

**User Involvement in Mental Health
Nurse Education:
*A study of the effect on the
interpersonal skills of student nurses***

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Abstract

This study makes an original contribution to the evidence base for service user involvement in the teaching of interpersonal skills. The study is a synthesis of three different types of research activity.

Firstly a systematic review which reviews the evidence base for service user involvement in interpersonal skills teaching. This review used inclusion criteria that restricted its scope to research that included elements that used outcomes, either qualitative or quantitative related to mental health service users involvement in teaching interpersonal skills. Four quantitative and eight qualitative studies met the criteria for inclusion. All the quantitative studies were methodologically weak. Qualitative studies lacked clear statements of qualitative methods used. Overall the studies reviewed provided some evidence of the efficacy of service user involvement. Qualitative findings included some negative effects of involvement.

The second research approach used was reliability and validity testing of the Observed Assessment of Interpersonal Skills Scale (OAISS) using Factor Analysis and Cronbach's Alpha. The OAISS is an observational instrument intended to measure an observer's impression of another's interpersonal skills

during simulated interviews. Two factors were retained that accounted for 34% of the variance within the scale. Internal consistency of the scale was good. Two factors were interpreted to produce subscales called feedback and collaborative reflection and listening.

The final study used mixed methods including a quasi-experiment and interview based qualitative data gathering. The quasi-experimental part of the study examined the effects on the student nurses ($n = 75$) interpersonal skills of a teaching intervention run by mental health service users. The experiment used a pre-test post-test design with a teaching as normal control group compared with the service user-teaching group. No significant difference was found between the two groups on measures of interpersonal skills. Qualitative results indicated that students had been affected by the service user teaching. Evidence was found of changes in empathic responses, attitudes and deep reflection on practice. Some polarization of views was also found particularly regarding the shocking nature of some of the personal accounts used in service user teaching and student concerns related to the representativeness of service users involved in teaching.

User Involvement in Mental Health Nurse Education: A study of the effect on the interpersonal skills of student nurses

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“The words we choose matter, and will serve either to perpetuate the problem or resolve it” (Hulme, 1999, p176).

Chapter 1. –

INTRODUCTION

Educational research in health professions, including nursing, has demonstrated that interpersonal skills can be taught, assessed and once gained are successfully retained (Bowles, Mackintosh & Torn, 2001b; Fallowfield et al., 2003; Maguire & Pitceathly, 2002). The education of mental health nurses at the University of Plymouth has a strong tradition in the teaching of interpersonal skills. There is also increasing involvement of service users in teaching students. This has developed over a number of years, and over time the two traditions began to be linked as service users became involved in an evolving approach to teaching and assessing interpersonal skills. This led to wide ranging discussion and collaboration in these areas about the style and content of service user involvement. Lecturer and service user experience up to this point had been that service users had a mostly positive effect on students, and that they both enjoyed and gained from service user contact. However there was also a recognition that there was a mixed effect in some areas, and that fitting service user involvement into a fairly packed and proscribed curriculum had its problems.

As a lecturer involved in this process the author became intrigued by the effect this type of teaching had on students. Of particular interest were the ways in which service user involvement and student interpersonal skills were linked. This led to the development of the research set out in this thesis which examines the impact service users have on student interpersonal skills and whether these impacts, either positive or negative could be better understood.

This thesis includes a synthesis of different research data gathered using a range of approaches to the investigation of service user involvement in teaching interpersonal skills to mental health nursing students. These include a systematic review, mixed methods and instrument testing studies.

1.1 Summary of Research Aims

Whilst each of the different approaches adopted in this study have individual sets of aims the overall aim of this research is to obtain a deep level of understanding of the links between service user involvement in teaching and the development of student interpersonal skills. This deep level of understanding is obtained by looking at service user involvement in terms of the existing evidence base and new ways of looking at the effect of involvement using a range of different research approaches. The specific aims of the different research approaches are as follows:

1.1.1 - The aims for the different research approaches:

Systematic review aims:

1. What can the current evidence base reveal about the effects of mental health service user involvement in the teaching of interpersonal skills to mental health students?
2. What are the effects of this type of involvement in comparison with more traditional methods of teaching?
3. What were participants' experiences of this type of involvement?
4. Does mental health service user involvement in the teaching of interpersonal skills to mental health students have negative effects?

