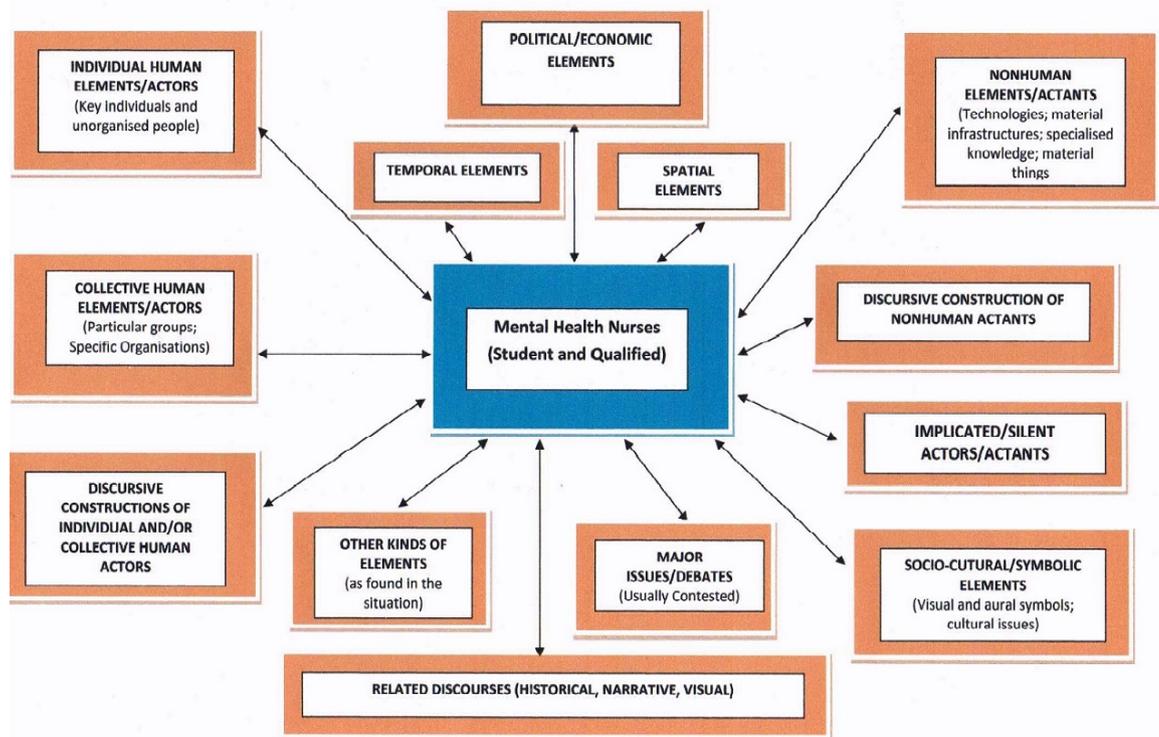


Figure 5.3: Situational Map for Mental Health Nurses

Focussing upon mental health nurses (both student and qualified/registered), these elements were considered in turn in identifying specific factors within each. The pertinent elements and factors relating to the current and historical context of mental health nursing were derived from literature as outlined in chapter two, together with researcher personal/professional experience and theoretical sensitivity. These listed factors were augmented during analysis of participant interviews, adding factors within the elements which had not been identified at that point. Specific relevant factors within the 12 elemental areas derived from this process are presented in a tabular fashion in Table 5:4 below.

1. Individual Human Elements/Actors	2. Non-Human Elements/Actants
Mental Health Student Nurses; Care assistants; Other Students (Nursing, other Health-Care, non-Heath Care); Educators (Lecturers, Guidance tutors - Pre-Reg & CPD); Service Users & Carers; Non-nursing professionals in Mental Health (Doctors, Psychologists, Occupational Therapists-the 'inter-professional context'); Qualified Mental Health Nurses (Student Mentors; Team Leaders); Voluntary Sector workers (e.g. MIND); Other non-MH Professionals (e.g. Social Workers, Physical Health workers); Managers in Host Organisation; Key Theorists (e.g. Peplau, Barker). Individual researchers.	Clinical Service Context; University; All other actors' roles as social objects; Service Users as 'objects' of treatment and research; Specialist training/education. Physical treatments such as ECT and medication. Therapeutic modality or techniques as 'technology'; Curriculum for Pre-registration; Curriculum for CPD. Technology of establishing 'evidence' (Research). Media portrayals of MH professionals.
3. Collective Human Elements/Actors	4. Implicated/Silent Actors/Actants
Nursing as a Profession, MH Nursing as Sub Profession; Nursing Teams; Student Nurses; MH Student Nurses; Student Nurse Cohort; HEI Staff Collectives (Course Teams; Department; Management Structure); Nursing & Midwifery Council (NMC- Statutory); Unions; Professional Organisation (e.g. RCN); Collective Service users (Service user groups as classified or organised); Carer groups; Other non-MH orientated collectives (e.g. for Social work or physical care); Collective Hierarchy of management in host organisation. Research teams.	Some service users/carers as disempowered; Voluntary sector. Anti-Mainstream theorists/dissenting voices - e.g. Szasz, Foucault, Phil Barker. Some forms of research ranked as less credible (e.g. qualitative approaches compared to RCT).
5. Discursive Constructions of Individual and/or Collective Elements	6. Discursive Construction of Non-Human Actants
Aetiology of Mental Health Issues; The Curriculum for Pre-registration; Curriculum for CPD; Theoretical Issues in Mental Health Care (associated values and practices); 'Care'; 'Recovery'; Mental Health Act (associated guidance); Risk assessment & Management. The nature of valid research and 'evidence' as seen by collective groups.	NMC curricula requirements; Requirements of other bodies (e.g. for specialist therapeutic modalities); 'Missions' of Services; NMC Code of Conduct (Ethics). Research approaches & criteria for evaluating 'evidence'.
7. Political/Economic Elements	8. Socio-cultural/Symbolic Elements
Prevailing Government Policy; Statutory Structural organisation (NHS/PH England); Nursing & Midwifery Council (Inc. Code of Conduct); Students' Union; Professional Organisations (RCN, BABCP, AFT). Research funding bodies.	Status as student; Status as graduate; Status of 'Nurse'; Status of other Professions; Stigma in Mental Health.
9. Temporal Elements	10. Spatial Elements
Age/Life experience; Students - Year 1,2,3; Qualified Staff- Length of experience; Time to retirement ('Winding Down'). History of mental health and mental health nursing.	In-Patient; Community; Place of Practice (or placement); University Site (Classrooms; Facilities). Historically, Institution as a place.
11. Major Issues/Debates	12. Related Discourses (Historical/Narrative, and/or Visual)
Future of NHS - Private/Public/Balance; Role of Voluntary Sector; Future of Nursing - In general, MH in particular; Move to generic preparation of nurses. What is classed as valid research and 'evidence'.	Medical; Mentally ill as 'Mad' and 'dangerous'; Nurses as 'caring'; Asylums as 'Bins'; Nurses as Custodians ('Men in White Coates'). Risk Discourse. Discourse of Mental Health Nursing? 'Science' as a discourse for a hierarchy of 'evidence'.

Table 5.4: Situational Elements for Mental Health Nurses

These 12 elements were then 'clustered' into 7 'elemental themes':

- Mental Health Nurses (Students and Qualified/Registered)
- Individual and collective human elements.
- Non-human elements and implicated silent actors/actants.
- Temporal and spatial elements.
- Political/economic and Socio-cultural/symbolic elements.
- Discursive constructions of individual/collective human/non-human elements and related discourses.
- Major issues and debates.

These seven elemental themes were then subjected to 'relational analysis' whereby each theme is systematically related to the others, and the issues emergent from each of these paired analytic considerations identified and noted. Twenty-one potential pairings of elemental themes were yielded during this relational analysis. For example, the elemental theme 'Mental Health Nurses' was considered in relation to each of the other six elemental themes, in turn, and the emergent issues noted. *Appendix (v)* to this report contains the tabulated summaries of these analyses. The wider influences at the socio-political level are clearly important, and reflect in much of the literature, particularly that concerned with policy, in chapter two. They are thus inherent within the analysis insofar as they influence the situation, but they are not the prime explicit focus of this research.

The issues identified during this relational analysis were grouped into three broad categories of pertinence to the research question. These are; the influence of structures, discourse-related issues and the nature of professional role, now briefly outlined and discussed in turn.

Influence of Structures

As identified and summarised in chapter two, historically, the National Health Service (NHS) within the United Kingdom has been subject to review and re-organisation at regular intervals. There are, of course, non-NHS organisations and services within the voluntary and private sectors within which mental health nurses operate, but these too are subject to the influence of health policy direction and implementation at any given time. Re-organisation of services at a national level frequently involves implementation of policy which has a direct bearing upon the role of mental health nurses in practice. A notable example of this is the wide-scale diffusion of mental health-related services from an institutional/residential model to a more community-focussed provision in the latter half of the last century. The structural organisation of professional groups themselves, both nursing and other health care-related professions, is thus also subject to re-organisation in order to meet needs created by the changing structures within which these

professions practice. The broader structure and organisation of health services and resources forms a backdrop against which services are organised. These aspects of influence should all, of course, relate to perceived needs of service users, and the available 'technologies' of intervention available to meet these needs. Caliminus (2013) itemises the organisational principles by which most statutory mental health services in the UK configure their services. He lists these groupings as:

- Children and adolescents
- Adults of working age
- Older adults
- Adults with learning disability
- Adults with forensic needs
- Adults with behavioural disorders
- Services for people with substance misuse issues

Psychological therapy services complete this list. Thus, the specific structure and organisation of local services within which practitioners are deployed creates the day-to-day reality of practice environments. Table 5:5 below summarises the varying ways in which services may be configured in terms of the presenting problems of service users.

Table 5.5: Service Structure by Presenting Issues

		Service Structure/Organisation			
		1. Acute Crisis Provision	2. Generic non-crisis Provision	3. Specific Disorders Provision	4. Specific Therapeutic Interventions Provision
Service User Presenting Issues	A. Crisis	Acute generic admission units. Crisis assessment services.	N/A	Crisis/Risk assessment and management. Referral for admission as in A1 if specialist services not available.	Referral to Crisis services.
	B. Specific Disorders, Non Crisis	N/A	Ongoing case-work generic supportive intervention. Rehabilitation and 'recovery' contexts. Residential, community or day service based.	Matched Intervention case-work.	Matched case-work to intervention.
	C. Age Range Related	As A.1	Generic within age range.	Matched Intervention case-work.	Matched case-work to - intervention.
	D. Forensic Services.	Forensic in-patient units of varying 'security'. Forensic services for monitoring of community based interventions.			

These typologies of service frame the practice contexts within which mental health nurses, including the participants within this research, engage with their roles in terms of their own narrative experiences.

For purposes of this discussion, service user presenting issues have been grouped into four categories. Crisis services are in place to respond to identified urgent situations. Crisis services have a remit to assess the crisis situation with regard to whether admission to an acute unit is necessary, or whether an individual can be supported through a crisis situation without admission. For service users with specific identified disorders such as addiction, psychosis, anxiety, depression etc., there may be services available set up specifically to respond to these presenting conditions. Crisis services for such specific issues (e.g. a detoxification unit for addiction, or a unit dealing specifically with psychotic episodes) are not necessarily available, meaning that the more generic acute crisis services deal with a range of presenting issues. An exception to this is seen in presentations relating to dementia, where services routinely have crisis admission facilities specifically relating to the condition. This leads to the category relating to age-range. Mental health services specifically for the older person (dementia tending to be an issue of later life) are commonly part of any comprehensive mental health service. Within services for the older age range, the distinction between 'organic' (i.e. dementia) and 'functional' (the range of other mental health related problems which may occur) is often made. For the latter category, the generic and specialist service configuration should be available as outlined above. Some services focus upon longer-term users of mental health facilities, with a remit to maximise independent living and minimise the propensity for relapse in the spirit of rehabilitation and recovery. Child and Adolescent Mental Health (CAMH) is dealt with by services designated to the younger age group and often encompassing 'the family' in remit. The range of disorders and presenting issues within children and young people means that there are particular services within this age-related category, such as conduct disorders and eating disorders. The final category for presenting service user issues is that of forensic services for mentally disordered offenders (including services for young people), deemed here as a specific category with a very specific remit to monitor and manage risk in this user group. Again, the defining factor here is offending behaviour, within which there is a range of presenting mental health issues.

A final important point to make regarding the way in which services are configured to meet service user needs concerns presenting complexity. Many service users present with co-morbid conditions involving co-existing issues of anxiety, depression, psychosis, drug and/or alcohol addiction, personality disorder and learning disability. Such individuals can be challenging to deal with in terms of which is the most appropriate service for them, and which issues are prioritised.

The pre-registration student participants within this study, as with all student mental health nurses, are exposed to a variety of placement contexts which span the range of presenting problems and service configurations itemised in Table 5:5. As examples from the qualified/registered participants within this study (see Table 4:1, chapter four), participant 9 is located within a context dealing with older people with dementia (specific disorder), which also receives crisis admissions for that particular condition (an in-patient assessment unit). Participant 11 works in a crisis team (acute crisis provision) where her role involves assessing service users in psychiatry in terms of whether admission to an acute unit is necessary. Participant 19 worked in a forensic context for some years, before moving to a neuropsychiatry setting. In contrast, participant 17, prior to working in higher education, worked as a cognitive behavioural therapist within a service specifically set up to provide CBT for individuals presenting with anxiety and depression. Participant 13, currently working in a managerial role, outlines a long career which has seen her work within services in most of the categories represented by Table 5:4. Importantly, the way in which services are configured also influences the structure, duration and quality of contact between mental health nurse and service user in terms of the development of a therapeutic relationship, and the degree to which therapeutic interactions can be structured.

In summary, there are a wide range of mental health-related problems with which service users may present with for assistance or management in some way or other. Services are structured in particular ways in terms of responding to these presenting issues, within which there is often complexity. The discourse of medicine (in the form of psychiatry) is fundamentally influential upon the way in which service user presenting issues are understood in terms of aetiology and categorised, including the nomination of appropriate interventions and, thus, how services are organised. Since it is within these service configurations that mental health nurses execute their day-to-day roles, the influence of this discourse is significant.

In terms of the interventions available to service users, there has been an increasing emphasis since the latter part of the last century upon treatments/interventions having a valid 'evidence base' in order to be offered to service users. This is enshrined in ethical codes for health care professions, such as the Nursing and Midwifery Council (NMC) code of conduct in the case of Nurses (NMC, 2015a). In the United Kingdom, the arbiter of what is considered to be valid evidence for health care interventions is the National Institute for Health Care Excellence (NICE), from which key practice guidelines concerning evidence-based practice within the arena of mental health are summarised in chapter two. In the context of mental health services, 'care pathways' reflect the matching of identified needs to appropriate care and evidence-based interventions. Importantly, the provision of these interventions is increasingly expected within commissioning arrangements. It is within this structural context that therapeutic approaches/modalities such as cognitive behavioural

therapy and systemic/family therapy have emerged and consolidated an evidence base. It is thus apparent that, beyond the creation of a provision/service, there are specific expectations regarding the nature of service activity.

Discourse-related Issues

Clarke (2005) outlined the ways in which consideration of ‘discourse’ and related ‘discursive practice’ are important considerations within situational analysis. Clarke suggests that within organised human collectives we are:

‘awash in seas of discourses that are constitutive of life itself’ (P.91).

It thus follows that in analysis of a situation relevant discourses and associated discursive practice within the situation become of interest. The relational analysis conducted between the factors identified within the positional map (*see appendix (v)*) reveals some key ways in which discourses and discursive practice are present within the situation of this research.

Medical discourse in the explicit form of the discipline of psychiatry is at play in the very way in which mental health services are organised. This is reflected, as discussed in chapter two, in the continued use of the diagnostic and statistical manual of mental disorders (DSM) in the categorisation of people presenting to services with mental health problems. With this psychiatric discourse firmly in control of the way in which mental health service users and their presenting issues are classified, and with services designed to meet perceived needs of those so classified with, for example the construction of care pathways, then psychiatric discourse maintains control of service organisation. Since mental health nursing roles are influenced by the context of practice, then these roles are also significantly influenced by the same discourse.

Turning to therapeutic approaches or modalities, they also can be seen to rest within particular underpinning discourses. Two notable examples of therapeutic modalities commonly engaged with by mental health nurses (and reflected within the participants of this study) are cognitive behavioural therapy (CBT) and systemic/family therapy. The latter builds upon systems theory more generally, with an associated discourse which sees presenting problems within service users as indicative of problems within the wider human system (typically a family) in which the service user is engaged. Its underpinning discourse veers toward the relativist/post-modern in terms of how presenting problems are contextualised within systems (Carr, 2012). CBT, on the other hand, rooted in the theoretical and practice discipline of psychology, shares aspects of psychiatric discourse in accepting the DSM classification systems of diagnosing presenting problems to which CBT as an approach can then be employed as an intervention. In this sense, the theoretical and

discourse related underpinnings of therapeutic modalities embrace the categorisation system rooted in psychiatric discourse to different degrees, but all must engage with it in the practical reality of everyday clinical practice.

A second discourse of relevance is that of 'risk'. This concerns the wider view of people with mental health problems within society and their portrayal within the media. As outlined in chapter two, a common representation of mental health service users within the media has a focus upon risk, dangerousness and a lack of responsibility/control for actions. This fuels the ongoing problem of stigmatisation of people with mental health problems within society, and the discourse of risk presents ongoing dilemmas in the management of people with mental health problems, particularly within an ethos of community care. This assessment and management of risk from users of mental health services is thus a central issue at all levels, including national policy, within the level of service organisation through to individual practitioners.

A final important discourse-related element influencing practice is seen within the way an evidence base for practice is articulated and the degree of credibility afforded to sources of evidence. Discussion in chapter two argued that what is considered to be science-based evidence is essentially rooted within discourses underpinning much professional practice. In terms of the main influential discourse of medicine and NICE as the key arbiter of credible evidence, what might be termed the 'harder' scientific research approaches (the random controlled trial) are typically seen as more credible approaches in terms of research studies than those approaches rooted in more sociological or 'soft science' academic disciplines. This 'scientific' approach has also pervaded approaches to the assessment and management of risk, and is explicitly incorporated into the practice of mental health professionals with organisational policies and approaches. Though it is not the intention here to outline the debate between the relative merits of quantitative and qualitative research approaches, this issue, as will be seen later, is an important one.

Nature of Professional Role

Clarke, Friese and Washburn (2015) identify that, within a situational analysis, the classic sociological considerations of structure and action (Bauman, 1990) and the interplay between them become an explicit focus. The 'structure' aspect is involved in the consideration of structures earlier in this section. This section takes the focus explicitly to the 'action' aspect.

Role-related aspects concern the individual human actors (mental health nurses) executing their roles with the situation under study. A central task for student mental health nurses (Participants 1-8 and participant 16 within the study informing this thesis) is to establish themselves within role in a baseline sense, and go on to engage with the necessary dimensions of the mental health nurse

role. The ongoing task for qualified/registered mental health nurses (participants 4, 9-15 and participants 17 -19) is to maintain this engagement with role and adapt to evolving/changing roles throughout their careers. As qualified/registered nurses, they must then adjust and adapt to the associated levels of accountability and responsibility. In the longer term, further development is acquired through experience, education and training as nurses develop and incorporate new and additional skill sets within their capabilities. The relationship between mental health nursing and therapeutic approaches presents a fundamentally significant factor, and will be developed in later discussion within this chapter and the next.

There are several parameters which influence the nature of contact mental health nurses have with service users: service users' presenting problems, degree of crisis/risk, the nature of the care environment (in-patient, community/out-patient setting), the time available for contact, and the duration of contact (short term 'cross sectional' case involvement, or longer term case-work). Two factors relating to therapeutic interventions are the level of competency within specific therapeutic approaches, and the degree of autonomy/legitimacy afforded to mental health nurses within specific contexts to adopt particular approaches.

An often-cited aspect of the role of the mental health nurse concerns the amount of time spent with service users. The idea is that, as mental health nurses spend more time with service users within a given 24-hour cycle, this creates a unique aspect to the professional/service user relationship compared to other professions within mental health, who's involvement is much more specific and time-limited by comparison. However, whilst this may have been more generally the case within the historical context of institutional psychiatry in the earlier part of the 1900s (Nolan, 1993), contemporary mental health nursing roles span a far greater variety of contexts, within which the residential/in-patient setting is just one, though within that setting the time spent with service users does stand out as a factor in comparison with other mental health nursing roles.

A final important factor re-emphasised here returns to the nature of what is considered to be 'evidence' with regard to evidence-based practice. As discussed in chapter two, nursing has become a graduate profession incrementally since the latter part of the last century. As a graduate profession, a consideration and understanding of the nature and characteristics of valid evidence underpinning practice is, arguably, central.

Summary: Situational Map

The use of a situational mapping approach has identified several key areas of relevance. Through relational analysis of these areas, three broad thematic aspects have emerged, those of influence of structure, discourse-related issues and professional role issues.

From the perspective of the structures within which mental health nurses practice, it is immediately apparent that the way in which structures are organised has a significant influence upon the way in which mental health nurses conceptualise and engage with their professional roles, including therapeutic interventions and the assessment and management of risk. This, in turn, has influence upon the agenda for educational programmes concerned with both the initial preparation of mental health nurses, and continuing professional development.

From the perspective of individual professional roles, student nurses have the task of engaging with the role of mental health nurse as distinctive from other professional roles. As mental health nurses move from student to qualified/registered status, they must engage with the additional accountability and responsibility for practice which accompanies this transition. They then face the task of on-going role development over the rest of their working careers, responding to the dynamic relationship between discourse, structures and the adjustments to role requirements which emerge.

Finally, the process of systematically mapping the situation of enquiry has made explicit key relevant discourses evident within the situation of enquiry. Firstly, the continued dominance of medical discourse in the form of psychiatry and its ongoing influence in the categorisation of mental health disorders continues to pervade. This influence is central to the organisation of services for people presenting with mental health disorders, which is in turn influential upon mental health nursing roles in day-to-day practice. The second key element of discourse lies in the consideration of risk and how it is identified and managed at the level of service and individual practitioner. The final element of discourse evident within the situation concerns the nature of what is perceived as valid evidence for practice.

This chapter now goes on to consider the second of the three areas of mapping within situational analysis, that of social worlds/arenas maps.

Mapping Social Worlds/Arena's

The situational mapping process in the previous section has outlined the major relevant human and non-human factors of relevance within the situation of interest for this study. This has included identifying relevant discourses and associated discursive practices at play. The mapping of social worlds/arenas builds upon this to explicitly identify the key social worlds present within the arenas, and their interaction with reference to the focus of interest. The notion of 'social worlds' relates to the theoretical perspective of symbolic interactionism as explored within literature in chapter two, and was also a central perspective within the conceptual framework and methodological approach underpinning this research as outlined in chapters three and four.

Genat (2015) summarised arenas as the substantive areas of practice/operation of individual and collective social actors within the situation of interest. Social worlds are 'sites of commitment' involving groups of people who come together through shared interests within which they share elements of technology and discourses in pursuing mutual concerns. In this sense, social worlds thus encompass both action and discourse (p.174). Within this study, two main interconnected arenas are identified. Firstly, the arena of mental health practice is outlined and explored in terms of inter-connected social worlds. Mental health nursing is, fundamentally, a practice-based discipline. In terms of that aspect of this study which has a focus upon pre-registration mental health nurses, fifty percent of the educational programme for initial preparation is delivered in mental health practice settings. Qualified/registered mental health nurse participants within this study were all engaged in practice, studying on a part-time basis. Secondly, the arena of the higher education institute is similarly explored in terms of social worlds relating to the mental health agenda.

Social Worlds Within the Arena of Mental Health Services

Figure 5:6 below presents in diagram form the relevant social worlds operating within the mental health practice arena. Overlaps between social worlds indicate the presence of shared aspects of interests within the mental health practice arenas. In terms of the overall arena of mental health practice, the fundamental shared interest is the provision of services for people with mental health-related problems. In this sense, all social worlds are bound by this common factor and interest, and the social world of service users/carers. More specific overlapping issues of interest are indicated by further overlaps within mental health practice arena, and are summarised in the context of each social world in the discussion below.

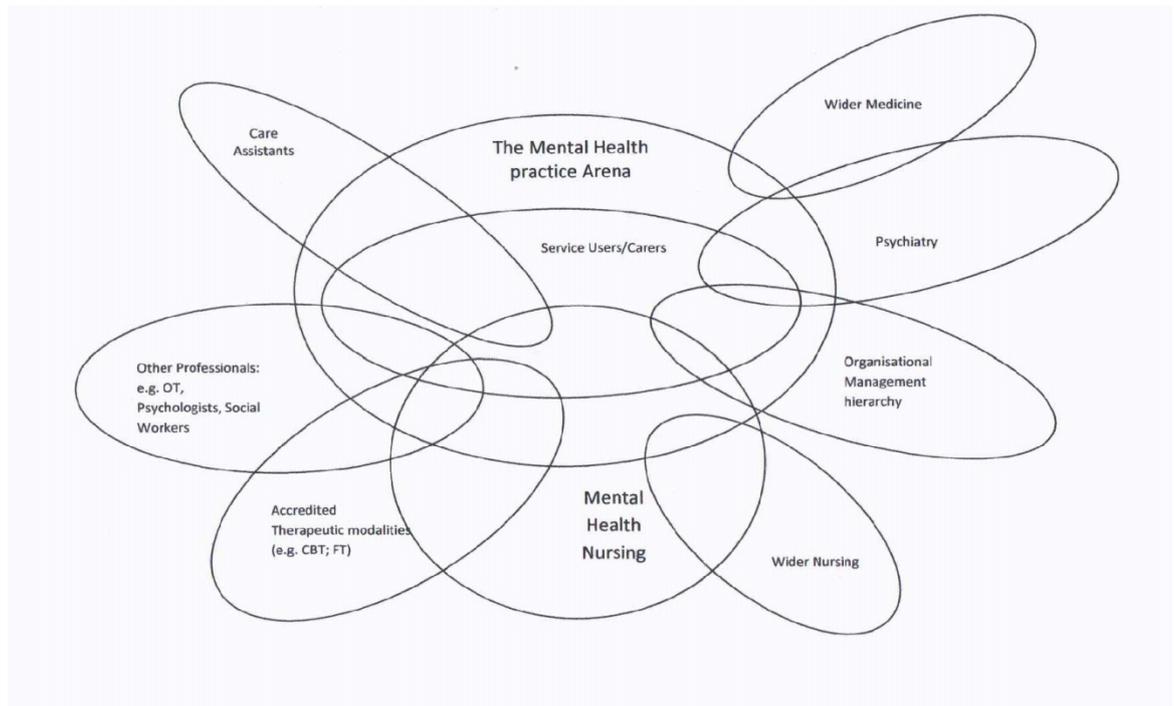


Figure 5.6: Social Worlds/Arenas Map for Mental Health Practice Context

Service users and their carers are portrayed centrally within the mental health arena, reflecting their centrality to all the interwoven social worlds. This is not to suggest that all service users have equity of access to services, as discussed in chapter two there are some service user groups which are harder to reach than others, or have voices which are less heard. There is an explicit link to discourse and discursive practice within the social world of service users/carers of mental health services, since they are the very subjects of discursive practice.

Psychiatry in effect represents 'wider medicine' as illustrated within the mental health practice arena. The situational map outlined earlier underlined that medical discourse, in the form of psychiatry, remains pervasive and highly influential within the practice setting of mental health services in that categorisation of presenting mental health problems is defined by accepted norms defined by medical diagnosis relating to DSM criteria.

The organisational management hierarchy is an important social world consideration within the practice setting. Student mental health nurses must assimilate the organisational structures within placement areas as part of the task of engaging with the placement. Once qualified/registered, mental health nurses become a more formalised part of this hierarchy, which incorporates more senior levels in terms of nursing roles and subsequent career development. There is also the real world of allocation of resources within defined constraints which presents dilemmas in the operational delivery of mental health services.

A further function of management hierarchy is to interpret and locally implement policies regarding the way in which mental health services are organised and delivered. This includes creating and implementing specific organisational policy for the assessment and management of risk as presented by service users. As discussed when considering the situational map, the fundamental influence of psychiatric discourse is echoed in the way in which services are organised and policy created and implemented. In terms of overlaps represented within the social world map, the management organisation overlaps with psychiatry as the profession of most status and powerful discourse, and with nursing as the largest workforce, particularly if care assistants are considered as aligned with the nursing workforce. Organisational hierarchies within the mental health practice arena also constitute key stakeholders in the commissioning, design and content of mental health nursing curricula for pre-registration mental health and continuing professional development, since they are employers of registered nurses and potential employers of student nurses once they are qualified.

Care assistants are perhaps most closely aligned to nursing in day-to-day work and contact with service users. In terms of line management, care assistants are most often managed within the hierarchy of the nursing workforce. Indeed, many care assistants have gone on to study to gain necessary entry qualifications to study to become mental health nurses, and many mental health nurses work as care assistants prior to commencing programmes of study, or work on a part-time basis from 'banks' as care assistants whilst students to augment income. The balance of qualified mental health nurses and care assistants in specific clinical settings reflects wider discussion in terms of appropriate resourcing in clinical practice areas. The social worlds of care assistants and mental health nurses overlap most evidently in the day-to-day clinical care environments within which they operate.

Other professions, in particular occupational therapy, social work and psychology, together with psychiatry, represent the main professional disciplines with which mental health nurses overlap in terms of social worlds within the clinical practice setting. Clear understandings of roles are important in responding to presenting issues/problems of service users. There has increasingly been the requirement for effective multi-disciplinary working between the different professional roles which input to service users. This, as discussed in chapter two, has become manifest in more recent years as 'inter-professional' working and learning.

The mantra of evidence-based practice is a common theme across professions, though the understandings of what represents evidence are more rooted within 'scientific' principles of validation (in a positivistic sense) with some disciplines than others. As has been noted earlier,

therapeutic approaches or modalities such as cognitive behavioural therapy (CBT) and systemic practice (family therapy) have assimilated evidence bases demonstrating efficacy as interventions. In order to attain recognition as a viable, valid therapeutic modality, an approach must be demonstrated in terms of effectiveness via evidence. In terms of recognition as an approach which can become a formal part of the services on offer from an organisation, this evidence is usually in the form of the 'gold standard' random controlled trial, and thus accepted and sanctioned by NICE via guidelines.

Mental health nurses are the focus of this study in terms of how they develop and maintain role congruity. The social worlds/arenas map shows the overlap of the mental health nursing world with wider nursing, though the map also illustrates more substantive overlaps with other social worlds relating to the mental health practice arena. As a sub-field of nursing, mental health nurses are very distinctive as a professional group, with perhaps more affinity with the learning disability field than those more concerned with physical health. The social worlds/arenas map also shows the overlap with organisational management hierarchy. Nursing is usually represented at senior level, as it is usually the largest workforce element (particularly when care assistants are considered as part of this workforce). The other overlap of significance is between the social world of mental health nurses and that of therapeutic approaches/modalities. This particular overlap is an important one in relation to the aims of this research, and will be elaborated within later discussion.

Social Worlds within the Arena of Higher Education Institutes (HEIs)

Figure 5:7 below outlines in diagram form the key social worlds at play in the HEI arena insofar as issues relating to health, and specifically mental health, are involved. Again, the overlapping areas indicate issues of mutual interest are indicated in the discussion below.

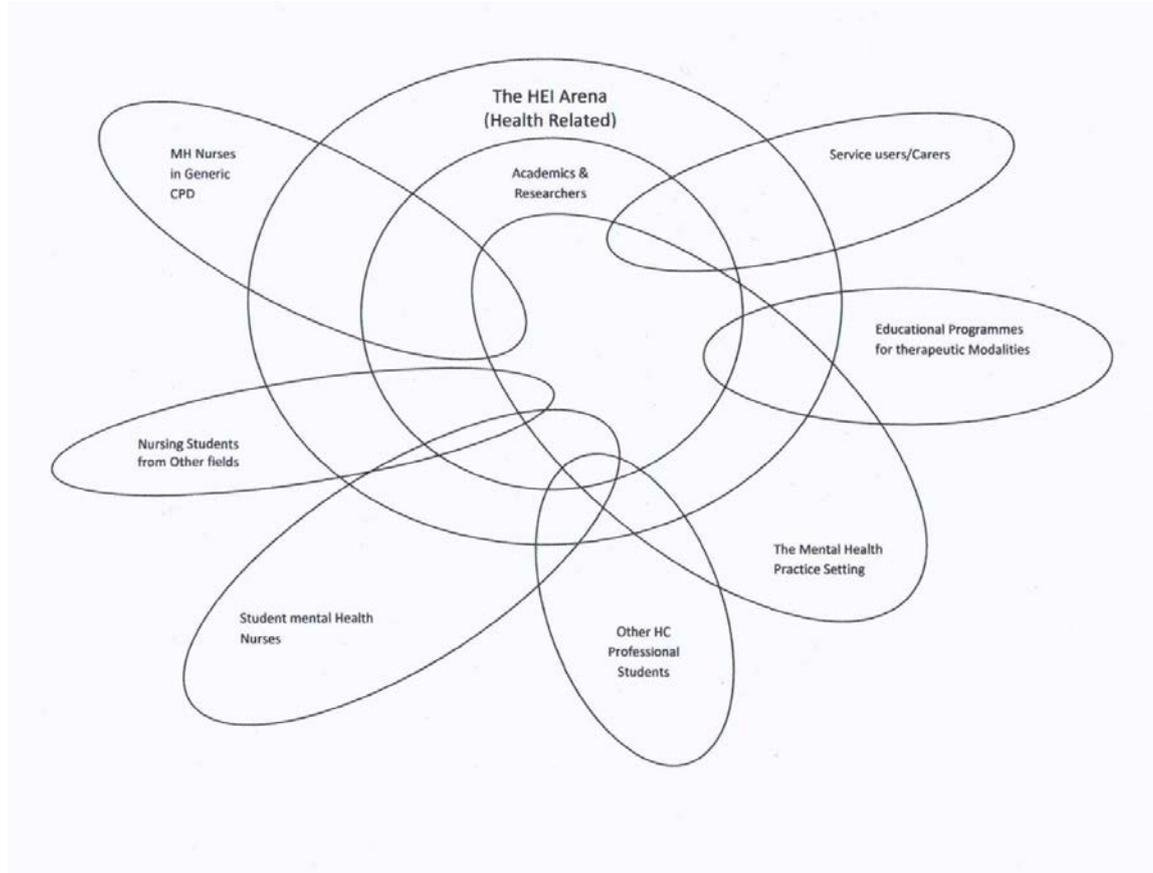


Figure 5.7: Social Worlds/Arenas Map for Higher Education Institute (HEI)

The mental health practice setting as a social world within the HEI arena represents the overlapping of this arena with that of mental health. This is reinforced by the overlap with student mental health nurses, mental health nurses and other professions (such as occupational therapy and social work) undertaking CPD, and educational programmes preparing therapists. The social world of academics and researchers also represents a linkage of the HEI arena with the mental health practice arena. Clinical practitioners with specific expertise within areas of mental health are quite commonly engaged within the delivery of academic programmes on associate lecturer or consultancy bases. Specific research programmes may also bring academics and clinicians together, and there are some specific roles which bridge the arenas of HEI and mental health practice, such as practice mentors and roles specifically designed to act as conduits between clinical practice and educational arenas in facilitating effective student journeys through academic programmes.

Service users/carers are again present as one of the social worlds within the HEI arena, but are portrayed less centrally compared with the arena of mental health practice. In terms of curricula concerned with health, there are increased expectations that service users and carers are involved within the design and delivery of programmes of study, with curricula having an explicit element which leads students to consideration of the service user perspective throughout their programme of study (DOH, 2006).

There is a significant overlap between all social worlds within the HEI health-related arena and the mental health practice setting by virtue of several factors. Fifty percent of a pre-registration mental health nursing programme is comprised of clinical practice placements. Practice-based student mentors are prepared via HEI-based mentorship programmes. This links to the notion of continuing professional development (CPD), a requirement of the Nursing and Midwifery Council (NMC) in order to satisfy criteria for ongoing maintenance of professional registration, now termed 'revalidation' (NMC, 2015b). CPD is commissioned to be relevant to the practice of registered mental health nurses. Mental health services and their organisational management hierarchies have been identified in the previous section as significant stakeholders within the design and delivery of both pre- and post-registration education programmes for mental health nursing.

The social worlds of students of other health care professions, including other fields of nursing, have a demonstrable overlap with mental health nursing students. Pre-registration students often have organised shared 'inter-professional learning' across their disciplines, 'learning together to work together'. For registered practitioners, CPD may not be specific to nurses, but be open to practitioners of other disciplines who have gravitated to roles within mental health services. Much CPD provision is not directly related to therapeutic approaches/modalities in a substantive sense. Where CPD does relate to therapeutic approaches, it is often in the form of single modules of study enhancing 'skills for practice' rather than ensuring a particular level of competency attainment. As has been identified in the discussion earlier, educational programmes for therapeutic approaches or modalities have increased in terms of availability and market. This is in response to policy drivers nationally and organisational management hierarchies more locally recognising the value of increasing the proportion of workforces who possess particular therapeutic expertise. The availability of this expertise is also increasingly an expectation of commissioners of services.

The final social world aspect identified within the HEI arena is that of academics and researchers. An important overlap is evident in terms of academics and researchers within the HEI context who are also mental health nurses. The social world of mental health nurse-academics overlaps with several other heterogeneous social worlds. There is the overlap with mental health nurses in practice either in links to the practice arena or in liaising with mental health nurses (and other

professionals) contributing to educational curricula in pre-registration and CPD. There is also the overlap with nurse academic colleagues from other fields of nursing, within which the field of learning disability perhaps offers more shared ethos. Importantly, there is also an overlap with academic disciplines such as sociology and psychology. Discourse-related issues pervade again here in terms of the theoretical underpinnings of these disciplines, and favoured research approaches within them. This influences the way knowledge and evidence for practice are framed within a given curriculum of study. Research is closely related to the notion of evidence in that it is the process which generates evidence. In the United Kingdom, universities are driven to produce published research through mechanisms such as the 'Research Excellence Framework' (HEFCE, 2014). In terms of the focus upon health and mental health issues, research activity occurs with a variety of scope and level, from small-scale research undertaken by mental health nurses studying within continuing professional development, to more substantive research contracts commissioned nationally or locally around the mental health agenda. Even for those students and HEI-related professionals not directly engaged in active research, the context of educational programmes creates the climate and culture for them to be 'consumers' of research within teaching and learning processes. This brings back into focus the nature of evidence and evidence-based practice, given that mental health nurse academics are charged with constructing and delivering curricula for pre-registration and post-qualifying (CPD) study for mental health nurses.

Summary: Social Worlds/Arenas Maps

Analysis of the social worlds/arenas map for the mental health practice context has served to underline the continued influence of psychiatric discourse. This influence manifests in the sense that mental health services are configured according to service user needs which are, in turn, categorised by psychiatric diagnostic criteria which frames the actions and interactions of social worlds within the mental health practice arena. This influence extends to the HEI arena in the sense that mental health services are key stakeholders influencing the nature of educational curricula and provision from HEIs which currently, and have for the last two decades, host the educational programmes for the initial preparation of mental health nurses. HEIs also host educational activity relating to the continuing professional development of mental health nurses. CPD provision includes that more generally concerned with professional academic development, such as leadership, more specific provision relating to mental health contexts such as the assessment and management of risk, and provision relating to therapeutic interventions. This latter category of provision varies from introductory modules designed to equip participants with skills to be incorporated to enhance practice, through to substantive accredited programmes of study and training within a given therapeutic approach or modality. This underlines the emergence and subsequent establishment of some therapeutic approaches, with associated social worlds in their own right, both in practice and education arenas.

The mental health practice context also figures significantly in the social worlds/arenas map for the HEI context in connection with educational and research activities relating to mental health. The research agenda itself within the HEI arena serves to underline the issue of what is perceived to be credible evidence to inform practice, both in terms of the specific research areas engaged with, but also the research approaches utilised in terms of what methodologies are seen as more credible.

Positional Maps

The third type of mapping process involved in situational analysis concerns the construction of 'positional maps' (Clarke, 2005). Within this approach, the 'positions' of interest are identified via the situational maps, the social worlds/arenas maps, and from the research data. These positions are 'discursive' in the sense that they are concerned with discourses identified within the situation, and identify positions both taken and *not taken* with regard to research participants within the study itself. The analytic nature of positional maps is such that the outcome of this process is more logical to present following the presentation of findings from the analysis of qualitative interviews with participants, to which attention now turns.

Findings from Qualitative Interview Data

Following the protocols and procedures for the analysis of qualitative data within a grounded theory study outlined in chapter four, the transcribed data from interviews was subjected to coding and analysis, forming concepts which became grouped into categories, the inter-relationship of which was then established in the form of a theoretical model 'Establishing Role Congruity'.

Within this section, the sampling process and sequence in terms of 'theoretical sampling' is first briefly summarised. The data categories postulated from the analysis are then briefly itemised and defined in terms of their scope. Each category is then outlined sequentially in more detail, illustrated with data from the participants and summarised. The inter-relationship between the categories is then illustrated and discussed in terms of interplay as an emergent, grounded theory.

Theoretical Sampling Process

Table 5:2 at the outset of this chapter summarises the demographic characteristics of the participants within the research informing this thesis. Table 5:8 below summarises the sequence and rationale for the process of 'theoretical sampling' in terms of the sequence of interviews, and an indication of how evolving analysis informed subsequent sample selection and interview agenda.

Table 5.8: Sampling sequence based on emergent analysis

Time Phase	Participants	Emergent Issues from Analysis
Sept 2012 - Oct 2012	1, 2, 3 (Pre-Reg)	Initial concepts regarding developing within dimensions of practice as pre-registration MH nurses. Participants about to embark upon MH 'branch'.
Feb 2013	4, 5, 6 (Pre-Reg)	Consolidation of development of dimensions of practice as MH nurses. Initial concept of 'developing an approach' emerging. Participants entering transitional phase to qualification.
March 2013	7, 8 (Pre-pre-reg)	Pre-course commencement. Exploration of background issues prior to commencing programme of study.
August - Sept 2013	9, 10 (Post-Reg)	First post-registration participants, selected on basis of committed areas of practice. Checking relevance of categories to post-qualifying.
March 2014	3, 8 (Pre-Reg) 4 (Then Post-Reg)	Re-interviewed on basis of initial interviews and emergent analysis.
May 2014	11 (Pre-Reg)	Pre-reg participant, interviewed on opportunistic basis, on shortened, post-graduate pathway to registration. Re-affirming emergent analysis.
Sept-Nov 2014	12, 13, 14, 15 (Post-Reg)	Selected for diverse specialism by service user group and types of intervention employed in practice.
Nov 2015 - Jan 2016	16, 17, 18, 19 (Post-Reg)	Further post-qualifying participants selected on basis of engagement with specialist areas and/or therapeutic modalities.

Each sampling stage represents a point at which data collected were analysed, with the subsequent data collection phase informed by this analysis in terms of the interview agenda, and in later stages the selection of participants.

The Categories

The interview transcripts from the first three interviews with pre-registration student participants were analysed and tentative concepts/groups of concepts identified. This was built upon with analysis of five further pre-registration participant interviews, further refining the identified concepts, and grouping them into tentative categories. This process continued with the analysis of interview transcripts from post-registration participants, with the emergent concepts/categories evolving in definition to incorporate the reported experiences and considerations of both pre-registration and post-registration participants. The resultant five categories are:

1. 'Establishing Role Congruity; Engaging with the role of mental health nurse' (Core category): Encapsulating the factors which contribute to an individual developing preferred ways and means of approaching the role of mental health nurse, relationships with service users and fundamental ideals which underpin professional practice more globally.
2. 'Engaging with dimensions of the role of the mental health nurse in practice': Concerned with the day-to-day specific aspects of role which mental health nurses must engage with and enact.
3. 'Previous and concurrent personal experience': Incorporating cumulative personal experiences outside of direct professional experience but which may still influence approach to professional practice.
4. 'Previous and concurrent professional experience': Encompassing the cumulative experiences within professional practice which influence an individual's approach to professional practice over the span of their professional experience to date.
5. 'Developmental support': Comprising the sources and types of support which an individual may receive (or not receive) with respect to their professional practice as a mental health nurse.

During the process of analysis, sub-categories were identified within each of the categories, as the analysis deepened. These categories will now be presented and illustrated in sequence, with each category presented in turn, and sub-categories identified alphabetically for each. Data quotations are labelled by participant number as defined in figure 4:1 in chapter four of this thesis. The participant number is identified at the end of each cited quotation in square parenthesis as P1, P2,

P3 etc. For the participants who were re-interviewed, the interview source is further identified as 'Int-1' or 'Int-2'.

Category 1: Establishing Role Congruity; Engaging with the Role of Mental Health Nurse (Core Category)

This category is concerned with the way in which mental health nurses initially engage with and internalise the requirements of the role, and subsequently develop their approach in a variety of contexts in terms of their ongoing development and experience. Sub categories are:

- a) Communicating as a mental health nurse
- b) Engaging with people with mental health problems
- c) Evolving perception of mental health nurse role
- d) Sense of integration into role of mental health nurse

The category and sub-categories are illustrated diagrammatically in Figure 5:9, below, following which they are defined and illustrated.

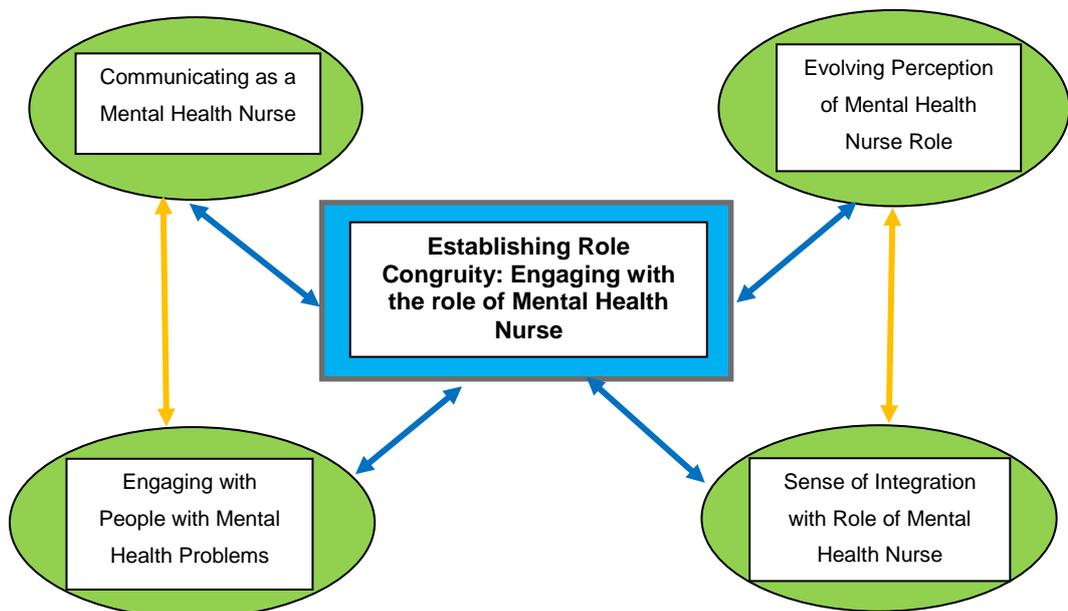


Figure 5.9: Diagram portraying the category of 'Establishing Role Congruity: Engaging with the Role of Mental Health Nurse'

a) Communicating as a Mental Health Nurse

A key initial issue for student nurses lies in the realisation that they are entering into communication from the specific role of mental health nurse. One participant had experience of working in mental health settings as a 'housekeeper' prior to commencing nurse education. She describes the contrast:

"It was interesting seeing the different relationships... as a housekeeper you sort of, you are part of the routine and the two wards I worked on were very different...like you were part of the daily routine and they were there... then people would approach you with things and talk to you because you are not a nurse, they'd talk to you... not necessarily totally different to how they talk to the nurses, but a bit more relaxed because they know you are not there to, like... nursing them, ha, ha." [P.3. Int-1].

One of the initial tasks pre-registration students must engage with is becoming familiar with new terms and incorporating them into the everyday communication with which they must engage:

"Words I have not heard before, ha, ha... Getting used to all the jargon and all that." [P.1].

When asked how they would define mental health nursing, student nurse participants were more articulate in their definitions as they gained more experience and engaged more with the language of mental health nursing and settings. The participant below, interviewed at the end of her first year, was able to reflect upon the way in which she attempted to articulate the scope of mental health nursing had evolved:

"...it's very varied, isn't it? We work with lots of different client groups... and I suppose it's about helping people with mental illness to have a good quality of life and to sort of empower them to be as independent as possible and have control over things and... just to improve their quality of life... so I suppose a lot of it is about relationships with patients and forming a therapeutic relationship". [P.5].

Students must also become familiar with terminology regarding fundamental issues such as the nature of placements with differing mental health focus:

"I wasn't really sure what to expect... it said 'enduring' and I thought: well I don't even really know what that means. 'Enduring', what's that?... so I wasn't sure what to expect, to be honest. And obviously when I got there, it was kind of like rehab." [P.5].

With increasing experience and exposure to mental health environments and culture, students develop an understanding of the language and terminology which frames practice contexts:

"But I just think my first placement was... I didn't know what it was about at all, I just knew that it was elderly care whereas the placement that I have just been on, I knew what acute meant and what to expect and what not, and things like that." [P.6].

Student nurses also come to recognise that there are particular forms of communication in a therapeutic sense. The participant below, interviewed at two years into her programme, shows how learners come to recognise particular patterns of therapeutic communication. In this case, she recognises the employment of dialectical behaviour therapy (DBT).

“it was really interesting hearing... one of the guys was in the community was also training to do DBT and hearing his conversations with his clients on the phone... Like, you’re in the office and it was like you could sort of understand his approach in the way he is speaking is related to, like, DBT.” [P.3-Int-2].

The learning of language and terminology is closely related to the development of knowledge itself, as recognised by the student participant below:

“...things have been pointed out that I wasn’t aware of because I didn’t have the professional knowledge, so like information of medication and the implications of the medications that they were on with other sort of conditions or other medications and it was sort of... the need to keep learning and keep developing... me self really.” [P.4. Int-2].

When making the transition from pre-registration student to qualified practitioner, the same participant was able to compare communication with other disciplines from student and qualified perspectives:

“I remember as a student having conversations with consultants in carrying out in a, trying to be aware of how I approach it and doing it very polite and sort of very careful manner as a student nurse... as a qualified nurse I had to be less careful with how I approach things, with them, basically put it to them straight and to the point... relationships are there and I suppose it builds an understanding of each other... I suppose as a qualified nurse I see it as part of my role.” [P.4. Int-2].

With more experienced, qualified participants, there is necessary communication within nursing teams, and with other professionals with regard to the management of service users:

“MDT disagreements are quite common. We have a policy for that. But that’s why on the back of an after action review, either myself or the band sixes will go in to the MDT because you’ve got a senior presence there... somebody to provide a bit of balance and objectivity, ‘cos our consultant’s very passionate, but he doesn’t always see what the staff nurses see, so we’ve got the band six who’s kind of detached and can play that mediation role between the two parties... and usually we’ll reach some sort of compromise.” [P.9].

Qualified respondents were able to draw upon their experience and fluency with language relating to mental health settings in articulating the role of the mental health nurse, as in the example below:

“Knowing what I know now as opposed to what I knew then, I would probably have given a different answer back then, but now I see myself pretty much like a systems analyst and I look at people’s systems. How they’re working; how they’re ticking... and where they want to be and to see if there’s anything that I can do to bridge that gap”. [P.10].

The qualified nursing role also involves communicating crucial information, such as assessed risk with service users. The participant below works within the context of a crisis team, where the assessment and management of risk is very much to the fore:

"we do have discussions around it if people are discussing people's care plans and things, because obviously you all work as a team and one person doesn't see the same person all of the time; it would depend who is on shift really." [P.11].

This participant also offers an example of how, within coordinated and planned approaches to service users, specific communication is framed within agreed care plans:

"You know, sometimes in the care plan you have a set time to spend with this person and have a set agenda I suppose and how, you know, problem free talk and, although acknowledge things but you know it's a very structured approach which I do see the benefits of..." [P.11].

This particular example concerned the way in which the crisis team planned responses to some service users diagnosed with 'personality disorder', who were regularly encountered by the team as presenting in crisis. Implicit in the above example is a particularly important aspect of communication, that of documentation. The importance of accurate documentation was realised by student nurses quite early:

"I work with a nurse who I didn't feel was particularly confident in my own opinion and was very defensive in her practice but her record keeping was brilliant..." [P.4. Int-1].

"He wasn't so good with documentation and stuff, but, he was, he had a real, a right passion for the patients." [P.1].

Once qualified, and with further career development in the form of seniority, the importance of documentation is redoubled in terms of accountability and evidencing planned and delivered care. This is illustrated in the following example from a ward manager relating to the requirement of documenting risk assessment:

"...people can get quite defensive, because they think: 'well, I've just updated it'. Well you may have done so, but you haven't put the information in that you need to be putting in and it has to be robust. It has to be clear. It has to be detailed. It can't just be a cursory 'well we'll just change the date and things haven't changed here'." [P.9].

There may be elements and principles of communication specific to particular environments. The participant below is referring to a medium secure forensic context:

"...within a medium secure environment, you're furnished with keys and key straps and radios, so you have to learn the phonetic alphabet and the processes around that..." [P.19].

There is a particular emphasis here upon following particular procedural aspects of communication as a fundamental element of role.

As a final example of 'communicating as a mental health nurse', an interesting aspect is evident from the following participant:

"...in family therapy we talk about approach method technique, and on an approach level some of the values and beliefs that I was introduced to... once I started the formal journey in family therapy, it was just giving me some sort of language to what I already believed, or I was already doing some of the techniques and methods". [P.14].

This highlights how particular specialist approaches, in this case family therapy, embody a specialist language of their own. It also illustrates this participant's engagement and affinity with the approach which provides language to express her already existent intuitive beliefs and approach.

This sub-category illustrates that communicating as a mental health nurse is fundamental to establishing role congruity. Pre-registration student nurses show an increasing fluency with the language of mental health settings and mental health nursing as their experience progresses. Fluency with this language is also centrally related to the acquisition of knowledge and skills relating to mental health nursing.

A transition in role is evident from student nurse to qualified practitioner. This entails a further experiential realisation of the manifest increased responsibility and accountability which accompanies this transition. With ongoing requirements for continued professional development, there is an agenda for the qualified nurse to continue to engage with new knowledge and skills. This development may be in simply accruing further experience and absorbing new practices, knowledge and language experientially whilst 'in role'. It can also be more structured in the sense of pursuing further recognised expertise in the form of acknowledged, accredited formal qualifications.

b) Engaging with People with Mental Health Problems

Engaging and interacting with service users and their carers is clearly central to the mental health nurse's role. In the first instance, students must learn to interact at a basic level. Students are inevitably curious and interested in the experiences of mental health service users, and the issues which contribute to their historical and current circumstances.

The participant below, interviewed before commencing the education programme, worked as a support worker with people with longer term mental health problems before deciding to become a registered mental health nurse:

"...I worked with an individual who's got mental health problems and many difficulties and trying to understand them... the more you try to understand them is the more you get confused... 'why this?' 'Why that?' 'How is this?' 'How is that?...' and that's why I'm here." [P.7].

Students without prior experience of mental health settings could feel ill prepared for their first placements:

"But then when I went onto placement it wasn't how I expected it to be... I didn't think that there was enough preparation at university... I felt like I was a bit dropped in at the deep end... for somebody who has never been on a ward before." [P.6].

Qualified participants could also recall uncertainty within early interactions with service users when they were students:

"I remember being exposed to a very distressed upset lady on my first placement... really distressed and upset and tears and hysterical and I remember thinking: 'Oh, God, I don't know how to deal with this lady.' And I felt: I'm not prepared; we haven't covered this in class; I don't know what I'm supposed to do, but I just did what I thought was right. You know, I kind of put my arm around her and she held my hand and we kind of... with time, she kind of started to calm down a little bit and I think that my learning curve must have been huge on that first placement." [P.9].

Expectations of clinical placements and mentors were not always clear in terms of the stage of students' educational programme, with mentors often erring on the side of caution regarding what aspects of care and interaction students could be encouraged to participate within:

"...I felt a little bit like I had my hands bound by my mentor in the placement, although I didn't feel like that at the time, it was only afterwards when I went on my second placement that I, and reflected back... because I had a lot of 'oh well you're not supposed to do that it's your first placement, first year student". [P.2]

Depending upon the placement context, students in the early stages of their programme can be encouraged to enter into basic human interactions with service users. The participant below is describing her first placement, within a longer stay rehabilitation-focussed placement:

"The staff were all really good, really friendly, the clients were really, really friendly and they would talk to you and tell you about what's going on... tell you about themselves, just be able to get involved in everything that was going on in [place name] really, and really get stuck in and get asked questions and you didn't feel stupid for asking questions." [P.3. Int-1].

Students could be given defined roles/tasks with service users:

"So I was taking them all shopping, I was going around their house and just helping them with different things; help people get jobs, help people sort out their benefits. I just loved it; I just loved every minute of that placement... It was a really good first placement". [P.1].

Another student recalled her first placement:

"I think, I mean I did a lot of tea making which is obviously is important, I did a lot of personal care which is important, but I wasn't stretched or challenged... so I don't think I learned that much from the placement." [P.2].

The same participant described a contrasting experience as she drew towards the end of the first year of her programme:

"...the last placement was really, really good. It was a community based placement... the mentor sort of watches you, talks to you, gets to know you as an individual and then you know, what they said is 'well if you do this lead, if you lead the conversation when we go on this visit and then we'll talk about it, if there's anything you know that you can't handle, just give me a look and I will jump in', but giving me much more opportunities to communicate more with the patients and the clients and come up with ideas..." [P.2].

The participant below provided an example of sound advice from his mentor within his first mental health placement:

"My first mentor... I was on the [Ward named] assessment ward at [Hospital named] and he had a really good approach. He said for the first two days, just get to know people and you'll be amazed at how often people come up to you. 'Cos I was a bit worried that it's my first placement, people are just going to go 'Oh, I'm not going to talk to him, 'cos there's no point', but he said if you get those personal skills, the interpersonal skills right, everything else can just fall into place." [P.12].

Students were generally encouraged to interact more specifically in 'therapeutic' approaches under supervision as they attained more experience:

"...and that was like half way through second year so the nurse, who had supported me, she would say 'what are you going to do in this session?'... and then afterwards she would sit down and spend time with me and discuss what came out of the session... you had that support even though you were able to go off and do it yourself." [P.3. Int-2].

The degree to which students have the opportunity to engage with service users in the early part of their programme thus varies with the mentorship approach to students. With gathering experience, and certainly when qualified, interaction with service users becomes more oriented to clinical management and therapeutic interaction. However the nature of relationships between mental health nurses and service users is set against the back-drop of sometimes tragic circumstances. Even when qualified for some years, participants could vividly recall particularly critical incidents in terms of service users with whom they had developed relationships whilst they were students:

"[as] a first year student on first placement... a young male patient I got to know very well committed suicide... same placement, a woman I think in her forties come in, was very depressed... had responded really well to treatment, went home and hung herself... very significant things..." [P.9].

Qualified nurses were able to frame their interactions with service users in a more articulate way, either in terms of specific intervention approaches, or in a more general sense of their 'approach':

"It's about that rapport building, which to me is absolutely fantastic. Somebody actually opening up to you for the first time; somebody telling you their darkest fears or worries, but also the challenge of somebody not doing that as well, and the kind of skills that I need to be able to kind of work with that person when they're later in a position to be able to do so." [P.9].

Just as the practice placement contexts vary for student nurses, the contexts within which qualified nurses interact with service users varied considerably depending upon role and service user group. The participant below works with a 'crisis' team, and encounters service users in a variety of contexts:

"Yeah, you know, it could be the house, police cells, A&E departments, walk in centres, GPs." [P.11].

Participants with a longer career history had more time-distant recollections to call upon. The participant below recalled her perception of the difference in staff/service user relationships when she moved from a learning disability context to a mental health context in the 1980s:

"I was working in a hospital for people with learning disabilities and the 'residents' – that was our term then – used to call you 'Miss' and 'Sir' and were very deferent and the institutionalised behaviour that had been enforced on them..." [P.13].

The participant below reflected upon the different influences framing therapeutic relationships in a child and adolescent mental health (CAMH) context as compared to her previous experience:

"...with the kids you got them on a different, you had different relationships with them; you worked with them, you went to school with them, you played with them and you were there like talking with them with the families..." [P.14].

There are specific issues in the context of crisis working:

"It's just people who are in that initial crisis, so a lot of what we do is sort of support them through that crisis and then signpost them or refer them onto other, be it community teams, family therapy, IAPT, things that for ongoing... for anxiety and depression and that sort of thing." [P.11].

The nature of contact with service users in crisis is often short term, which means the development of a longer-term therapeutic relationship is not part of the practice context in the sense of the way that service is configured.

Some service user groups can be unpopular with some mental health nurses, such as those with addiction-related issues. The student participant below recognised the negative effects upon her mentor within that context:

"I think that mentor in particular... I think she was just really burnt out... working in addictions is a hard job, and I can well see how people get burnt out with it and disillusioned and just de-motivated." [P.1].

In relation to therapeutic relationships, the participant below underlines the importance of feedback with regard to the therapeutic relationship, process and outcomes:

"What every good therapist does is they get feedback. They ask for it and they get it and they use it and they put it into practice." [P.17].

Several of the qualified/registered participants recognised that the increased leadership and management role often detracted from contact with service users:

"I make myself visible. Although it's difficult, because I've become an office manager really, but I do make the time to go out and speak to the staff every day. I do go into the day room and spend time with the patients... I get involved clinically when I can." [P.9].

Gravitating to more 'managerial' roles is often cited as being synonymous with reduced contact with service users and 'grass roots' staff, and is echoed by other participants within the leadership sub-category outlined in analysis later in this section.

The final example from this category illustrates how non-verbal elements of communication with service users can be important to consider:

"...I would always wear a shirt outside of my jeans, so that you couldn't see that I was wearing a belt with a variety of bits and bobs on it. 'Cos there was no need of that. You're trying to create as normal an environment as you can in an extremely abnormal environment and I think it helps with forming those therapeutic relationships..." [P.19].

The imperative of this participant in a forensic practice setting was to 'play down' the indicators of power and control (communication devices and keys) as far as possible

Engaging with people with mental health problems is central to the role of the mental health nurse. For both pre-registration students and qualified nurses there are many contexts within mental health in terms of the types of environment, types of service users and their presenting problems and issues.

Though it may not be considered as particularly valuable at the time, what might be considered as 'low level' or ordinary day-to-day interaction, for example simple conversation and mundane tasks such as shopping, can be seen as serving a useful function for students, particularly within early placements.

With increasing experience and ultimate assumption of a qualified nurse role, it is evident that mental health nurses do, as part of 'establishing role congruity', adjust to accommodate the

combination of factors which interplay in specific mental health contexts. Participants identified that specific contexts, such as working with children/young people or within a 'crisis' team, frame the context of engaging with service users very specifically. There are service user groups and practice contexts which are perceived by some mental health nurses as less popular than others, and examples cited by participants included people with 'personality disorder' and people with addiction-related problems.

c) Evolving Perception of Mental Health Nurse Role

This sub-category is concerned with the way in which mental health nurses come to understand the essence of the mental health nurse role in terms of its scope, function and general nature.

It is evident from the earlier sub category of 'communicating as a mental health nurse' that student nurses offered more complex articulation of the nature of mental health and mental health nursing as they gained more experience. The focus of that sub-category was the increasing complexity of language that participants drew upon as they gained more experience, through to assuming the role of qualified practitioners. Here, the focus is more on the content of definitions offered.

There was a common factor across student participants' in their tendency to offer more purely 'illness'-focussed definitions early in their experience:

"I would have probably focused more on the illness side of things... whereas now I don't see it like that as much... because it's not the illness, it's the symptoms..." [P.1].

The participant above amended her definition of mental health nursing to incorporate 'life-skill' approaches with service users, to develop strategies which increase self-confidence and coping strategies, rather than simply medicating for illness. The participant below, whilst not rejecting the importance of diagnosis and illness, brought in the concept of 'recovery', together with demonstrating an understanding that the degree of recovery attainable is dependent upon the nature of the presenting condition:

"I don't think there would have been so much focus on recovery. That's something that I have learned over the last twelve months...it's not a label that you are stuck with, it's an illness like any other. And depending on that diagnosis will depend upon the level of recovery that you can expect to see." [P.2].

The participant below echoed these considerations, but saw a 'holistic' approach being, on the one hand 'broader', but on the other hand 'simpler':

"...you think about the role of mental health nurses in the early days as being to do with medication and talking therapies and things, but I think now, it broader and simpler if you like... in that you are helping people to live their lives in any way they need... whereas then

you didn't necessarily see the connection into all factors of life... the sort of holistic side of things if you like, it wasn't as clear then." [P.4. Int-1].

The notion of helping people to 'live life in any way they need' may seem 'simpler' as a summative definition, but behind this notion lies the complexity of the myriad mental health problems people may present with, and the correspondingly myriad ways in which services are constructed in order to meet these presenting problems and needs. This kind of broad definition of role can then be built upon with specific detail relating to specific presenting problems. The example below relates to dementia care as a context:

"...and sometimes it's just helping people like, in dementia where... it deteriorates, rather than it can be managed or improved... it's things like helping people to brush their teeth and to maintain independence longer... and helping the carers to look after them properly, so that the person has the best quality of life, for as much as the illness can detract from that." [P.3. Int-1].

Qualified participants were able to draw upon a longer historical time-frame of experience to illustrate changing perceptions. The participant below reflected back upon her own early practice two decades before:

"...and we very much talked in the language of mental illness as opposed to anyone having mental health." [P.14].

Particular values are explicit within nursing, and particularly within mental health nursing. Values such as being 'non-judgmental' are readily expressed by students from very early in their programmes of study. However, as students gain more experience, a more reflective consideration of how their own existing values 'fit' with specific aspects of the mental health nurse role can be seen. In the example below, the participant has matched the notion of 'hope' from her pre-existing values to NICE (National Institute for Health and Clinical Excellence) guidelines:

"...it probably sounds really silly, but like some of the things that we learn in class like, the NICE guidelines on schizophrenia that say hope and optimism and stuff like that is something that, as a Christian, like, there is, I believe in hope and like, and stuff like that". [P.3. Int-1].

Once students enter the realm of practice as a qualified mental health nurse, the process of 'evolving perception of role' continues. The participant below, originally interviewed as a student, amended his definition of the role of mental health nurse to incorporate the notion of resource constraints evident within the reality of day-to-day practice:

"...it's still the same to an extent now, but mental health nursing now is helping people live their lives within the constraints of the organisation and the NMC and the Trust and the resources and everything else..." [P.4. Int-2].

In the absence of direct experience of particular mental health practice contexts, assumptions can be made regarding the nature of working. The example below is a response from a participant with experience of working in a forensic context, in response to the common perception that episodes of violence and aggression are frequent:

"Complete myth! I think because you work in a secure environment and because you have systems and processes in place to deal with all eventualities..." [P.19].

The point made is that the training, anticipation and preventative awareness within the context largely minimised episodes of aggression.

A particularly stark example of perception of role is seen in the example below. This participant, having a career spanning over three decades, had originally started her nursing career in the learning disability field (then defined as 'mental handicap'). She had occasion to return to the learning disability field for a time after some years working in mental health:

"Have you ever watched Quantum Leap, where he leaps into...? Well I felt as though I'd walked out of ... 2000, walked through the door and I'd turned into 1972 really... as if... those older days, as if I'd gone back to that... to walk back into that, I thought: blimey." [P.13].

Participants with a longer career experience to draw upon could also identify changes in roles which had incrementally become manifest in practice. The participant below recalled one of the first mental health nurses within his experience becoming a 'therapist'.

"And certainly there was no nurses working in specialist psychotherapy at that time. I never came across one. But [name] had a significant background and interest in psychotherapeutic work in that particular area and she started to supervise me, supervise my counselling work, which is what I would classify it as at the time....and this would have been '85, '86, '87... it was, three years, of meeting with her regularly and talking about what I was doing. So I was a nurse; I would still identify myself as a nurse at the time, talking to another nurse and during this whole process, she was going through this training to be a psychotherapist and by the end of my time there, she'd become that." [P.17].

Since that time, it has become more commonplace for mental health nurses to undertake specialist training and education within psychotherapeutic approaches. The participant below works in a context where mental health nurses have been prepared to be psychological therapists via accredited education programmes. This has removed the monopoly of the discipline of psychology upon such 'specialist' interventions:

"I think disciplines are quite interesting to think about... nursing's moved on massively in the last 15 years and I think once upon a time, we would have been satisfied... with just... "Ooh, I think somebody else really clever needs to do that"... we've moved from that... we're now more in a position where we feel that we have got knowledge and skills and we're up there... within the MDT... as valuable as anybody else." [P.15].

All qualified nurses have a requirement to continue to develop, professionally speaking, following their initial preparation and qualification/registration. Education and training in specific therapeutic approaches is a common avenue to meet this requirement. Established therapeutic modalities such as CBT or systemic/family therapy are the more accepted pathways to pursue in this sense. However, practitioners may also become interested and involved in less 'mainstream' approaches. The participant below described how his engagement with NLP (neuro-linguistic programming) and hypnotherapy has impacted upon his view of mental health issues and, by implication, the role of mental health nursing:

"...it's only since I've started doing... as you know, I'm doing the NLP and the hypnotherapy and stuff, that I've come at it from a different angle and started to think about it more as a thinking disorder." [P.10].

The same participant encountered resistance within his service management to offering NLP as an intervention, as it is not supported by NICE.

The final example within this category illustrates how the actual perception of the role of mental health nurse is influenced by the specific practice context and service structure. This participant works within CAMHS (child and adolescent mental health services) and draws comparison to 'adult' mental health services:

"...I think... the discipline mental health nursing is different in CAMHS than it is in adult, I think it is more well defined in adult because the structures are set up differently... they do have that strong sense of nursing, or what nurses do... where in CAMHS I think there is a lot of trying to be similar." [P.14].

This sub-category has drawn out some key issues of importance. Student nurses demonstrate a rapidly evolving perception of the role of the mental health nurse, as they move through many different service placement contexts within their educational programmes. However, the evolutionary nature of perception of role continues into initial and subsequent practice as qualified/registered nurses.

d) Sense of Integration with Role of Mental Health Nurse

This sub-category is concerned with situations whereby someone has integrated sufficiently into their role as a mental health nurse to feel 'part of' the profession in both a general sense, and specifically within their day-to-day practice. This sub-category is closely and reflexively related to but distinct from the previous sub-category of 'evolving perception of mental health nurse role'. The journey toward this destination begins on commencement of the pre-registration programme.

The participant below sums up the journey to the situation of being integrated/assimilated into the role of mental health nurse:

"...because, you know, it's like when you are first learning to drive... once you have learned what does what and how the car moves and what makes it go forward and you need to put petrol or diesel in it, you are less anxious about what you have to do..." [P.2].

In keeping with the metaphor of learning to drive, the point at which a student feels more integrated does not imply a specific critical incident, though there may be some situations which provide an anchor point for students to realise they have become more integrated with the role. In reality it is a more gradual, intuitive process.

In the early period of their programme of study, the sense of integration is low, or even an opposite sense of not being integrated, engendered by unfamiliarity with new environments, new people and roles, different service user groups and presenting issues/needs. The student participant below described this situation:

"...in that placement, it was definitely that they were the team and I was the student, to be honest. I mean, obviously, that was a shorter one, only six weeks." [P.5].

She then contrasted this with a later placement, where her sense of greater integration was evident:

"I definitely would say I felt... seeing my last placement just gone... addictions, I definitely felt part of the team there. Definitely... Perhaps people prefer third year students... they can help a little bit... Perhaps that's just because you've got a bit of knowledge by the third year." [P.5].

The incremental journey towards integration can be seen across the student participants. There are also incrementally increasing expectations upon students from both academic and practice perspectives. The sometimes unclear nature of practice placement expectations is identified within the sub-category of 'engaging with people with mental health problems', discussed earlier in this chapter. The participant below expressed this in terms of the knowledge base she felt will be expected of her at a given stage in her programme of study:

"I don't feel like... you know, you have like those moments and then like, you get into second year and you feel like the pressure because you are in second year now, you've got to like know more now than you do, I mean I know you have got to know more... I don't feel as though I know as much as I should... I am not where I want to be... part of me wishes I could just wave a magic wand and I will be ten years down the lines and I will have all the knowledge." [P.3. Int-1].

She did, however, have a sense of 'where' she needs to be, in terms of integration with the role of mental health nurse. The participant below also indicated an awareness of the destination of being integrated with the role, and was able to visualise herself within the role:

"I think I can definitely imagine... I am worried about things but I am still definitely imagining me self doing it, and I know that eventually through experience I'll be able to be a nurse, ha, ha, yeah..." [P.6].

The student participant below demonstrated a reflective awareness of how the various elements of his programme were contributing to integration into role:

"I think things are piecing together now... it's incorporating them all... whereas in the past you sort of concentrated on communication skills solely and other skills... now you are thinking about lots of things at the same time in doing what you need to do." [P.4. Int-1]

The participant below presented an interesting example from her learning journey in the first year of her programme. The first year is shared with all fields of nursing, at the end of which she changed her field from 'mental health' to 'adult':

"I have really enjoyed first year... on placements they do this hub and spoke thing now... so I was really enjoying it, went away to my spoke which was a placement at the... [General Hospital] on the cardio ward... and I really, really enjoyed it... because we spent some time doing, you know, the vital observations... And I thought 'I quite like this', you know? I'd quite like to be able to keep using these skills and build these skills." [P.8. Int-2].

Far from integrating with the mental health nurse role, she actually discovered more of an affinity with the role of 'adult' nurse.

Turning to the qualified and registered participants, the example below presented an alternative narrative to that of the participant above. She had undertaken the 'child' nursing field as her original pre-registration programme. She had encountered a child and adolescent mental health (CAMH) placement context early in her programme, and found a strong affinity in that context. Unable to change nursing field to mental health at that time, she went on to qualify as a children's nurse, but on qualification continued to pursue a role working within CAMH, ultimately securing a role working within a community-based service:

"I think even now, I sometimes feel a bit of a fraud, because I work in a mental health setting, but I'm not a mental health nurse. I think that's just my perception and actually, I do the job and it's fine... the transition obviously from hospital to community was strange." [P.12].

There is an ambivalence expressed here, in that on the one hand she feels a 'fraud' in not having a pre-registration background in mental health, though she also reports undertaking the role comfortably. She goes on to express a firm sense of integration with the role:

"I really love what I do. I absolutely love it... there's just something that I just really love about kind of what I do; the role that I'm in right now..." [P.12].

This is echoed by other participants who are working in a context with which they have a high affinity and sense of integration with their role in that context. The participant below worked in two mental health contexts before securing a role with a crisis team:

"I think, well, I love doing this... the crisis role, because it's so different, it's so varied and you do, you are dealing with risk and I do like dealing with risk, and you see all sorts of situations and you're on your feet all of the time." [P.11].

The participant below expresses the sense of integration with her role in terms of 'job satisfaction':

"But then, my job satisfaction and my worth... my contribution, I feel, and my self-satisfaction is so much... the boxes are all ticked doing what I do." [P.9].

She goes on to express a lack of affinity for a more managerial role, which some might see as a logical career progression:

"I've been a ward manager for twelve years now, but I've been a manager in lots of different settings... I look at the role above me, which is clinical nurse manager and I think: I don't think I want to do that, because you lose all clinical contact." [P.9].

This participant's sense of integration within her current role was such that she had no desire to engage with a position of greater responsibility (and financial remuneration) since day-to-day contact with service users is an aspect of role she would not wish to relinquish. This is echoed within the example below, as this participant found additional managerial responsibilities were added to her existing role during an organisational re-structure within her Trust. Her role prior to that had been at the same level of seniority, but much more clinically focussed:

"The clinical feels easy-peasy... Give me somebody who's trying to kill themselves and that's fine... Give me a situation which requires HR involvement and requires disciplining somebody, I find... If I'm really honest... I'm not particularly a policy queen." [P.15].

This participant's sense of integration with her role is thus disrupted by an organisational re-structure which brings in aspects of role with which she has less affinity and integration.

A final important area within this category concerns the conflict involved in engaging with substantive education and training within a specific therapeutic approach or modality. The participant below recounted a conversation with his mentor/supervisor, as his practice as a CBT therapist became more prominent in terms of his day-to-day working role:

"I think it was me talking about feeling that I wasn't a nurse anymore; that I was becoming something else... She quoted somebody else... a statement she believed, which was: if you have ability in this area, you have to leave nursing... and I thought that was a cynical thing to say at the time... but as the years went by, I think I began to understand it more and.... as I trained and developed myself as a therapist... into the '90s, even beyond that... It altered my relationship with my nursing colleagues; that they would regard me as being something different to them and it was a difficult bridge to cross sometimes..." [P.17].

This raises the important issue of how mental health nurses incorporate substantive engagement and qualification/experience in specific therapeutic approaches into their understanding of the mental health nurse role.

In terms of 'integration/assimilation' with the role of mental health nurse, several key issues are evident in terms of how the sub-category contributes and relates to the main category of 'establishing role congruity'. Student nurses necessarily undertake a journey towards the destination of integration/assimilation with role. Those who do not complete the educational programme, or who change to an alternative field of nursing, do not complete this journey effectively. Once pre-registration preparation is complete, a transition is made to the role of qualified mental health nurse. Whilst there may remain a sense of integration at a general level, i.e. to 'being' a mental health nurse, there are still aspects of day-to-day practice and contexts which qualified mental health nurses may feel a greater or lesser affinity and integration with. In terms of context, factors include the service user group(s) involved, the nature of the service in terms of how this is organised to meet presenting needs and the structural role of the individual in terms of the managerial hierarchy in place. Importantly, there is also the issue of how mental health nurses can incorporate and reconcile substantive training and experience within particular therapeutic approaches with their nurse role, retaining a sense of assimilation.

Summary

The first two sub categories are concerned with the fundamental aspects of learning to communicate as a mental health nurse and engaging with people with mental health problems. Learning to communicate from within the role is an early task for student nurses, but also presents an ongoing undertaking for qualified nurses as they encounter different mental health contexts and the ongoing need to develop knowledge and skills. It is also evident that, once qualified and registered, communication assumes an enhanced nuance relating to the increased accountability and responsibility ascribed to the role by both nurses, service users and other professional groups.

In engaging with service users, normal basic 'human' interaction presents a relatively safe starting point for students, for whom placement expectations regarding their interaction with service users are not always clear.

The category also represents the key aspects which integrate together within an individual to inform the way in which they fundamentally approach the role of mental health nurse, how they 'fit' with the role as individuals. This is particularly reflected in the interaction between the two sub-categories of 'evolving perception of the mental health nurse role' and 'sense of integration as a mental health nurse'. The processes taking place between these two sub-categories governs the

perception and understanding of the role itself, but also the role in relation to self as an individual. Participants with longer career narratives can recount significant evolution in the mental health nurse role and their own engagement with the role as influenced by policy, technology and knowledge development, service user expectations and associated service and educational system re-organisation. Student participants generally demonstrated increasing integration as they 'piece together' the role in a way that makes sense to them. This process continues through and past the point of qualification and registration. At this point, participants may develop more affinity for some practice contexts than others.

Category 2: Engaging with Dimensions of the Mental Health Nurse Role in Practice

This category encompasses five very specific aspects of the role of mental health nurse which emerged from analysis as integral to the main category of 'Establishing Role Congruity' '. These role aspects are identified and grouped together as five further sub-categories:

- a) Developing a therapeutic skill set
- b) Integrating theory and practice
- c) Assessing and managing risk
- d) Statutory & legal requirements of role
- e) Leadership and organisation

The category, with these five discerned aspects of practice role, is outlined in diagram form in Figure 5:10 below, following which each is defined and illustrated.

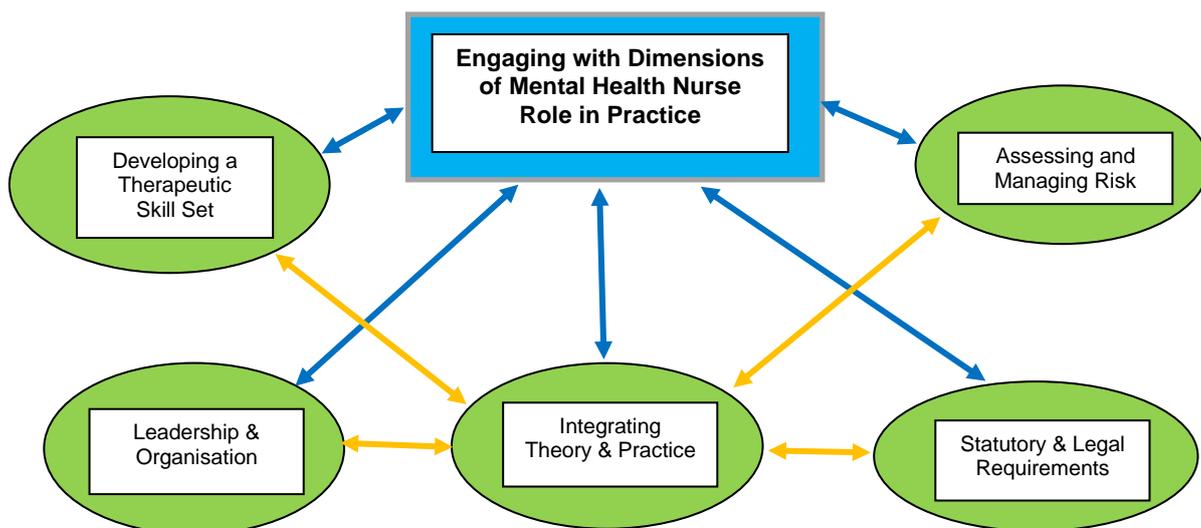


Figure 5.10: Diagram portraying the category of ‘Engaging with Dimensions of the Mental Health Nurse Role in Practice’

a) Developing a Therapeutic Skill Set

One of the central tasks for student mental health nurses during their period of initial preparation is to develop an appropriate repertoire of therapeutic skills. Once qualified and registered the task becomes one of maintenance and development of skills.