Systematic review objectives:

1. A review of Interventions and outcomes of interest in studies of mental health service user involvement in the teaching of interpersonal skills
2. An assessment of the evidence on the positive and negative educational effects and experiences of mental health service user involvement in the teaching of interpersonal skills to mental health students. To make a selective quality appraisal of the evidence base supporting the involvement of service users in teaching interpersonal skills
3. To summarise research findings
4. To make recommendations for future research activity

Validity and Reliability testing

Aims:

1. The development of the OAISS as a valid and reliable instrument for testing student interpersonal skills

Objectives:

2. In order to develop this questionnaire as a valid instrument a principle component analysis will be carried out to test the validity of hypothesized and reveal additional latent variables. These should provide an indication of the dimensions being tested by this scale.
3. Reliability testing will be carried out on the OAISS as a whole and on retained dimensions using Cronbach's alpha. This will demonstrate that the OAISS is a reliable instrument for testing the dimensions identified by aim two.

Mixed methods study aims:

Broad aims for the study

1. The investigation of the student and service user experience of service user involvement in teaching interpersonal skills
2. The completion of a mixed methods study to explore the mechanisms driving change in attitudes, skills and empathic responses within the context of the shared student and service user experience of involvement in teaching interpersonal skills

Specific Aims for quantitative qualitative parts

1. Quantitative part - To examine the theoretical perspective that user involvement in the teaching of mental health nurses produces more competence in interpersonal skills using Skills, Empathy and attitudes as measurable dimensions
2. Qualitative part - To explore attitudes, skills and empathic responses and change within the context of the shared experience of user involvement
3. To contrast and where possible synthesise the results of the quantitative and qualitative parts to gain a deeper understanding of the mechanisms driving interpersonal skills learning when service users are involved.

This chapter sets out to explain and justify the range of approaches adopted and the way in which they can be linked together in order to expand the evidence base on the involvement of service users in teaching interpersonal skills to mental health nurses. It also sets out the definitions of key terms used and describes the teaching intervention used in the mixed methods study. Chapter two reviews the historical background and current status of mental health nursing interpersonal skills and service user involvement in teaching the mental health professions. This includes a broad summary of the evidence base for this type of involvement. There is some overlap between the research reviewed in this chapter and systematic review set out in chapter three. However the systematic review looks at the evidence

in a very different way seeking to examine its quality and contribution to a specific evidence base rather than using it to provide a broad context for research in this area.

The systematic review is original in that it makes a link between interpersonal skills teaching and service user involvement that has not been the basis for any previous reviews. The establishment of this link and of the extent of the existing evidence base in this area serves to justify the mixed methods study that follows in chapter three. This study is also original in that it attempts to expand the evidence base using methods that have been missing from other studies in this area meeting some of the criticism of the evidence base set out in the systematic review. The instrument testing study set out in chapter four attempts to meet the need for reliable instruments for the testing of interpersonal skills that have been developed in collaboration with service users. Such tools are required for effective teaching and formative assessment of students and for a rich and reflective style of interpersonal skills teaching in which service users are involved.

There is a common research purpose running through the aims and conduct of the different research studies; systematic review, instrument testing and mixed methods. This common purpose is to provide a basis for the evidence based involvement of service users in mental health nurse education. The different studies meet this purpose in the following ways. The systematic review provides an overview of the evidence base for involvement (see 1.1.1 Page 10 Systematic Review aim 1.). This focuses specifically on the comparison of traditional teaching methods with teaching approaches that

include elements of service user involvement, and the student experience of such involvement (see 1.1.1 Page 10 Systematic Review aims 2&3). This review covers quantitative, qualitative and mixed methods approaches. This provides a context for the research methods used in the studies set out in chapters three, instrument testing, and four mixed methods. The systematic review also provides an examination of the quality and findings of existing research in this area. The review goes on to make recommendations for the conduct of research into service user involvement in teaching interpersonal skills (see 3.12). These recommendations underpin the aims and conduct of the instrument testing and mixed methods studies.

The instrument testing study (see chapter 3) sought to begin the process of developing a valid and reliable instrument that can be used in testing the effect of different approaches to interpersonal skills teaching (see 1.1.1 Validity and Reliability testing aim 1.). Tools like the OAISS, that are designed to make comparisons across the dimensions of interpersonal skills defined as skills, empathy and attitudes, are recommended for use in studies of service user involvement in such teaching by systematic review recommendation 2. (see 3.12).