The participant below identified 'self-awareness' as one of these fundamental aspects:

"Because I don't think it's just academic and I don't think it's just learning the job, it learning about yourself, I find, I think, totally, about yourself. Because you have to be able to control yourself to be able to help other people..." [P.1].

The importance of these fundamental skills is also illustrated from the student participant below, citing the advice given from a mentor in his first placement:

"...but he said if you get those personal skills, the interpersonal skills right, everything else can just fall into place." [P.16].

Students must also develop an understanding of the point at which they will arrive at the end of their preparation, as new registrants. The student participant below illustrated this realisation, together with the importance of on-going development, once qualified and registered:

"To be able to develop me skills to be able to be comfortable in all situations that the role might find us in really... I have realised... in me nurse education up to now that when I qualify I will probably have a limited knowledge base to any role because it's been generic and I suppose all encompassing... but not specific to the point that I can gain an expert

knowledge of any particular speciality and I suppose, look forward to developing me skills and knowledge when I am qualified to meet the role." [P.4. Int-1].

The opportunities to create the situations where these skills can be safely learned and practiced is important, as illustrated within the example below:

"...so it started off it was one session each week with a patient... it was me and the nurse... and gradually like it was just me." [P.3. Int-2].

This can include the opportunity to be exposed to more specialist interventions:

"...my mentor was just on a family therapy course, but like you can get involved in that... I got to read about it and then I got to discuss it with him and with another family therapist." [P.3. Int-2].

The actual level of expertise in a given therapeutic approach or modality in practice varies. The participant below cited various courses she has undertaken to enhance her skill base:

"I applied for the post in the crisis team because I wanted to work with people, I wanted to use the skills that I had done... I had done lots of previous courses like the PSI and things like, CBT, Drug and Alcohol, I didn't feel as if I was using those, I was able to use those because I didn't, I had very little patient contact as a clinical lead." [P.11].

The level of skill and knowledge within these varied identified 'courses' is not specialist in-depth, but sufficient to be able to employ aspects of the related skills within her day-to-day role, which she identified herself:

"You know, little bits of things with different people at various different times... I would use a little bit of whatever skills that I have learned." [P.11].

The idea that some skills are transferable and valuable on that basis is cited by the participant below, speaking with reference to the forensic context:

"...I think it's the same core skills that you need to be a forensic nurse than you would in any other field... I think the only difference is that clearly the environment and the paraphernalia which you have to wear for safety reasons... You still have to have those core skills of being able to communicate effectively. You need to be able to deescalate, you need to be very observational and I think above all else... Even though it may sound a little bit cliché, you've got to have that sense of hope." [P.19].

The participant below, an accredited CBT therapist, expressed caution in terms of mental health nurses developing 'eclectic' roles drawing upon multiple therapeutic approaches:

"Eclectic?... Places an enormous responsibility on them to learn an awful lot of stuff and I think that's probably impractical for most... I can't think of how anyone realistically could learn it all. You couldn't. So you end up specialising, so whatever it is they want to specialise in, if they want to continue being mental health nurses, they need to know details, conceptually understand what it is... if they're going to do a cognitive behavioural kind of intervention, they need to understand what that actually is and what science that comes from..." [P.17].

The participant below took an alternative view in terms of incorporating approaches, formalised within an approach of 'Psycho Social Interventions':

"...it's an umbrella kind of thing... but I try and explain and make analogies for the students to understand and I always use the analogy of a tool bag. You know? And PSI affords me a lot of different tools to go into that bag... myself as the main therapeutic tool... and I've seen it work... I don't need to... Be restricted by one particular practice." [P.18].

The participant below stressed the lengths of time her specialist programme, leading to accreditation as a family therapist, took to complete (4 years, part-time):

"For family therapy it's four years and it's a different level, do you know what I mean, and it does get to your attitudes and your beliefs and your reflexivity." [P.14].

She also stressed the 'level', and gave an indication of the fundamental influence upon practice. She went on to compare her specialist modality to others:

"I am just using CBT as an example... I have seen it and I know people that do it extremely well and they are very respectful and collaborative, but to me in my head, CBT is almost like a technique." [P.14].

This suggests she sees family therapy as a more pervasive approach underpinning her practice, and perhaps legitimises the 'incorporation' of, in this case, CBT as 'techniques' within practice.

Therapeutic skills may also be developed experientially within a working role. The participant below, a qualified nurse who had commenced working within a community CAMH team, cited the example of CBT:

"I remember one of the people that we had in the team... I'd joined him for a case and there was a young lad that had OCD and he was planning to start CBT, so I'd said... 'Oh, I'd really like to see how that's done, what your approaches are'... and he just said 'well why don't you do it'... "well it's not rocket science" and that was it. And I thought: 'right, okay'. Is this really something that I can just dabble in?... but so far, I do it, I haven't been to university; I haven't done the CBT course. I'm sure it isn't pure CBT, but I suppose you measure success by whether or not the patients get better and they tend to." [P.12].

In terms of safety it is evident that she was 'supervised' by someone with an appropriate knowledge and skill base. This participant also made the point that approaches often need to be adapted to suit specific situations or service users:

"...you get people who are very... "This is CBT and you cannot deviate from that", but then if you're doing that with a child who's 12 and maybe doesn't have the right understanding of you know, the things that you need to know for that, then you need to adapt it and I think that's probably beneficial in some ways that I haven't had that training... I'm not doing CBT; I'm doing something and it's working and it's loosely based on this model, so..." [P.12].

Aspects of specialist approaches are thus often 'incorporated' into a more generic skill base. The student participant cited below recognised this as a legitimate part of learning:

"...I suppose, being open minded in that you don't necessarily have to use a model for its specifically designed purpose if you can see that there's qualities and attributes of a theory or a model that you can apply to different areas to help engagement or things like that." [p.4. Int-1].

The same participant, interviewed after one year of practice as a registered nurse, showed a recognition that he is fundamentally responsible for the scope of his own practice, and having a 'foundation' to build upon:

"I know all the things I should and shouldn't do and practice and I can make those decisions and I suppose practice in a safe way with regards to what is expected by us by the Trust... and I suppose it's trying to keep those, that foundation there and build on it rather than letting some of the foundations slip." [P.4. Int-2].

Some therapeutic approaches have a less developed and accepted evidence base than others. The participant below discussed his engagement with NLP (neuro-linguistic programming):

"A colleague had actually done the NLP course and she invited me to go and do the taster... I decided to enrol on the full course. It is a huge shift from traditional mental health nursing. I... I did it from a position of interest; but I suddenly... I began to realise that there are elements of that that can be used in everyday practice." [P.10].

When mental health nurses are deployed into or gravitate toward other roles, opportunities to practice therapeutic skills they have developed may reduce. This often is associated with increased managerial responsibility, as with the participant below:

"...so I used to do a lot of talking therapies you know, motivational, a little bit of CBT an little bit of PSI... but I've become detached from that to some degree and it's quite sad, really. The core stuff is there." [P.9].

For those mental health nurses who also attain specialist, accredited status within particular therapeutic modalities, there is the question of how the specialist modality status fits with the role of mental health nurse. The participants below, a mental health nurse also qualified and accredited as a family/systemic therapists gave responses integrating the two:

"...and I would say that I am a nurse first and foremost because that's what my first qualification is in but I am also a qualified family therapist, but I would find it hard to differentiate between the two." [P.14].

The participant below indicated the usefulness of systemic approaches in other aspects of her role:

"I think I do use the systemic thing... Certainly in team meetings... I definitely fall back on those skills, or that knowledge. I think it sort of becomes a part of you, doesn't it? It's a strange thing, I think, mental health nursing, 'cos actually all you've got is yourself... I think it just becomes embedded in who you are." [P.15].

The participant below, however, illustrates conflict in trying to reconcile the role of mental health nurse and cognitive behavioural therapist:

"...When I started to experience all of that, it just made me kind of think about myself, or think about my identity as being less and less a nurse than a therapist, and especially when it came to working predominantly with psychologists." [P.17].

Evidence-based therapeutic approaches have emerged and become substantive practice roles in their own right over recent decades. The final quotation within this category, from a participant who's career has spanned this period of time, neatly raises the question as to whether having a generic role is of less value than a specialist role:

"...it might be what's held me back. I originally come to this Trust 25 years ago... I'm exactly the same as where I was when I came 21 years ago. It's perhaps to my detriment that I can come off the bench and play anywhere on the field... rather than specialising..." [P.13].

In summary, the development of therapeutic skills is at the very centre of the mental health nurse role. It is an expectation of student nurses, reflected within the practice-based competencies which they are required to demonstrate over the period of their pre-registration education. It also continues ongoing learning following transition to registered nurse status.

b) Integrating Theory and Practice

The task of integrating theory and practice has resonance with all dimensions of the mental health nurse role in practice in the sense that 'theory' and 'evidence' underpins and justifies particular approaches. But there are also wider theoretical considerations in terms of the mental health nurse role. This includes, for example, theories relating to the causation of mental health problems, the organisation of services and the nature of leadership.

Student nurses are aware from the outset that their programme of study includes both theory and practice. The participant cited below was interviewed just prior to their course commencing:

"I think it's obviously going to be a very intense course... we're doing the half theory and half practice because... it would probably be good for me to strike a balance between not just sitting in university, studying all day, but that there would be work placements to use your skills that you have learnt in the classroom." [P.8. Int-1].

The actual process of integrating theory and practice tends to be an individual journey in the sense of the myriad factors which converge, the order of placement experiences being one:

"...it's funny. Sometimes you'll get one before the other. I suppose it would be more helpful to have it in theory before practice, but I suppose it just can't always work that way, can it?" [P.5].

The participant below expressed the task of integrating theory and practice as a puzzle:

"...it's like a big puzzle I see it, and I try and fit it all together. I like it to make sense. I don't like to sit and listen about a theory and then just forget about it, I like to go on placement and then think right where does that theory fit into that, or does any theory fit into that." [P.1].

Theory and practice do not always come together in an explicit way, as the student participant below explained:

"I suppose a lot of the theories and things... working in practice, sometimes you have to try hard to link them... they don't talk about it openly and verbally that this model, or this theory being applied..." [P.4. Int-1].

There are also instances where even accepted theory is not manifestly present within practice areas:

"...it's not always the way it's completely recommended... It just depends on the culture of environment in wards and I know things aren't always done how it's said in the literature are they?" [P.5].

There are more 'value'-orientated elements within what can be classed as theory within educational programmes and stated practice philosophies which evidently resonate with individuals. The student participant below very evidently identified with the value of a 'recovery'-based approach:

"...I think like the work that we have done in uni and like on placement around recovery... you can have control of your life again... when we started learning about recovery, like, I really believe in it." [P.3. Int-2].

The student participant below, though suggesting some aspects of his programme have been disjointed in terms of theory and practice, identifies a particular model of mental health practice as providing a unifying framework:

"Personally, I've found that it's a little bit disjointed. I find that I really enjoy the university work and I really enjoy the placement work... there's maybe a few strands that cross over... I enjoy reading the Tidal Model, Phil Barker's book. I've took a lot of that in and that's changed the way that I approach..." [P.16].

The student participant below took reassurance that people contributing to the educational programme with particular areas of expertise and knowledge have that 'expert' status. This perhaps emphasises that no-one has that level of expertise in all things:

"That's one of the things when I think about the lectures here because when you are talking to people, and people are like 'this is my speciality', and it sort of reassures you that you don't know everything." [P.3. Int-1].

Turning to qualified practitioners, there are aspects of practice which can be very complex in terms of applying theory, and are better understood with greater experience, as indicated by the participant below, working in a crisis service setting:

"...everything we do, I do, is evidence-based, of course... but again, situations are different ... you could come across sometimes really complex situations and although you do, I do follow evidence... I think as the more I go on in this role, or sort of in this career, the link becomes much clearer." [P.11].

Many experienced registered mental health nurses are engaged with CPD in order to attain graduate status. Not all would see themselves as 'academic' in a natural sense, since these expectations were less evident during their initial programmes of study. However, once they have completed their academic journey and attained graduate status, they can often see the value of having made the journey, as illustrated by the participant below:

"...I remember saying... 'I'm not an academic and I never have been'... you've got to learn how to write academically... in terms of the theory, but the practice and the reflection has been the most exciting thing for me because I've done a lot of reflection about myself... how I learn..." [P.9].

The process of becoming a graduate implies the development and enhancement of critical-thinking skills. The participant below used a critical argument which he developed in writing the dissertation for his degree to take issue with what may or may not be classed as 'evidence':

"...there's lots of books on how to do NLP, but there's not a lot of research on its effectiveness. But I think Richard Bandler, the guy who developed it with John Grinder was so... angry at psychology and psychiatry for the way they treated people... drugging them and poisoning them in his words, that he really... he didn't go down that route; he went down the route of sort of being a bit of a guru and you know, proving to these people that he could resolve people's issues in 20 minutes. He got lost at that point and he didn't formalise any of the work that he was doing, so it never got... it never drifted into the realms of evidence-based practice and that's where I fell down in the essay, because I could never prove that. You know?... Not to say that it doesn't work." [P.10].

He went on to suggest that:

"Yeah, theory and practice... there's a big difference between evidence-based practice and practice-based evidence." [P.10].

The idea of generating theory from practice was also raised by the participant below:

"...and then it sort of almost turns the tables doesn't it where you get theory to your practice but then as you do it all more, then you get new theory and then you can do new practice and then..." [P.14].

The participant below, a CBT therapist, saw theory and practice as inseparable:

"...theory and practice are kind of synonymous in my head... Although for education purposes, you've almost got to separate them... I think that's an artifice, to be honest, because when it actually gets down to: what is it you need to be able to do to be an effective therapist, for example... this is something that runs through my head. What do you need? And there's work being done on this; there's empirical work being done on this." [P.17].

The same respondent did, however, recognise the problems inherent in generating and interpreting 'evidence' relating to human therapeutic relationships:

"It's a form of evidence, but it's not evidence in the same way that it's say evidence in engineering. Like, say, they do scientific studies in engineering about the tensile qualities of certain grades of steel... There's no equivalent to that in psychological therapy..." [P.17].

The final example below from a participant completing her professional doctorate illustrates an important issue in terms of theory, practice and the nature of mental health nursing as a practice-based discipline:

"And certainly the courses I've been on, whether it be first, Master's... have all been practice-based... they've not been academic for academic's sake..." [P.13].

Mental health nursing is, fundamentally, a practice-based discipline. The task for student mental health nurses is to integrate theory and practice to a requisite level by the time they are at the point of registration. At the very outset, very fundamental skills and values such as self-awareness and very basic social interactional skills are foundational, and are themselves rooted in theory relating to human interaction and communication. Mentor figures within the practice placement setting can enhance the potential for theory/practice integration by 'signposting' links or directing students to appropriate theory. Due to logistics, placement sequence cannot always be organised so that particular aspects of theory are engaged with in educational settings prior to commensurate placement contexts. Students thus become adept at revisiting theory already engaged with when the associated practice context presents at a later stage, or making connections when the theoretical aspects emerge at a later stage.

The volume of theory and practice with which it is feasible to engage within during the initial pre-registration preparation period can only be a generic blend across mental health contexts. This then becomes the starting point for the transition to qualified, registered practitioner, and the task of ongoing professional development. The possibilities for qualified mental health nurses in terms of directions for ongoing development then become more diverse in terms of areas of practice and development of skills.

c) Assessing and Managing Risk

Another central role of the mental health nurse lies in the assessment and management of risk. Student mental health nurses are exposed to concepts relating to risk theoretically, and also encounter the day-to-day experiential manifestations of risk across the variety of mental health settings they engage with during their practice placements.

For some student participants, their initial encounters with the notion of 'risk' concerned their own safety. The participant below found herself in a situation with a service user, and her mentor discussed the situation with her later:

"Yes, he said like, he said 'risk assessment-wise that was not a very good thing to do'." [P.1].

Encountering the notion of risk assessment and management in a variety of settings allows students to make comparisons and appreciate that different dimensions of risk present in different mental health contexts:

"...working in the crisis team in assessment... and doing the initial the assessments in that placement, and discussing the differences in my perspective of risk... having previously been in completely different placements... made us reflect... how the different practitioners in different roles, I suppose, find their own comfort zone with regards to risk." [P.4. Int-1].

Crisis services, particularly in the context of community care, do present to student nurses as particularly 'high stakes' compared to other care contexts where risk can be mitigated by controlling environments. The student participant below recounted a particular critical incident for her:

"...I was in the crisis team and I went out with a nurse and the lady was talking about how, why she was feeling suicidal and rather than skirt around the subject or not mention that word, he actually said to her 'what are the pros and cons then, what are the pros and cons then of you killing yourself?' and I was like 'Gasp'... I think it was fantastic now, but at the time I was shocked... he actually went to say 'it's a decision like anything else... and we need to go through that process of what are the pros and cons'. And like my heart was pounding and I was thinking 'when we walk out of here she is going to take a boat load of tablets and she is going to kill herself'." [P.2].

The realisation of the subjective nature of risk was echoed by other student participants:

"...it's so subjective. I mean risk in the crisis team is completely different to risk in a non-psychosis community team. Something that's been presented... Maybe to a GP, or to a service like IAPT, there's going to be a huge risk, considering... If that was talked to the crisis team, they would probably think: 'Oh, maybe that's just a one, where it could have like a three or a four in a different service'." [P.16].

The student participant below identified the ethical aspects that can present with the management of risk:

"...risks that you know are there but it would be unethical... to manage those risks to eradicate them and that you would be taking people's rights and liberties away when you didn't necessarily have the rationale to do that." [P.4. Int-1].

Turning to qualified and registered participants, risk assessment and management becomes more of a direct issue in terms of professional accountability.

Mental health nurses often see the distressing outcomes for service users in circumstances where risk was not anticipated:

"...and there was an unfortunate incident where a young girl had set fire to herself on the ward at the beginning of a night shift... really serious burns. She was transferred to the burns unit at [Town named] General and needed one to one nursing because she was a mental health patient. She couldn't move... couldn't do anything, but the nurses in the burns unit, as is often the case would want a mental health nurse there." [P.18].

The response to risk from the general hospital staff is interesting to note here, with the requirement to have a mental health nurse present on the basis of this young girl's status as a 'mental patient', despite immobility.

The participant below described how she found the requirement to conduct assessments in a more detailed way when she moved into the arena of a crisis management service:

"...it's much more... much more in-depth, it's much more mental health focused as well because obviously you have to go through the full mental state exam and everything, which I hadn't previously." [P.11].

The same participant described how, in the event of a negative incident despite a risk assessment and management being instigated, the important issue is for the service to review the situation in order to take lessons for future practice:

"...that for me is a light bulb moment I think, and you go over what they are doing, what was the rationale for that decision or what was that other person's rationale for that decision and I think you just explore things and look much more deeply into things... and that's across the board, that's whether you are on assessment or telephone triage." [P.11].

The importance of services, individuals and teams learning from negative outcomes was echoed by the participant below, who also referred to the organisational policy for risk assessment and management:

"...Trust policy is very clear. You must update the first risk assessment... before any period of leave, before any discharge... reassess and redevelop your crisis and contingency plan... learning from critical indicators... It's all that learning and it changes and enhances and develops the practice of the staff nurses and the new nurses... It is part of the handover process as well and it is discussed as part of the MDTs and the daily reviews." [P.9].

The participant below illustrated how a whole service structure is designed around mitigating risk in a forensic setting:

"It was a massive part of it. But again, you have to remember within the forensic services, a typical pathway would be: you would go to [Higher security], initially and you would probably spend between six months to a year. Then you would move to [Medium security] which was more of a continual care and you would probably stay two years on there and then you would move to [Lower security] and you would possibly do another six months to a year and then into the community from there, so it was a very... When it came to risk... things were assessed regularly throughout that journey and hopefully, you saw marked improvement as time went by." [P.19].

A final aspect of this exploration of risk relates to therapeutic modalities, which have emerged within the analysis so far as an important factor for consideration of mental health nursing roles. The question posed concerned how practitioners operating from different therapeutic modalities might potentially perceive risk differently:

"I would hope... whichever modality you come from, that you would get to the same end point. You might actually have a journey there slightly differently but I think risk is risk and whether it's child protection risk or mental health risk, criminal risk or whatever..." [P.14].

In summary, the assessment and management of risk is a central component of day-to-day practice for all mental health nurses. Student nurses are thus exposed to the concept from early in their programmes, both theoretically and in practice placements. Over a variety of different mental health contexts, they encounter the multi-dimensional nature of risk. Once qualified and registered, issues relating to risk are high on the agenda when realising the additional responsibility and accountability which accompanies the status of registered nurse. National and more local organisational policies relating to the assessment and management of risk are important in informing best practice, which should focus on effective learning at individual, team and service levels of consideration when, despite assessing risk, outcomes are adverse.

d) Statutory & Legal Requirements of Role

An important aspect of mental health nursing role is concerned with statutory and legal responsibilities and capabilities. This includes the statutory requirement to take appropriate action in the event of children being deemed to be at risk of harm following 'safeguarding' processes, and an aspect which has been a formal part of the mental health nurse role since the Mental Health Act of 1983 (amended in 2007). Since the enactment of this legislation, mental health nurses have had the legalised capability to restrict the freedom of individuals with mental health problem, in the event that they are adjudged to present a 'danger to self or others' due to their mental health problems.

This is a significant legal function to have access to, entailing the legal right, via a registered qualification, to deprive another person of their liberty for up to four hours, within which timescale a medical practitioner or a mental health professional in the role of 'approved practitioner' with greater statutory power in this sphere can extend this holding period.

The enactment of this power can often be in disturbing circumstances:

"...a very unpleasant restraint situation... a team of us and we've had to restrain somebody... Restraining a pregnant patient who was so ill, she had to be medicated. So there are lots of things that I haven't forgotten." [P.9].

The prospect of compulsory admission is synonymous with work in crisis teams:

"...particularly in the crisis team where you are seeing somebody in the community and making a decision whether you are going to, as a team, treat them in the community or whether they need hospital admission." [P.11].

This participant also indicated the overlap of the issue of compulsory detention with situation specific risk assessment and management:

"But ultimately you can only assess the person at the time to make a clinical decision... and as long as you can sort of have a rationale why then... potentially there is always something that you can't control, what people do, you can only assess them at the time." [P.11].

The participant below indicated that deprivation of liberty is also a common issue presenting in the practice of care for older people in confused and frail states due to dementia:

"And you know, to an extent there is the whole... that deprives the person of their liberty because they are constantly under supervision, they are constantly controlled, you know, and when you look at the policies regarding deprivation of liberty and things and they say... 'can you do it in the least restrictive manner'." [P.4. Int-2].

Students often see this aspect of the mental health role enacted during their placements. The student respondent below described seeing a respected mentor figure enacting the process of enforced medication administration:

"...there was a patient who... was really unwell... trying to leave the ward and there was the decision making of whether to administer PRN... she [mentor] just kind of took charge and was able to go through things and followed out, like she liked everything done properly and I think that's the way I do as well." [P.6].

Some mental health settings are more synonymous with the statutory/legal aspect of managing service users than others. The participant below identified how the forensic setting has particular requirements:

"...it's learning forensic sections, which is something that you didn't really touch upon throughout your training that much... But that's a key part of things, absolutely. And you get exposed to that quite a lot. Again, a very early stage, because there's a lot of tribunals and that, that you've got to attend..." [P.19].

These elements of the mental health nurse's role represent significant legal capabilities in terms of exerting power over people with mental health problems. Some roles have a greater propensity to involve this territory than others, such as forensic and 'acute admission' settings, though there are situations such as within care contexts for older people with cognitive impairment where restriction of liberty may seem less evident but is actually quite pervasive.

It is interesting that, whilst discomfort with some of these scenarios is expressed, there is an underlying acceptance of legitimacy among these participants of that aspect of the mental health nursing role which involves being an 'agent of social control'.

e) Leadership and Organisation

It is an expectation that, once qualified and registered, mental health nurses will find themselves in a leadership role to some extent. Typically, this will be 'taking charge' of defined clinical areas for periods of time or the duration of a 'shift'. Mental health nurses with career aspirations within 'management' will, if successful, assume a management/leadership role over wider areas and levels of responsibility.

As their pre-registration programme of preparation progresses, students become aware of this impending role and 'rehearse' for it in collaboration with their mentor figures and other staff within placement areas. The final placement within a pre-registration programme is often explicitly oriented to this specific preparatory function:

"...and I understand the responsibilities of that and I feel quite comfortable and confident in stepping into that role... and I am looking forward to me management placement with regards to that as well... a practice run if you like for when I qualify." [P.4. Int-1].

Students become aware of the requirements of this role throughout their practice placements, and actively reflect upon how the role will 'fit':

"...I have got a lot more to learn, like, and I think it will come and I will develop... the leadership role that you need... to like coordinate and stuff... I think it will come... not just naturally... I can probably envisage it more now that I could even six weeks ago." [P.3. Int-1].

The student participant above, interviewed one year later, was actively engaged in rehearsing for the leadership role:

"I've like had four placements since then, it seems like such a long time ago... sometimes when taking on the role of coordinating the shift as a student, I have had patients... sort of be like 'oh do you think you're in charge now' sort of thing." [P.3.-Int-2].

The participant below, re-interviewed one year after qualification and registration, demonstrated the approach he has developed in order to enact the leadership role with care assistants:

"...now you have responsibility for ensuring that the band threes are, you know, performing and doing things as care plan... and I have found I have developed relationships a bit more with some of the band threes... they know how I am... what I like to do on a shift but I have done it in a really friendly way... continually sort of dropped hints and highlighted that maybes you shouldn't be doing that like that, but it's never really been anything of any harm." [P.4. Int-2].

The transition from a student role to a responsible, accountable, leadership role can be a difficult one to make. The participant below described how, early in her career, she was deployed to an area where staff were not easy to lead and manage:

"I was interviewed for what was an E grade... it was a post for a ward where all the 'naughty nurses' got put. You know, the milk and sugar went in the teapot; patients were lined up in the corridor; there was no privacy, there was no dignity and I remember reporting it. I was absolutely appalled. I lost a stone in two weeks I think, with the stress. And I kept telling the ward manager, but she was part of it. She wasn't interested; she just used to sit and knit all day." [P.9].

She was clearly not well supported by those in more senior positions within this context. The participant below, having secured a role as 'clinical lead', also described feeling unsupported:

"And I don't know if it was possibly because, you know, I had gone up a band and there was more expected of me... I felt it wasn't a transition, a smooth one, I felt it was 'ok, now you are the clinical lead' rather than 'you're a new clinical lead and you'll have to develop in that role', I felt it was a bit 'you're now the clinical lead and that's it' and I didn't feel that I got the support." [P.11].

The participant below, a mental health nurse and accredited family/systemic practitioner, demonstrated a commitment to the role of senior nurse for CAMHs across a geographical region:

"...I very much strongly believe that in, that mental health nursing does need leadership, does need... clinical expertise, development and that's what part of my role is about, for strengthening it for the rest of the nurses and giving them a voice and some empowerment, but also challenging the culture of the trust..." [P.14].

She also stressed that she saw value in retaining some clinical contact with service users:

"I think my clinical, my allegiance to clinical work in families is first and foremost, and whether that is clinically because that keeps your skills up to date and keeps you grounded in reality in what's going on..." [P.14].

As a final example for this sub-category, the participant below described how a more senior leadership role was imposed upon her during an organisational re-structure:

"I've been in management for three years now. It wasn't a choice. I was working clinically and a position arose and I was sort of informed that I either did it, or HR would manage me into that process of being a team manager." [P.15].

This participant had been operating within a clinical role at a given level of responsibility and remuneration in terms of grade/band, but in order to retain that grade was obliged to accept increased managerial/leadership responsibilities.

All mental health nurses will find themselves, once qualified and registered, in leadership roles to some level. This is understood as part of the role from the outset. Student nurses actively rehearse for this role as they near the end of their period of pre-registration study.

Some mental health nurses will gravitate to positions of explicitly-increased leadership and management scope and responsibility. This often entails reduced or absent clinical contact with service users, which can be a reason for some to avoid such roles. There may also be situations where a senior clinical role can be re-designated during organisational re-structuring, so that individuals find increased leadership/managerial responsibility gravitates toward them.

Summary

This category illustrates how these five dimensions of the mental health nurse's role inter-relate and are, in their application, very context specific. The development of a therapeutic skill set relates explicitly to the integration of theory and practice, whilst dealing with risk is related to the statutory/legal aspects of role, though in both cases the relationship is close but not exclusive. Leadership and organisation are, to a certain degree, an expected and anticipated part of the registered mental health nurse role. Leadership roles at more senior levels of organisational hierarchies are an aspiration for some, but by no means all, mental health nurses.

As they progress within their preparation, students need to move towards a more therapeutic intent and basis within their interactions with service users. This process continues once qualified and registered as mental health nurses, often in different contexts, and again from a more enhanced and explicit level of perceived responsibility and accountability, with considered use of structured therapeutic interaction. This may lead to higher levels of expertise in specific therapeutic interventions, which can create conflict in terms of how this expertise fits with the mental health nurse role, an aspect which will be returned to in later discussion.

This thesis now turns to presentation of analysis from the remaining three identified categories, before drawing the analysis together, beginning with the category of 'previous and concurrent personal experience'.

Category 3: Previous and Concurrent Personal Experience

This category is concerned with personal experiences recounted by participants which are related either historically or concurrently to their role as mental health nurses. It encompasses four sub-categories:

- a) Personal encounters with mental distress/ill health
- b) Pre-professional encounters with mental health nurse role
- c) Previous education and employment experiences
- d) Personal reflexivity

Figure 5:11 below summarises the category of 'previous and concurrent personal experience' in diagrammatical form, following which each sub-category will be defined and illustrated.

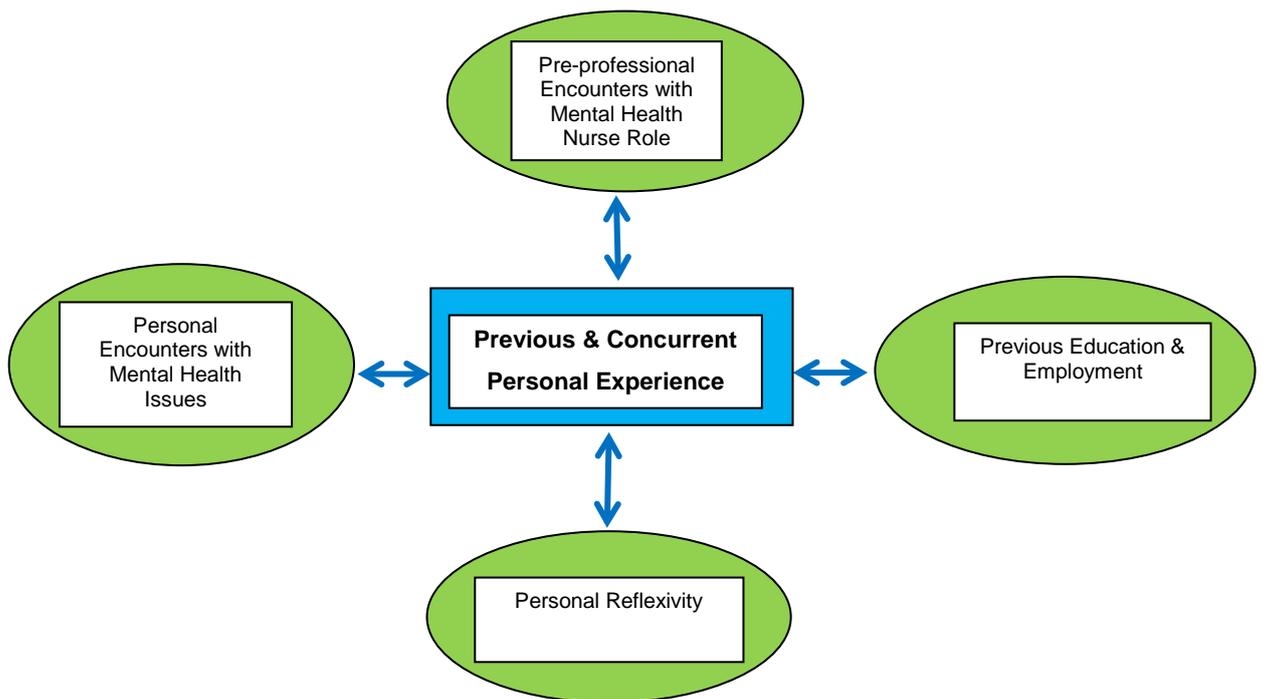


Figure 5.11: Diagram portraying the category of 'Previous and Concurrent Personal Experience'

a) Personal Encounters with Mental Distress/Ill Health

This sub-category is concerned with participants' disclosed personal experience with mental ill health or distress, either directly for them as individuals, or within their close personal networks in terms of family and friends.

The participant below underlined the fact that the experience of psychological discomfort is a generalised 'human' issue:

"...and I am sure everybody has experienced times when they have been upset or something." [P.11].

The student participant below illustrated how issues can often be picked up within the educational 'system' following identification of issues which may affect a student's ability on placement or academic performance. In this case being noticed to be very 'fidgety' in the context of a practice placement:

"...I am undergoing an assessment on it to see if I have got adult ADHD... which would account for the fidgetiness in some ways." [P.1].

The participant below described how her own experience of mental distress, culminating in a diagnosis of postnatal depression, was (when appropriate) incorporated into her professional practice:

"...didn't want to go and see my GP... I didn't want to be a mental health patient, being a mental health practitioner. And that made me think: 'how can I feel like that when I'm so an advocate for the profession and that really changed my perception of mental health?'... because I thought: 'it can happen to anybody at any time, any social class'... I remember my GP saying to me...' if you knew the number of people who come into my office with depression, you wouldn't believe it'... and now, over time, because I've embraced my mental health more than I had, I'm not afraid to self-disclose and say "I've been there myself; I know what it's like". [P.9].

There is inevitably a discomfort in simultaneously having a role as a 'mental health patient' and a mental health nurse concurrently, as the same participant pointed out:

"...and I did have postnatal depression and antenatal depression. It must run in the family, because my mum had it quite badly, but I had it after my daughter and with my son when I was pregnant and that was quite difficult being a pregnant mum and having to access mental health services as well... it changed my perception very much." [P.9].

The examples above are concerned with direct self-experience with mental health issues. Issues relating to mental distress and ill health within close personal networks of family and friends were more prevalently cited across the participants. The student participant below indicated an episode of mental ill health experienced by her brother:

"...and that included going through, my brother, like had a psychotic, he had an episode of psychosis... the December, like, a few months before I started." [P.1].

The participant cited below had a history of working within the armed services prior to pursuing mental health nursing as a career. She retrospectively noted the presence of mental health issues within the armed services during her tenure there:

"I was in the army before I did, before I came into mental health nursing... and there is quite a few people, unbeknown to me at the time what these mental health issues were but it was clearly, they had mental health issues around anxiety, depression, PTSD... things like that, and the support in the army wasn't that great." [P.11].

For the participant below, an experience of mental ill health within close personal networks became part of the motivation to become a mental health nurse:

"Well for me it was back twenty years ago, my mum had some mental health problems and it was really borne out of the poor care that I witnessed that she received but also the families were not considered. And it was that sort of desire to want to make a difference, to appreciate that services have moved on in the last twenty years, that there had been a change, but also to be part of that and to improve that change, which is sort of what made me initially apply to the university." [P.2]

This was echoed by the participant below:

"Personally, the only experience I've had was that my granny had dementia and went into a long stay psychiatric ward, which again, you know, you sort of look at her and think: 'yeah, she needs care', but it wasn't... It felt as though it could have been better." [P.15].

Personal experience also engendered a direct experiential appreciation of how mental health problems can be stigmatised within wider society:

"...one family member had schizophrenia... I never really knew a great deal about that and it was until very recently... but I sort of knew that they had a tough time with the stigmatisation and as well it had effected their health...affected their life in a big way." [P.4. Int-1].

The final example for this category illustrates that it doesn't need to be severe personal mental health issues which have a potential influence on mental health nursing as a career choice. What would seem to be a 'normal' process of dealing with personal issues may still contribute to reflection:

"...at the time and the stage of life I was at – I was 21 – I was working in industry; it wasn't going anywhere... I was dealing with lots of other personal stuff as well, coming out of that and it was an opportunity for me to begin to embark on a career that appeared at the time to me to have the values that I thought were important to me as a person." [P.17].

Given the prevalence of mental health ill health/distress, personal encounters with the issue among mental health nurses are highly likely, whether that be personal individual issues or among close social networks of family and friends. This is evidently the case among the sample of participants

within this research. From the perspective of student participants, issues can be identified during their educational journeys. In the pre-history of individuals prior to becoming mental health nurses, encounters with mental ill health/distress can be a part of the motivation to enter a caring profession.

b) Pre-Professional Encounters with Mental Health Nurse Role

All participants indicated that they had some exposure to the role of nurse, and most to the role of mental health nurse, prior to embarking upon a career pathway to become one. Parents and family who are working or have worked within nursing is a frequent narrative:

"And also my mum was registered as a learning disability nurse... so I sort of had a bit of insight into nursing from her job..." [P.5].

"Yeah... my mum was a general nurse." [P.8. Int-1].

A family history of mental health nursing, or nursing/health care roles more broadly, is a contributory, rather than directly causative factor, in seeking a career as a mental health nurse. The participant below indicated other strategies in addition to her father being a retired mental health nurse:

"...I had a little 'return to learning' interview which was really good... had a little chat with a few people and thought yeah, going to go for it... my dad was a mental health nurse... so I always had little chats with him." [P.8. Int-1].

This is a similar story to the participant below, who also indicated the exposure to mental illness via family/social ties with a particular institution at that time (the 1980s) had removed some potential anxiety regarding working with mental ill health:

"...I've been brought up very exposed to mental illness... from sort of quite a young age, what with the pantomime, the social element I think, of the hospital life, so it wasn't something that I felt any prejudice against or anything that I particularly had anxieties around." [P.19].

The participant below had initially become a 'general' (adult) nurse, but subsequently moved into mental health. It is interesting to note her father (a general practice doctor) perceived working in mental health as less prestigious than broader physiological medicine:

"I think it wasn't seen to be a proper job; I think... Nursing seemed to be a proper job. General nursing... dad's a GP, so mental health nursing was a bit of a sideways step, it felt. I didn't feel that and certainly, as soon as I started my training, I thought: this is it. This is what I've been wanting to do." [P.15].

In addition to family history of employment within mental health nursing, historically, large psychiatric hospitals were significant local employers for the localities within which they were situated, as indicated by the participant below:

"...there was a strong narrative in my own family of mental health nursing... my maternal grandparents were both mental health nurses..." [P.14].

Some working roles participants had been involved with prior to entering the mental health nursing preparation programme had exposed them to the mental health nursing role, as in the case below:

"...worked at the Drug Treatment Service... I was the receptionist there and I just loved it, I loved everything that they did and the whole process of it, and that's when I changed my mind from paediatric to mental health." [P.1].

Many individuals who enter the mental health nursing profession have prior relationships with people who are existing mental health nurses. Often, but not exclusively, these are family members. Another common angle of exposure to the role of mental health nurse is via working in support roles within mental health settings. These can be administrative or more domestic, and may be employment positions which individuals take in order to generate income whilst they decide upon a career pathway. In some cases, that career pathway becomes mental health nursing.

c) Previous Educational and Employment Experiences

Previous education and employment experiences often contributed valuable and relevant knowledge, insight and awareness for participants. This can be in terms of previous formal education and training, as in the case below:

"I knew quite a bit about theories... I will go on any training course, ha, ha... I worked at parenting and fostering for six years so like I know all about attachment theories and all them kind of things." [P.1].

The participant below studied directly relevant subjects within higher education before applying to become a mental health nurse:

"I always wanted to do nursing or something to do with health and social care because I was quite good at health and social care when I was at college." [P.6].

The participant below cited an example of a specialist mental health team contributing to the care of individuals in a context where he worked as a support worker:

"We work with another team, called the Behaviour Analysis Team... It's a mixture of different professionals... and everyone is working towards analysing the behaviour of the client; how to support him; building up the support and care plans." [P.7].

The participant below secured employment as a support worker in a mental health setting via a fairly serendipitous route prior to embarking on a programme to become a registered mental health nurse:

"I actually got into it by accident... I was working in the prison service and I was looking to make that full time, 'cos it was only a 12-month contract and someone who worked at

[Hospital named]. She was a support worker. Her goal was to be a police officer erm, but she got into the prison service and she told me there was some jobs going out at [name] Hospital. So I applied, knowing that my contract was about to come to an end." [P.10].

The participant below found himself working within a supported housing project, and discovered details of the nursing course to which he applied whilst working on a night shift:

"...I like the rehabilitation side... so I got as job in a supported housing accommodation project in [location identified] and then on a night shift, I found this M-Nurse course that was just a two-year duration, I thought: that's ideal, really. So it just led on from there." [P.16].

Some more mature students have longer employment experience prior to entering the programme of study to become a mental health nurse. They can cite specific examples of life-skills and experience which they see as relevant to the role of mental health nurse. The participant below worked as a manager in a 'call centre':

"...I have had lots of managerial positions and I have confidence..." [P.2].

The participant below, interviewed just prior to commencing her nurse education, worked as 'cabin crew' with an airline prior to embarking upon study. She was able to relate a very specific transferrable skill, of reassuring nervous flyers, from that previous context to the role of mental health nursing:

"Usually at the boarding steps... the point that they don't want to get on the aircraft and yeah you have to go down and deal with that situation... I actually quite like doing that sort of work for those people and try and help them feel better because as soon as you start talking to them and regulating their breathing..." [P.8. Int-1].

The same participant sought experience within a mental health care context to gain further insight, prior to deciding to embarking upon the mental health nurse education programme:

"...I do do a little job in a care home... I went in to get some volunteering work to get an idea... and for my UCAS application and they offered me a bank job there, so, I could fit it in with my flying; I do one or two shifts a month in there." [P.8. Int-1].

Historically, it was often the practice within large psychiatric facilities to offer prospective student nurses roles as care assistants prior to commencing their nurse education programmes:

"...the training was due to start in September and I got offered a few months prior to that the opportunity to go and be a nursing assistant, just waiting for the school, the next school intake." [P.14].

The final data example below shows how individuals can draw upon more general experience within previous employment contexts to understand workplace dynamics within the context of mental health services:

"...the politics and the redundancy threats... the way that the company was managed... so I sort of had an understanding that that can happen... had worked with different types of managers in the past, seeing it in nursing wasn't a surprise..." [P.4. Int-1].

Previous learning, both academic and experiential, can bolster an individual's approach to and experience of engaging with the role of mental health nurse. Such learning may be related to mental health directly, or more subtly. It can involve working in roles within the same arena as mental health nurses, such as support worker, or roles even less directly associated such as housekeeper. For those with less directly comparable working roles within their own personal narratives, there are still transferrable skills and values which can be of use in re-application to the role of mental health nurse. This includes an experiential appreciation of work-place 'micro politics'.

d) Personal Reflexivity

The final sub-category within this category of 'previous and concurrent personal experience' is concerned with the reflexive effects of personal and professional life roles running concurrently. All participants had something to contribute about this reflexive aspect. The participant below described how engaging with the means of understanding others carries through from professional role to personal self in a general sense:

"...it just gives you kind of different ways to think about things and to think about people... different approaches and I suppose it does become a bit of 'who you are'. My role is very much a part of me. I find it difficult to kind of differentiate between 'work me' and 'home me'. I think there's definite overlaps." [P.12].

The expertise possessed by mental health nurses can carry through to social situations:

"...in a pub I could talk to somebody and know all about their business and they might not know my name... The way you can communicate with people, how you learn to... assess situations." [P.13].

This is not always perceived as useful and positive:

"I think sometimes... If you spoke to my kids, certainly when they were teenagers, they'd just say 'Just take your bloody psychiatric head off.'" [P.15].

Student nurses are instructed from a very early stage that they are entering a profession and, as such, they have a global responsibility to behave professionally:

"Yeah, because you think about, like, really all the time, it would influence what you do and things, like, when you first come onto the course they talk about how it's supposed to be professional and you should take it into all aspects of your life and things like that and

social media and things like that and I think I personally always think about stuff like that, like, whether I am being like... continuing to be a nurse outside of placements." [P.6].

Student participants earlier in their trajectory of 'establishing role congruity' focussed particularly upon finding themselves being less quick to judge situations or individuals:

"Perhaps when I started, I would have said I was non-judgemental, but I probably was... whereas now... if a friend were to come to me and say something, I don't think I would be as judgemental as perhaps I would have been." [P.5].

The participant below suggested her general principles, values and personality were congruent with central aspects of the mental health nurse role:

"I think for my personality... I do think I am very empathic as a person and I do... try and help people and I think it suits my personality, people who know me would say they can see that's what I would do... I think it suits how I am." [P.11].

The student participant below identified how the formal values of the religion to which she is committed fit congruently with mental health nursing:

"And love, and like understanding that as a human, like, for me personally, wanting that and finding that in God... and then you talk when you are working, you are working with people that are looking for acceptance, or looking for love or looking for significance... like the spirituality part of nursing. Like I know like it's not necessarily other people are looking for god, but to find, looking for the same sort of aspects." [P.3. Int-2].

The principles of positive mental health inherent within therapeutic approaches can be embraced at a personal level in being more healthy, as suggested by the participant below:

"I'm quite interested in psychological therapies as well, so I do a lot of reading around like CBT approaches and it's quite interesting how you can take the wider aspects of that and apply it not only to... patient care, but staff care and personal... Looking after yourself." [P.16].

Life experience which people have as they come to engage with the role of mental health nurse was cited as significant. The two examples below both suggest that coming into mental health nursing at a relatively older point in life, with more life experience, can be beneficial:

"...I don't know whether it's also a kind of growing up process as well... I did nursing straight out of school. When I think back to the job on the ward, I felt too young to be there. I didn't have enough wisdom... or life experience to do it..." [P.12].

"...I think it was beneficial that I came into mental health as a mature student... coming in at 18, you know, I would have found that fraught - never having had any life experience that some of the people on the wards were... I was 24, but never the less, you know I had a bit more... under me belt really, and could perhaps empathise a bit better." [P.13].

In summary, a number of issues present in relation to this sub-category. Firstly students, and indeed all registered nurses, are explicitly directed to the notion that they are professionals and, as such, this applies even when they are 'off duty'. The influence of working within the field of mental health nursing inevitably emerges in other personal contexts. This can manifest in various ways, depending upon specific contexts or personnel involved. Individuals also have, or bring, their own value systems to the role of mental health nurse, hinting that some individuals have a pre-disposed tendency, personality-wise, to gravitate toward a role of this nature. Finally, the issue of how much life experience individuals bring to their initial role preparation is cited here by some participants as relevant.

Summary

This category is less complex than the previous category outlined earlier in the sense of structure of interrelated sub-categories. Nevertheless, personal experiences are evidently important in contributing to the state of role congruity. Personal experience of mental health distress in self or family/close social networks has a significant impact upon the perception of mental health distress or illness in professional activities. There can be conflict and discomfort in having the status of a mental health service user whilst also being a mental health nurse, which perhaps indicates the pervasive effects of social stigma. Empathy is considered to be an important part of the formation of therapeutic relationships. While personal experience can only enhance this, care should be taken not to assume the experience of all service users and carers are homogeneous. For some, personal experience can also contribute to the decision to become a mental health nurse. Student participants reported the impact of engaging with mental health issues within their studies and placements from quite early in their programmes, with a particular emphasis on becoming less judgmental. Student nurses also form the realisation early in their preparation that they are expected to conform to professional standards within their life beyond the nursing role when on duty, including the need to take care when engaging with social networking internet sites. Students may also identify issues with their own mental health, or have them identified, and seek support from guidance and pastoral systems. This aspect is also discussed later in the category concerned with support.

Most participants identified some degree of pre-professional encounters with the mental health nurse role. Often, family members had been health care professionals, if not mental health nurses precisely, and though this was often from a different era of care it nevertheless establishes some shared aspects of professional identity. Similarly, participants who had engaged with previous study and/or work roles demonstrated how aspects of those experiences can translate to their developing roles as mental health nurses. This includes less explicit 'transferrable' aspects such as communication and management skills and experience.

All participants could identify how their role as a mental health nurse exists reflexively alongside their personal lives. Finally, the issue of having life experience before becoming a mental health nurse was raised as significant by some participants. Life experience can be seen as a valuable pre-requisite to appreciating the life-event factors which can impact mental health service users negatively.

Category 4: Previous and Concurrent Professional Experience

This category addresses participants' experiences relating to their professional role as mental health nurses. In a temporal sense, these experiences are drawn historically and retrospectively from the very outset of participants' embarkation upon pre-registration programmes leading to professional registration, through to their most contemporary issues. It encompasses four sub-categories:

- a) Managing role in different settings
- b) Influence of role models
- c) Ongoing learning and professional development
- d) Career development and anticipation of future roles

Figure 5:12 below summarises the category of 'previous and concurrent professional experience' in diagrammatical form, following which each sub-category is defined and illustrated.

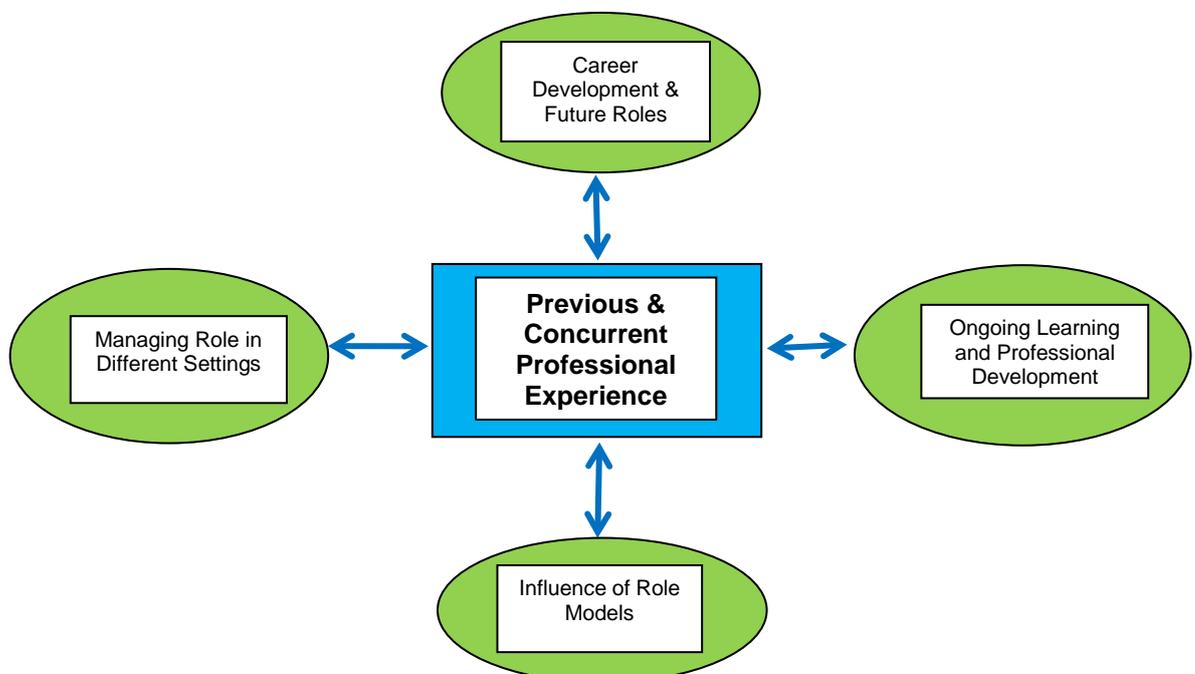


Figure 5.12: Diagram portraying the category of ‘Previous and Concurrent Professional Experience’

a) Managing Role in Different Settings

Though this category overlaps and links with category of 'engaging with dimensions of mental health nursing roles' presented earlier, it differs in that it is concerned with the way in which mental health nurses use previous and concurrent professional experience in a variety of actual settings in an applied and integrated sense, whereas the focus of the category 'engaging with dimensions' focuses upon the individual dimensions. Student mental health nurses are, during their pre-registration programme of preparation, necessarily exposed to a variety of practice placement contexts. These practice contexts focus upon different service user groups in one way or another. While some are defined by age group, other contexts are defined by presenting problems of service user groups, and encompass community-based services, in-patient services, day care services and crisis services. There are also some specific services and/or roles defined within these service demographics such as 'dual diagnosis' (for service users who have co-morbid addiction and severe mental health problems), rehabilitation (helping to move service users from in-patient settings to more independent living circumstances) and forensic (for offenders with co-existing mental health issues). This complex array of practice contexts also represents the range of practice roles within which qualified and registered nurses are deployed.

For student participants, the variety of placements could present somewhat of a 'whistle-stop tour' of mental health provision:

"...it's hard... changing placement all the time because it's like you get stuck and used to people... you find your role and where you fit... you're starting to get on well with everybody, getting to know them, and then 'bang', you are out... then you have got to start again." [P.1].

The student participant below indicated that some placement areas are seen as less attractive than others:

"I did older people's community placement and to be honest, I wasn't really looking forward to it, but then it's the thing of when you actually understand something. It's a prejudice as well; everyone seemed to be regretting, or not looking forward to the older people's placement... but I really enjoyed it. It's been probably one of my favourite experiences. Maybe 'cos I wasn't expecting to get as much out of it as I did, but it comes back down to the stigma again. I mean, there's a stigma towards that kind of work, within nursing itself." [P.16].

Student participants varied in their views of where they might like to gravitate to upon qualification and registration. The participant below reflected upon her placement experiences in terms of where she might wish to work once qualified:

"When I first started I would have said CAMHS... and I still think I have an interest, but I don't think we get much opportunity to actually see what that is all about. And when I first started I was adamant that I didn't want to work with people with dementia, but my second placement was with people with a dementia assessment ward and that completely changed,

so I am not... I don't think forensics is for me, I think I know that, but I don't really have a definitive 'that's what I want to do'. I did thoroughly enjoy my time with the crisis team and if I could, have a job on the crisis team when I left university, I would be very happy." [P.2].

The participant below approached the issue in terms of what areas he definitely would not wish to work within:

"I think I would stay clear of the, I suppose the non-psychosis side of working age adult." [P.4. Int-1].

Once qualified and registered, some participants had very clear preferences for particular practice contexts. The participant below indicates that working with adolescents became her ambition following a practice placement in the area. This became her area of practice and career development:

"And I chose to go down the adolescent inpatient unit...at that point in time. So I went and did my twelve weeks down there and from that point was hooked... so quite early on in my career I was sort of hooked into working with adolescents." [P.14].

Interestingly, the same participant drew attention to a policy which was, historically, prevalent within large psychiatric institutions up until relatively recently:

"And at that point in time, at that time in the nursing culture, especially at [hospital named] it was that staff nurses don't stay on a ward more than two years." [P.14].

It was somewhat against this trend that she ultimately secured a role within her preferred area, and remained within that area, developing specific expertise.

The example below captures a point in the participant's career history which illustrates the beginnings of development of mental health nursing roles in a community setting:

"The hospital was the main focal point around that time... I started in 1983. We went along the same loops during our enrolled nurse training... long-stay placement... very institutional orientated and based. The CPNs around at that time, they were few and far between; they were seen as like the equivalent of the ward manager... charge nurse... an elite kind of bunch at the time... a prestigious role to have. But then obviously with the deinstitutionalisation and things like that... my role changed but essentially from qualifying...there was always the adage that... you need to kind of get a good inpatient experience under your belt to be of any value before you can go on and do anything else, which perhaps was a bit more true then than it is now." [P.18].

For the participant below, exposure to the field of CAMH occurred within an educational setting for continuing professional development (CPD):

"I can remember the day that I decided: that's where I wanted to be and I was at the university in [City named]... and there was the 603 course, which was the old... CAMHs

course. I thought: 'I'm going to do that' and it was a really strong drive and that's when I started looking round for CAMHS jobs and then one came up quite quickly." [P.15].

The participant below has worked in a variety of mental health contexts, but had a very clear affinity for working with older people:

"And I have worked with younger adults and I did enjoy it, but I've definitely, me, as a person, I'm definitely an older person's nurse at heart." [P.9].

The participant below presented a very stoical stance to being deployed as needed across a range of settings:

"...I remember when I were... just moved into mental health wards, some people would go off sick rather than be moved to another ward for a shift... I've never been precious about what desk I sat at, or whether I went to another ward for a day or a week... help the cause really, so it's just your nature isn't it?" [P.13].

Participants with longer career histories were more likely to have experienced a range of practice contexts, perhaps indicating a period in the development of mental health services where nursing roles were more immediately transferable between contexts, as in the case below:

"...it was kind of the usual apprenticeship of acute admission wards. I did that a couple of years. Then I moved into drug and alcohol, worked in that for two and a half, three years... did some extra training... worked in what would now be known as CAMHS... for over four and a bit years... with a little bit doing something else in the middle of it not for very long. And then into working in... the university department at the [Hospital named] as was just newly developed then for severe affective disorders." [P.17].

The participant below, though having found her ideal working context (CAMH), still felt her historical experience in other mental health-related contexts was useful:

"I'm glad I've had time in adult services... in older person's services and rehab and day hospital, because I think all that feeds into the knowledge that I know, so if I'm seeing sort of a programme or youngster, I have got an idea of what they could potentially be like in ten years' time." [P.15].

Re-locating roles to different settings can spring simply from the desire for a change in working context:

"I feel as if sometimes – not in a big-headed kind of way – but you feel as if you outgrow some areas or there's a necessity for newer challenges or you've got ideas that perhaps take you in a slightly different direction..." [P.18].

The participant below outlined how she first qualified, then worked in two roles before finding her 'ideal' role:

"So I did that, as a band 5 obviously, for about two years... and then I applied for the clinical lead post on the female adult acute admission ward... and I did that for about nine months. I found the role of clinical lead to band 5 very different as well... although I was clinical lead I was expected to be the lead of more complex cases... often didn't have time for that because of the meetings that you would go stand in for if the manager was off..."

rotas, dashboards, things like that... which is why I applied for the post in the crisis team because I wanted to work with people." [P.11].

The clinical lead role she referred to clearly did not manifest her expectations in actual practice. In keeping with the issue identified within previous categories regarding leadership roles, engaging with this role led to reduced contact with service users. She added:

"I do, I think, well, I love doing this what I, the crisis role, because it's so different, it's so varied and you do, you are dealing with risk and I do like dealing with risk, and you see all sorts of situations and you're on your feet all of the time." [P.11].

A particular issue of note was participants' anticipation of (students) or experience of (qualified registrants) the transition from the role of student to that of qualified, registered, accountable practitioner. The student participant below expressed this anticipation:

"I can definitely imagine... definitely, I am worried about things but I am still definitely imagining me self doing it, and I know that eventually through experience I'll be able to be a nurse." [P.6].

Students also encounter newly-qualified nurses during their placement experiences and are able to identify with the transition agenda and potential issues they may encounter through seeing the experiences of others, as reflected by the participant below:

"I still think you need a lot of support as a newly qualified... I remember in my second year, seeing a preceptorship nurse who sort of came on to a ward with all her new ideas... and she was... quite ridiculed really, by some of the more junior staff and it was quite awful to watch from my perspective." [P.5].

The participant below was re-interviewed one year into his qualified registrant status, and reflected upon his transition:

"I have sort of settled in really quickly and I am... performing above my experience level... sort of initial I suppose honeymoon period if you like is starting to wear off... the politics of other staff are starting to wear us down a little bit now." [P.4. Int-2].

The final example below illustrates how participants with longer career histories were able to reflect upon their experiences in comparison with the way in which transition is managed in the contemporary context:

"It was really difficult... because then you didn't have the preceptorship support that you've got now... I often joke: one day you're wearing a white dress as a student; the next day, you were kind of a staff nurse with a blue dress on and suddenly people were asking you your advice and your opinion... and that was really, really quite alarming and scary." [P.9].

In summing up the key points for this sub-category, mental health as an arena of practice is, in reality, a myriad matrix of services and contexts.

Student mental health nurses are exposed to this variety of contexts during their preparation for registered practice via time-limited periods of experience in each, with some opportunities to gain insight into associated services as part of their placement experience. They also have the concurrent agenda of increasing expectations in terms of responsibility as they move through the placements across their period of preparation. There is then the transition from the student role to the qualified registrant role. Students are aware and anticipate that they face the task of transition at the end of their initial preparation. Participants with a longer time period since qualification and transition reported less structured processes to enable the transition.

In terms of preference and affinity for particular practice contexts, some student participants recognised very early in their programmes where their affinity lay. Others consciously defer expressing preference until they have experienced the variety of settings within their placement schedules. A similar picture was evident amongst qualified and registered participants. Though the initial context which individuals begin their registered practice within might be restricted by availability of posts, those with firm aspirations to work within particular mental health contexts can, within a period of time, position themselves to move to a more preferred role. Some had identified their particular preference early within their careers (or whilst they had been students) and gravitated toward this. Others had gravitated to a number of roles prior to establishing their preferred practice context, and still others might take opportunities to 'move on' after a period of time simply for a change of context.

This variety of contexts within which mental health nurses practice brings the debate concerning generic/eclectic approaches and specialist interventions explicitly into focus. This will be addressed more explicitly in chapter six.

b) Influence of Role models

Given the practice-based nature of the discipline of mental health nursing, and the emphasis upon learning experientially in practice as well as academically, it is not surprising that most participants were able to recount particular individuals and/or incidents which had influenced their own professional development in some way.

At a general level, such influences are not necessarily critical, earth-shattering incidents. The student participant below outlined what she felt to be the influence of competent practitioners within practice placements:

"I think it's about being able to reflect on somebody else's practice... in an analytical way and take the good bits that you would like to take on board and develop into how you

would want to practice in the future and take away the negative bits, because nobody is perfect, so you could have the best nurse in the world but there is going to be some negative part to what they do, so it's trying to pick out the bits that are best for you..." [P.2].

This was echoed by the participant below, who suggested that influence can be a gradual, building process and may take place cumulatively over a period of time rather than a particular episode:

"...just being able to observe their behaviour and their attitude... and talking to them... like I probably spent a week with one lady and it wasn't even a week, it was like a couple of hours on one day and like a couple of hours on the next... at the end of the week... you just sort of build that respect for that person and you see, and you watch them work and that's where you like respect them as a practitioner..." [P.3. Int-1].

However, all practitioners have strengths and weaknesses within the dimensions of their practice, as pointed out by this participant:

"...every person I have worked with I tried to take strengths from and some people have had a lot more strengths than others... I worked with a nurse who I didn't feel was particularly confident... and was very defensive in her practice but her record keeping was brilliant and stuff..." [P.4. Int-1].

Some of the above participants recognised that there are weaknesses as well as strengths for all practitioners, including role models. Student participants had encountered individuals who were very poor role models. The participant below drew two extremes of comparison:

"I mean, you know, people that are so passionate about what they do that it virtually seeps out of every pore in their body and then you have got other people who, 'well, three years, two days and ten minutes and I will be retired it doesn't really matter'." [P.2].

A particularly negative example was given by the participant below:

"...that mentor in particular I think she was just really burnt out... and like on my first day she said 'you're here to spark enthusiasm in me' and I thought 'right, that's not why I am here like'... before I left, she was saying she was thinking of moving to doing something different." [P.1].

Participants did recount a lot of good practice which they had seen modelled, and some nurses in practice placements were particularly inspiring:

"Say for example, the addictions placement I had, where I just visited, that mentor there would bend over backwards to help patients. He really did. He was very, very good. I've had a few mentors that have been really excellent." [P.5].

For student nurses, inspiration can also come from the educational setting, as outlined by the participant below:

"...it was that child branch lecturer... it wasn't just felt by me, it was felt by others in the class... it was so profound, it was refreshing to listen, to engage in conversation, to talk about, she shared lots of personal experiences and personal things with us... really made you think about the impact on children especially... it was a real light bulb one... it sort of speeded your own sort of internal drive and passion." [P.2].

Good role modelling isn't necessarily the exclusive domain of the qualified, registered nurse:

"From nursing assistants... who are exceptional at communication and brilliant at engaging with patients..." [P.4. Int-1].

The importance of good and effective role models does not diminish on qualification and registration. With the emphasis on continued professional development, when qualified nurses pursue more advanced accreditation within particular therapeutic approaches, a mentor/role model is often involved. The participant below reported establishing an ongoing advisory and supervisory relationship with one of her early role models, a nurse and family therapist. This relationship continued as the participant followed the pathway of this role model into the same specialist therapeutic modality:

"I approached her and she agreed to be my supervisor at that point... that was at the beginning of 603 [CAMH course]... and it continued for years and transitioned from, not just the 603 but transitioned, my own transition from inpatient to community and then into family therapy." [P.14].

This extends to leadership roles and styles. The participant below, diverted into a more managerial role following a restructure of her organisation, cited a role model she still draws upon in trying to balance clinical contact with service users with her management and leadership responsibilities:

"...she was a team manager, but she was a CPN by background and I think she really managed the team, but kept a really clear clinical focus... in management, it's really difficult to not get distracted by targets and performance... especially now... and she always kept a really strong focus... that the patient was central, so now... I'll always bring it back to what [name] would have thought... think about the patient first." [P.15].

Student nurses were also able to contextualise an individual's experience. In the example below, the participant took the length of service of a nurse into account, and found positive aspects for herself:

"I don't mean it in a disrespectful way, I just mean like you're looking at someone with knowledge and like thirty years' experience and looking at how they are working thirty years down the line and you are like 'yeah', like, if, I would be quite happy if thirty years down the line I was, you know... I maintained that." [P.3. Int-1].

Participants could also frame themselves as role models, as in the example below:

"...just how important role modelling is, you know, as a, for me to see and look at role models who I would see as a role model, a good role model, and as well as me to be one as well, because we get a lot of students." [P.11].

The participant below related a particular incident which resonated with him even after some time, relating to a young person's mental health unit, after an incident of self-harming behaviour:

"I remember one qualified nurse, who sat for three hours, just holding this girl's hand after the event... they had a really good relationship... And that was a good example of what we do; what we can do... you have to have instinct and the instinct was to sit and nurture this girl and hold her hand until she felt better..." [P.10].

The final example below, from a qualified participant with many years of experience, underlines the lasting impressions that both positive and negative role model influences can leave:

"There are charge nurses and sisters that you would think: 'absolutely not would I treat or behave like that', or... 'that's what I'd like to be'... a bit like the teacher that you remember at school that said you were doing alright... well equally for ward sisters and charge nurses and you know... 30 years ago, I can remember their names." [P.13].

Within a practice-based discipline such as mental health nursing, role models are an important part of the learning process in terms of knowledge, skills and attitudes. At the most positive extreme, good role models in education and practice contexts can inspire learners. However, much role modelling is not related to earth shattering critical incidents, but rather the demonstration of consistent good practice over periods of time, resulting in a cumulative recognition. Student participants also recognised that different individuals have different balances of strengths. This is in keeping with the notion of 'dimensions' of the mental health nurse role outlined in the first analytic category. It is also worth noting that not all role models for good practice are necessarily qualified registered nurses, as experienced care assistants and support workers have a potentially valuable role to play, particularly earlier in student experiences when they need to engage with fundamental aspects of practice.

There are examples of less than positive practice cited by participants. Where this has been the case, participants report still taking a positive learning outcome from this, in the sense of what they would wish to avoid within their practice. The importance of positive role modelling is evident in the way that individuals can recall important episodes and/or individuals many years after events. The importance of role models continues after qualification and registration as individuals pursue further expertise, or move to management/leadership roles.

Lastly, it is evident that part of appreciating good role models for students and mental health nurses earlier in their career trajectories is the realisation that they themselves become, in turn, role models for subsequent learners.

c) Ongoing Learning and Professional Development

Within the structure of their pre-registration programme for preparation, student participants were, by definition, engaged in ongoing academic/theoretical study and practice competency development within placements. Beyond the set assignments and documents to have competencies 'signed off' when in placements, a variety of avenues could be created for engagement with learning.

The participant below recounted how assignment work and deadlines helped to focus and discipline learning:

"...it keeps you on task... and you can think 'well, I have not done that yet, I could do that'. I have done a lot of case studies in mine [placements] and things like that which I found helpful. It depends on your mentor I think. Some mentors don't even want to see it... But I like doing, I much rather I be on placement if someone gave me a project to write about or something, than just sit there and read for reading's sake." [P.1].

However, she also finds that being asked to engage with project work when on placement helps give focus rather than 'just reading'.

Students are also encouraged to keep a reflective account of their learning in the form of a 'Personal and Professional Development File' (PPDF):

"I have built up loads in my PPDF, I have put in different things. And some people have hardly wrote anything in the PPDF, mind. But I am pleased I did". [P.1].

The kind of learning opportunities available can, as recognised in the earlier category of 'Establishing Role Congruity', be dependent upon the stage students are at within their programme:

"I think it's placement dependent... in my last placement... I felt very much an integral part of the team... I wasn't just taking, I was bringing things as well and challenging nurses ideas about things by giving a different perspective... it was more of a two way learning process, which I didn't feel in the first placement... but again, I think that's due to my own knowledge increasing throughout the year." [P.2].

Having shared learning throughout much of the initial year of their preparation programme with other fields of nursing, students generally saw an increased focus of relevance when they moved into the 'branch' of their mental health programme:

"But this year... especially all of the branch specific lectures, it's just, I just keep thinking 'why didn't we have this last year'... that's just one of the things isn't it like?" [P.3. Int-1].

In keeping with the notion of transition from student nurse to qualified, registered nurse, the same participant anticipated the task of continuing with her learning and development once qualified:

"I have just thought... how when I am qualified how I will continue to develop... make sure that I reflect and that I am still an effective practitioner?" [P.3. Int-1]

On the same theme, the participant below was re-interviewed one year into his practice as a registered nurse, and outlined his approach to continuing with learning and professional development:

"...when I was coming up to Uni I suppose it was different, more time management then... struggling to find the time to come over to the university library and things... I registered with the Trust library... and I have accessed a little few things there but not too much, but I have also... I registered for NHS Athens account... so that gave us access to a lot of the stuff I used to use regularly as a student anyway." [P.4. Int-2].

Qualified and registered participants within the study were all (as part of sampling access) engaged with some form of academic, University award bearing study. An important aspect to keep in consideration is that this is *one* form of pursuing knowledge and professional development. Simply by engaging in practice over a period of time, individuals will accrue experiential knowledge and skills, learning from other practitioners. Trusts also increasingly provide education and training for their workforces, as the participant below indicated:

"...the Trust's own training and sort of things but stuff that you don't particularly need to do as part of the role on the ward but that's helpful like leadership courses and things run by the Trust..." [P.4. Int-2]

It can, however, be difficult for some working in full-time roles to embrace the discipline of professional updating and reading, unless it is linked to structured learning:

"I think through the dissertation, through other courses and studies that I have done... it becomes more apparent how important it is... the main thing for me is that you can read stuff." [P.11].

The participant below, in the process of completing her degree-level study, commented upon the impact of her study in practice terms.

"Because I've done my dissertation... done my degree, my whole thinking has changed... I am by heart a very practical, hands on kind of nurse. I trained twenty odd years ago. Things were very different. But... especially now I've done my dissertation and I've looked at a piece of work in my own kind of work environment, I can now look at the value of critique, debate, analysis, reflection and how that impacts on my practice. I'm still at heart practical. That's not going to change, but I've now got a more kind of theoretical, academic hat, which has changed my thinking quite a lot." [P.9].

The attainment of a degree has clearly boosted confidence, having framed herself as 'very practical' originally, and not abandoning this, she added an 'academic hat' to her wardrobe.

Some qualified nurses have a greater affinity for engaging with study than others. The participant below, completing her Professional Doctorate at the time of this study, described the sequence of her study chronologically:

"First degree, 1996... 2008 I got my masters and almost immediately went into a professional doctorate, 'cos it felt like if I stop now, I won't start again', and it went well with work, funding, timings... I think everybody at one point were getting their first degree and masters... so we're now striving for the doctorate and what are they going to do to us then...?" [P.13].

She indicated that, as the academic basis for nursing has consolidated and developed, the prevalence of degree and master's level study has become increasingly expected and normalised. However, the idea of having academic attainment 'done' to oneself would seem a somewhat passive stance.

Some degree-level programmes for continuing professional development are of a more 'generic' nature, with the intent of fostering graduate skills and values of, for example, critical thinking. Part of this provision and the engagement of individuals and their organisations with it has also been concerned with the qualified and registered workforce catching up, in an academic sense, with the baseline academic level of newly-qualifying nurses. It is also the case that, over the last twenty or so years, many nurses in practice have engaged with programmes which are both academic, and also lead to accredited expertise within particular therapeutic modalities. The participant below engaged with a programme of study to become an accredited family therapist/systemic practitioner:

"The best course I've ever been on was the systemic psychotherapy training... I'd been working in family therapy teams for years and then suddenly, the theory really underpinned my practice and... really helped with my confidence. 'Cos you sort of pick up bits and pieces, but to have that thorough training and think: 'Aah, okay, I know what we're talking about now'.... that was really helpful... family therapy, I think my practice did change quite significantly." [P.15].

The last example here concerns a therapeutic approach which is not so solidly established within an evidence-based framework. The approach concerned is 'Neuro-Linguistic-Programming' (NLP). NLP is an approach which purports to be able to address common mental health issues such as anxiety, depression and generally improve human performance. In this case, the participant below combined NLP with hypnotherapy:

"The whole... actually, NLP itself made sense once I'd done the hypnotherapy... 'cos it's all about the mind and once I'd made that link, I was away... I'm starting a master practitioner's course... to go to that next level... I'm drifting away now from the traditional mental health treatment practice and... because from my own perspective, I'm thinking about the whole thing in a completely different way." [P.10].

This participant, though clearly enthusiastic with regard to NLP as an approach, was on a less solid and established footing when using it than with family therapy or CBT. Though NLP has a popular following within some quarters, it does not meet the requirements for what would be considered a credible evidence base within influential policy-guiding bodies such as NICE. This being the case it is increasingly less likely that support for development and practice within less well evidenced approaches will be encouraged or supported at service level. This is not to say, however, that approaches such as NLP may not be able to develop an acceptable evidence base over time.

Student nurses are by definition engaged within structured learning tasks in both theory and practice. Student participants here described how such structured tasks can assist their learning. They also indicated an increased relevance in the application of learning once they progress beyond the first part of their programme, where much of the learning is shared with other fields of nursing. They also demonstrate an awareness that, once qualified and registered, they are required to demonstrate ongoing professional learning and development, and they do anticipate this.

Once qualified and registered, mental health nurses do not achieve ongoing professional learning and development via the route of academic study alone. From an experiential point of view, they learn simply by increasing experience over time, and under the influence of other practitioners. Mental health organisations, as employers of nurses, also offer statutory, mandatory and other types of 'in-house' training such as leadership and preceptorship, and may well commission specific training for their workforce where a need is identified.

However, it is still evident that nurses continue to gain benefit from University-based graduate programmes in terms of graduate skills, with the structured aspect of learning that this can provide helping with organisation and momentum for study. The attainment of graduate status is still an issue for much of the established mental health workforce in terms of catching up with the graduate status of standard preparation programmes. There are generic programmes leading to graduate status, e.g. in nursing or practice development, which can furnish participants with graduate skills. There are also specialist programmes relating to particular therapeutic modalities such as CBT or family therapy. These are therapeutic modalities with accepted evidence-based foundations, and nurses who engage with modalities which are less well established in the sense of underpinning evidence are likely to find difficulties in pursuing programmes and translating approaches into their practice in an acceptable way. This brings back into focus the debate between generic and specialist practitioners. This issue has emerged across several categories and sub-categories within this analysis and will be discussed more substantively within the summary of this chapter and within further discussion in chapter six.

d) Career Development and Anticipation of Future Roles

The narrative cited below comes from one of the participants with a longer career history. It is an extensive quotation to use from one subject, however the way in which the narrative encompasses the range of roles with which mental health nurses engage is very illustrative:

"...I worked at older people's and was ward sister there for quite a while... did my first degree.. and well, I think after about seven years it felt a bit staid really... I needed a new challenge and I think doing the studying opened my eyes to different things that I could try, so from there... I mean, this was just pure luck where I worked – there was a secure ward, so I applied and got a job down there. I don't know where the link is really, from older people's services into secure young males, but that's where I ended up and again, enjoyed that. I enjoyed the forensic side, it were new learning for me and I didn't know about the Mental Health Act for that type of work and the court visits and assessing people to come to a specialist unit... I really quite enjoyed that, but there were a time when this unit was closing down and a new unit was opening and it got a bit unpleasant really... So I sort of fell out with that service... went back to older people's, which was really like leaving on a Friday and going back on a Monday. It was just a complete slot in, in fact I didn't quite go back to the same ward... It was the same hospital... so that was really a seamless transfer back and then from there really, there was a... circumstances again, I got moved because of a disciplinary action against someone and they had to be moved out of their area for the

investigation... and the only one in the entire three wards that had had some adult recent experience, albeit forensic, was me, so I got moved into severe and enduring... we had a recovery then... Ward. So all this were ward based. Did a couple of years there and actually, that was just... I was almost like being refreshed all these new areas, 'cos I've not worked there, so I enjoyed that. I enjoyed the engagement, I enjoyed the public engagement that we did with schools, to learn people... 'Cos we lived in a... It were a smaller unit, so we lived by the side of the schools and we did a lot of engagement with the local village, so from there, I moved into a CPN role." [P.13].

This career narrative reflects a point in time where mental health nursing roles were perhaps more inter-changeable. It is unlikely that the student participants within this study will find such a variety of deployments at the requirement of their employing organisations. They do, however, have a variety of options to consider, though they may need to be prepared to actively pursue particular avenues of interest for any areas they have an affinity for.

As reflected within other areas of this analysis, few student participants identified a very strong vocational affinity for any particular area. They were more likely to identify areas they did not wish to work within. Most of the student participants also saw a need to 'consolidate' their early career positions, once qualified and registered, as reflected by the participant below:

"I think there will come a point where I want to move on so with regards to a speciality I think, I will probably have to wait and see how me career goes before I decide on where I want to move towards in sense of a speciality." [P.4. Int-2].

The need for consolidation of position following qualification and registration was also summarised by the student participant below:

"I think a lot of people as well, who are qualifying are wanting to move up the ladder far too quickly. There seem to be a lot of people on wards, especially who are band sixes and they've only been qualified for two years and to fully learn the band five role, it's going to take quite some time and to rush it, I think you're putting yourself into quite a dangerous position really, with the level of responsibility." [P.16].

The student participant below came to his programme of study at Master's level, having completed his first degree in forensic psychology. He was able to see a potential future role which could unite his interests and knowledge. He also formulated a potential pathway to such a role, ensuring appropriate consolidation of skills and experience prior to reaching that point:

"I've really enjoyed the work in the crisis team, or to work on the criminal justice side, but I want to build up the skills first, like on a ward placement, then build up the skills on a community placement and then link them together, because the street triage is a bit of both. It can be quite acute, mental health relapse, but it's also the skill that you need that you develop in the community, so I don't want to leave myself short and compromise myself and other people, really." [P.16].

For many of the qualified/registered participants, the focus of career development was not about progressing through management hierarchies, but about which service user group they found an affinity to work with. The participant below, working within a crisis service, identified an interest for working with people with 'Borderline Personality Disorder' (BPD).

"I suppose from writing the dissertation which was borderline personality disorder and self-harm, not right now, but certainly at some point in the future I would like to specialise in that." [P.11].

More generally, qualified/registered participants at given points in time might be very satisfied with their current role, and not be actively thinking about changing their working context:

"I really love what I do... there's been kind of other job opportunities that have come up in different Trusts, different teams... but when they come along, I think: should I? But then I end up not, because there's just something that I just really love about kind of what I do; the role that I'm in right now..." [P.12].

Similarly, the idea of career development within greater management responsibility, as reflected elsewhere within analytic categories, was not attractive to all by any means:

"I've been a ward manager for twelve years now, but I've been a manager in lots of different settings... where I end up later, I really don't know, because I look at the role above me, which is clinical nurse manager and I think: I don't think I want to do that, because you lose all clinical contact." [P.9].

There also comes a point where retirement becomes a closer prospect, particularly for those who still retain the status of 'Mental Health Officer', with the associated option of retirement at the age of 55. This does not necessarily mean that individuals are not still engaged with their professional roles:

"I have no immediate plans... and I've only got five years left to do... I haven't got any other burning ambitions that are out there; I've kind of fulfilled that and I really do get a tremendous sense of job satisfaction from here and I think because it is very much a growing service." [P.19].

With the development of more areas of specialist intervention, career pathways for contemporary mental health nurses entering the profession are evidently less 'generalist' than those initially encountered by participants with longer career narratives. This aspect is reflected within the structural changes to mental health services and the initial education of nurses outlined in chapter two. It also represents an explicit aspect of analysis in later discussion within this thesis.

Summary

Mental health nurses learn to manage their roles in a variety of mental health settings, from being students encountering a variety of placements through the transition to qualified/registered status where they consolidate experience. Whilst some individuals may identify particular affinity with specific areas of working quite early, even as students, most have a clearer ideas of where they

would not like to work. Within the narratives of participants of this study, it is in early roles as qualified/registered nurses that individual preferences for particular roles developed. Again this may be a process of experiencing several roles, prior to finding an ideal role. Ideal roles do not necessarily remain ideal for long periods of time. Roles can be affected by service reorganisation or by expectations of securing specialist status in order to work in particular roles.

The influence of role models can be of great importance. For student nurses, role models can simply be concerned with day-to-day competence within a given role. Some role models can have an influence upon areas of affinity in terms of professional development required to secure roles in particular areas. Aspects of role modelling can also manifest retrospectively, when individuals find themselves in particular aspects of role and reflect back to how their role models did approach, or might have approached, particular issues.