The mixed methods study seeks to follow the recommendations made by the systematic review, most specifically recommendation 3. (see 3.12) that studies using quantitative methods should be comparative and should ideally adopt an experimental approach using at least quasi-experimental methods. This recommendation also notes that quasi-experimental methods are “commonly used”. The quantitative part of the mixed methods study aims to

“examine the theoretical perspective that user involvement in the teaching of mental health nurses produces more competence in interpersonal skills using skills, empathy and attitudes as measurable dimensions” (see 1.1.1. Broad aim 2. Specific aim 1 for the mixed methods study). The study uses a quasi-experimental approach meeting the standard set by recommendation 3. Further links between the systematic review and mixed methods studies are that the mixed methods approach comprises quantitative and qualitative methods using an underpinning mixed methods methodology based on that set out by Cresswell and Plano-Clark (2007) and Brannen (2005) (see 5.1 Methodology for more detail on this approach). This constitutes a clear methodological position for the study as recommended by review recommendation 5. The methodological background to this study is discussed in more detail in section 5.2 - Mixed Methods Research Designs (section 5.2). This methodology provides a basis for methods that included the gathering of both quantitative and qualitative data. Recommendation 4. states that qualitative data is should be gathered in order to triangulate quantitative findings. Specific aim 3 for the mixed methods study states that the study will “contrast and where possible synthesise the results of the quantitative and qualitative parts to gain a deeper understanding of the mechanisms driving interpersonal skills learning when service users are involved”. This aim meets the requirements of recommendation 4 by providing a basis for using qualitative data to provide an explanatory narrative for quantitative findings (Cresswell & Plano-Clark, 2007).

1.2 - Definitions of key terms

This introduction also includes definitions of the terms 'service user', 'involvement' and 'interpersonal skills' that will be used for all following chapters. The development of the intervention used in the gathering of empirical data set out in following mixed methods chapters is also described. The final section discusses the context and need for further research in this area and provides a justification for the research-based chapters that follow. It should be noted that some elements of the research approach were added as the studies developed. The main impact of this was on the mixed methods study. This study originally only involved University of Plymouth students. Advice at transfer viva regarding the generalisability of results led to an expansion of the study to the University of Bournemouth to broaden the sampling strategy for qualitative and quantitative data collection.

1.2.1 - Mental health service users and service user involvement

The term service user has become widely used 'to describe people who receive, have received or are eligible for health and social care services, particularly on a longer term basis' (Beresford, 2005, p.471). The term 'involvement' indicates participation in areas that had previously been the preserve of professionals in employment either in education or health services. Service user involvement is usually defined in the literature as being linked to specific activities including: Pressure groups organized and acting at

national and or local levels, involvement in planning, developing and managing of services, involvement in care planning (Truman & Raine, 2002).

Service user involvement has been described as operating at different levels or as a ladder of involvement. This ladder analogy for involvement and participation was originally developed in the United States as a tool for measuring what was called “citizen participation” in public programmes (Arnstein, 2003). This concept has been developed for use in mental health service user involvement (Goss & Miller, 1995) and used as guidance for assessing the quality of mental health education programmes (CCAWI, 2005). Involvement in discussion fora and consultation processes are at the lower rungs of the ladder of involvement and have been described as potentially tokenistic involvement. Rush (2006) describes token or tokenistic involvement as a frequently used criticism by service users of attempts at involving them, for instance including a single service user in a professionally dominated meeting. Full strategic decision making and operational involvement in which service users act as full partners in processes with access to training and payment are placed at the highest rung of involvement. The way in which service users were involved in the teaching intervention used for the mixed methods study in this thesis sits at the “collaboration” level of involvement when assessed using guidance from the National Continuous Quality Improvement Tool for Mental Health Education (2005). This is the second highest level.