Ongoing learning and professional development are more likely, in contemporary practice, to relate directly to roles. This development may be experiential and occur 'within role', and it may involve 'in-service' training within particular aspects of practice. There remain, at this point in time, many registered mental health nurses who are not at 'graduate' level. For those with significant periods of time before retirement becomes an option, professional development often involves securing graduate status via generic 'nursing' or 'practice development' qualifications. Another option for some individuals is to pursue specialist study in a particular defined and accredited therapeutic modality such as family therapy or CBT.

Category 5: Developmental Support

This category addresses the avenues of support participants experience or may draw upon in relation to their role as a mental health nurse. It has been labelled 'developmental support' as it is particularly concerned with support available or drawn upon within the context of mental health nurses as 'developing' within their roles. Sources of developmental support are separated into three sub-categories:

- a) Practice arena
- b) Educational arena
- c) Personal arena

Figure 5:13 below summarises the category of 'developmental support' in diagrammatical form, following which each sub-category is defined and illustrated.

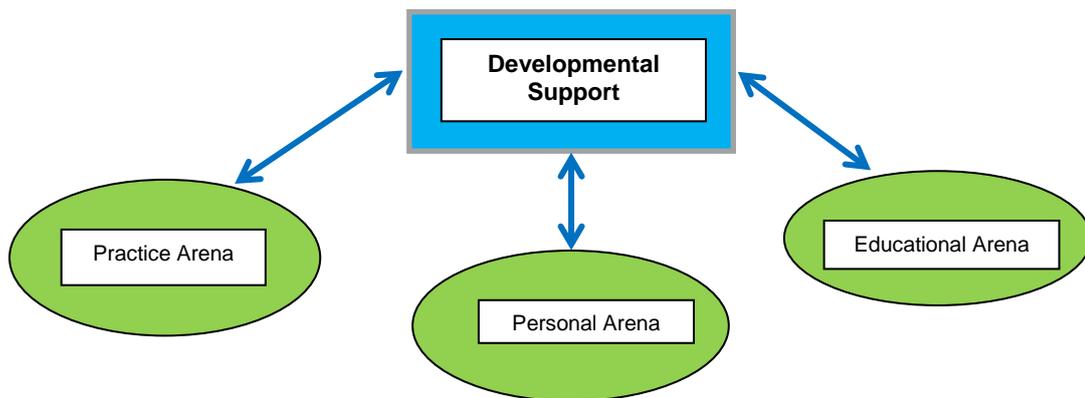


Figure 5.13: Diagram portraying the category of ‘Developmental Support’

a) Practice Arena

Since mental health nursing is a practice-based discipline, developmental support within the practice arena represents a significant aspect of support for both student mental health nurses and qualified/registered nurses.

For student participants, support is valued throughout the process of pursuing practice-based competency, particularly in earlier placements, as has been demonstrated within other categories and sub-categories. This support is not always solely from designated mentor figures:

"The nurse had a really good attitude to work and to others and she wasn't my mentor or my co-mentor but she just took me under her wing and like encouraged me..." [P.3. Int-2].

Students often need less overt and explicit handholding as they move towards completing their programmes, as summed up by the participant below:

"...the last placement, I felt I did the role of the nurse with very little input and it was mainly just because I needed their say so to do things that I didn't necessarily have the, I suppose, the authority to be able to make those decisions because it needs to be a qualified practitioner to do those things... whereas early placements it was like I was looking for reassurance in everything I did." [P.4. Int-1].

There were occasions reported by student participants when they felt a lack of support within practice placements:

"And it was a very busy ward so nobody had time to explain anything, they showed us around the ward and then just left us in the sitting room... so it was definitely not what I expected and it could have been a lot better if there was more support on the ward." [P.6].

However, the opposite extreme can also manifest, whereby students could feel over-supported:

"...other mentors were very defensive and weren't willing to pass on any trust or sort of responsibility and they wanted to stand over us in everything I did and, that's quite limiting... it knocks your confidence and it's quite difficult to work in that sort of environment really." [P.4. Int-1].

A particular time of importance for support, as identified in other categories, is the transitional phase between completing initial preparation programmes and becoming a qualified, registered practitioner.

The participant below described how this transition is stressful, though her experience of support is a positive one:

"To be honest it wasn't without its sort of stressful moments because I think everybody when you qualify... you know, because you think 'oh my god, I'm now accountable, I'm now...', you know what I mean?... they have the keys and you are responsible for the patients on the ward... it was very smooth because I had such a supportive manager." [P.11].

The participant below, re-interviewed one year after initial qualification and registration, recounted how an initial lack of support was identified and addressed.

"...I was just thrown in and because I did well, people just let us get on with it but later on people were sort of realising well actually you haven't had your supervision as often as you should have done and you haven't had any sort of formal support and any discussions so there was the deputy manager then took responsibility and says well actually we're going to give you some supervision and help you a bit more." [P.4. Int-2].

This brings the subject of clinical supervision into focus. The same participant identified how the process of clinical supervision can become a perfunctory exercise if the supervision process is not openly negotiated to address identified needs:

"Depends who is doing it... the manager when he has done supervision because he's been the one around and it has needed to be ticked off in the monthly supervision file... very much a paper exercise... but I have also done me clinical supervision training with the Trust since... and I have nominated me own supervisor, and now it's a lot more sort of helpful and I suppose I explained to them what I would like from my supervision and they are really helpful and what they expect from me as well, so it's a lot better now." [P.4. Int-2].

The participant below demonstrated how the purpose and nature of different types of supervision require clear understanding and differentiation:

"...I was supervised by the consultant psychiatrist, who I had weekly supervision with and that was very much about... case discussion... if I was stuck on something, kind of how to work past that... but then they also brought in... discipline supervision. So we had nursing supervision... which was in a group of nurses, but that was very much about case management and getting though the numbers... so that was probably thinking more about the process than the patient, whereas we thought about the patient in the clinical supervision." [P.12].

Interestingly, in this case, the clinically-focussed supervision is contributed by the consultant psychiatrist, and the more managerial, case-management focus from the nursing structure. There is often a need to separate out these aspects of supervision, particularly where therapeutic modalities are concerned, and where clinical supervision regarding case-work needs to relate to the therapeutic approach. Tensions can be raised where clinical supervisor and supervisee have different therapeutic focus. The participant below, practicing from a particular therapeutic stance with which he had become interested and within which he had developed a degree of expertise, found himself being challenged within clinical supervision:

"...just challenging what I did and I don't think that's what it's about. Not that I did anything dangerous... it just didn't fit in with what that person felt they might have done, so they challenged what I did, but that was a complete shift from... from the way she used to do, so I changed my supervisor; it wasn't a problem, but... it has to be supportive, because I think things are difficult enough as it is." [P.10].

The participant below illustrated the importance of clinical supervision in the practice of specific psychotherapeutic approaches, which also entails a strong emphasis upon the education/training function of the supervision relationship, including promotion of very specific reflection:

"And think: Oh, there's gaps in my knowledge there, so therefore I've got to study that. I've got to go to somebody who knows more about this and find out more about that. It's usually a lot of it is actually reading. You're only ever going to get so much from a supervisor. Supervisors have slightly different functions for therapists; as providers of knowledge... and that deep interest in what you're doing and a desire to develop and hold on to a deep level of knowledge of the conditions that you're treating and then an ability to put that into direct practice or subject that, that's a better way of putting it, subject it to direct practice and reflecting on that as you're doing it." [P.17].

Some participants with a longer career narrative could compare and contrast experiences of support over their career development to date:

"And there were times when I really needed somebody just to say "that was absolutely brilliant" or "next time, consider these things". So I found my early development was very much coming from myself, 'cos there wasn't a lot of nurturing and support. I get a lot of that now as I'm on a band seven, but I didn't at the time. I've worked for and had some excellent support and some people have had dreadful support from others. Well, it's been non-existent." [P.9].

As with good role models, good sources of support within the clinical arena were also remembered, as cited by the participant below:

"Professional support, I've had one manager really stands out massively, when I was working in the day unit and I think she really promoted me to keep on developing and keep on studying and it had been through the study that I've found more opportunities for the different jobs." [P.15].

This highlights a dimension of support concerned with encouraging ongoing professional development.

Support at the level of service/team from more senior quarters is important, and its loss or reduction can be palpably felt, as indicated by the participant below:

"I wouldn't say throughout that time I felt supported. I would say that certainly initially... we had a very... Tightly-knit, but not in a negative sense... I think there was a number of us that were innovators, that wanted things to change and our knowledges at that time were of a similar ilk and mind set, so I think that yes, I would say initially, very supported and then to the latter part, there was organisational change and different people coming in and at that point, I would say that I wasn't... Significantly." [P.19].

The example below demonstrates the importance of support around particular identified difficult individuals and situations, which can be particularly challenging for those with less experience:

"I think there was a lot of disharmony on board with most of the staff, a lot of staff members didn't like each other, didn't like working, and as a clinical lead, you know, I was often approached and they'd say, you know, 'I don't want to be on this shift because such and such is on this shift' and it was difficult to manage... I just didn't feel that support." [P.11].

The same participant recalled an earlier role in her career, introducing the dimension of peer support:

"...we used to have a thing on the ward as well, called 'huddles'... at the end of each shift when members of that staff who had been on would just meet for five, ten minutes before the end of the shift just to talk about how they thought the shift had been." [P.11].

This was echoed by the participant below, who recounted a particularly supportive environment from her past career:

"I liked being a Ward Sister in older peoples' wards, I think that's because that's when we were left to it then, 'cause we were still NHS then, - we'd not gone to Primary Care... and it felt like a family really, good ward team, good solid supportive ward team it were, and I enjoyed that." [P.13].

The nature of and need for support within the clinical arena encompasses several dimensions. These range from the support required by student nurses during their engagement with basic skills and functioning within mental health contexts, to the ongoing support required by all practitioners within their day-to-day roles. This involves formal support in the form of clinical supervision structures and protocols, and less formal support mechanisms, including peer support. Issues of support relating to the educational arena are now considered.

b) Educational Arena

Student participants were very explicit regarding the nature and degree of support they felt they had, or could have had more of, within their pre-registration preparation. Processes and protocols within the university systems can be quickly implemented where required. The participant below encountered a problem with her mentor in practice, resulting in being re-allocated to an alternative placement:

"...my placement was changed... at my request, straight away... So, that way yeah, it was facilitated, but I think the support around it could have been better." [P.1].

She made a valuable point here in that having systems to respond to issues is one aspect, but the actual implementation of these systems also entails an agenda for support. The same participant outlined how 'routine' aspects of support around clinical placements can be perceived as perfunctory:

"I want someone to come and say 'ah well, how are you doing, like?', but she'll not, she'll actually just come and go 'is she going to pass then?', that's it . Mind, a lot of people in my group... they love that, but it's not for me." [P.1].

Interestingly, she indicated that some students prefer the process to be handled quickly and efficiently.

Needs and perceptions are, however, very much individual issues. The participant below, a more 'mature' student, indicated that she perceived the learning support available from her study programme infrastructure to be more intense than she had expected:

"...I wasn't expecting that level of support, being sort of like a mature student in a university environment, I thought it was going to be more of 'well, you're here by choice, nobody's forced you, it's not school, just get on with it', so that was a nice surprise for the actual learning side of things." [P.2].

The same participant demonstrated an acceptance of responsibility for engaging with support, in the spirit of adults learning:

"...you are told about the support and then it's up to you if you take it... I have been to all tutorials... a big support, a big help. Some people don't go and then they get... not a very good mark and then it's like 'oh well, I didn't get any help or...' but sometimes you have to chase that support, but again it's an adult environment, and I don't think that's beyond our means to do that..." [P.2].

There are other avenues of support for students who are concurrently engaged with other life arenas. The participant below identified awareness of an available avenue of support related to her religious beliefs:

"Because there's a Christian Union as well, at the university." [P.3. Int-1].

Qualified registered participants were all engaged with some aspect of post-qualifying educational provision within the university. They tended to be less directly explicit about the nature of support during their studies than pre-registration participants. This may relate to the part-time nature of their studies, with which they engage concurrently with their practice roles. They were more likely to relate their educational experience in terms of enjoying study, as with the participant below:

"Hmm. Yeah. I'm enjoying it; I'm enjoying the CAMHS modules... the portfolios. They have to be done; they're quite stressful... but having never written a dissertation, obviously, 'cos I did the diploma, so I'm finding it a bit daunting, but I'm getting there." [P.12].

Qualified/registered practitioners are often re-engaging with education processes after significant periods of time without experience of study. There are support systems available to explicitly assist individuals to re-engage with study, introducing new technology and, as the participant recognised, gain insight into learning styles.

"I mean I'm going back 20-odd years... I think they were all limited sources of information. I think now, you are encouraged to look at a wide range and a breadth of information to see what other people have to say as well, so I think that's given me the ability to look at things from a more balanced point of view, so you're not biased towards one source. You kind of look at it more from a more broader spectrum and you have to evidence everything; you can't just say something unless it's supported by somebody else. 'Cos I've done assignments and they've said 'Well you haven't got the references that agree with that' but you need to evidence it with... or support it as suggested by so and so." [P.9]

The final example of this category, below, illustrates that the value of specialist knowledge, skills and clinical experience, in addition to being of value whilst students are on placement, may also be incorporated more formally into university-based educational programmes:

"and [I] was an advanced or specialist practitioner with the psychosis team and I'd done the psycho-social interventions course at [City named] Uni and those kind of things, so I was talking about that to a lot of the other staff and trying to get them up to speed with recovery and the concept of recovery for people with psychosis. So there was an element of training still in the job that I was doing and an opportunity came for a part time lecturer at [City named] University to teach on their PSI course and the Trust were obliging and allowed me to go two days a week to [city] to teach, so I was still doing my clinical work, still doing the... and doing the work at [city]." [P.18].

In summary, participants outlined a number of aspects of support within the educational arenas with which they were engaged. Pre-registration participants were more explicit in outlining their engagement with and perceptions of this support. It is important to recognise that, though formalised support systems are important, it is within the implementation of these systems that the actual perception is rooted. Post-qualifying students present with different needs to pre-registration students. They come to their study with more experience and, often, expertise. They also are often re-engaging with study after some time, and technology supporting education develops very quickly. The value of ongoing study and academic development for qualified practitioners is clearly evident in both general terms in developing 'graduate' skills, and specifically in application to practice-related study.

c) Personal Arena

This final subcategory is concerned with aspects of support which emanate from the more intimate, personal life of individuals. Working roles are, by definition, a large part of day-to-day, week-to-week and year-to-year existence. It has also been identified earlier with the category 'previous and concurrent personal experience' how an individual's professional and personal identity and roles are reflexive.

Much personal support is of a very practical nature, in terms of agreeing to organise personal domestic arrangements in order to make the pursuit, sustainment and development of a career in mental health nursing possible when balanced with family and other personal commitments. In the example below, this participant's husband had, historically, worked collaboratively with her to ensure her career in nursing was manageable:

"Home support... Was... My husband's always been really, really keen that I should continue with my career, so he's been really supportive and really supportive in the studying I've done; he's been great with it. He works for himself, so he's had loads of flexibility with the kids and they're all grown up now." [P.15].

As seen within the category 'previous and concurrent personal experience', many mental health nurses, including participants within this study, have family members who are, or have been, mental health nurses. This provides a ready source of advice, particularly for students encountering new situations. The mother of the participant below was a practicing mental health nurse:

"If I was stuck on something like, if there was something that had happened on the ward that I wasn't sure about, like I could ask her..." [P.6].

Given that mental health nursing can involve exposure to distress and emotional situations, family members with experience are also in a good position to offer empathy and support should these factors affect individuals, though there were no specific instances of this reported within the data here.

In terms of more general personal support, the participant below, who had made an important career decision in changing her studies from mental health nursing to the 'adult' field, cited how her family were supportive of the decision she had made:

"Things are just... they are happy to make sure I am doing something that I enjoy." [P.8. Int-2].

This may not always be the case. The participant below, on deciding not to pursue a career in 'general' children's nursing but look for roles within CAMH, found herself working in non-nursing related roles whilst waiting for an opportunity to emerge:

"Much to the dismay of quite a lot of my friends and family, but I just said: it's not the kind of job that I can do without fully loving it and being committed to it, so the months went by." [P.12].

As a historical example, the participant below recalled how her father, a general practitioner doctor, was somewhat disdainful when she decided some 25 or so years ago to move from 'general' nursing to mental health:

"I think it wasn't seen to be a proper job; I think... Nursing seemed to be a proper job. General nursing... dad's a GP, so mental health nursing was a bit of a sideways step, it felt." [P.15].

The final example within this sub-category illustrates that individuals can have supportive relationships in personal social arenas which are not necessarily family/friend-orientated:

"Like, this might sound very silly, ha, ha... I just see being a Christian and being like working as... like, I just rely on God, so like as each day starts I will ask God for help and put my trust in him... so like I pray whenever I am on my way in and stuff and I think just, it's, because God is like something in every part of our life, so, I am dependent upon him in every part of my life." [P.3. Int-2].

In summary, and in concordance with analysis within other categories, it can be seen that the developing professional role of the mental health nurse is not lived out in isolation from other aspects of personal identity. Support from the more personal dimensions of life can be essential to effective engagement with the role of mental health nurse.

Summary

There is an evident interaction between this category and aspects of the other categories, particularly those concerned with previous and concurrent personal and professional experience. The factor which differentiates this category as worthy of remaining separate is the *developmental* emphasis. The particular aspect of support emphasised is that which contributes to the ongoing development of an individual in terms of their role as a mental health nurse. This has been related to in terms of the practice arena, the educational arena and the personal arena. Again, within these three sub-category areas, there is interaction and overlap, such as personal friends can often be professional peers, and any well-functioning system of initial preparation for mental health nurses should see an overlap between the educational and practice arenas by definition.

In terms of the practice arena, the developmental support required by student nurses is evidently qualitatively and quantitatively different from qualified practitioners. Unsurprisingly, students earlier in their programme require more explicit basic support to help orientate them to the mental health role. It should not be assumed, however, that all students at given stages have the same support needs. The precise amount and nature of support may be in a similar 'ball park' but still

individual negotiation and identification of needs assures assumptions are not made. In most cases this does occur, through established protocols and intuitive practice. It is also worth noting that some of the more positive experiences reported by students concern not only the placement formally-acknowledged mentor role, but the whole team. In this sense, a supportive placement culture is as important as a supportive mentor. There is then the process of transition from student role to qualified, registered and accountable mental health nurse. Participants reported some positive and some less positive experiences related to this. Again, specific, negotiated approaches to this 'preceptorship' period seem to foster the more positive outcomes. This brings the discussion to the support processes related to clinical supervision for qualified, registered practitioners. Policies relating to clinical supervision are now embedded within service organisational structures. But still, the more positive aspects of clinical supervision related by participants focus upon negotiation of the agenda for supervision, and an agreement as to who will provide it. The nature of supervision in terms of managing the self and workload relates more to line management supervision, whereas the approach to clinical working with service users is more the true domain of 'clinical' supervision. This distinction becomes more crucial when specific therapeutic modalities such as CBT or systemic family therapy become embedded within an individual's practice, whether this is being drawn upon as part of an eclectic skill base, or becomes the person's approach. Another key aspect of support within the practice arena for qualified nurses is peer support. Participants identified positive contexts relating to the presence of peer support, but also negative experiences when it was less evident.

Turning to the educational arena, pre-registration student nurses were demonstrably more steeped within their ongoing educational experience than were the qualified participants. This is not surprising, since student engagement with education represents their explicit 'day job' on a full-time course (the 50% practice element also has explicit learning outcomes and competencies to attain). The key issue from the analysis here is that, though students identified much positive practice in terms of the support they receive and educational programmes have clearly developed protocols for support, the human facilitation of these processes remains the main perception for the student. Post-qualifying nurses in education are usually engaged within part-time programmes relating to continuing professional development (CPD). They are thus typically engaged with study whilst also juggling work roles and personal lives. They also often engage with educational systems after varying periods of time without study experience. These factors generate potentially different support-related agendas for those in this position. Qualified nurses engaged with CPD studies did report value in and from their engagement. This was both in terms of developing critical graduate skills, and being able to focus in an academic and theoretical sense upon areas of specific interest within their practice roles.

The final sub-category of the personal support arena speaks for itself in terms of importance. Without such support, it would have been difficult, if not impossible, for many to become mental health nurses or to maintain their ongoing professional development. In this sense, participants here represent, by definition, those who are in receipt of an adequate level of personal support.

Having now outlined, defined, presented and illustrated the categories and sub-categories which have emerged from the analysis of interview data, the final section of this chapter draws together this analysis in an overview discussion of the emerging theory as it has been delineated up to this point.

Assembling the Emergent Theory

Each of the categories and associated sub-categories derived from the analysis of the research interviews has now been presented, defined in terms of meaning and scope, and illustrated with representative data from the participant interviews. This section will now draw together and summarise these categories and the interplay between them, in anticipation of further discussion within the following chapter. In drawing this analysis together, and as discussed within chapter three earlier, it is important to identify a 'core category'. The core or central category within a grounded theory study links together the identified categories in a meaningful way with respect to the identified research questions. The core category within this analysis is very evidently 'Establishing Role Congruity: Engaging with the Role of Mental Health Nurse', since the other identified categories are clearly facilitative to the development of role congruity. In this sense, role congruity is seen as the outcome of successful interaction of the categories in action. This inter-relationship of the categories in terms of facilitating 'role congruence' is illustrated diagrammatically in Figure 5:14, below.

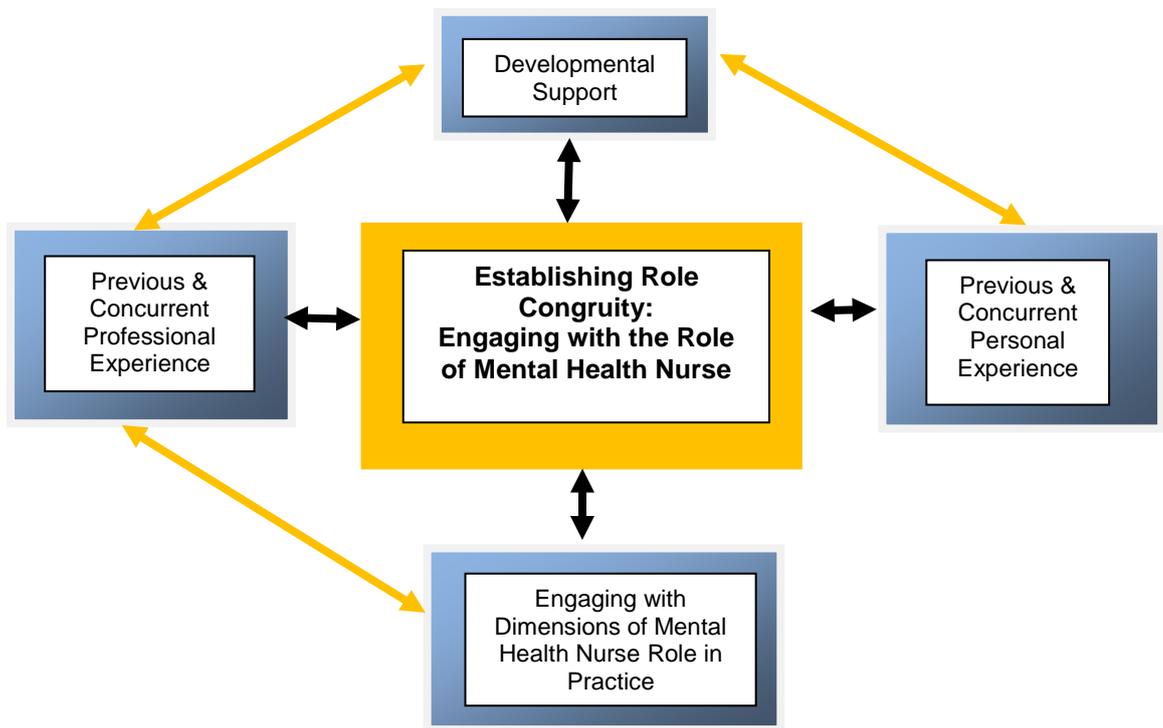


Figure 5.14: The Inter-relationship of Identified Main Categories with the Core Category ‘Establishing Role Congruity’

In accomplishing the tasks and actions encompassed within this core category and its related sub-categories, pre-registration student mental health nurses and qualified, registered mental health nurses must engage with several dimensions, often simultaneously. In the case of pre-registration students, successful engagement with these dimensions fosters the development of role congruity. In 'establishing role congruity', within the sub-categories of 'communicating as a mental health nurse' and 'engaging with people with mental health problems', mental health nurses become fluent and familiar with the language of mental health nursing and settings, and comfortable and confident in engaging with people with mental health problems. The sub-categories of 'evolving perception of mental health nurse role' and 'sense of integration into role of mental health nurse' are concerned with affective/attitudinal aspects with regard to the role, and the degree to which mental health nurses identify with and absorb the role and feel part of the community of mental health nurses.

The category of 'engaging with dimensions of the mental health nurse role in practice' encompasses the day-to-day practice reality of enacting the role of mental health nurse. The specific aspects of role captured within this category encompass the five aspects of; developing a therapeutic skill set, integrating theory and practice, dealing with risk, statutory and legal aspects and leadership/organisation. Student nurses within initial preparation face the task of developing at

least a basic competency within these dimensions. This competency engagement continues through transition from student role to qualified, accountable practitioner and beyond in terms of ongoing professional development, and potentially into specialist roles in particular areas of practice in terms of service user group or therapeutic approach. The three other categories postulated here underpin and influence the core category of 'establishing role congruity' in key ways.

The category of 'previous and concurrent personal experience' encompasses previous personal experience within four key aspects. Individuals often have experience of mental health issues personally, either from their own experience, or that of close family/friends. This lived experience can serve to influence fundamental attitudes and, in turn, personal approaches to people with mental health problems. They also often have prior experience of the mental health nurse role from connection with family and other close personal networks, which can serve to illustrate how people come to integrate personal and professional identities. Previous education and employment experience is also brought to the role of mental health nurse. Some of this is very direct in relevance, but other aspects are concerned with more 'transferable' experience, knowledge and skills, such as previous development of management, organisation or communication skills. All participants within this study also identified how their developing role as a mental health nurse unfolds reflexively with their more global ongoing development as human beings. The inter-linking experience of personal and professional aspects of life is, arguably, at the heart of the development and maintenance of role congruity.

The category of 'previous and concurrent professional experience' incorporates four key aspects. Firstly, both student nurses and qualified nurses must learn to manage the role of mental health nurse within a variety of settings with varied service user groups. Student nurses encounter these different contexts in rapid succession, placement by placement. Qualified nurses, on making the transition from student, then tend gravitate to contexts of practice with which they have greater affinity, thereby maximising role congruity. Second is the importance of role models, the influence of which can encourage individuals to incorporate aspects of practice into their own developing 'approach'. Third is the importance of ongoing learning and professional development. This extends beyond initial pre-registration preparation as a professional requirement for qualified nurses, for whom it may take the form of 'in role' development, training facilitated by employing organisation, or more formal academic continuing professional development. This may involve the pursuit of formal, accredited education and training within a specific therapeutic modality, or remain more 'generalist'. In either case, the importance of developing and maintaining role congruity remains a concurrent issue during career development, including anticipation of future roles.

The final category of 'developmental support' overlaps and interacts substantially with the other categories in influencing the core category of 'Establishing Role Congruity'. The emphasis within this category is upon the developmental aspect, relating directly to the idea of 'establishing role congruity'. Developmental support emanating from practice, education and personal arenas interact together to underpin individual development of approach, whilst establishing and maintaining role congruity. Students need to be supported within their task of becoming a mental health nurse and then through the transitional stage of 'preceptorship'. Once qualified the ongoing need for effective support remains, and includes engagement with clinical supervision and peer support. In educational terms, qualified practitioners often present with particular support needs for their ongoing development.

Summary

This section has presented the categories derived from analysis of the qualitative interviews undertaken with the pre-registration and post-qualifying mental health nurse participants within the study informing this thesis. The categories postulated within the analysis have been presented, defined and illustrated with data quotations from the interview participants. The analysis has been further developed to illustrate how the identified core category of 'Establishing Role Congruity' relates to and is underpinned by the three other categories of 'previous and concurrent personal experience', 'previous and concurrent professional experience' and 'developmental support'. The interaction of these categories and sub-categories has been delineated and discussed in terms of how this interaction contributes to the development and maintenance of role congruity. When aspects of the categories interact in a positive, 'virtuous' way, then role congruity is likely to develop for pre-registration students or be maintained for post-qualifying mental health nurses. When this interaction is problematic, then role discomfort and incongruity is more likely to result.

The next section proceeds to bring together the 'positional mapping' element of situational analysis with the theoretical model derived from analysis to further elaborate findings.

Mapping Key Positions Within the Analysis

This chapter began with a presentation of the issues identified during situational mapping of the context of enquiry. Three broad areas were identified within that analysis, those of influence of structure, discourse-related issues and professional role. Earlier discussion at the outset of this chapter identified how the way in which services are structured frames the day-to-day working contexts for mental health nurses. This is echoed by the analysis of the social worlds within the arena of the mental health practice setting in terms of the ways in which the different social worlds overlap and interact in order to enable structures to function. In terms of how mental health nurses within this study engage with their roles, two key positional areas can be identified. The first is concerned with the kinds of therapeutic interactions which mental health nurses can, or are required to, offer in specific practice contexts. The second is concerned with discourse framing and underpinning interactions. Both are now considered in turn.

Positions Relating to Therapeutic Interactions

Situational mapping at the outset of this chapter identified that a number of factors influence the precise role(s) which mental health nurses have in relation to contact with service users. Key identified factors are:

- Service users' presenting and/or ongoing problems.
- Degree of crisis/risk.
- The nature of the care environment (in-patient, community/out-patient setting).
- The time available for contact.
- The duration of contact (short-term cross-sectional case involvement, or longer-term case-work).
- Level of competency within specific therapeutic approaches.
- Degree of autonomy/legitimacy within systems to adopt given approaches.

The NMC requirements for initial registration, in effect the outcomes to be achieved by the end of the three-year pre-registration education programme for mental health nurses, represent the level of knowledge and competency which can be expected for newly-qualified mental health nurses. These competencies represent a very generic baseline starting point to build upon with ongoing experience and development following a transitional period of preceptorship.

These fundamental baseline values and competencies can be assumed to be present in all mental health nurses at the point of registration. In terms of ongoing development, mental health nurses need to build upon this baseline to develop particular knowledge and skill sets relating to the

context within which they practice in a day-to-day sense. In terms of particular skill sets, Table 5:15 below summarises these in relation to specific contexts.

Table 5.15: Mental Health Nursing Skills Applicable to Specific Contexts

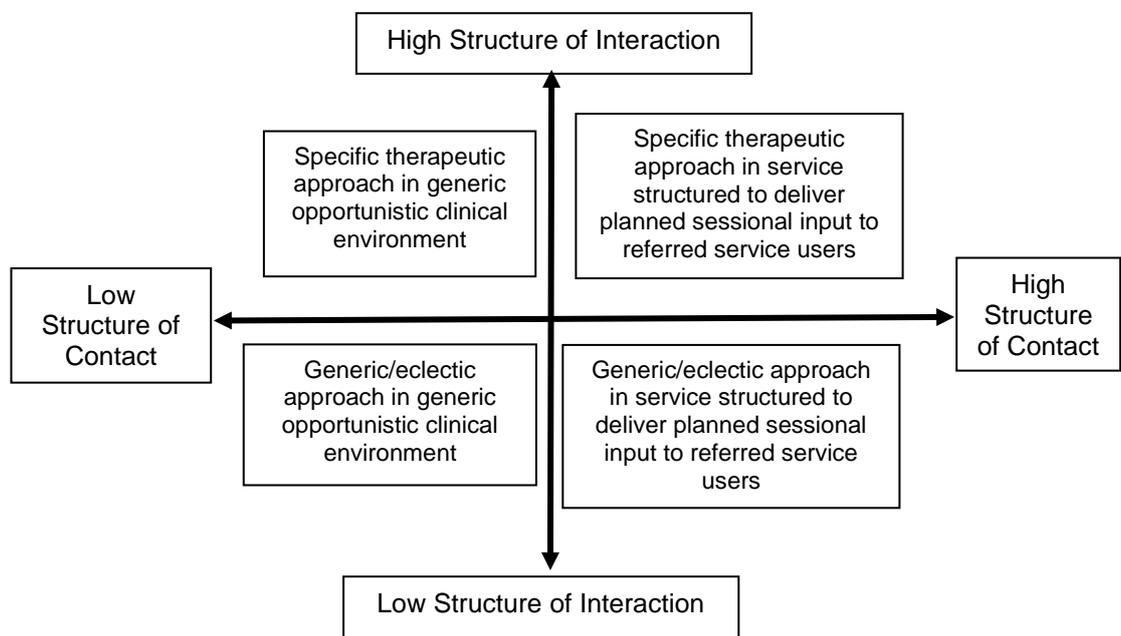
		Service Structure/Organisation			
		1. Acute Crisis Provision	2. Generic non-crisis Provision	3. Specific Disorders Provision	4. Specific Therapeutic Interventions Provision
Service User Presenting Issues	A. Crisis	Skills Crisis & Risk Assessment and management. Support. Generic facilitative skills. Management of challenging behaviour.	N/A	Skills Crisis & Risk assessment and management in specific presentations. e.g: Addiction, Psychosis, Anxiety, Depression, Confusion, Disorientation.	Skills Recognition and assessment of crisis for appropriate referral to crisis services.
	B. Specific Disorders Non Crisis	N/A	Skills Generic. Assessment. Support. Education. Counselling facilitating problem solving.	Skills Generic with added degree of expertise to disorders. e.g. Motivational Interviewing for addiction. Ongoing supportive-educative approaches.	Skills Matched case work to specialist intervention. Typically more developed competency within particular approaches. e.g. CBT, Family Therapy.
	C. Age Range Related	As A.1	Skills Generic within age range.	As B.3	As B4.
	D. Forensic Services.	Generic plus: Specific Risk management; Environment, Individual. Knowledge of legal issues and processes relating to mentally disordered offenders. Managing of challenging behaviour in forensic context.			

The knowledge and skill sets relating to these contexts can be summarised in three broad clusters. The first represents a broad and generic/eclectic knowledge and skill base in responding to a range of presenting issues, for example a community mental health nurse who deals with people with psychosis, and also others with non-psychotic issues such as anxiety or depression. The second

represents a mix of knowledge and skills pertaining to a specific service user group. Competency may still be represented by a mix of skills, but applied to particular presenting issues such as addiction, or interventions in psychosis. Mental health nurses within these two contexts may develop specific skill sets around therapeutic interventions, but to a limited extent as 'skills for practice'. The final knowledge and skill set represents more advanced specialist knowledge and competency in the delivery of a defined, structured therapeutic intervention such as CBT or family therapy, within the context of a service which is primarily designated by the therapeutic intervention on offer. In this sense, the first two scenarios are, in effect, matching the broad skill-mix/set within the service to match a broad range of presenting need(s) of the service user. The final scenario invites referral of service users on the basis of defined presenting issues which the service is configured to address.

Considering service user presenting issues together with configuration of services and required skill sets serves to underline the way in which the organisation of services influences the roles of mental health nurses. As a further means of considering, Figure 5:16 below combines the two dimensions of 'structure of interaction' with 'structure of contact' in terms of mental health nurses working with service users.

Figure 5.16: Structure of Intervention considered with Structure of Contact



In terms of needs of service users and appropriate skill mix of staff/workforce, the top-left quadrant represents a somewhat wasteful scenario if a high degree of expertise in a particular therapeutic approach such as CBT is deployed in a context where there is low structure of contact. This might make more sense in the context of a setting with a particular milieu where all staff share in

particular principles of an approach. A low structure of both contact and intervention typifies a context where a generic/eclectic practitioner is working within a clinical environment where interaction with service users is opportunistic. Low structure of intervention with high structure of contact typifies a context where a generic/eclectic practitioner works within a service with structured, session-based contact with service users is the norm, such as a generic community psychiatric nurse dealing with working age adults. High structure of both interaction and contact is typified by a specific therapeutic approach such as CBT within an agreed 'course' of intervention.

These two dimensions of structure lie upon dimensional ranges, rather than the complete extremes. An example of this could be in the context of an admission unit where a 'key worker' system provides some protected time with individual service users for 'one-to-one' work (structure of contact). This work could be of a generic nature, or might be more structured to an intervention, such as a CBT-related focus around a specific issue.

Discourse Framing and Underpinning Therapeutic Interactions

There are two intertwined discourse-related issues underpinning these considerations of therapeutic interactions. The first is evident within the way in which service users are categorised in terms of presenting problems and issues. The predominance of medical discourse in the form of psychiatry and the DSM system of applying diagnosis is such that it has a fundamental influence with regard to the way in which services are configured. This includes the expectation that appropriate 'care pathways' are constructed in relation to specific presenting problems or disorders.

The second discourse-related issue concerns the way in which evidence underpinning practice is considered and valued. Care pathways for specific presenting issues such as depression are considered valid only to the extent that the interventions within these pathways have demonstrated efficacy in addressing those specific presenting issues. The demonstration of evidence of efficacy, in turn, is framed by a discourse of 'hard science' in terms of what is considered to be credible evidence, with the random controlled trial representing the gold standard.

Mental health nurses have always worked within systems dominated by prevailing psychiatric discourse, as services have always been organised around principles driven by it. As the discourse of evidence becomes more prevalent in terms of expectations of what therapeutic interventions are required within services to respond to particular identified disorders, a central dilemma presents in terms of what degree mental health nurses develop expertise within these approaches, and how this expertise fits with mental health nursing roles in the sense of congruity.

Summary: Key Positions

Consideration of the positions implicit within the structure of services within which mental health nurses practice serves to underline the influence of key discourses. In some ways, the positions

taken within structures are passive in the sense that these discourses pervade the service infrastructure and to practice within them implies participation in the related discursive practices. Psychiatric discourse, rooted in medicine, has continued influence in terms of how services are structured to meet service user needs. This, in turn, influences the specific roles which mental health nurses enact with service users, including the nature of therapeutic interactions and interventions. This influences the direction of development of specific skill sets which build upon the baseline competencies established upon initial professional registration.

For mental health nurses, the possible directions for development of therapeutic skills would appear to lie in remaining eclectic and generic in terms of skill set, being able to function in a variety of contexts with a variety of service user presenting problems, or to gravitate to a particular specialist avenue. Within the prospect of specialisation, the available options are to become specialist with a particular presenting mental health problem or related set of problems, or to become specialist within a particular therapeutic approach. In the case of the former, skills are still drawn from an eclectic range, but more defined and focussed. The latter scenario involves commitment to a particular therapeutic approach involving a very defined skill set employed in defined ways with defined presenting problems.

Finally, accepting the credibility of particular approaches implies a degree of acceptance of discourses underpinning them in terms of evidence for their efficacy, the specific procedures employed and the way in which service user presenting problems are framed.

Conclusion

This chapter has outlined and summarised in detail the findings which have emerged from the research study informing this thesis. The elements of situational analysis employed have served to illustrate and help make explicit the key important features present within the research situation.

Situational mapping has illustrated and underlined how the structural organisation of mental health services is related to the discourse of medicine in the form of psychiatry in that it orchestrates the way in which people with mental health problems are diagnosed and categorised. Importantly, this includes significant overlapping influence in the judgement of which therapeutic approaches constitute credible, efficacious interventions for given presenting conditions or problems. In turn, this way in which services are structured and intervention approaches sanctioned, accepted and developed has, historically, and continues to have a direct and significant influence upon the required role(s) of mental health nurses.

The mapping of social worlds within the two identified arenas of mental health practice and higher education institutions (HEIs) has served to make explicit the complexity of interaction between

social worlds involved within and between the two arenas. Exploration of the social worlds interacting within the mental health practice arena illuminates the overlap between the social world of mental health nursing and those of other disciplines. With established disciplines such as psychiatry and psychology, this overlap has existed and been managed for many years. However, newer social worlds are emergent with the development and professionalisation of therapeutic modalities such as CBT, which can present a dilemma to mental health nurses in terms of what social world represents their 'referent group'. Similarly, examination of the social worlds interacting within the HEI arena reveals the complexity of interaction between the social worlds of mental health nurse academics and academics from other health-related disciplines. The mental health practice arena is itself present in the HEI arena, illustrating the overlap and inter-connection of the two arenas. Given that the HEI arena encompasses both pre-registration preparation and ongoing continuing professional development for mental health nurses, the tensions and dilemmas identified above within the mental health arena become manifest in the educational provision from HEIs.

The grounded theory model 'Establishing Role Congruity', derived from analysis of the interviews conducted during this research, captures the processes influencing the way in which pre-registration students initially engage with the role of the mental health nurse and also captures the way in which qualified/registered mental health nurses continue this engagement as their career narratives unfold. The application of situational analysis within this research serves to contextualise the processes captured within the 'Establishing Role Congruity' model. The final element of situational analysis mapping, that of positional mapping, again serves to make explicit the influence of medical discourse by considering positions which mental health nurses occupy from the perspectives of service structure, therapeutic interactions and the way in which discourse frames and underpins therapeutic interactions.

Mental health nurses at the point of registration have a basic functional set of skills and competencies for practice. As they consolidate through a transitional period from student to registered practitioner, the pathways for ongoing development are: to retain an eclectic/generic skill base and focus or to move towards a specialist focus. The notion of specialism presents two further possibilities, to focus upon a given service user group/set of issues, or to focus upon a particular therapeutic intervention approach.