Both the terms ‘service user’ and ‘involvement’ emerged from the growth of consumerism within public services and pressure group politics of the

1970s and 80s. This is discussed in more detail in the background chapter, however it should be noted that the terminology in this area has been a subject of debate. The use of the term consumer or service user in relation to mental health services has been viewed as particularly problematic. Mental health services inescapably contain an element of coercion under the Mental Health Act (Department of Health, 2007) in that some treatment is forced and carried out whilst the individual concerned is detained. This then makes the description of them as a consumer inaccurate, as to be considered a consumer the individual must have choice over what they consume (Beresford, 2005; Truman & Raine, 2002). Similarly the concept of service use and service user involvement has been described as meaningless in a system where professional judgment and action can take precedence at any time (Cowden & Singh, 2007). Criticism of the use of the term service user has been summarized in the literature as follows:

- It presents people as if their main and perhaps sole identity is through their consumption of public services (services which they may dislike and reject)
- It suggests people are in a passive role as recipients of services, rather than as the active individuals they may see themselves as
- It ignores the fact that many 'service users' have no say in whether or not they use services. They are involuntary service users they may be compelled to use services
- The term is employed indiscriminately, when some people to whom it is attached do not view themselves as service users and would not use the term about themselves
- It reduces the complex identities which people may have and suggests artificially that they all have something in common

(adapted from Beresford 2005 p471)

Despite these criticisms for the purposes of this review the term “mental health service user” or “service user” will be used. This should be taken to indicate that the people being referred to have experienced mental health problems and or used mental health services. This definition has been used because it is one that the trainers recruited from the organization involved in the mixed methods study used to describe themselves. Alternative terms such as service survivor were discussed but ultimately rejected. It should also be noted that the term “hearing voices” or “voice hearing” will be used as an alternative to “auditory hallucination”. This term is preferred as it is the term commonly used by service users and service user organisations to describe this part of their experiences within a context of recovery (National Institute for Mental Health in England, 2004). In some passages of this thesis the term client is used instead of service user to refer to someone actively in receipt of talking therapy.

1.2.2 - Interpersonal Skills

Within the literature definitions of the terms ‘communication’ and ‘interpersonal skills’ have considerable overlap and are frequently used interchangeably (Brereton, 1995). Some authors make a distinction between interpersonal and communication skills or micro and macro skills (Duffy et al., 2004) and this is the approach preferred in this study. Definitions of communication or micro skills include the performing of specific tasks and behaviours such the use of a specific questioning style or therapeutic

technique. Interpersonal or macro skills are described as focusing on the process of forming and maintaining relationships, demonstrating empathy and monitoring and responding to the effect of communication on others. This definition views interpersonal skills as being of a higher order than communication skills. These higher order skills were described at the Kalamazoo II conference on assessment of medical communication and interpersonal skills as “humanistic qualities” including empathic responses, required to form and maintain therapeutic relationships (Duffy *et al.*, 2004; Mangione, 2002). Other definitions of interpersonal skills are that these skills are used to reach a goal in collaboration with another person within the context of a helping relationship (Cormack, 1985). This would require the helper to deploy the main components of such skill which have been described as “appropriate knowledge ... behavioural skills ... positive attitude ... availability of opportunity” (Brereton, 1995, p.115). Hargie and Dickson emphasise both the macro skills involved in social encounters such as mutual respect for rights and the micro skills involving the formulation of goals and implementation of actions to achieve them (Hargie & Dickenson, 2004). The split between higher and lower order skills is common to all these definitions.

In the United Kingdom recent policy and advice has made it clear that it is the combination of the application of micro and macro skills that provides the foundation of an effective approach to gaining competent interpersonal skills (Department of Health, 2006b; Department of Health, 2006a; Nursing and Midwifery Council, 2004). A brief definition of interpersonal skills based on the main elements of the definitions above is set out in table one (Duffy *et al.*,

2004) (see table 1 below). This is intended as a tool to underpin the research in this thesis rather than provide a detailed and comprehensive definition.

Table 1 - Elements of interpersonal skills

| |
|---|
| 1. Attitudes - respect for the rights of the client and yourself |
| 2. Empathy – having a caring intent, a focus on the importance of the relationship |
| 3. Skill - |
| a. Paying attention to the client using open / closed verbal, nonverbal, and intuitive communication as appropriate |
| b. Use of technique or therapeutic approach |
| c. Flexibility or the ability to monitor the relationship in real time and adjust actions as necessary |

The central feature of this definition is that it combines macro skills (1,2) that focus on values and attitudes and empathic responses with micro skills of style and technique (3). This is not just a convenient way of conceptualising interpersonal skills; it is also a way of understanding how they are learned. Micro skills can be learned through observation and practice of specific techniques, macro skills are obtained in a more subtle and complex manner. The generation of positive attitudes, values and beliefs that underpins the macro skills elements of interpersonal skills involves addressing phenomena such the negative attributions that generate stigma and discrimination and professional distancing and socialisation that prevent empathic communication and the formation of therapeutic relationships. The research into the creation of positive attitudes, values and beliefs towards people suffering from mental health difficulties indicates that these are generated through the actions of protest and pressure groups and through education and contact with sufferers in situations in which positive appraisals are made possible (Corrigan, 2000).

For the purposes of this document the term interpersonal skills will be used to denote this combination of micro skills of technique and style and macro skills including values attitudes and empathic responses. This combination of items does not claim to be comprehensive in that it includes all qualities that contribute to good interpersonal skills. It is intended to provide a reasonable working heuristic model to allow the concept to be investigated. This definition of interpersonal skills contributes to the structure of both quantitative and qualitative parts of the study. Its main elements are used as the basis for outcome measures in the quantitative part of the study and they are included as topics in the prompt questions for all focus groups and individual interviews.

1.2.3 - The educational intervention used in this study

The educational intervention used in this study developed from an initial involvement of service users in an awareness raising session in which service users spent a day with second year mental health nursing students at the University of Plymouth looking at the experience of hearing voices. The involvement of service users in this way was, in part, an attempt to combat the professional distancing that the teaching team, of which the author was a member, had observed developing amongst students. In professional distancing nurses use their relatively powerful position to avoid the emotional cost of effective interpersonal work through the use of jargon, a task centred orientation or simply by being interpersonally absent whilst engaged in other

professional tasks. This seemed to develop at a very early stage in training. Some students with prior experience of mental health appeared to bring this with them fully formed before they started their training. The existence of processes such as professional distancing and the related process of professional socialization in which peer pressure to conform to bad practice instils this in students and newly qualified staff is well recognized within nursing and is discussed in more detail in the background chapter. Both these phenomena have been recognised as being perpetuated by both nursing education and the culture within nursing practice (Chant, Jenkinson & Randle, 2002a; Warne & McAndrew, 2006). The major impact of these phenomena appeared to be on student's ability to develop effective interpersonal skills and some students resistance to a style of interpersonal skills training that focused on the elements listed in table 1.

A variety of experiential techniques and narrative accounts were used in these service user-teaching sessions, to address student attitudes to their clients and their experiences. A recovery model of mental health difficulty and the use of survivor narratives of psychotic experiences underpinned these sessions (Anthony, 1993; Deegan, 1988; Romme & Escher, 1993). A second session again involving a full day with the students has more recently been incorporated into a module based on interpersonal skills (see appendix 8 for module programme). The aims for this session are set out in table two and include both macro and micro interpersonal skills. It was this session that was used as the intervention in the mixed methods study reported in chapter 5 (the content of the service user training sessions can be seen in appendix 5). A

control group teaching session run by lecturers also used the same set of aims. Both the intervention and control groups involved experiential and taught teaching and learning (more detail of the experimental method is given in chapter five). The teaching aims set out in table two had been developed collaboratively by service users and the academic team.

Table 2 - Aims for interpersonal skills session

| |
|---|
| Two aims |
| 1. The first aim is to help students develop a style of conversation to include: |
| Warmth |
| Comfort |
| Genuineness – “Be yourself” “Don’t say things unless you mean them” |
| Clarity – How easily understood is the student? |
| Empathy / support – How easily does the student “tune in” and react to the clients emotions / needs |
| 2. The second aim is to help them ask questions which might be helpful in a skilful manner, this includes being able to show the ability to: |
| ▪ Ask “why” and “how” type questions – “Why did that happen?” “How could that have been different?” |
| ▪ See things from different angles – No one absolute truth |
| ▪ Unfazed - by anger, upset or other strong emotions but able to acknowledge and talk about them |
| ▪ Enquire – Open ended questions not requiring specific answers |
| ▪ Take Interest in the detail – Asking questions which open with- how much, how often, how easy, how difficult, and how long – How to phrase such questions |
| ▪ Get the story – Time and encouragement for people to tell their story - “Could you tell me a little bit more about that?” |
| ▪ Focus – Homing in on something which is clearly significant or helpful |
| ▪ Checking understanding - summarising |

The mixed methods study examined the effect of such an intervention on students at an early stage in their first year before they had had any substantial mental health experience or academic input.

BACKGROUND

This background chapter provides a context for the links made between service user involvement and student mental health nurse interpersonal skills teaching in the research described in chapters three, four and five. This context is established by examining two main areas. Firstly the development of mental health nursing and mental health care. Secondly the historical development and contemporary influences shaping both service user involvement in mental health care and the teaching of interpersonal skills.