The aim of this research was to explore how 'role congruency' is achieved in the case of pre-registration mental health nursing students and maintained in the case of registered mental health nurses. Chapter six goes on to more critically explore and address the development and maintenance of role congruity as the research aim and focus, identifying the key issues for mental health nursing as a discipline within contemporary mental health services and linking these findings with literature explored in chapter two.

Chapter 6: Further Discussion: Contribution to Professional knowledge

Introduction

It is useful at this point to re-state the research questions for the study informing this thesis:

- 1) How do student mental health nurses develop role congruity within their pre-registration preparation for practice?
- 2) How do mental health nurses maintain role congruity within their ongoing professional practice?

The concept of role congruity is central, and is defined within the context of this study as:

"A sense of having an agreed, consistent role (or aspects of role), appropriate to given context or contexts of practice and, conversely, an absence of role conflict."

Role congruity is further defined as a balance between the three aspects of role adequacy, role legitimacy and role support. A successful balance between these elements from this 'sensitising concept', as discussed in chapter three as part of the conceptual framework for this research, can be seen as the outcome of successful engagement with the role of mental health nurse.

Having presented the grounded theory model derived from analysis of qualitative interview data in the previous chapter, in this chapter I will present a consideration of this model in terms of how it illuminates the research aim and question set out on commencement of the research informing this thesis.

Firstly, the 'Establishing Role Congruity' model developed from my findings is discussed and illustrated, with key issues arising from the consideration summarised. Consideration then turns to the influence of discourse and structure of services as illuminated by situational analysis, including an outline of developmental pathway prospects for mental health nurses from their initial pre-registration preparation through to the prospective roles which they may occupy within clinical services for mental health service users. Discussion then explicitly addresses the development and maintenance of 'role congruity', the stated aim and focus of this thesis. This takes the form of a novel model of 'Role Congruity Alignment', where 'Establishing Role Congruity' is placed in the context of the factors of role adequacy, role legitimacy, role support and ultimately role congruity.

The importance of social worlds and arenas, the second key element made explicit through the employment of situational analysis, is then discussed, before finally examining the relationship

between mental health nursing as a professional discipline, and the way in which evidence-based therapeutic approaches may be incorporated into practice.

In addressing these issues, case examples drawn from the participants of the research informing this thesis are used as exemplars. I have selected these four particular participants as they represent the range of positions and developmental processes captured within the models. Table 6:1 below summarises the demographic characteristics of the specific participants chosen as illustrative examples throughout this chapter. Finally, the key issues for the development and maintenance of professional role congruity in mental health nursing are summarised.

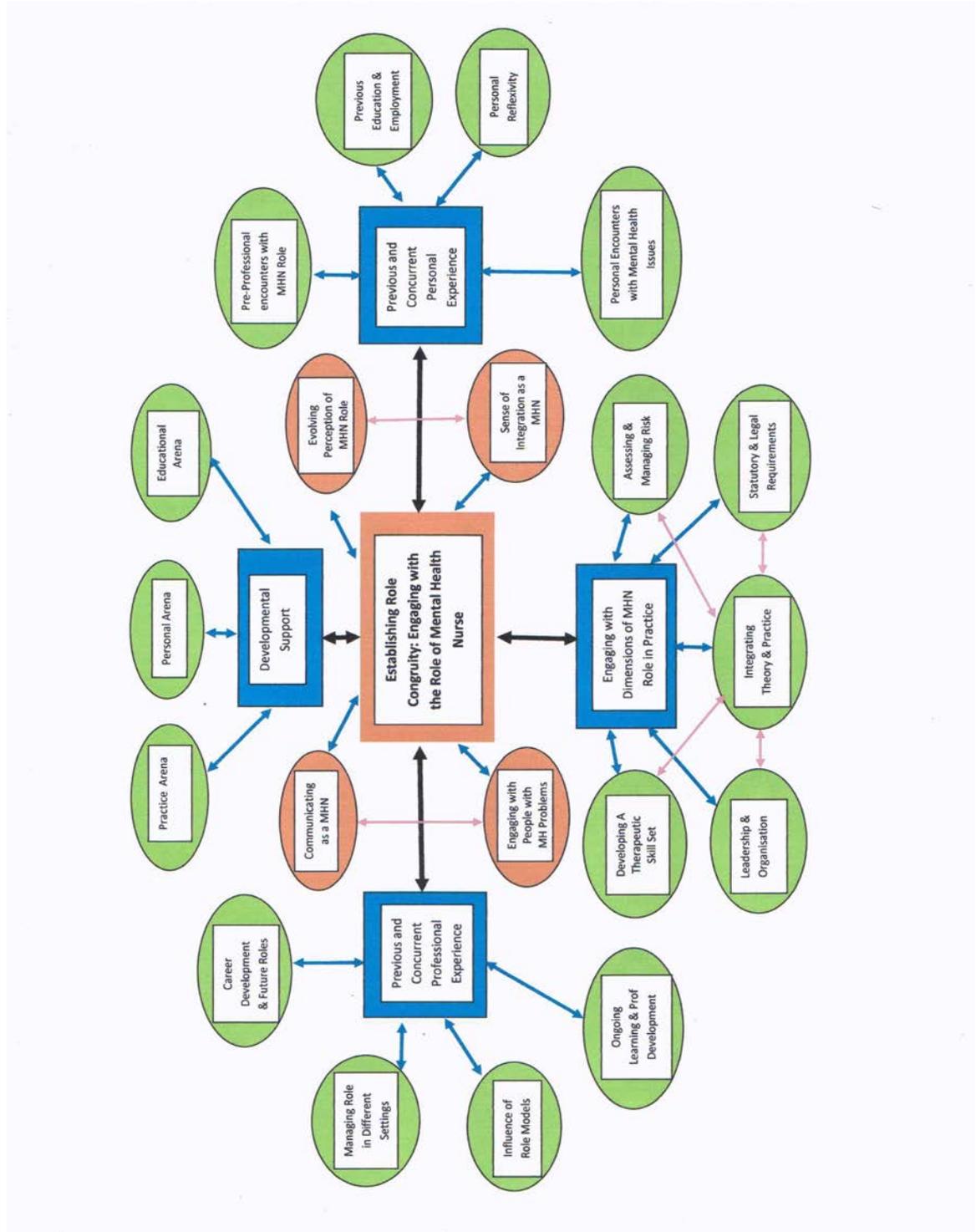
Table 6.1: Demographics for Illustrative Participants

Participant	Gender	Age	Brief Relevant Biographical Details
4	M	30	Pre-Reg: Sept 10 Cohort (2.5 years into course). Worked in motor trade prior to course. 2nd Interview 1 year post qualifying.
11	F	34	Post Qual: 5 years Qualified (2009). Former Army (not Nursing). Crisis team practice context (3rd Role).
13	F	50	Initially LD. Converted to RMN. Vast experience as ward/senior manager. Completing PhD at time of interview.
17	M	55	HEI role teaching CBT and other therapeutic skills. 30 + years' experience in practice, the latter 10 as an Accredited CBT practitioner (Master's level).

Establishing Role Congruity in Action

Picking up from the point at which the emergent grounded theory was assembled in the previous chapter, the model which emerged is now summarised, with reference to research participant exemplars. As individual mental health nurses develop their approach to professional role, several key factors converge and contribute to the process. Figure 6:2 below represents my grounded theory model 'Establishing Role Congruity' with sub-categories expanded, illustrating the interplay between the elements of the model.

Figure 6.2: Expanded Diagram of 'Establishing Role Congruity'



Working from the centre of this diagram, where the core category is placed, outwards, four foundational processes are at play. Firstly, the individual needs to learn to communicate as a mental health nurse. My findings indicate that this ability develops in relation to other mental health nurses, other mental health professionals, and with service users. Becoming fluent in the specialist language of mental health settings and mental health nursing was a central task for student nurse

participants from the outset, where participant 4 was when first interviewed, and participants 11, 13 and 17 recalled within their narratives. Importantly, this included engaging with an understanding of the diagnostic categories used within the organisational system and the associated language driven, as discussed in chapter two, by the DSM (APA, 2013). It also included becoming comfortable with communicating 'in role', in an experiential sense. This entailed the realisation that others (service users, other nurses and other professionals) are perceiving given communication from the role of mental health nurse, in a reflexive sense.

The second foundational process is concerned with engaging with people with mental health problems. In the first instance, this constituted low level desensitising social interactions in terms of becoming familiar with dealing with this stigmatised group. My data shows that the complexity and purposeful nature of these interactions increased over time with experience, understanding and engagement with therapeutic intent. For student nurses in my study, such as participant 4 particularly, in their first encounters with service users, the task of engaging with a new role within new, unfamiliar environments was a significant one. This relates to the interactionist process of secondary socialisation, outlined in chapter two (Berger & Luckman, 1967). Though this is inevitable, there are times when the boundaries delineating the nature of student involvement with service users are unclear. Another issue evident within participant narratives is coming to terms, as students, with the distress which mental health service users often present, in terms of managing the impact of this upon the self. The qualified participants (11, 13 & 17) clearly represent more specific and purposeful engagement and interaction with service users. Participant 17, in his previous role within a CBT service, evidently engaged with very structured interaction, within a defined approach and informed by clinical supervision, to foster 'fidelity' to the approach.

The third and fourth foundational processes are interwoven. The individual's evolving perception of the role of the mental health nurse develops together with a sense of integration within the role, and ultimately the profession of mental health nursing. Participant 4, interviewed as a third-year student and then again one year after qualifying, was able to articulate his journey in terms of evolving perception and integration into the role of mental health nurse. The qualified participants could all recount journeys through different settings of practice within their career development, and reflected upon their own perceptions of the changing role of the mental health nurse in their direct experience. Chapter two outlined the way in which mental health services have evolved over the longer term, more recently, and the current direction of policy drivers, the most recent of which is represented by the 'Five year forward view' (DOH, 2014). Analysis here has shown that the evolution of clinical services and the way in which mental health care is delivered often requires nurses to work differently, and this can manifest in terms of the need for new knowledge required

to work with a particular service user group, new skill sets relating to particular therapeutic approaches, or a mixture of both.

This process relates interactively with the other four categories of: engaging with dimensions of the mental health role in practice; previous and concurrent professional experience; previous and concurrent personal experience; and developmental support.

My findings indicate that in engaging with the role in practice, the development of a therapeutic skill set is an important task for students, and an important ongoing task for all mental health nurses, some of whom may elect or be required to develop very specific skill sets relating to specific roles. This relates closely, but not exclusively, to the task of integrating theory and practice. It is here that the notion of evidence underpinning practice lies in terms of demonstrating effectiveness, with the integration of theory and practice applicable to all dimensions of the mental health nursing role in practice, indeed as required within the nursing professional code (NMC, 2015a). Each of the exemplar participants presents a different picture in terms of skill set. Participant 4 acknowledged that he was at a fairly generic, neophyte stage even one year after qualifying. Participant 13 had taken her generic skill set through a variety of practice settings within her career journey. Participant 17 had clearly developed a high degree of very specific skills in relation to CBT.

A further explicit aspect of the mental health nursing role is that of dealing with risk as a day-to-day concept and issue presenting in practice. Chapter two summarised the development of this concept of risk, culminating in national policy relating to risk management (DOH, 2007), which manifests in specific policy for local services and individual practitioners. My findings indicate that students are exposed to and must engage with this concept from early in practice settings where it is a very explicit part of organisational policy. Participants did, however, discern the often subjective and relative nature of the concept of risk as they experienced different practice environments and individual practitioners and their approach to risk, with some being more defensive in practice than others. The concept of risk relates closely but again not exclusively to the statutory and legal aspects of the mental health nurse role (Williamson & Lawton-Smith, 2013), which often become explicit in memorable critical incidents within practice. These latter two aspects are particularly explicit within my study data in terms of the role transition to qualified, registered practitioner in relation to responsibility and accountability. Though all participants were required to engage with the notion of risk in relation to their practice, participant 11 provided a particularly acute consideration of risk in her day-to-day work with a crisis team. Interestingly, though participants were clearly affected by some reported issues of management of presenting aggression and distress, they did not express any fundamental conflict or incongruence in terms of their roles as agents of social control. Arguably, this relates to the structural expectation of mental

health nursing roles in this respect, and the absence of alternative practical strategies to address such presenting behaviour and risk.

A certain level of leadership and organisational responsibility is expected and anticipated as part of the role of registered mental health nurse, and is explicit in NMC competency requirements for newly-qualified registrants (NMC, 2010). Rehearsal for this role and development of personal styles or 'approaches' is evident within my study data. However, though some individuals may demonstrate a desire for a more influential/senior leadership and management role within defined hierarchal structures, others had no affinity for such roles, citing reduction in contact with the more direct practice arena as a central reason for this. Thus, engaging with dimensions of the mental health nursing role in practice involves developing a therapeutic skill set, integrating theory and practice and becoming familiar with the consideration of risk. It also presents the requirement to engage with the required leadership and organisational element of the role. At the point of qualification, new registrants can be considered to have a foundation of generic skills for safe practice. There remains an ongoing requirement and expectation for the further consolidation and development of therapeutic skills (NMC, 2015b). The key issue here is concerned with what direction this ongoing development may take.

Previous and concurrent professional experience of participants informed and supported the engagement with dimensions of role in practice in a cumulative sense, drawing upon the influence of role models, ongoing learning and professional development. Previous and concurrent personal experience was also drawn upon within this process. The experiential impact of mental health issues manifesting within the self and significant others, and the attendant knowledge it provides, bring the potential for enhanced empathy with service user groups. This also includes a direct experiential realisation of issues such as the impact of stigmatisation of those with mental health problems/issues (Scambler, 2009). Addressing the issue of stigma was not, however, a component of the formal roles or remit of any of the research participants here, though some indicated they did challenge issues of stigmatisation within their personal lives and networks as part of 'personal reflexivity'.

All of the processes identified within my model for 'Establishing Role Congruity' are underpinned with developmental support from the personal, practice and educational arenas. The practice arena, importantly, also incorporates clinical supervision relating to individual practice.

For student nurses, in their initial period of preparation, a three-year time period is allocated for this developmental process. My findings highlight the point of transition from the role of student to that of registered nurse, where the process outlined above becomes resurgent in a steep, applied

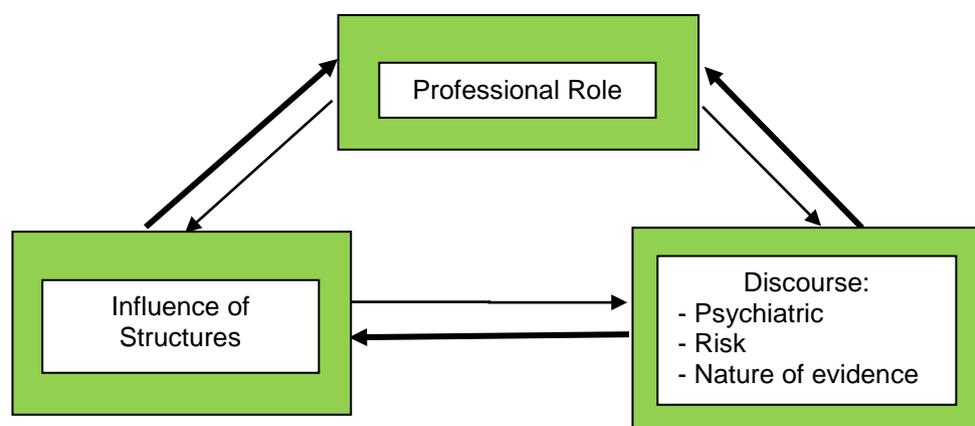
learning curve. The process then continues through the working lives and career trajectories of individual mental health nurses, in the spirit of ongoing secondary socialisation (Berger & Luckman, 1967), which is never total, and never complete.

This section has summarised the processes inherent within the core social process of 'Establishing Role Congruity', the grounded theory model which emerged from analysis of the qualitative data within my study. Attention now turns to the contextual dynamics identified within the situational analysis aspect of the study.

Situational Analysis: The Influence of Discourse and Structures

The first component of situational analysis, situational mapping, illustrated interplay between the three elements of discourse, structures and professional role. This is expressed diagrammatically in Figure 6.3 below.

Figure 6.3: Discourse, Structure and Professional Role

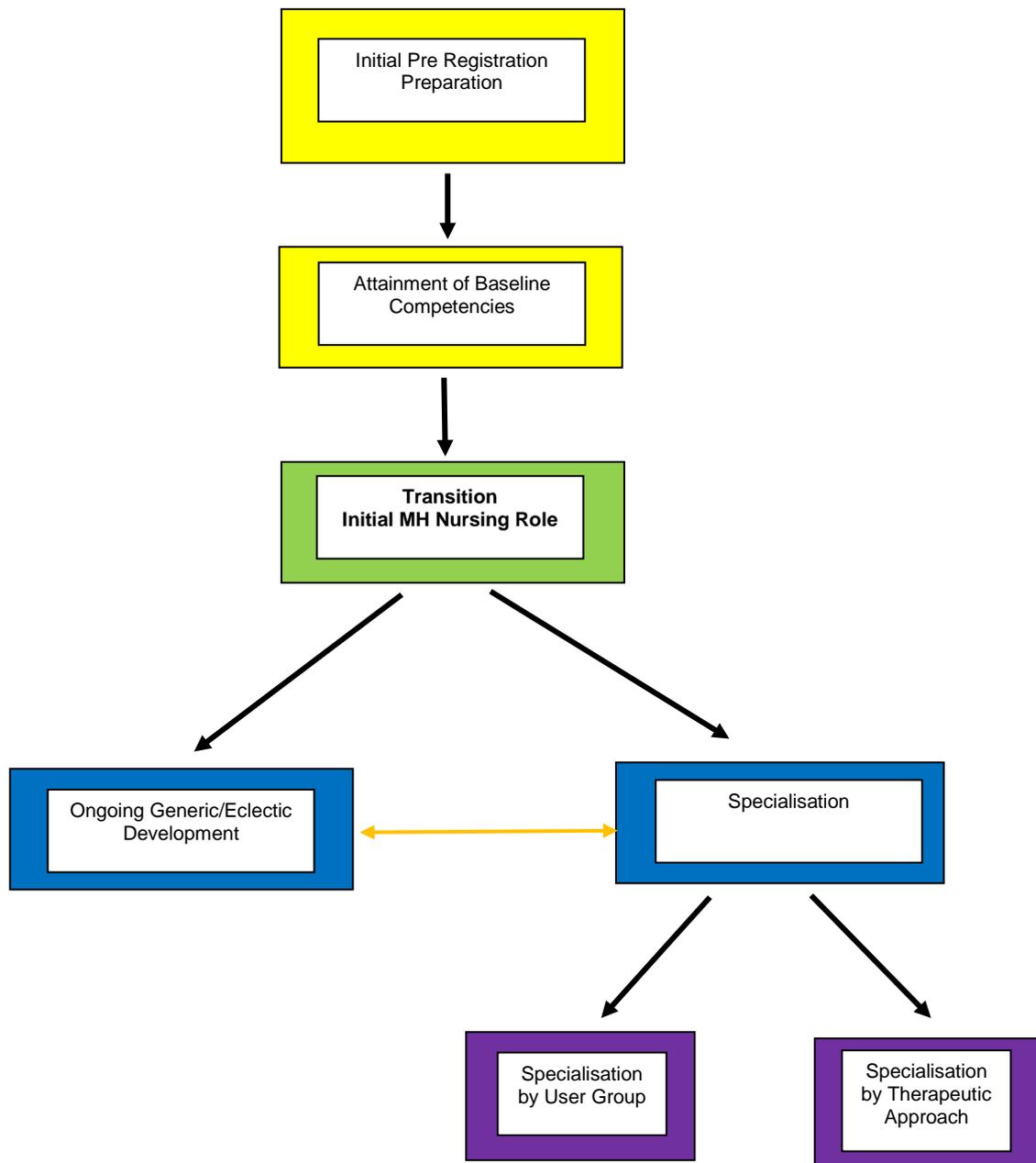


The weight of the arrowed lines represents the suggested degree of relative influence between these three elements based upon my analysis. It is evident from my analysis that the way in which services are structured strongly affects the required role of mental health nurses in practice. It is also evident, in turn, that the structuring of services is heavily influenced by medical discourse in the form of psychiatry, which drives the fundamental process of categorising people with mental health-related problems. Structures also include the relative position and functioning of mental health nurses within the wider multi-professional teams working within services, with clear understanding of respective roles within such teams being important for effective team working (Onyet, 2009). The three elements captured here reflect the sociological consideration of the

relationship between structure and action (Bauman, 1990). For the mental health nurses within my study, interaction between and within these three elements defines and dictates *where* and *with whom* they engage in practice.

The third element of situational analysis, positional mapping, identified specific positions within which mental health nurses were deployed relating to the structure of mental health services. Based on this analysis, Figure 6:4 below captures the potential progression and development pathways for mental health nurses from initial pre-registration preparation, through transition to the status of registered nurse and the possible initial clinical practice settings to which they may gravitate.

Figure 6.4: Initial Career Development Trajectory for Mental Health Nursing



It is useful to illustrate these possible trajectories by drawing upon exemplar journeys from research participants. Participant 4 was first interviewed as a third-year student nurse. At that time he was able to describe his journey up until that point as moving toward attainment of the required baseline competencies. He was re-interviewed at one year post-qualifying, at the point where he was undertaking his mentorship study module. At this point he was able to provide an account of his transition to his initial post-qualifying role. He reported perceiving less than satisfactory initial support in this process within his employing Trust, though took steps to address this by negotiating alternative clinical supervision arrangements. His first substantive role as a qualified nurse was within a residential dementia care setting, indicating the beginnings of specialisation by service user group in terms of Figure 6:4, though at the point of re-interview he had not consolidated this with any further pursuit of formal educational knowledge/skills in that area. He reported, however, consolidating and building upon his baseline competency whilst in practice.

Participant 17 described a longer career trajectory and narrative. This had begun with the process of initial preparation and transition, followed by being deployed sequentially within a variety of care contexts at a time when this was typical practice. At this stage, he could be seen to be in a generic/eclectic phase of development. He then sought out a role in the specialist setting of working with people with addiction problems, a specialisation by service user group. This was underpinned with 'in-house' training and education within that specialist setting. Within this context, he became interested in the therapeutic modality of cognitive behavioural therapy. He pursued accredited status and clinical/academic qualifications within this modality, thus specialising by therapeutic approach. He went on to work within an adult IAPT service, mainly with people with depression, before securing a role within an HE setting training others in the modality of CBT.

Participant 11 presents a further example. She related her initial period of preparation and transition to practice, through to her initial post-qualifying roles. Her role upon interview was working with a crisis assessment team. In terms of Figure 6:4 this would represent a more generic/eclectic role, since crisis services respond to a wide range of presenting issues, drawing upon a range of knowledge and skills, with risk assessment being very much to the fore.

Prior to the last 15 to 20 years, when services became increasingly differentiated by service user groups and therapeutic approaches in terms of the way in which they are organised (Caliminus, 2013), the early experience of participant 17 of being periodically re-deployed to contrasting care contexts was quite usual. Participant 13, with a long career history and trajectory, summarised the intent of this strategy at the time as *'being able to come off the bench and play in any position'*. As specific knowledge and expertise has accrued in therapeutic approaches for particular conditions, it

is logical that services become organised accordingly. This serves to further demonstrate the way in which mental health nursing roles are shaped and influenced by evolving practice contexts.

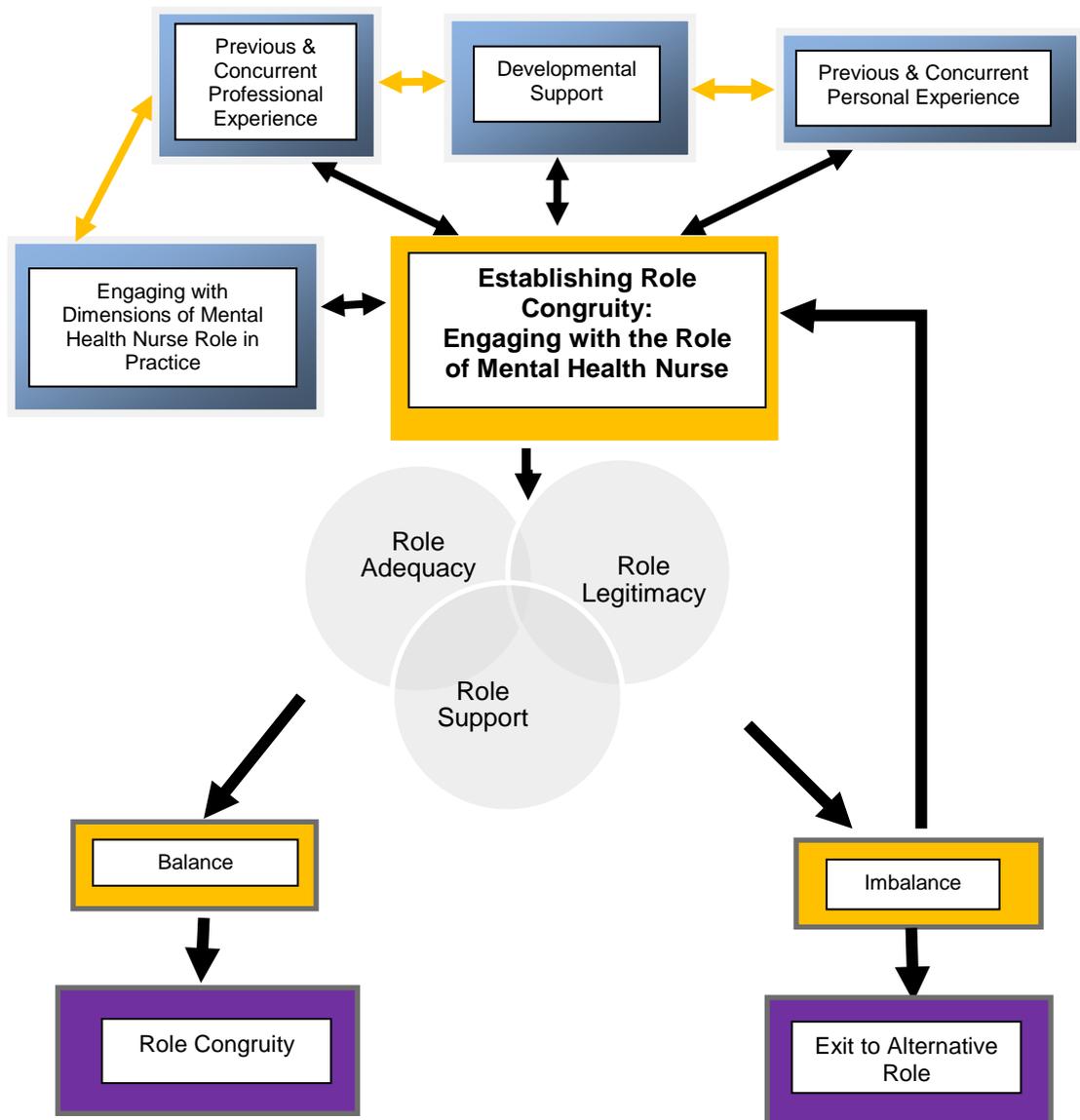
This section has summarised the way in which situational analysis has illuminated the practice context of my research participants in terms of the structures within which they practice as mental health nurses. The following section builds upon the model of 'Establishing Role Congruity' in addressing the way in which participants strove to initially attain, and then maintain, role congruity within these practice contexts.

Role Congruity Alignment

In addressing the aim of establishing how mental health nurses initially attain and subsequently maintain professional role congruity, a novel model of 'Role Congruity Alignment' is now outlined. The model of 'Establishing Role Congruity' is placed within the context the contribution this process makes to the establishment of role congruity, which is in turn defined here in terms of a functional balance between the elements of role adequacy, role legitimacy and role support (Machin & Stevenson, 1997).

Figure 6:5 below presents this model in diagrammatical form. This model demonstrates that, when the development of individual approaches is favourable, then a balance between role adequacy, legitimacy and support is attained, resulting in role congruity. Problems can arise in this process when the balance of one or more of these factors is affected with a deficiency. The factors and processes described within 'Establishing Role congruity' can then enact to address imbalances, moving the individual back toward role congruity.

Figure 6.5: Role Congruity Alignment for Mental Health Nursing



The task for student nurses, through the processes outlined in 'Establishing Role Congruity', is to attain a balance between the elements of role adequacy, role legitimacy and role support. During the three-year preparation time, role adequacy in terms of knowledge and skills is developed and assessed in both academic and practice settings. Students must also gain an ongoing and developing sense of role legitimacy appropriate to given time points within the three years (i.e. first, second and third years). Sources of role support emanate from both academic and clinical practice placement processes and individuals. The balance students attain on completion of their pre-registration programme needs to be requisite to their initial practice as a registered nurse, and is

further developed through a transitional phase of preceptorship. Once this transition is made, role congruity alignment becomes an ongoing process.

Where an imbalance relates to role adequacy, there will be a need to focus upon dimensions of the mental health role in practice, addressing the development of specific knowledge and competency within a given practice context. Where an imbalance is concerned with role legitimacy, then the issues may be more fundamental, requiring examination the level of the employing organisation, or even at the level of the whole profession. An example of this can be seen in the development of roles for nurses as non-medical prescribers, approved clinicians and responsible clinicians. Even then, individual practitioners may not be comfortable with the legitimacy of some specific areas of practice. Where an imbalance is concerned with role support, individuals might seek alternative sources of support and/or organisations might engender specific support mechanisms.

I propose that successful re-alignment results in the re-attainment of role congruity. Where re-alignment is not successful and imbalances persist, then individuals may need to find alternative roles. This may entail moving to a different context of practice, or at an extreme, leaving the profession altogether, including the prospect of becoming a 'therapist' rather than a nurse. As in the outline of the 'Establishing Role Congruity' model earlier, the process involved in 'Role Congruity Alignment' can also be illustrated by drawing upon participant examples (see Table 6:1).

Participant 4, a third-year student when first interviewed, demonstrated an ongoing consolidation of development of the balance between role adequacy, legitimacy and support appropriate to that point in his educational programme, as did other student nurses at various phases of development. He recounted, as did other students, feeling 'lost' in the very early stages of his pre-registration programme. In terms of role congruity alignment, this represents the very beginning of developing aspects of role adequacy (low knowledge and skills) and legitimacy (fundamentally engaging with the mental health nurse role). It is thus the aspect of role support which is important at this early stage. This support is manifest from both practice and educational settings, and is very evident within the study data, both in terms of presence and absence. Importantly, some student participants were more pro-active than others in seeking support, with more effective mentor figures, personal tutors and others in support roles being aware of this and responding accordingly. During his transition to qualified status and initial role in practice, participant 4 reported perceiving less than satisfactory role support. He responded to this imbalance by actively seeking more effective support, thus redressing the balance in role congruity.

In his early experiences, participant 17 maintained a balance between role adequacy, legitimacy and support within the various contexts of care to which he was allocated. This was principally

done by developing adequacy (knowledge and skills) and legitimacy (boundaries of practice) within those settings, whilst being supported by colleagues and peers, and drawing upon previous adequacy and legitimacy in the form of experience. On moving to an area dealing with the specific, specialist service user group of people with addiction problems, he developed specific aspects of role adequacy from in-house training and experience, together with gathering appropriate specialist knowledge through reading and study. This led to a greater sense of legitimacy, with appropriate support being available in context, including clinical supervision. His move toward becoming an accredited CBT therapist presents an interesting example. He described feeling increasingly 'different' and being perceived as such by colleagues, as he developed this new knowledge and skills within more generic mental health nursing contexts. In terms of role congruence, this was perhaps rooted within the aspect of legitimacy, in terms of having this new knowledge and skill-base, but not being in a service context which valued it. This also implies aspects of support in terms of feeling valued for this new knowledge and skills. Moving into a role within a service specifically designed to provide the very knowledge and skills which he had developed addressed this imbalance, resulting in a much more congruent role, with a more congruent referent group in terms of social worlds. Interestingly, he maintained his ongoing registration as a mental health nurse in this latter context, even though the role was not specifically a nursing role, but that of a CBT therapist. He remembers, at one point, being told by psychologists he was an '*honorary*' psychologist. Importantly, within the context of CBT practice, participant 17 underlines how clinical supervision is not only a source of role support, but also an aspect of role adequacy development, 'part of the training' in his words.

Participant 11 described her role working in a crisis team as being 'ideal', which implies role congruence. In terms of role adequacy, she had undertaken various skills-based training in areas such as cognitive approaches, solution-focussed working, motivational interviewing and risk assessment. This represents an eclectic mix of potential approaches to match to presenting situations, which is logical and congruent with a crisis service. In terms of role legitimacy, risk assessment protocols allow for some degree of uncertainty, so long as protocols are followed. There is also an ethos of mutual support within the crisis team, when there are untoward incidents, and these are folded back into a culture of learning, which informs role adequacy. Thus, at the point of interview, this participant described an ongoing balance of role adequacy, legitimacy and support, resulting in role congruity, despite what can be a very demanding role. However, in her earlier role, there was a less favourable balance. She described the role in practice as not being what she had imagined, less legitimate in the sense of role congruity alignment. She also described not feeling supported by her immediate managers and, given this role was more senior than her immediate peers, somewhat isolated. Others with a more 'management'-focussed career trajectory might have addressed this imbalance by consolidating managerial and leadership skills (role

adequacy) and seeking support from avenues related to that. Her response was to move from this role to her role working with a crisis team, which for her addressed the imbalance and resulted in a more congruous role.

This section has introduced a new and novel model capturing the process of 'Role Congruity Alignment', which addresses the fundamental focus of this thesis, and the research informing it. The next section will focus upon a further important consideration which emerged from the situational analysis aspect of my study, that of social worlds.

Situational Analysis: The Importance and Influence of Social Worlds

The second element of situational analysis, the mapping of social worlds and arenas, has illustrated the social worlds which exist, overlap and influence that of mental health nursing. The professions of mental health nursing, psychiatry, psychology, occupational therapy and social work all present discrete social worlds in a professional sense, each entailing their own balance of role adequacy, legitimacy and support in attaining and maintaining role congruity. Overlaps between these social worlds occur, however, not least of which is the continuing and uniting presence of the social world of service users.

Machin et al (2012), in their analysis of professional roles in health visiting, identified the importance of 'referent groups', namely the referent group of fellow health visitors, and other referent groups within an inter-professional context. In this sense, the social worlds identified within the mental health practice and HEI arenas can be seen to be referent as groups. In terms of professional identity, a referent group and associated social world such as mental health nursing share important features in terms of role adequacy, legitimacy and support. Overlaps with other referent groups and social worlds occur in day-to-day practice within the mental health practice and HEI arenas.

Another important overlap has occurred, however, over the past three decades or so in the manifestation of evidence-based therapeutic interventions. Many of these approaches, or modalities, have become professional social worlds with referent groups in their own right. A tension becomes apparent in that these modality-related social worlds are also occupied in overlap with other 'core' mental health professions such as mental health nurses, psychologists and psychiatrists. The notion of 'theory/knowledge of' and 'theory/knowledge for' professions (Machin & Stevenson, 1997) becomes illuminating in this context. An intervention approach, for example CBT, could be seen as 'theory for', or perhaps more accurately 'knowledge and skills for', another, core profession such as mental health nursing. However, the body of knowledge and attendant skills encompassed by some approaches has, arguably, become professionalised and over-arched

by an attendant 'theory of', leading to the role of 'therapist' for particular modalities such as CBT. A dilemma may thus present in terms of professional role and identity, belonging to two concurrent social worlds and referent groups. This has resonance with the work of Castels (1997) who suggested that where there was a lack of clarity around role boundaries and practice differs, role-identity fragmentation within groups may occur. For existing mental health professionals, such as mental health nurses, the dilemma presents in terms of whether they incorporate CBT approaches as knowledge and skills for their practice as mental health nurses, as in the case of participant 11 in this research, or become a therapist of the CBT modality with its own 'theory of', as with participant 17.

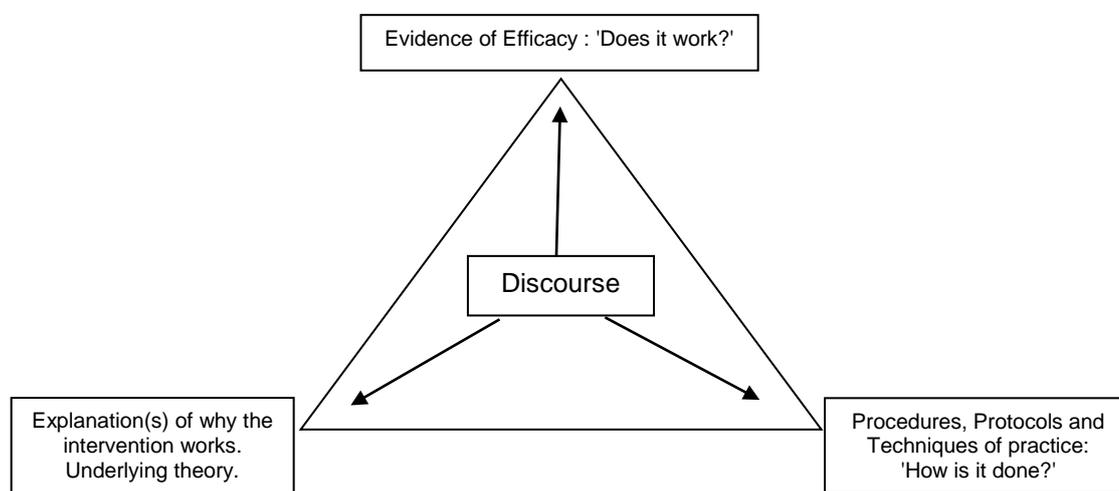
In the sense of social worlds and their associated referent groups, 'theory of' a discipline or profession is unique to that profession, whereas 'knowledge and skills for' resides in the overlap between the social worlds of a therapeutic modality and that of an existent discipline such as mental health nursing. The issue of 'evidence' underpinning practice remains a key influence within these considerations. The next section engages with this issue from the perspective of 'positional mapping' relating to therapeutic approaches.

Situational Analysis: Positional Mapping for Therapeutic Approaches

This brings discussion to the positions which mental health nurses may take in relation to therapeutic approaches. The credibility of evidence for these approaches is a crucial consideration here.

The issue of evidence for practice has emerged at several junctures in the discussion so far. It emerged within the situational map in connection with professional role, structures and discourse. It also emerged within social worlds/arenas mapping in terms of the professionalisation of therapeutic approaches and associated social worlds. It is evident within the data analysis from research participants in terms of the commitment of some individuals to particular approaches. Drawing these trails together, three important aspects emerge with regard to evaluating the credibility and value of any particular therapeutic approach. These are represented diagrammatically in Figure 6:6 below.

Figure 6.6: Evaluating Credibility of Therapeutic Approaches



First is the evidence of efficacy for the intervention, which is to ask 'does it work?' The efficacy of a particular approach is measured in terms of improved outcomes for service users who have been engaged with the approach with respect to the target condition, e.g. depression. As outlined in chapter two, the key arbiter of what constitutes valid evidence of improved health outcomes within the United Kingdom is the organisation NICE. In hierarchical terms, the gold standard evidence considered credible by NICE is generated by research studies involving random controlled trials (Davies et al., 2000). This aspect of credibility feeds directly into role legitimacy for the approach. Importantly, from the perspective of both student and qualified participants, the need to critically understand research approaches is requisite to interpreting this evidence. It is here where the caution in interpretation of evidence suggested by McCrae (2012) has relevance, as evidence should not be unquestioningly accepted and needs to be critically understood in terms of the context within which it is generated.

The second aspect of credibility is concerned with the procedures, protocols and techniques associated with the approach, or 'how is it done?' This constitutes the 'nuts and bolts' of how a therapist within a given approach or modality conducts the process of therapy from assessment through to intervention. This relates to 'developing a therapeutic skill set' within my 'Establishing Role Congruity' model. Credibility regarding this aspect is developed and enhanced via publication of texts (particularly of an academic nature) outlining the procedures, and by the creation of programmes of study and qualifications relating to the approach. The pinnacle of credibility for an approach is to establish processes for 'accreditation' as a competent practitioner of the approach and

an associated professional body or organisation, which also particularly relates to professionalisation. It also implies the development of competency in the form of skills and techniques (role adequacy) within arrangements for appropriate clinical supervision (role support) for specific therapeutic approaches.

The final aspect of credibility is concerned with the explanation of how the approach works, or 'how and why is it effective?' A coherent explanatory framework will account for the aetiology and origin of the target disorder/problem, for example 'depression', and how the approach under consideration addresses the issues in practice. In this sense, the explanation outlines how individuals come to have the condition, and how the therapeutic approach acts to alleviate or improve it. This involves engaging with particular knowledge and understanding of specific presenting conditions, and thus implicitly, if not explicitly, engaging with underpinning discourses relating to this knowledge. This aspect informs both role adequacy, in the sense of knowledge, and role legitimacy, in the sense of reinforcing an underpinning rationale for the approach.