This includes a discussion of the way in which a number of key factors have shaped the need for nurses with effective interpersonal skills, and how this can be linked to the current debate surrounding the need for service user involvement. One such factor is the effect of social and political changes since the 1800's in the United Kingdom (U.K.). This period saw the growth of humane treatment for mental illness, the rise and fall of the asylum system, the birth of the NHS and the growth and development of mental health nursing and of community based care for mental health problems.

Another important influence impacting on nursing and the use of interpersonal skills is the growth of public empowerment and consumerism in the health arena, most specifically the growth of the service user movement in

mental health. Within this context the need for and extent of service user involvement in nurse education is also discussed.

2.1 The Emergence of Mental Health Nursing

From *William Tuke, Quaker philanthropist to Hildegard Peplau the mother of modern mental health nursing, interpersonal skills have been placed at the heart of the nurse's role. Tuke introduced 'moral therapy' as a response to the inhuman conditions he witnessed at the York Asylum in the late 1700's. He highlighted the role of what were then known as attendants to the insane, viewing their interactions with their charges as being a powerful influence in returning the insane to a 'moral path'. As we will see later in this chapter Peplau has been one of the most influential thinkers in mental health nursing in the post-world war two period, and placed interpersonal skills at the heart of her model for nursing.*

The first step from untrained attendant who implemented the will of medical superintendent's to trained and registered nurse's was the publishing in 1885 of "The Handbook For The Instruction Of Attendants On The insane" (Brimblecombe, 2006). By 1923 this book had been renamed "The Handbook for Mental Nurses" and nursing had begun its journey from a role as "doctors' helper" and "patient's keeper" that existed within the asylum based system of psychiatric care that prospered between the world wars. Asylums have been described as a requirement of a developing industrial society in which it was economically convenient to remove those who were unproductive (Foucault, 1967). Asylums had been created both by philanthropic individuals like

William Tuke and increasingly by parish and county authorities as a consequence of the County Asylums Act of 1808. The “New Poor Law” created by the Poor Law Amendment Act of 1834 accelerated the construction of asylums. This act promoted institutional care for those who could not look after themselves. This led to increasing institutional provision was made for “lunatic paupers” including the creation of “pauper asylums” which had already begun to emerge in the 1700s and increased rapidly in number with the Lunacy Act of 1845. This act required county authorities to provide asylums. Most of the UK psychiatric hospitals were built over the following 25 years.

Asylums were self-sustaining communities that offered little effective treatment or therapy (Nolan, 1998). They could be viewed as largely concerned with controlling a perceived threat to society from madness should it be left at loose amongst the wider population (Foucault, 1967). Despite the beginnings of a more defined role and training of nurses within the asylum system they remained largely involved in the smooth running and maintenance of status quo within these institutions until the aftermath of the second world war.

Pressures on mental health services brought about by the Second World War led to shortages of medical staff and a growth in mental illness. This growth was due in no small part to returning service personnel with posttraumatic disorders. Ironically this had the effect, to an extent, of allowing nurses to become more involved as practitioners in their own right, rather than the purveyors of medical clinical decision making.

Mental health nursing as we now recognise it began to emerge in the UK in the post world war two period. As nurses were given increasing responsibility for therapeutic involvement with their patients, beyond the traditional roles of the attendant in an asylum, some began the work of creating and defining a mental health nursing profession based upon interpersonal skill. Two such nurses were Annie Altschul (Nolan, 1999) and Hildegard Peplau (Barker, 1999) who worked with returning soldiers at Army mental hospitals in London.

Annie Altschul was an Austrian refugee in England during the Second World War who had become disenchanted with the rigidity of general nurse training and practice and consequently, chose to train as a psychiatric nurse at Mill Hill, part of the Maudsley Hospital specialising in the treatment of mental illness in the armed forces. Altschul was greatly influenced by the collaborative approach adopted at Mill Hill. She went on to have a very influential career becoming principal tutor at the Maudsley and promoting the skills of understanding and promoting human relationships as an essential component of psychiatric nursing (Nolan, 1999). In so doing Altschul did a great deal to raise the profile of Hildegard Peplau and the significance of her seminal work, "Interpersonal relations in nursing" (1952). Peplau emphasised the importance of talking as therapy based on psychodynamic principles. Peplau and Altschul were amongst the earliest nurses engaging in the post war debate as to the proper scope and direction for psychiatric nursing. Altschul was able to be particularly influential in the training of nurses, she introduced the idea of training in the skills of creating and maintaining

therapeutic relationships, seeing these as central and substantial parts of nurse training (Tilley, 1999). Altschul and Peplau were the foremost mental health nurses of the post war period. Their legacy is a research and development focus on interpersonal skills within nursing.