When these three elements unite in a coherent way, strong credibility is established. Positions taken regarding the evidence for and credibility of particular therapeutic approaches are thus influenced by discourse in that 'scientific' discourse remains dominant in the hierarchy of research evidence demonstrating efficacy of approaches, and accordingly the aetiological explanations for mental health conditions are linked strongly to medical discourse.

When applied to interventions which can be seen in isolation, the link between the three elements can be succinctly and effectively demonstrated. Examples would include drug treatments and 'courses' of therapy such as CBT.

The neatness of this triangular consideration becomes less succinct for more complex presentations and intervention responses which can be less isolated out as a course of intervention specifically identifiable as responsible for a given outcome. Analytical psychotherapy or certain forms of counselling are so individualistic as to be difficult to compare in terms of equivalence between individuals receiving to present as examples here. A similar issue exists for complex presenting crisis problems involving input from multiple aspects; times, disciplines, drugs, individual practitioners, the passage of time itself in terms of crisis resolution, removal from crisis situations. Furthermore, it is ethically questionable to separate out 'control' groups which are denied some aspects of these inputs in order to measure the relative importance of them to eventual positive outcomes. Yet, in these contexts there are positive outcomes which have been and continue to be seen. This includes the complex and multi-faceted nature of mental health nursing itself.

Despite the proliferation of 'evidenced' care pathways, within which the attraction of neatly evidenced and packaged approaches for clearly presenting and categorised conditions can be seen,

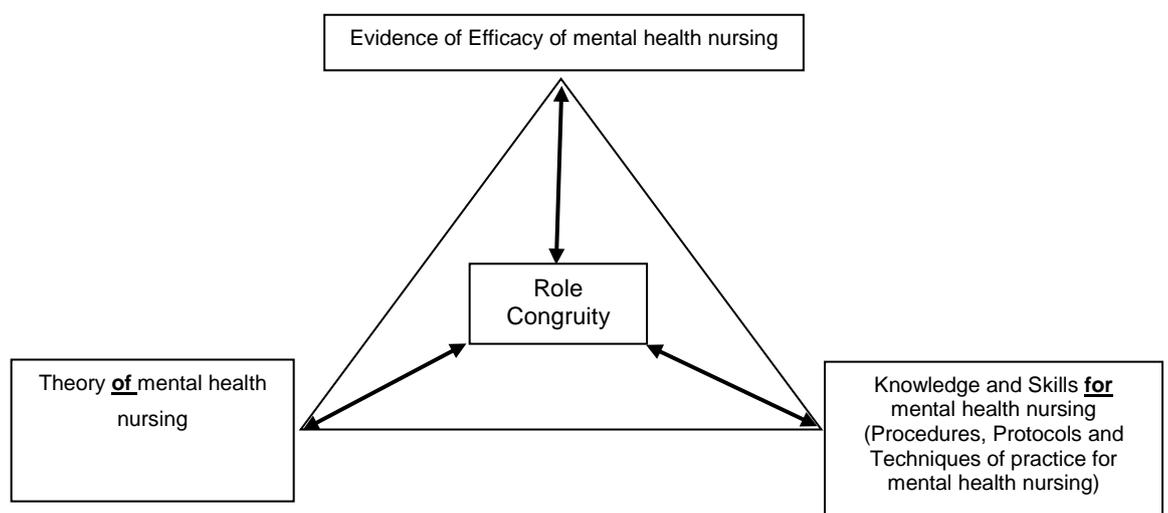
many service users do not present in neat categorical ways, and many presentations to mental health services continue, at least initially, to be complex and urgent. It is in this context that the value of a more generic, adaptable mental health nurse can be seen.

This section has been concerned with individual therapeutic approaches. The following section widens consideration to mental health nursing more broadly.

The Credibility of Mental Health Nursing

Analysis and discussion so far has demonstrated that mental health nursing covers a complex array of multi-faceted, not easily articulated, roles. Discussion has also highlighted how the contemporary practice context increasingly requires demonstration of an evidence base underpinning practice. The framework for considering credibility of therapeutic approaches, outlined in Figure 6:6 above, is applied to mental health nursing more globally in Figure 6:7 below, and offers a useful means of attempting to articulate mental health nursing roles, when considered at the level of 'profession' rather than specific approach.

Figure 6.7: Credibility of Mental Health Nursing



Evidence of efficacy for mental health nursing is potentially available from a multitude of sources; nurses themselves, service users and other disciplines, in addition to various sources of data that abound within clinical services regarding aspects such as discharge rates, length of stay, risk assessment outcomes, and degrees of 'recovery'. Mental health nursing as an 'intervention' perhaps encounters the same evaluation issues as psychodynamic psychotherapy and 'counselling', discussed in chapter two, as it is pluralistic in aspects of role and individualised within therapeutic relationships. More pluralistic evaluation strategies are available to capture complex inputs and

outputs. One such approach is 'realistic evaluation' (Pawson & Tilley, 1997) which has been used in many complex contexts for evaluation purposes.

Turning to 'knowledge and skills for mental health nursing' (procedures, protocols and techniques of practice) this encompasses the functions demonstrated within 'engaging with the mental health nursing role in practice', in terms of the therapeutic use of self. Therapeutic 'micro skills', counselling skills and use of aspects of therapeutic modalities such as CBT and systemic practice all fall into this aspect. The precise mix here will depend upon the setting of practice and the individual's approach as it develops. More generic-type roles will have a correspondingly generic blend of skills. A more focussed skill set will be evident in roles matched to particular service user groups. It is the appropriate level of expertise around specific skill sets which is the issue here. In the distinction between 'knowledge and skills **for** mental health nursing' and 'theory **of** mental health nursing', it is the latter which remains the overarching ethos for practice.

'Theory of mental health nursing' is the central aspect of importance in terms of mental health nursing as a discipline, encompassing the core ethos and values of mental health nursing. Returning to the literature reviewed in chapter two, Hurley and Rankin (2008) called for integration of 'emotional intelligence' competencies to be incorporated into mental health nursing. This aspect would fit within the core ethos and values of a 'theory of' mental health nursing. Norman and Rylie (2013) distinguish between the 'interpersonal' tradition and the 'evidence-based' tradition within mental health nursing. Within the framework outlined in Figure 6:7, the interpersonal tradition could be seen as incorporated within the 'theory of' mental health nursing, whilst the evidence-based tradition is reflected within the aspects of 'knowledge and skills for mental health nursing' and 'evidence of efficacy for mental health nursing'.

Analysis here has shown that when mental health nurses develop a high degree of expertise in a particular therapeutic modality, they can experience role identity conflict and associated imbalance in role congruity. If they fail to reconcile their expertise as 'knowledge and skills for mental health nursing' then they may, as Hurley and Lakeman (2011) suggest, exit the identity of mental health nursing and adopt a modality therapist identity, whereby 'theory of' the modality and 'knowledge and skills for' the modality are more congruent.

Three practice-related scenarios have been identified within analysis here, those of generic-type roles, specialisation by service user group or specialisation by therapeutic approach. These scenarios raise issues relating to the notion of 'advanced practice'. Rolfe (2014) identified how advanced practice has often been equated with the adoption of medical roles, from an 'adult nursing' perspective, and called for the advanced nurse practitioner role to be focussed upon the core values and skills of nursing, rather than be seen as a role encompassing more advanced technical practices associated with the discipline of medicine. It may be argued that the 'therapist'

role presents an equivalent issue within mental health nursing, encompassing aspects of role more usually associated with the discipline of psychology, though elements of the medical role also pervade in the form of, for example, non-medical prescribing. In the context of mental health nursing, the question arises, should the 'generic' and 'specialisation by service user group' roles not be valued equally with the 'specialisation by therapeutic approach' role? This issue is reflected within the suggestion by the NLIA (2010) that the continuum from generalist to specialist, when considered together with the continuum from novice to expert, can result in the valid position of 'expert generalist'. This involves accepting the notion that one can be an 'advanced generic practitioner' with the same esteem as an accredited modality therapist.

The framework proposed by Nancarrow and Borthwick (2005), exploring the practice-related boundaries between disciplines has direct application within this discussion. They examine prospects from both intra-disciplinary and inter-disciplinary angles. In terms of inter-disciplinary possibilities, professions may either diversify or specialise. In the context of this thesis, it is apparent that, historically, mental health nurses have diversified into new roles as required by service contexts and systems as they have evolved. In terms of specialising, analysis here suggests the two avenues presenting are to specialise by service user group, or to specialise by therapeutic intervention.

In terms of inter-disciplinary role boundaries, the two prospects suggested are vertical and horizontal substitution. Vertical substitution involves a profession taking on the work of another (typically more esteemed and thus better remunerated) profession. Examples include the roles of non-medical prescribing, or 'responsible practitioner' within mental health nursing contexts. It has been suggested above that the role of 'therapist' may be a form of vertical substitution to aspects of the clinical psychology role. However, the professionalisation of modality therapists in their own right, with professional roles specifically created within organisations, for example CBT therapists within IAPT services, refocuses attention to the idea of 'exiting' to a different role identity (Hurley, 2009).

Horizontal substitution occurs where roles are less well-defined between disciplines. In mental health services and teams, where psychiatrists, psychologists, occupational therapists and other 'therapist' roles may co-exist, Onyet (2009) emphasised the need for clear differentiation between roles.

A further important consideration relating to 'vertical substitution' arises with the advent of 'associate practitioner' roles. A central part of the Willis report (Willis-Commission, 2015) recommendations for the future of nurse education concerned the creation of a more consistent role for what we currently call 'care assistants'. The Willis review also called for formalised education and training for these roles, and the prospect of a clear progression pathway to enter nurse

education. One potential title for this role is 'associate nurse'. These roles will, effectively, assume aspects of roles currently the territory of mental health nurses in the sense of 'vertical substitution', and issues of role congruity will arise both for these roles, and the way in which they interface with established mental health nursing roles. This will include consideration of leadership and coordination skills for qualified/registered nurses.

In terms of the Willis recommendation for a shared common core of two years for all fields of nursing at the outset, there are potential dangers of diluting the process of identifying with a referent group and social world. This is perhaps one of the reasons the mental health nursing students undertaking a shortened, Master's programme in the study by McCrae et al. (2014) found it difficult to identify with nursing culture. Added to this is the cautionary example of the Australian and New Zealand context (Hemmingway et al., 2016), whereby recruitment and retention of mental health nursing fell on implementation of a generic nursing programme, with those newly qualified nurses who elected to practice in mental health being under-prepared for the role. In the context of analysis within this thesis, this would indicate problems with role adequacy, legitimacy and support, and thus role congruity on initial qualification. This would also seem to run counter to the call to more clearly articulate a 'theory of' mental health nursing.

Summary and Conclusion

My proposed grounded theory model of 'Establishing Role Congruity' derived from analysis of qualitative interview data presented in chapter five has been further consolidated here by locating it within a novel process model of 'Role Congruity Alignment'. The three thematic outcomes derived from the situational analysis aspect of the research informing this thesis have also provided valuable perspectives.

The influence of discourse and structures illustrates how mental health nursing roles have been and continue to be shaped and influenced by the way which the services they work within are configured. These services have increasingly moved towards configuration on the basis of presenting problems of mental health service users defined by diagnostic criteria (principally the DSM), and the perceived/recommended appropriate therapeutic responses to these problems.

This analysis has led to consideration of initial career trajectories for mental health nurses within these service configurations. At the point of initial qualification and registration, mental health nurses can only have a generic initial competency profile. Following this, the transition to practice as a registered mental health nurse leads to three avenues down which to progress, all of which have been illustrated here with examples from among the research participants. There are some contexts which call for a generic, composite blend of skills, such as a crisis team or an acute admission ward, catering for a range of potential presentations. Forensic services also fit here, since

the nature of mental health problems is not the grouping characteristic, but the fact that those mental health problems have led to offending behaviour.

There are two further contexts which require more specialist, specific skill sets. The first is related to services which are configured for a specific service user group, such as people with addiction problems, first presentations of psychosis or people with problems relating to dementia. Though some common core skills will cut across all contexts, these specific groups also have specific needs in terms of the range of skill sets required. An example would be the use of motivational interviewing strategies in addiction-related settings. The second form of specialisation is to do so by therapeutic modality/intervention. These intervention approaches are often specific to particular presenting problems, an example being CBT for depression. Some practitioners may develop such expertise and incorporate it into their practice, using the expertise when appropriate within day-to-day work. Some, however, typically those who develop higher degrees of expertise within a specific modality such as CBT, may employ this expertise within services which are configured around its availability, such as 'therapy centres'. The important distinction here is that such services are configured around expertise and service users with problems amenable to that expertise are referred on that basis. In the case of more generic roles, or roles with specific service user groups, the skill set required is defined by service user group needs.

In all three scenarios, role congruity alignment occurs for mental health nurses when the requisite aspects of role adequacy, legitimacy and support are aligned to the needs of the users of the service. My suggested process of role congruity alignment has been illustrated here with reference to narrative examples from among participants within my research. For some mental health nurses, imbalances in role congruity can be addressed within current role with appropriate adjustments as outlined within the model. For others, addressing such imbalances might involve moving to different practice contexts. In the case of specialisation within a therapeutic approach this may even involve 'becoming' a therapist rather than a mental health nurse. This prospect has resonance with the study by Hurley and Lakeman (2011), reported in chapter two, whereby becoming a therapist of a modality amounted to an 'exit strategy' as one of the possible identity journeys they propose.

This relates to the second theme identified within the situational analysis, that of social worlds. Mental health nurses in more generic roles and those specialising by service user groups still share their social world and referent group of mental health nursing. Though the other social worlds with which they overlap might vary, they remain just that, an overlap rather than a competing social world in the sense of identity. Those mental health nurses who elect to specialise in a therapeutic approach, with its own referent group and social world, can become conflicted in terms of which becomes more dominant.

The final theme from the situational analysis is concerned with the credibility of therapeutic approaches utilised by mental health nurses. The imperative to demonstrate that therapeutic approaches are based upon credible evidence is apparent within the realms of policy, service structure and professional requirements. Examining the issue of credibility of approaches from the three aspects of; evidence of efficacy; procedures, protocols and techniques; and underlying explanatory theory offers a more expansive means of considering therapeutic approaches than evidence of efficacy dictated by an evidence hierarchy alone.

The application of this 'credibility framework' to mental health nursing itself serves to reinforce the call for articulation of a 'theory of' mental health nursing as an overarching ethos within which to congruently absorb the knowledge and skills requisite to specific and varied practice contexts. Those aspects which relate to the inter-personal dynamics and the 'art' of mental health nursing are perhaps most effectively captured within a 'theory of' mental health nursing. Those aspects which relate to evidence-based strategies for intervention can then be more coherently framed as 'knowledge and skills for' mental health nursing.

In terms of the concept of 'political identity', proposed by Castels (1997) and outlined in chapter two, 'legitimising identity' for mental health nursing cannot be assumed, and may be under real threat. This perhaps leads to 'resistance identity', manifest in the current climate within which a radical change to the way in which mental health nurses are prepared for practice is being proposed. My theoretical models of 'Establishing Role Congruity' and 'Role Congruity Alignment', with the attendant analysis of mental health nursing roles can contribute to the debate engaging with 'project identity' for the discipline of mental health nursing at this potentially challenging point in its history.

The next, penultimate chapter will summarise issues of credibility for the research informing this thesis itself, together with a consideration of reflexivity from the perspective of myself as researcher.

Chapter 7: Critical Reflection Upon the Research Process

Introduction

A central theme emerging within this thesis is that of credibility of evidence. This chapter gives pause to the discussion of theoretical models emergent from the research study informing this thesis to consider issues of credibility within this study itself.

In relation to qualitative or 'interpretive' research more generally, there are differing stances regarding credibility, including issues of generality. Juliet Corbin (Corbin & Strauss, 2008) notes the proliferation of terms applied to judging qualitative research such as 'rigor', 'truthfulness' or 'integrity'. An extreme constructivist position, epistemologically speaking, might suggest that qualitative research findings are constructions and the idea of 'truth' unattainable, since there are multiple 'truths'. I have stated here that my position does not travel to the extremes of relativism. I do, however, acknowledge that the research informing this thesis, in its attempt to portray and relate reality, is constructed and influenced by myself as researcher. This chapter will thus consider the process involved in this research, drawing upon evaluative frameworks for grounded theory approaches, and then turn to the related issue of reflexivity for myself as the researcher.

The Credibility of this Research

Glaser and Strauss (1967), the originators of grounded theory as an approach to enquiry, itemised four criteria by which a grounded theory study and findings might be judged. These are; fit, generality, understanding and control. A well-executed study should fit the substantive area under investigation, be comprehensible to those practising in that area (understanding), demonstrate sufficient conceptual interpretation and be abstract enough to be applicable to a range of contexts relating to the phenomenon and, finally, give potential control in terms of action toward the situation/context under study.

Glaser and Strauss were originally writing in 1967, since when the notion of 'generality' from qualitative research is perhaps the most contentious of these four criteria in terms of how far beyond a given study context the theory generated might have applicability. Williams (2000) suggests that, more generally in qualitative or 'interpretive' research approaches, the attitude of many researchers towards the issue of generality has been akin to that of middle class Victorians toward sex. That is to say, they do it, and know that it takes place, but find it difficult to admit or discuss. His conclusion calls for what he calls 'moderatum' generality, whereby aspects of situations can be seen to be instances of broader, recognisable sets of features, reflecting degrees of

cultural consistency. He also sees a value in interpretive approaches being employed within more pluralistic approaches to research processes.

In terms of Glaser and Strauss's original criteria, considering the conceptual theory generated from this study, I would comfortably claim that there is a 'fit' to the substantive area of mental health nursing roles, and that it would be readily comprehensible to mental health nurses in that they would be able to see their own career trajectories and current roles in terms of 'Establishing Role Congruity' and 'Role Congruity Alignment'. Mental health nursing peers and colleagues who have been exposed to these models during development, either during informal presentation or in academic discussion, have demonstrated resonance and have seen the utility of the frameworks in application.

The issues of generality and control are more the territory of the next and final chapter, where the potential utility of these frameworks within mental health nursing practice and education are discussed, relating to 'control', and some tentative suggestions regarding wider applicability of these frameworks beyond mental health nursing are suggested, relating to 'generality'.

Strauss and Corbin (1990) outline explicit criteria by which a grounded theory study may be judged, though they emphasise these are guidelines only, given the variation in specific studies. Their specific criteria fall under three broad interrelated areas. First is the credibility of the data, second is the adequacy of the research process, and the third is the 'empirical grounding' of the theory. The credibility of the data and the research process are concerned with the sampling process, as are the conceptualisation of categories and identification of a core category. The degree of empirical grounding is concerned with how concepts and categories are systematically related, with linkage, conceptual density and how the broader conditions of the area under study are captured.

In terms of these criteria, I have tried to make the use of data credible and transparent. All participant voices are represented across the categories in terms of clearly designated data examples supporting each of the postulated categories within the presentation of findings and analysis in chapter five. In terms of the adequacy of the research process, chapters three and four of this thesis have outlined the conceptual framework and specific design issues relating to this research. There have been necessary trade-offs in conducting the research, mainly related to the resource of time. This is both in terms of being a part-time researcher and adhering to a necessary timescale for completion.

The principal trade off here concerns the degree to which the sampling involved in the study has followed the principles of 'theoretical sampling' as required in a grounded theory approach. There were elements of 'convenience' within the sampling process in that all participants were students

within one higher education institution, either within pre-registration programmes or undertaking post-qualifying study of some kind. For pre-registration students, participants were selected on the basis of capturing exemplar participants at different stages of their programme of study. Within that sample frame, however, the agenda for the depth interviews was adjusted to incorporate emergent analytical themes as analysis progressed. For the post-qualifying participants, whilst not all possible practice contexts are represented, care was taken to seek a range of individuals in terms of the precise area of their practice at the time of interview, and the length of experience they demonstrated, based upon demographics known from student information. Again, emergent themes were incorporated into interviews sequentially, as analysis unfolded. Sampling of post-qualifying participants with forensic, CBT and systemic modality focus was also theoretically driven as analysis emerged.

In terms of empirical grounding, in addition to the use of illustrative data quotations from participants, selected research participants have also been used as exemplars to illustrate aspects of the theoretical models presented in chapter six, lending conceptual density. In terms of the broader conditions of the area under study, the employment of situational analysis within this study directly and specifically identifies and engages with them.

Researcher Reflexivity within the Research Process

Mruck and Mey (2007) saw the issue of researcher reflexivity as part of the critical evaluation of a grounded theory study. Given the heterogeneous nature of qualitative research and researchers, an account of the relationship between researcher and research adds to the overall evaluative picture of any particular study. They suggested that research processes can be influenced by the time, place and context to which a researcher belongs, and researcher beliefs and assumptions in terms of epistemology, theory and disciplinary background. Reflexivity is concerned with understanding and making transparent these influences from initial formulation of a research question and choice of methodology through to the execution and writing up of the study. In relation to this, and at a very practical level, I kept a research diary throughout my research and thesis construction journey. Extracts from this diary are included in *appendices (iv) and (v)* as illustrative of theoretical development as the study progressed.

My own background, as stated at the outset of this thesis, is as a mental health nurse. Completing initial nurse education in the early 1980s, I worked initially within a large psychiatric hospital (Victorian asylum) as a staff nurse and charge nurse working with older people with dementia, before moving to a community role via specialist education to work with people with addiction problems. This is not the kind of leap in specialism that would be made in the contemporary context, but these services were only just being developed at that point. After working for some years in an addiction service setting, and studying a part-time Master's degree in health and social

research, I moved into an educational role in the early 1990s, within a nursing college, teaching mental health nurses. By 1995, the college of nursing had merged with a higher education institution as part of the move to raise the academic level of nursing qualifications. Since that time I have retained an interest in mental health nursing, but gravitated to teaching and facilitating post-qualifying and post-graduate programmes across health and social care in a more generic sense, though mental health nursing and issues of mental health, including a focus upon addiction, have always been represented within this. My knowledge around research approaches has also resulted in me leading post-graduate modules and programmes concerned with research methods, both qualitative and quantitative.

My interest in mental health nursing roles was fostered by the increase in diversification of roles from the mid-1980s onwards, and rooted in my own experience before moving into education, together with the many mental health nurses I have met and worked with either as colleagues or post-qualifying students and, of course, pre-registration students.

In terms of this research study and thesis as an opportunity to explore this interest in roles, I had engaged with the notion of 'professional identity', but found this very esoteric in terms of trying to capture specific dimensions and tangible focus. I had engaged with the concept of role adequacy, legitimacy and support via the work of Shaw et al. (1978) whilst working in the addiction field, and later tentatively applied this framework to mental health nursing roles. The framework of 'role adequacy, legitimacy and support' helped me to make sense of my own role at times, learning new skills and approaches within a specialist area in terms of service user group, whilst maintaining my mental health nurse identity. Mruck and Mey (2007) allude to how 'pet theories' can come to bear upon research processes, and I was very aware of this. However, on engaging with the notion of conceptual frameworks (Ravitch & Riggan, 2012) and Clarke's (2005) discussion regarding the differentiation between theoretical concepts and sensitising concepts (Blumer, 1969), I found that by relegating this 'pet' theory to that of a sensitising concept within a conceptual framework and framing the notion of 'role congruity', I had moved away from the esoteric (though related) concept of identity, to a tangible and potentially useful focus upon mental health nursing roles in practice.

My knowledge and familiarity with research approaches very quickly led me to see that a qualitative approach was appropriate, and given the focus upon processes of attaining/maintaining role congruity, grounded theory as an approach was evidently suitable. At this time, I was also engaging with situational analysis (Clarke, 2005) in terms of what it can add to and augment in grounded theory approaches. My knowledge of mental health services and systems as the context for mental health nursing roles led me to see that this approach could offer valuable insights, as well as the opportunity to become familiar with this approach in practice.

Having undertaken previous research using a grounded theory approach, the use of situational analysis as an adjunct has been illuminating. What would seem to be very obvious contextual factors emerge with heightened focus when considered in this way, though it may be that any good, systematic researcher would ultimately incorporate contextual factors at appropriate points in proceedings. The use of situational, social world and positional maps has most definitely augmented analytical thinking within this thesis, helped frame dimensions of the research agenda and contributed to the analysis of qualitative data from interviews.

In terms of my emergent theoretical models of 'Establishing Role Congruity' and 'Role Congruity Alignment' from this analysis, it may be enlightening to finish this exploration of reflexivity with a brief consideration of my own role congruity and the approach I am developing at this point.

The higher education sector (like the NHS) is becoming increasingly governed by the pursuit of targets, measured by 'metrics'. I am currently working toward completion of this PhD and thesis (role adequacy in terms of my role within the University), whilst working with colleagues within health and social care provision to reconcile the value orientation of mental health nursing and other health and social care professions with what seems to be becoming a very mechanised approach to the preparation of graduates from programmes, from a central University organisational perspective. The fit of these value-based professional programmes with standard University expectations is regularly challenged. For example, there are often more contact hours of teaching and more involved assessment processes, given the need to demonstrate competency attainment. In terms of addressing this imbalance, this is perhaps an issue of myself and other colleagues in this position securing role support from appropriate levels within the organisation, in justifying the necessary differential resource that this entails. However, given resource constraints as a reality, as an educator there may be issues of role adequacy in increasing my propensity to find creative educational solutions such as the use of technology and 'work-based learning', together with clinical practice organisation partners, to ensure appropriate initial preparation of mental health nurses, and ongoing continuing professional development. This will, in turn, however, involve perceiving these alternative approaches as legitimate to my role.

As a final consideration, there is my developing role as a researcher within the HEI context. A fundamental re-alignment of the direction of travel of my own organisation has meant that there is now an increased emphasis upon the profile of all academic staff in terms of the balance between teaching, research and administration. A central function of PhD study lies in the area of 'research training' (role adequacy). The shift in the expected balance between teaching, research and administration will entail fundamental re-consideration of my own role congruity moving forward.

Conclusion

This brief chapter has outlined critical issues, strengths and potential weaknesses in the execution of the research which has informed this thesis, together with a reflexive consideration of my role as researcher.

The following chapter will conclude my thesis by revisiting the aims I set out at the beginning and summarising potential implications. It will also summarise the potential utility of the theoretical models I have proposed for mental health education and practice, potential avenues for further research, and briefly consider potential wider applicability.

Chapter 8: Conclusion: Directions for Future Practice, Education and Research

Introduction

The aim of my thesis and associated research study, as set out in the introduction, was to explore how mental health nurses initially attain and subsequently maintain professional role congruity. Two key theoretical models I have derived from the research have been presented. The first, derived from the grounded theory analysis of qualitative interview data from research participants, 'Establishing Role Congruity', shows how individual mental health nurses develop their approach to practice during their initial pre-registration preparation, and subsequently following registration. The second model of 'Role Congruity Alignment' builds upon the first and addresses the study aim directly by demonstrating how mental health nurses initially strive to attain (during pre-registration preparation) and then to maintain (once qualified/registered) alignment of professional role congruity.

This chapter will explore and summarise the application of these novel theoretical models in relation to the world of practice. The relevance of these models to mental health nursing education and practice is first addressed. Potential avenues of wider application and further research are then outlined. The chapter, and the thesis itself, then ends with a summary of key issues relevant to the contemporary situation of mental health nursing as a discipline.

Mental Health Nursing: Education and Practice

In terms of practice at an individual level, my proposed models of 'Establishing Role Congruity' and 'Role Congruity Alignment' offer a means of self-reflection with regard to specific roles, and individual professional development needs. This can be of use in maximising the utility of supervision processes. More broadly, these models offer an individual means for mental health nurses to incorporate 'knowledge and skills *for* practice' into their over-arching identity as a mental health nurse.

At the level of a specific service, these models can offer a means of structured planning for development, both in terms of individuals within the service, but also considered at the level of teams when considering appropriate skill-mixes in an aggregate sense of role adequacy, legitimacy and support. They can also inform supervision protocols at an organisational level.

At the level of the profession itself, a recurrent issue throughout this thesis has been the difficulty in articulating a coherent 'theory of' mental health nursing'. In recent years, consideration of such an overarching ethos has fallen out of consideration. If a coherent and cogent 'theory *of* mental

health nursing' can be made more explicit, it would enable the incorporation of the myriad 'knowledge and skills *for*' mental health nursing more readily subsumed within it and, arguably, role congruity could be more coherently developed. Theorists such as Peplau (1991) have made valuable contributions to the consideration of an over-arching theory *of* mental health nursing, and are worthy of re-visiting on that basis.

The current proposals being considered for the re-organisation of nursing education and subsequent career development (Willis-Commission, 2015) do present a potential threat in the shape of a 'generic nurse' basis of education for the first two years of preparation. This may detract from the formation of fundamental mental health nursing identity (relating to role legitimacy) and baseline competency (relating to role adequacy) upon which subsequent development builds. Should these proposals be implemented, this would represent a different starting point for the development of role congruity in newly-qualified practitioners.

This brings discussion neatly to the implications for education of mental health nurses, which echoes much of the practice-related agenda. The models of 'Establishing Role Congruity' and 'Role Congruity Alignment' offer systematic ways of planning the pre-registration mental health nursing educational journey for students. These models could be of pro-active value in the formulation of new curricula for pre-registration preparation. In a sense they could be used as a form of 'reverse engineering', starting with the end-product of a mental health nurse with an effectively-developed approach to role congruity. The models could also be used reactively in terms of monitoring student progress to initial qualification. This could involve students using these models as reflective frameworks throughout their learning journey. This process could then continue in the transition from baseline competence at the point of initial qualification, through preceptorship and into the phase of initial role in practice. For student nurses, this process would involve the HEI setting, the practice setting and students in both group and individual contexts, as they move towards attaining initial role congruity.

Situational analysis within this study has highlighted the dominance of psychiatric/medical discourse within the mental health practice arena. This being the case, a pre-registration curriculum for mental health nurses should at the very least invite exploration of challenging perspectives to psychiatric discourse, such as the ideas of Szasz and Foucault. This is not to suggest that a generation of 'anti-psychiatry nurses' should be spawned, but inclusion of these considerations, in the spirit of graduate critical analysis, serves to make the point that valid challenges to Western psychiatry are mounted, and that there are perspectives other than medical/scientific/technical.

Turning to qualified mental health nurses in practice settings, the issue becomes one of maintaining role congruity. Situational analysis here has determined that there are three broad settings within

which mental health nursing roles may develop. The first typology calls for mental health nurses to have a broad range of eclectic/generic knowledge and skills. The second type of setting identified is configured for the needs of particular service user groups, entailing a more-defined knowledge and skill set relating to that group. The third setting type is configured to deliver particular interventions in terms of therapeutic modalities. Though there are core attributes of role adequacy, role legitimacy and role support which are evident and requisite in all three scenarios, each will also warrant a further, specific balance of these factors in terms of mental health nurses 'Establishing Role Congruity' within particular contexts. The models derived from my study offer a systematic way to identify the ongoing professional development needs of mental health nurses across these settings, in terms of structured educational provision, and continuing professional development within the workplace.

For the kinds of role involving a deeper engagement with a therapeutic approach, it has been argued here that role identity conflict may result, with competing rather than overlapping professional social worlds and referent groups. It seems evident that 'theory *for*' some therapeutic modalities such as CBT can be more cohesively articulated and logically bound than that of mental health nursing. However, the applicability and focus of such modalities is likely to be narrower and more focussed than the wider ranging remit of the 'mental health' within the title of 'mental health nursing'. So the relationship between, for example, 'theory of cognitive behavioural therapy' and 'knowledge and skills for CBT' is more clearly and readily articulated and understood, and role congruity more readily achieved. This relationship for mental health nursing is not so easily articulated, but this does not mean that it has any less value as a role.

Wider Applicability and Potential Avenues for Further Research

This thesis has explored issues of professional role congruity in terms of its attainment by student mental health nurses in pre-registration education, and its maintenance by qualified, registered mental health nurses. The qualified practitioners participating in the study were predominately working in roles directly in contact with service users. All had some element of leadership function, requisite to the mental health nurse role, and three had more explicit managerial roles, but this was not the primary focus of the research as such. In terms of potential further research, the applicability of these models of 'Establishing Role Congruity' and 'Role Congruity Alignment' could be explored in relation to other mental health nursing roles more purely concerned with leadership and management. Education and research-focussed roles might also present further research opportunities.

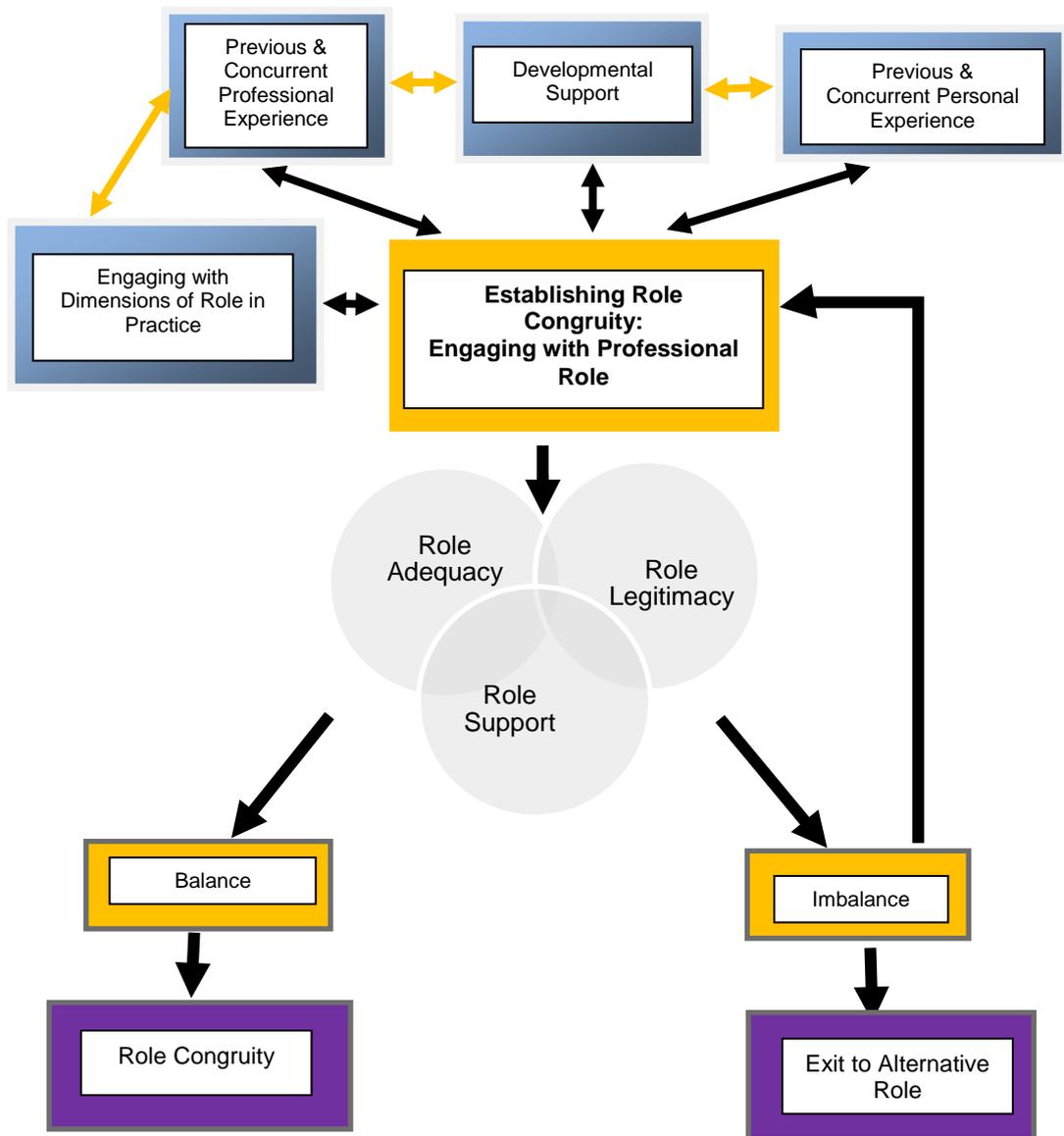
My proposed models of 'Establishing Role Congruity' and 'Role Congruity Alignment' have been developed from depth, qualitative approaches with a small number of participants. More generally, they could inform the development of data collection tools which could reach larger samples in exploring the balance of these factors across wider populations of mental health nurses.

An interesting exploration could be undertaken examining the differences between those mental health nurses who retain their mental health nurse identity and ethos despite attaining high levels of competency in therapeutic approaches and those who 'migrate' to a therapist identity. In terms of these potential identity dilemmas faced by some mental health nurses who develop higher levels of competency within specific therapeutic modalities, such as CBT, further research could be undertaken exploring what it is that mental health nurses bring to these approaches, in the sense of therapeutic alliance. This might help to clarify how modality approaches can be subsumed as knowledge and skills for mental health nursing within a wider ethos of 'theory of' mental health nursing.

Glaser (2007), whilst cautioning against the tendency to generalise, promoted the idea of 'formal grounded theory' as a more widely applied understanding of theory originally developed as a substantive grounded theory (i.e. relating to a specific area). He defines 'formal' grounded theory as a generalisation of the core category from a substantive grounded theory.

Figure 8:1 below presents the model of 'Role Congruity Alignment' in a more generic sense, for tentative consideration.

Figure 8.1: Professional Role Congruity Alignment



Potential applicability to other nursing roles and other roles relating to health and social care more generally can be tentatively suggested, including 'associate practitioner'-type roles, where the framework could be useful in establishing the parameters around 'vertical substitution'.

Conclusion

Mental health nursing has been an ever-present discipline within the development of mental health service provision over the past century or more. It has adapted and evolved as new knowledge and intervention approaches have developed, and services underwent transition from institutional bases to become more predominately community-based.

Throughout this development, the contingent development and articulation of a clearly identifiable over-arching 'theory of' mental health nursing has been elusive, and more recently arguably neglected. This has limited the degree to which mental health nursing vies as a profession amongst others within the field of mental health.

The study informing this thesis has demonstrated how individual mental health nurses develop and maintain congruity within their professional practice roles. The grounded theory model of 'Establishing Role Congruity' makes explicit how mental health nurses draw upon a range of influences and opportunities to develop effective approaches in three broad areas of practice; those of 'generic' settings, specialising by service user group and specialising by therapeutic approach. It has been argued here that these three areas of practice should be given equal credence.

The situational analysis element of my study has shown how mental health nurse roles are influenced by the interrelated elements of service structure, discourses and social worlds. The discourse of medicine in the form of psychiatry is of fundamental significance in that the diagnostic categories which it has created and reified drive the way in which services are organised and structured. A positivistic 'scientific' discourse similarly drives the way in which 'evidence' underpinning policy and service developments is considered in terms of credibility. This directly influences which intervention approaches are seen as credible and even required to be offered for service user presenting problems.

This drive towards 'evidence-based practice' presents a key problem for mental health nurses in terms of how they can incorporate these approaches into their practice whilst residing within the social world of mental health nursing. My model of 'Role Congruity Alignment' presented here offers a means of understanding how mental health nurses attain and maintain role congruity whilst developing their approach to practice, including incorporation of evidence-based approaches as 'knowledge and skills for practice'.

In considering mental health nursing as both an 'art' and a 'science', it would be useful if attention were re-focused upon the articulation of a cogent 'theory of' mental health nursing, which would help the attainment of role congruity at the level of the profession. The models presented within

this thesis may also be of utility to other professional groups presented with situational challenges where role clarification would be useful.

Though the development of care pathways presents an organised means of aligning service users to appropriate interventions, there are and will remain complexities when many service users present in terms of crisis, particularly for precise 'fit' and availability of interventions. The study informing this thesis has demonstrated through the presentation of the novel models of 'Establishing Role Congruity' and 'Role Congruity Alignment' how flexible and adaptable mental health nurses can be across practice settings.

This flexibility and adaptability is a key strength in mental health nursing, as a cornerstone of the mental health workforce whilst services continue to evolve in relation to the development of knowledge, evidence for practice and, perhaps most importantly, the day-to-day reality of service delivery.

"Philosophy, if it cannot answer so many questions as we could wish, has at least the power of asking questions which increase the interest of the world, and show the strangeness and wonder lying just below the surface even in the commonest of things of daily life."

Bertrand Russell (1872-1970).

Appendices

- i) Ethical approval confirmation, Participant Information and Consent forms
- ii) Interview schedule guides: Students/Qualified Staff
- iii) Examples of transcriptions with coding notes
- iv) Examples of memo's/notes during theoretical development
- v) Tabulated Relational analysis from Situational Mapping

Appendix i

Ethical Approval Confirmation, Participant information and consent form

* RE-13-01-12567



Professor Kathleen McCourt FRCN
Dean

Tony Machin
Northumbria University
School of Health, Community and Education Studies
Coach Lane Campus
Newcastle upon Tyne
NE7 7XA

This matter is being dealt with by:
Research and Enterprise Office
School of Health, Community & Education Studies
Room H007
Coach Lane Campus East
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6701
Fax: 0191 215 6083
E-mail: julle.blackwell@northumbria.ac.uk

17th May 2012

Dear Tony

School of HCES Research Ethics Panel

Title:

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent CRB and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
<http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard>

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

A handwritten signature in blue ink, appearing to read "David Stanley".

Professor David Stanley
Chair, School Research Ethics Review Panel

Vice-Chancellor
Professor Andrew Wathey

Northumbria University is the trading name of the University of Northumbria at Newcastle



Research Study: "The development and maintenance of professional role congruity: An illustrative, exploratory study of the discipline of mental health nursing."

Information for potential participants

You are being asked for your permission to take part in a research project. Before you decide it is important for you to read this information sheet so you understand why the research is being carried out and what it will involve. Reading this sheet, discussing it with others and asking the researcher any questions you might have will help you decide whether or not you would like to take part.

What is the purpose of the research?

This research is intended to explore the dynamics of contemporary Mental Health Nursing roles in terms of initial role preparation (newly recruited student nurses over the 3 year period of initial education and training to initial roles as qualified practitioners) and on-going role development across a variety of mental health practice contexts (qualified practitioners in career development). The central focus is upon how Mental Health Nurses see their own roles developing, and the factors which they perceive to influence this process.

Why am I being asked?

You are being asked to participate and contribute to this research as you are either a student Mental Health Nurse at some point of your pre-registration programme of preparation for practice at Northumbria University, or you are a qualified Mental Health Nurse undertaking a Northumbria University programme as part of your post-qualifying development. Your experience of role development since initial commencement, and subsequently is of central relevance to the research aim and objectives.

Do I have to take part?

No. It is up to you whether you would like to take part. This information sheet will help you make that decision. If you do decide to take part, you can stop being involved in the research whenever you choose, without telling the researcher why. Deciding not to take part, or requesting to leave the research at any point, **will not** affect you or your studies in any way.

What will happen if I agree to take part?

If you agree, to take part in the research, you will be invited to participate in an interview between you and the researcher. Interviews will take place at Coach Lane campus in a booked room, at a time of mutual convenience. The interview will last approximately one hour, and will be digitally recorded. Recordings will be stored securely in a locked filing cabinet and

Research information for participants

as quickly as possible uploaded onto the password protected University U drive of the researcher. Once uploaded the recording will be wiped from the digital recorder. The interview will be concerned with your experience as a student Mental Health Nurse in terms of your role development from initial commencement on the programme up until your development to date, and potential future intentions. Some participants may be asked to participate in a further interview at a later date, up until your completion of the programme.

What are the possible disadvantages of taking part?

Apart from the time commitment, there are unlikely to be any disadvantages or risks in taking part.

What are the possible benefits of taking part?

There may be no direct benefit for you from taking part in the research. However, being part of the research will help the researcher to explore and understand what factors influence the role development of Mental Health Nurses, from initial commencement of education/preparation, up until qualification and registration. Participants will also be provided with a summary of the research findings, once completed. More broadly, it is intended that the research will inform:

- The development and informing of pre-registration courses in the effective preparation of practitioners for initial professional roles
- The development and informing of post-registration CPD courses in effective development in on-going role and career development
- Wider aspects of self-reflection and clinical supervision issues in Mental Health professional practice.
- An approach to consider strategic planning for the development of Mental Health workforces, both more generally and specifically in relation to local services.

Will the fact that I have taken part in this research be kept confidential?

Yes. Your name will not be written in any reports or documents resulting from this research.

What will happen to the results of the research?

The research is part of a PhD doctoral study being undertaken by the researcher, and will culminate in a report in the form of a doctoral thesis. The results may also be shared with the wider academic and professional community in the form of conference presentations and publications in professional journals. A summary of the findings will also be made available to all participants.

Who is organizing and funding the research?

The research is not being funded other than support for the researcher from Northumbria University, and is being carried out by the researcher as part of a PhD programme.

Who has reviewed the research?

Research information for participants

Before this research could begin permission was obtained from the Ethics Committee at Northumbria University, School of Health, Community and Education Studies. The Committee reviewed the way the research was planned to ensure it follows appropriate ethical guidelines. The NTW trust has also given approval for its staff to participate, knowing that the university ethical criteria have been satisfied.

What do I do now?

If you do not want to participate then **you don't need to do anything**.

If you are interested in taking part please contact the researcher via the following contact points:

Researcher: Tony Machin:

E mail: tony.machin@northumbria.ac.uk

Tel: 0191 215 6655

Thank you for considering contributing to this research

The academic supervisor of this research study is available to discuss any aspects of the study if necessary:

Professor Pauline Pearson,

E mail: pauline.pearson@northumbria.ac.uk

Tel: 0191 215 6472

Consent Form for Interview

Name of Participant.....

Please tick the boxes alongside each statement to confirm your understanding and agreement to participate:

I have read the information relating to participating in this research study, and I confirm that:

STATEMENT	YES	NO
I understand the aim and purpose of the research:		
I understand the process of the research and agree to participate in an interview, recorded by the researcher:		
I understand that the recorded interviews, transcripts and analysis will be held securely, and that the details of participants will be confidential, with any data reported being anonymous:		
I have read and understand the Information Sheet for this research and have had the opportunity to ask questions which have been answered to my satisfaction:		
I understand that it is up to me to choose to take part in the research project, and I can change my mind any time I want, without saying why. If I choose to leave the research by withdrawing there will be no consequence:		

I(name of participant)	
Understand the information presented to me regarding this research, and agree to participate:	
Signature..... (Participant)	Date.....
Signature.....(Researcher)	Date.....

Consent form for Interview/Participation

Appendix ii

Initial Outline Interview Agendas

Outline Interview Schedule: Student Nurses

1. What originally attracted you to Mental Health Nursing?

2. If someone were to ask "what does a mental health nurse do?", how do you/would you respond?

3. What is mental health?

4. Beginning of the course:

- a) First day on the course
- b) First study block at University
- c) First clinical placement

5. This point in the course:

- a) Last University block compared to first one
- b) Last placement compared with first one
- c) Is it unfolding as you expected?

6. Key incidents/points in time:

- a) Any key critical incidents?
- b) Any key time points you would focus on for any reason?
- c) Any crisis points/thoughts of leaving?

7. Knowledge and practice:

- a) Relating University blocks/theory to practice
- b) Generally - relationship between theory and practice

8. Influence of other people:

- a) University setting
- b) Practice placements
- c) Other sources

9. Have you always felt supported?

- a) Sources of support
- b) Examples of support

10. Areas of practice:

- a) Any areas of particular like/dislike
- b) Future - initial qualification, any preferred areas?
- c) How do you see the role of qualified nurse compared to student role?

11. Globally- has coming into mental health nursing affected you as a person? How so?

12. Any questions? Anything you would add?

Outline Interview Schedule: Qualified Nurses

1. What originally attracted you to Mental Health Nursing?

2. If someone were to ask "what does a mental health nurse do?", how do you/would you respond?

a) Would you say this has changed over time?

b) If so, how? What has influenced this?

3. What is mental health?

a) Has this changed over time?

b) If so, what has influenced this?

4. Key incidents/points in time in career to date:

a) Any key critical incidents?

b) Any key time points you would focus on for any reason?

c) Any crisis points/thoughts of leaving?

5. What characterises your approach as a mental health nurse? How does this differ from the approach of others?

6. How do you see the relationship between theory and practice?

a) Has this changed over time?

b) How does CPD relate to this?

7. Influence of other people:

a) University setting

b) Practice placements

c) Other sources

8. Have you always felt supported?

a) Sources of support

b) Examples of support

9. Areas of practice:

a) Any areas of particular like/dislike

b) Future - qualification, any preferred areas?

c) How do you see the role of qualified nurse compared to student role, for you?

10. Globally- does being a mental health nurse impact on you more broadly? How so?

11. Any questions? Anything you would add?

Appendix iii

Examples of coding notes on 4 Transcript Pages

(Participants 2, 4, 9 and 17)

Fragment from Participant 2 Transcript

110
111 P: I think I was also surprised by the amount of people that had or have their own
112 mental health issues on the course.

other students with MH issues

113
114 I: Oh right.

115
116 P: Not that I don't think that people with mental health problems can't have a job, but
117 it surprised me I think that, you know, that there were so many of them in the group
118 and then a lot of them are obviously are talking from personal experience about
119 things that they have gone through, and listening and sharing, and with them being
120 that much younger than me they had a different perspective because they are
121 looking at more modern perspective, as opposed to, you know, my mum was in an
122 institution for a while, and you know, ECT twenty years ago isn't the same as ECT
123 today, so you know, there was lots of different perspectives, and it was good to share
124 those, and the group is quite dynamic in its make up, which has good points and bad
125 points to it.

Personal Experience of MH issues

126
127 I: That was a GT group. In terms of your first placement though, you know, the same
128 kind of thing again, you know, thinking about that first placement, what was your kind
129 of experience going into that?

130 ** Prior experience caring*
131 P: Well, I never had any experience of health care at all so going into that first
132 placement, it was, I was very nervous firstly, but secondly I felt a little bit like I had my
133 hands bound by my mentor in the placement, although I didn't feel like that at the
134 time, it was only afterwards when I went on my second placement that I, and
135 reflected back to what I learned on my first placement, that that's how I felt because I
136 had a lot of 'oh well you're not supposed to do that it's your first placement, first year
137 student, oh don't do that because it's a first year' and I felt like, you weren't treated
138 necessarily as an individual with life experiences that you bring into that placement,
139 you were treated as a first year, first placement and you were put in that little box as
140 opposed to being your own accountabilities and your own abilities being matched by
141 the mentor in that placement and which would then give you more learning
142 opportunities and I felt you were sort of a little bit pigeon holed.

Restricted in early stages

Consequence of a job course

143
144 I: Yeah. So that, would that have been something that you expected or not expected?

145
146 P: I don't think I expected that no, I think, I mean I did a lot of tea making which is
147 obviously is important, I did a lot of personal care which is important, but I wasn't
148 stretched or challenged, I wasn't really questioned about things I was doing or
149 decisions, I mean I wasn't really allowed to make any decisions, but even
150 theoretically I wasn't challenged, you know 'what would you have done in that
151 situation' or, so I don't think I learned that much from the placement and you know,
152 coming back into university and listening to other peoples experiences, there was
153 things they were mentioning, there was no real 'my first placement', things that they
154 were mentioning, I was thinking 'oh I can't say I don't know what it is' you know, 'I
155 look silly I have been on a placement now', so.

Mandate? less from First placement. Membership issue?

156
157 I: In subsequent placements you were kind of able to make, to put that placement
158 more in context.

Prior experience of caring

159
160 P: Aha, and I think it did give me, as I say I had no care experience, doing a lot of the
161 personal care and making teas and talking to people, it gave me that little bit of
162 confidence to do that which was obviously missing because I had no experience
163 before, and maybe if I had of been thrown into a placement which was very busy and
164 a lot of expectations maybe, I wouldn't have survived it, I don't know. But I didn't feel

Engaging with MH issues.

Fragment from Participant 4 Transcript

④

143 P: Erm, autonomy, erm, working without instruction and knowing what to do and being allowed to do that as well.

144 I: Yeah.

145 P: The opinion of staff towards me and their sort of views change because of where I was in the programme; they had more belief and trust in that I could just be left to work.

146 I: Aha, do you think that's just about your point in the programme or?

147 P: I suppose it's, it'll be assessing me as well and you know, picking up on who I am and what I can do as well and I suppose it's a good thing that they feel it and trust us and stuff but, it was, I suppose, I've tried to go into all, each placement and try and perform the role of a nurse.

148 I: Aha.

149 P: As much as a I possibly could, and the last placement, I felt I did the role of the nurse with very little input and it was mainly just because I needed their say so to do things that I didn't necessarily have the, I suppose, the authority to be able to make those decisions because it needs to be a qualified practitioner to do those things.

150 I: Ok.

151 P: Where as early placements it was like I was looking for reassurance in everything I did.

152 I: Aha, do you think there's, you know, besides this point in the programme that your at, would you see a different kind of mentor figure, or qualified figures in placements, do you think they have different approaches to students?

153 P: Definitely, aha, erm...

154 I: I mean, can you think of an example of that?

155 P: I have had quite a good number of mentors, erm, three possibly, who were really encouraging, erm, seemed to be interested in getting to know us, as a person, as well as a nurse. So they can, I suppose, make an assessment and a judgement on my ability and what they could trust me to do and where I might need extra help, erm, that came across in initial interviews and things and in ongoing practice.

156 I: Aha.

157 P: Erm, other mentors were very defensive and weren't willing to pass on any trust or sort of responsibility and they wanted to stand over us in everything I did and, that's quite limiting.

158 I: Yeah.

159 P: In your learning and things as well, it knocks your confidence and it's quite difficult to work in that sort of environment really.

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Handwritten notes:

- Autonomy - Increasing with progression on programme
- Role of student.
- Perform the "role"
- Perform Role → Become role??
- Seeking Support.
- Support.
- Contrasting experience of Mentors.
- Trust.
- role of student.
- Defensive practice - Allowing students = RISK?
- building confidence
- Individual Support needs - individual ability.
- Assessing ability.

Fragment from Participant 9 Transcript

154 stone in two weeks I think, with the stress. And I kept telling the ward manager, but she was part of
 155 it. She wasn't interested; she just used to sit and knit all day. Erm, so I went to the manager upstairs,
 156 who at the time shuffled all the staff around, which was what was needed, but you could
 157 [indecipherable] support, 'cos I used to say "I need support with this" he said... 'Cos I said "How do
 158 toy think I'm performing as a staff nurse" and I'm doing what was an E grade and he said "well look
 159 at it this way, if there was anything wrong, I'd tell you" And there were times when I really needed
 160 somebody just to say "that was absolutely brilliant" or "next time, consider these things". So I found
 161 my early development was very much coming from myself, 'cos there wasn't a lot of nurturing and
 162 support. I get a lot of that now as I'm on a band seven, but I didn't at the time. I've worked for and
 163 had some excellent support and some people have had dreadful support from others. Well, it's been
 164 non-existent.

165 I: Right. So you know, that's an example of support in terms of looking to implement change and
 166 [indecipherable] unsupported. On the other hand, I mean, would you... can you think of any
 167 examples where you've had some excellent support? Can you think of any examples of excellent
 168 support?

169 P: Yeah. I think back to one particularly excellent service manager, who sadly as part of the business
 170 model review for my Trust didn't sustain her post, but erm, she kind of saw something in me, I think
 171 and she was just so positive all the time. She gave me projects to do; she supported me throughout
 172 them and we had the kind of relationship where I would pre-empt what she would ask me, so I did it
 173 before she even asked. But there was just something about her personality; she was so grateful. If
 174 you did something, she made sure you got the credit. If you needed emotional support, she was
 175 there all the time. She had like an open door policy; come and talk to me if you need to; she was
 176 nurturing, she guided, she pushed as well. Which sometimes I think you need a little bit of a push to
 177 come out of your comfort zone, but then you kind of flourish when you're at the other side. So she
 178 was absolutely fantastic and she's the one person I always come back to in terms of leadership.

179 I: Right. Separate concepts? Accessibility? Role Model?

180 P: And managing me and leading me; she was absolutely superb. She was just what we needed to
 181 take services forward and develop people.

182 I: Would you say... thinking more generally, over the period of time of your experience, would you
 183 say there's more support generally and knowledge available than perhaps it has been historically?

184 P: I think there's more... the Trust I work for attempts to support its colleagues and make some very
 185 big issue of what's out there. Health and wellbeing groups. Erm, counselling, support, erm,
 186 leadership development, improving working lives and all that kind of stuff. But I think you still have
 187 to... You have to seek it out. Do you know what I mean? It's there; there's lots of stuff in place, but if
 188 you're reluctant to take it, there's not a lot you can do, but there is stuff out there. There are lots of
 189 policies, procedures and I know there's a lot of emphasis in the Trust at the moment about nurturing
 190 and looking after its staff; it's in the staff charter. You know, we have good links with our team
 191 [indecipherable], which is the occupational health provider. So it's out there, but you have to ask.
 192 You have to ask somebody to refer you to do it. That's the thing. Apart from the counselling service,
 193 which you can just ring yourself and I have given that number out to a few people. But yeah, it's
 194 there. It's definitely there. But you might not be able to be able to access it when you need it

Handwritten notes:
 - Poor support (pointing to lines 154-164)
 - Challenging System (pointing to lines 154-164)
 - Seeking Feedback Support (pointing to lines 154-164)
 - Self reliance | Dimension -> + (pointing to lines 160-164)
 - Notable Feedback (pointing to lines 160-164)
 - The feedback! (pointing to lines 165-168)
 - The Attr. but of credit. (pointing to lines 169-178)
 - Separate concepts? Accessibility? Role Model? (pointing to lines 179-180)
 - Pro-active support from Trust Staff Charter (pointing to lines 184-194)
 - Responders not supporting others. (pointing to lines 192-194)
 - explicit support structures. (pointing to lines 192-194)
 - de-lister (pointing to line 194)

Fragment from Participant 17 Transcript

84 to manage my caseload and become much more of an independent practitioner and learn that and
85 then at the same time, developing as a CBT therapist and starting to, by the end of that, by the time I
86 got to like 1999/2000, by then I was supervising people.

*whilst still a MHN
supervision as
development - ? hierarchy?*

87 I: Right.

88 P: Erm, actually I'd started, just started to do some private therapy as well at that time.

Non-NHS.

89 I: Oh right.

90 P: So I was getting kind of a bit of a reputation for knowing some stuff about how to do CBT and I
91 ended up then working in the ~~place~~ ^{place} Cog Therapy Centre for a while. And [from] that into... Oh
92 yeah, I went into primary care psychology and basically, it was primary care psychology then for a
93 couple of years... It took about three years actually; about three years and then it was about five
94 years of secondary care and then it was, I finished my career, I finished back in primary care
95 psychology.

*specialism by
modality.*

*Managing role
in 2. Heron
Settings*

96 I: Right.

97 P: So I went like very much learning how to do my job in secondary care, practicing it in primary,
98 going back into secondary and finishing off in primary. But when I came to the end of the last sort of
99 six years of my career in the NHS, I held on to elements of working with severe... You know, like
100 secondary care level patients. I kept... There was always a proportion of the caseload... Even primary
101 care. Being in a primary care psychology department means that you got some fairly 'access one'
102 disorders to treat, you know, fairly non-complex mental health problems to treat. But you would
103 also get a fair proportion of quite severe, mainly personality problems, or co-morbidity. So I kept on
104 treating that, but also, I kept my interest up in cognitive therapy or psychological approaches to
105 psychosis for as long as I could and I kept that going in between all of that for about six years, five or
106 six years.

SAxis?

Specific interests

Complexity.

107 I: Right. From the point of view... I mean obviously the therapeutic side of it's very important, but
108 one of the things I've fastened on to is this balance between the 'nurse' part, the mental health
109 nurse and therapist. How does the mental health nurse and the therapeutic modality come together
110 for you?

*Specialism
by user group.*

111 P: Erm, I... In the '80s, when I was working in substance misuse - what was called 'drug and alcohol'
112 at the time, erm, at Parkwood House, there was a woman there, [name], who was one of the first
113 nurses to ever train as a psychotherapist at ~~place~~ ^{place}. And the reason for that was: until that point,
114 you had to be a doctor or a psychologist to actually get on that course. That's what I understood.
115 That might not be the truth, but that's what I understood. And certainly there was no nurses
116 working in specialist psychotherapy at that time. I never came across one. But [name] had a
117 significant background and interest in psychotherapeutic work in that particular area and she started
118 to supervise me, supervise my counselling work, which is what I would classify it as at the time. And
119 this would have been in '85, '86, '87? It was all building up about '88, when I left working inside
120 that... So there was a good two and a half years easily, probably about three years where I was...
121 Yeah, it was, three years, of meeting with her regularly and talking about what I was doing. So I was
122 a nurse; I would still identify myself as a nurse at the time, talking to another nurse and during this
123 whole process, she was going through this training to be a psychotherapist and by the end of my
124 time there, she'd become that.

*"Counselling"
prescriptions
about
CBT?*

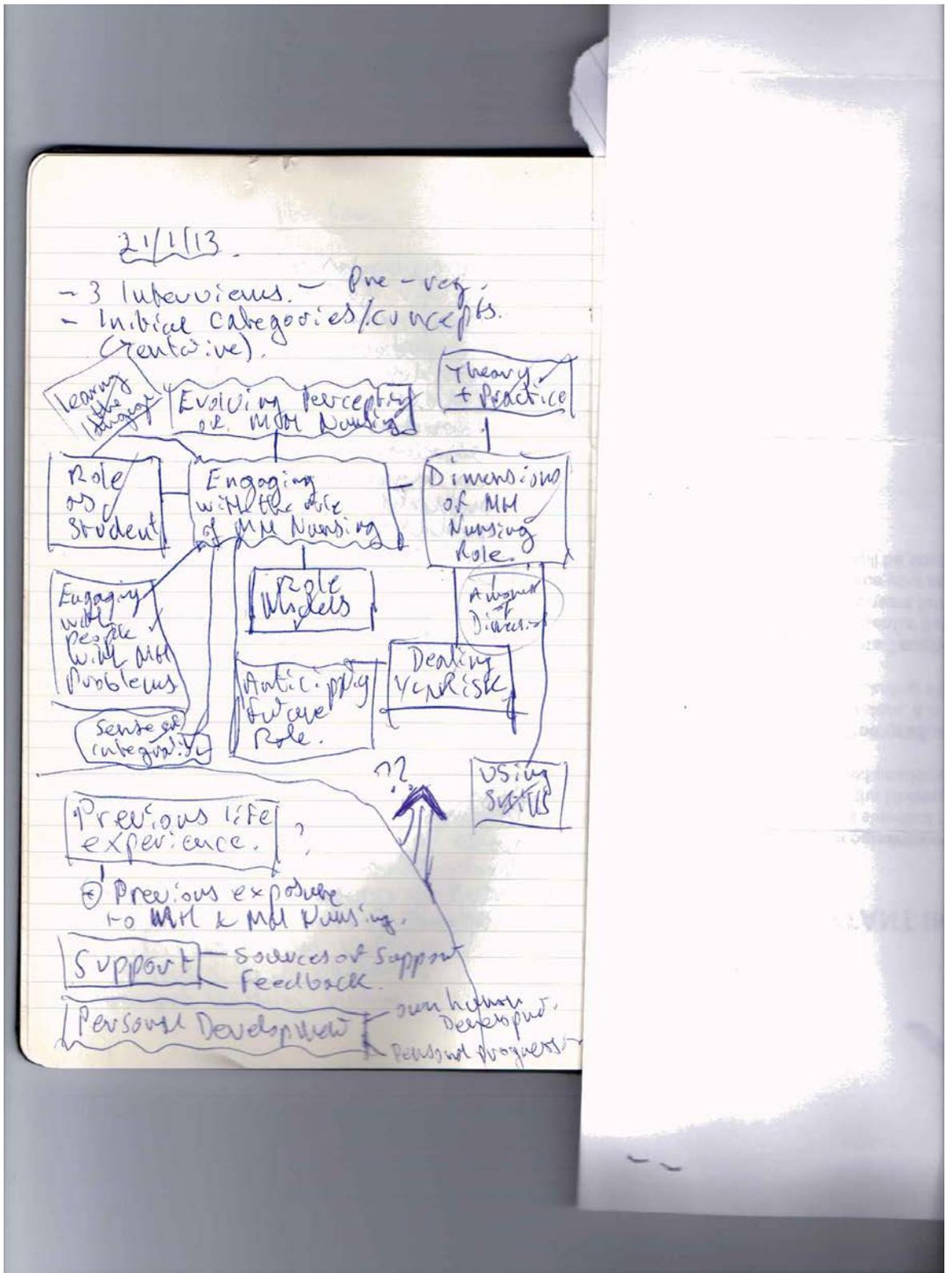
125 I: Right.

*Supervisor - guidance. @
"Becoming" a psychotherapist
rather than a nurse?
Role Model*

Appendix iv

Examples of memo's/notes during theoretical development

Initial Theorising around 'Establishing Role Congruity'



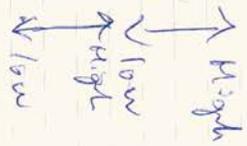
Theorising around structure of interventions

28/11/14

Convincours ~

Structure of intervention

~ structure of context



Modeling Specific/with opportunistic

High Judgment Structure

Formal (or) Informal (or)

Low context structure

High context structure

Opportunistic Pragmatic e.g. 'I've heard you're a...'

low intervention structure.

pragmatic/clinical intervention

↳ around it don't.

- Pre-req - structure of learning
- Post-req - structure of working note/context.

Rate of Clinical Suspensions? [#]

Students analysis & Diagram

Post analysis: -

→ I deal roles (see notes)

• All talk of transition

• where they are now

↳ play up

Pragmatic/clinical

vs Specialist.

• Role extension e.g. Mrs. had

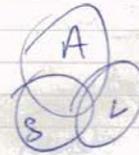
D. Hours

known Role specialism

Theorising around credibility of approaches

20/2/15 Pauline / Steve

Link to findings:~

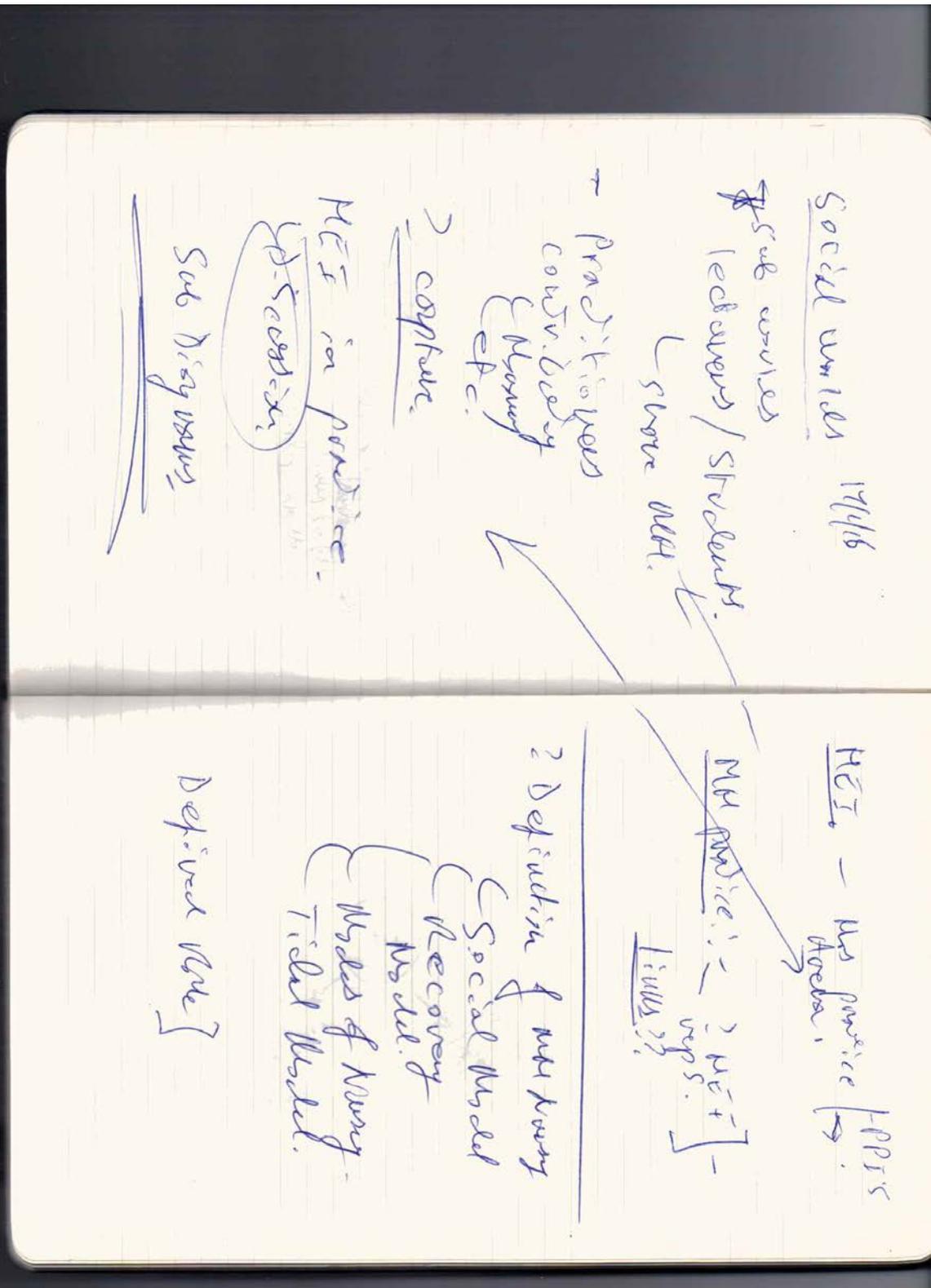


→ Mx Naming (Incorporating therapeutic approaches.)

Educative/pragmatic incorporation of theories for practice.

Specialist Skills Modelling

Theorising around social worlds



Appendix v

Tabulated Relational Analysis from Situational Mapping

Relational Analysis of Elemental Themes

Related Elemental Theme (Rows)	Focus Elemental Theme (Column) Mental Health Nurses (Students and Qualified)
Individual & collective human elements	<p><u>Students:</u></p> <ul style="list-style-type: none"> • Establishing own role and that of Mental Health Nurses in terms of individual relationships. • Establishing own role and that of other professionals in terms of individual relationships. • Becoming comfortable with working/interacting with individual service users. • Establish relationships with educators (Guidance Tutor etc). • Establishing these relationships within a variety of time-limited placements. • Beginning to establish aspects of leadership role later in preparation. • Absorbing and engaging with identity as a member of a profession (MH Nursing - within Nursing). • Engaging with Nursing Teams in placement as collectives. • Own cohort as 3 year learning group. • Service users/carers as collectives (seeing Service Users as collectives) • Being part of student body (NU). • Other professions as collectives - *Seeing things in 'social world' terms. <p><u>Qualified:</u></p> <ul style="list-style-type: none"> • Establish and maintain working relationships with other individual MHN in practice context (Team, colleagues). • Establishing/maintaining relationships with other MH professionals - Inter-Professional context. • Establish and maintain individual working relationships with individual service users/carers. • Establishing and maintaining role as an accountable registrant. • Establishing/maintaining leadership role with individuals as required. • Establishing/maintaining role within service structure with individual line managers. • Establishing/Maintaining role with Clinical Supervisor. • Establishing relationships with students on placement. Guiding/supporting roles (inc. Mentor roles). • Being part of an organisation (e.g. a 'Trust') • Being an accountable member of a Nursing Workforce. • Being a member of a Nursing team. • Being a member of an Inter-Professional Team. • More consistent contact with specific SU groups?
Non-human elements & implicated silent actors/actants	<p><u>Students:</u></p> <ul style="list-style-type: none"> • Clinical service context: Technologies (IT/notes Systems). • Processes of 'risk management'. • Learning the 'language' - technically. • Digesting the curriculum: Including appreciation of what is credible research/evidence. • Exposure to intervention skills and techniques as technologies (in practice and within curriculum). • Recognising the boundaries of practice (generic/specialist). • University systems - processes. • Some service users with less 'voice' (disempowered) - Advocacy role? • Dissenting voices/alternate views in theory (e.g. Szasz, Foucault) - not hugely present in curriculum/Practice. <p><u>Qualified:</u></p> <ul style="list-style-type: none"> • Engaging with technological change (new systems & processes). • Ongoing CPD - specific knowledge. • Engagement with Clinical Supervision infrastructure.

	<ul style="list-style-type: none"> • Developing skills for practice - generic Vs Specialist? • Awareness of Policy as locally implemented. • 'Silent actants' as for students • Ongoing exposure to ideas/theorists in terms of influence?
Temporal & spatial Elements	<p><u>Students:</u></p> <ul style="list-style-type: none"> • Age- previous life experience • Year 1,2,3 • Time within individual placements: Rapid engagement needed. • Experiencing several different placement environments. • University as a space as distinct from practice. • Clinical Skills centre as a space - less relevant to MH nurses? <p><u>Qualified:</u></p> <ul style="list-style-type: none"> • Length of experience since qualification • Time to retirement ('winding down'). • MHO Status still an issue for some (early retirement). • Spatial working environment more permanence. • Historical comparisons. • Keeping 'up to date': Revalidation.
Political/economic & socio-cultural/symbolic elements	<p><u>Students:</u></p> <ul style="list-style-type: none"> • Personal politics • National influence of MH Nurses: At National, regional & local levels. • Influence upon NIHCE & 'evidence'. • Influence upon Structure of services in re need Vs resources (e.g. 'care pathways'). • NMC Curriculum influence & Codes of conduct. • Socio-cultural place of 'nurses' and MH nurses in particular. <p><u>Qualified:</u></p> <ul style="list-style-type: none"> • As for students but with more experience and potential influence (Depending upon status)
Discursive constructions of individual/collective human/non-human elements & related discourses.	<p><u>Students:</u></p> <ul style="list-style-type: none"> • Medical Discourse and DSM • 'Nursing' Vs specific interventions. • Discourse of 'madness' • Press and Media reflecting discourse of Madness/dangerousness. • Nurse as Custodians Vs Therapeutic agents (historical). • Aetiology of MH problems & diagnostic criteria (DSM). • Curriculum (Pre-Reg & CPD) and potential for exposure to different viewpoints? • The structure of provision and intervention - care pathways. • The nature of 'evidence' for practice (NICE- RCT). • MH Act/Capacity. • NMC Code of conduct. • Discursive constructions within Policy. <p><u>Qualified:</u></p> <ul style="list-style-type: none"> • As students but with more autonomy to challenge?
Major issues & debates.	<p><u>Students:</u></p> <ul style="list-style-type: none"> • Future of NHS? • Future of Mental Health within NHS provision? • Future of Nursing? • Future of MH Nursing? <p><u>Qualified:</u></p> <ul style="list-style-type: none"> • As for students. More ability to influence agenda (at more senior levels)?

Related Elemental Theme (Row)	Focus Elemental Theme (Column) Individual & collective human elements
Non-human elements & implicated silent actors/actants	<ul style="list-style-type: none"> • Other professionals as professional stereotypes rather than individuals? • Professions and relative power/status. • Personal Vs Professional relationships- personal intimacy - working together over time. • 'Team' dynamics'. • 'Role descriptions'/job-descriptions. • Therapeutic modalities as non-human technologies • Degree of engagement with therapeutic modality: Expected as part of profession Vs extended role into modality accreditation? • Eclectic/pragmatic Vs Specialist level of engagement with therapeutic modality. • Therapeutic modalities attached to social worlds? • Influence of curricula of study. • Key theorists within curricula. 'Silent' voices (e.g. voice of dissent - Szasz others - 'hidden' curricula). • Appreciation of research approaches and findings. • Encounters with Voluntary sector (e.g. when on 'hub' placements or with reference to user groups). • 'Silent' change resisters/non-agreement with direction of services
Temporal & spatial Elements	<ul style="list-style-type: none"> • 'Community' /Residential ('in-patient'). Nurses as 24/7 contact now not always the case. • Variety of service places and contexts. Student placements, qualified as gaining experience within. • Use of spaces - specialist and 'generic' services. • Stage of training/Placement roles. • Historical legacies of Psychiatry, Nursing, Mental Health Nursing, Mental Health Nurse Education. • 'CPN' course in '80's/'90's as 'de-institutionalising' staff. • Temporal elements - need for change adjustment. • Individual narrative histories informing experience. • Placement sequences informing experience. • Emergence of new roles over time - professionalisation of therapeutic modalities. • Professional regulatory bodies for therapeutic modalities. Accreditation powers.
Political/economic & socio-cultural/symbolic elements	<ul style="list-style-type: none"> • Personal politics (NHS-Public Sector workers) • National influence of professions- Medical, Nursing. • Example of IAPT initiative informed by economic argument. • Policy/political - MH and 'parity' of esteem with Physical Health. • NHS/Service re-organisations. • Campaigns against stigma. • MH and legal system. • MH and disadvantage. • NIHCE and evidence. • NMC- Code of conduct and Curricula requirements/influence.
Discursive constructions of individual/collective human/non-human elements & related discourses.	<ul style="list-style-type: none"> • Individual alignment with discourse and discursive practice: Medicalisation: DSM: Diagnostic frameworks; Aetiology. • Collective professional alignments with these discourses (Medical, Psychology, Nursing, OT etc) • Treatment approaches, therapeutic modalities and alignment with discourse. • Nature of 'evidence' - Hierarchy of RCT via NIHCE - 'scientific' discourse and practice. • Content of curricula flow from 'evidence' • NMC code of conduct - stress upon 'evidence' • Other Bodies: BABCP, AFT etc.

	<ul style="list-style-type: none"> • Mentally ill as risky/dangerous. • Individual Vs Collective views of 'dangerousness' and perception of risk.
Major issues & debates.	<ul style="list-style-type: none"> • Future of NHS • Role of Voluntary Sector • Future of Nursing • Future of MH Nursing: Mental Health Vs Psychiatric, alignment with other professions? • 'Generic' preparation prospect. • Nature of valid 'evidence'.

Related Elemental Theme (Row)	Focus Elemental Theme (Column) Non-human elements & implicated silent actors/actants
Temporal & spatial Elements	<ul style="list-style-type: none"> • Service users - part of 'community' (prevalence) • Individual 'psychiatric History'. Chronicity of presenting issues/problems. • Actors roles as social objects - evolution over time • Professional roles as social objects - emergence of new professional roles in the form of accredited therapist within modalities. • Specialist interventions <u>where</u> appropriate <u>when</u> appropriate. • Waiting lists and treatment time volumes (number of sessions) • Time/Space: Mental Health service location • Building types.
Political/economic & socio-cultural/symbolic elements	<ul style="list-style-type: none"> • Political power domination from particular professions. • Policy directives. • 'Parity of esteem'. • Services delivered within political/economic parameters. • Re-structuring in line with ideology/resources. • Professional role/job descriptions and remuneration. • Funding arrangements for initial Nurse Education and CPD. • Status of research approaches.
Discursive constructions of individual/collective human/non-human elements & related discourses.	<ul style="list-style-type: none"> • Media portrayals- discourse of 'madness' and 'dangerousness'. • Organisational structures in relation to categorisation of service users and 'disorders' • Organisation of therapeutic modalities in relation to 'disorders'. • Discourse- (Aetiology/theory) underpinning therapeutic modalities. • Efficacy of treatments/interventions subject to testing via discourse of 'science' (RCT).
Major issues & debates.	<ul style="list-style-type: none"> • Future of NHS, Nursing, MH nursing. • Future of 'treatments' within MH. • Prescription Vs 'Talking' therapies. • What is seen as credible evidence.

Related Elemental Theme (Row)	Focus Elemental Theme (Column) Temporal & spatial Elements
Political/economic & socio-cultural/symbolic elements	<ul style="list-style-type: none"> • History and legacy of Health & MH related Policy • Stigma of spaces for MH treatment ('Bins'). • Institutions as part of 'lunacy' act. • Street with several services known as 'Stigma Street' • Labels and terminology over time: Become stigmatising and evolve (subnormal-M-Handicap- LD). • Cultural response to MH changing - influenced by Media discourse. • Waiting lists/times and targets. • Resources and access (e.g. CAMH T4) - geography of availability (Access to training and education-e.g. of CYP-IAPT) • Availability of resources in particular locations: 'Black-spots'
Discursive constructions of individual/collective human/non-human elements & related discourses.	<ul style="list-style-type: none"> • Historical practices • Association of places with practices - Asylums and 'incarceration' • Nettleton- Foucauldian analysis of drivers for community care. Discourse power diffusing into community from psych hospitals. • Discourse and place - professional concentration and dominance of place? • Changes in practice over an individual's narrative history. • Emergence and professionalisation of therapeutic modalities.
Major issues & debates.	<ul style="list-style-type: none"> • Major issues: Historical cycles • Generic roles Vs Specialist roles (Nursing as a whole and MH nursing) • Future of NHS - • Health and 'social' care and inter-relation • Elderly care and needs in particular focus. • Other countries: e.g. Europe - generic nurses. US-Private/public services.

Related Elemental Theme (Row)	Focus Elemental Theme (Column) Political/economic & socio-cultural/symbolic elements
Discursive constructions of individual/collective human/non-human elements & related discourses.	<ul style="list-style-type: none"> • How Discourse informs policy - medicalisation of MH • 'Scientific' (Positivist) discourse dominating the agenda in terms of what is seen as credible evidence. • Economic argument for IAPT • Resource allocation and political discourse/ideology. • 'The market' in health care organisation as discourse. • 'Parity' of MH with Physical health. (No Health Without Mental Health). • Rhetoric Vs Reality. • Services designed around 'care pathways' in turn designed around classification of MH informed by discourse. • Public health - discourse of mental illness Vs Mental health & Well being.
Major issues & debates.	<ul style="list-style-type: none"> • NHS Future - Private/public - role of Voluntary Sector. • Nursing - Generic move as expedient to resources/systems. • Poverty link- Marmot- Health inequalities.

Related Elemental Theme (Row)	Focus Elemental Theme (Column) Discursive constructions of individual/collective human/non-human elements & related discourses.
Major issues & debates.	<ul style="list-style-type: none"> • Discourse of MH/MI - identifies/frames nature of need. • Discourse of 'science' dictates what constitutes valid 'evidence'. • Thus: Nature of NHS provision for MH • Thus: Future of professional organisation in relation to needs • Thus: The organisation of nursing • Thus: The organisation of MH nursing.

Summarising All of These Situational Elements in Terms of Effects upon Role Congruity

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