Mental health nursing had begun to develop rapidly in 1940's and 50's. This post war period saw great social and political change. This included the birth of the National Health Service (NHS) in the UK. Immediately post war and in the years following the setting up of the NHS health professionals existed within a paternalistic comfort zone (Klien, 1995). The public was happy to ascribe decision-making power to professionals and to influence institutions such as the NHS solely through the politics of representation. This comfort zone however has been short lived.

The journey from asylums, as essentially a form of social control by segregation, to the emergence of the service user movement, and mental health nursing as a more interpersonally focused role, is indicative of the remarkable political and social shift in the public relationship with mental health services. This has, in no small part, been due to the closure of the asylums and also the shift in power dynamics between professionals and their clients in the wake of growing consumerism in health and the radicalism of campaigning mental health service user organisations (Barker, Jackson & Stevenson, 1999; Hopton, 1997b; Repper, 2000).

A major turning point in the journey from the asylum system to a more interpersonally focused role for nurses was "The NHS and Community Care Act" (Department of Health, 1990). This was a milestone in developing the

concepts of 'choice and independence' for people using services (Repper & Breeze, 2007b). The concept of choice and empowerment of service users was central to the huge changes wrought in mental health care brought about by the act. The political philosophy underpinning the act can be viewed as both consumerist, in that the way in which choice was to be offered mirrored choice making within free market economics, and managerial in that decision making was to be moved away from professional expert institutions and towards a general management structure. This political agenda also sought to allow increased influence and choice making in the conduct and development of the welfare state by seeking to make services more accountable to individuals in society.

The introduction of consumerist policies has therefore been a powerful force for the inclusion of single-issue pressure groups focusing on the rights of marginalised groups within society. This has led to direct involvement in decision-making and development of health services. The concept of 'consumerism' within healthcare has been a feature of the politics of the "New Right" in the UK since the late 1970s and influenced the health care policies of the Conservative government in the 1980s and 1990s. This included the introduction of general management in the NHS in 1983 heralding a very different approach to researching patient needs and views about quality of care. Changes were also introduced to NHS financial structures. Part of the purpose of 1990 NHS and Community Care Act was to increase competition and shift the culture of the NHS from "one determined by the preferences and decisions of professionals to one shaped by the views and wishes of users"

(Gabe, Bury & Elston, 2005). The Patients Charter, written in 1991, set out rights and service standards that patients could expect and was designed to improve quality and make the NHS more responsive to individual patients (Hanlon, 2000). This trend in policy making can also be seen within the politics of the “Third Way” adopted by New Labour which focused themes such as inclusion and involvement of socially excluded groups and community involvement in service delivery and in the “localism” agenda of our current coalition government. This combination of agendas acted to forge what may seem unlikely alliances between service users and policy makers and this has been an underlying influence on the increasing involvement on service users in previously exclusively professional areas such as higher education in health care.

Hospital scandals involving the abuse and deprivations of patients in psychiatric hospitals across the UK during the late 1960s and early 70s raised human rights issues in the popular press and sparked off early incarnations of the service users’ movement. The “People Not Psychiatry” group was set up in London in 1969 and aimed to provide support through informal networks. Its principles emphasised acceptance, uniqueness and an individual’s right to a self-determined life-style. In December 1972 the Mental Patients Union was formed again in London. They produced a pamphlet claiming that psychiatry was an instrument of capitalist repression (Roberts, 1981). Also in 1972 the National Association for Mental Health changed its name to MIND and appointed a new director with a civil rights campaigning background. This

organisation had been viewed as part of the establishment but now shifted its emphasis to lobbying for patients' rights (Darton, 1999).

The development of service user pressure groups are, to an extent, an international phenomenon, similar processes were experienced in the United States (U.S.) where an asylum system expanded in response to a call for humane treatment and was eventually dismantled in response to the post war deinstitutionalisation movement. This movement highlighted inhumane treatment and conditions and pressure for cuts in expensive social welfare programmes in the 1980s.

This rise in service user campaigning in the U.K. coinciding with public outrage at hospital scandals served to put pressure on government already faced with severe budgetary considerations. These factors were a major influence on the then minister for health Enoch Powell when he made the famous 1961 "water tower speech" which predicted a 50% fall in mental hospital beds over the next 15 years (Freeman, 1998). The subsequent "Hospital Plan" began the process of closing the Victorian asylums. By 1990 the National Health Service and Community Care Act (Johnson & Cullen, 2000) went still further in this direction. One effect of these closures was the expansion of community nursing to meet the needs of a developing community based mental health service. Community nursing predated the end of the asylum system having been developed at Warlingham Park Hospital in the in the post war period and most notably at Moorhaven hospital in Devon where John Greene developed the role and began to describe its elements, in particular its person centred and interpersonal nature (Nolan, 2003).

Community nurses had less time for a medical model based on a positivistic scientific tradition and became increasingly interested in a role which placed the unique interpersonal nature of the nurse client relationship at its heart (Brooker & Simmons, 1986; Nolan, 2003).

2.1.1 - The nature of service user involvement in interpersonal skills training

The developments set out above have led to a long history of government policy and advice on service user involvement in mental health (Department of Health, 1998; Department of Health, 1999a; Department of Health, 2000a; Department of Health, 2000b; Department of Health, 2006a; Department of Health, 2011b). As described above pressure for the creation of an internal market in health during the 1980s set off changes within health care in the UK that began to change the traditional role of the patient as passive recipient of care towards a stakeholder role in which consultation and active involvement are promoted (Rush, 2004; Townend *et al.*, 2008). The influence of consumerism in health care had the effect of contributing to the further development of service user pressure groups as they now saw opportunities to bring pressure to bear on providers now encouraged to view them as customers within a market.

Service user groups developed more sophisticated campaigns against the social exclusion of mental health service users, and for a greater say in their own care and for the provision of more flexible and responsive services (Townend *et al.*, 2008). These campaigns and new political philosophies in

health care led to the development of service users involvement in many aspects of mental health care. Much of this involvement focuses on the empowerment of service users in planning and controlling their care and on canvassing their views on the skills and attributes required of professionals in practice (Hopton, 1997a; Newnes, 2004). The development of service user involvement in health has not been without difficulty. As already discussed authors have highlighted that emerging trends in user involvement featured in literature are frequently reduced to procedural implementation and tokenism (Goss & Miller, 1995), which pays lip service to these concepts without adopting their original intent. Such tokenistic implementation has been noted internationally and across professions (Beresford, 1994; Dogra et al., 2008; Frisby, 2001; Lathlean et al., 2006; Schneebeli et al., 2010). Despite this caveat the user involvement agenda has developed apace.

2.2 - A Role and Purpose for Mental Health Nursing

The net effect then of social and political changes has been increased pressure for mental health nursing to examine its role and purpose (Barker, Jackson & Stevenson, 1999). Nurses were no longer able merely to be the facilitators of institutional care but also had to look beyond subservience to a medical establishment largely wedded to a system of “scientific” physical treatment. The shift of focus to community care has served to steer mental health nursing still further along the path set by Altchul and Peplau toward a role defined by the interpersonal and client centred nature of relationships with clients. This shift was encouraged during the move toward community

care because nursing activity was viewed by politicians seeking to reform the mental health system as more flexible and pragmatically based and above all cheaper than a system dominated by medicine.

It would be misleading however to claim that mental health nursing does not contain different schools of thought regarding the role and purpose of the profession. To an extent nursing is divided between scientific and humanistic traditions along similar lines to psychology and to an extent psychiatry (Forchuk, 2001; Repper, 2000). A number of different authors have expressed the concern that tightening budgets, increasing demands on nurse time in recording and documentation and the impact of a biomedical approach to mental illness all serve to move the emphasis of nursing away from interpersonal skills (Hewitt, 2009). Within mental health nursing there has been a debate as to its proper purpose. This has also impacted on the way in which nurses' use interpersonal skills. This debate has developed in the post war period as nursing evolved and continues to evolve as a profession.

The two sides of this debate can be viewed as on one side a tradition within mental health nursing and indeed nursing as a profession that viewed the person as an "irreducible whole" (du Mont, Chambers & Collins, 2006, p.24) and that rejected pathophysiological explanations of mental health problems and pharmacological treatments. The other side of this debate can be described as a response to advances in neuroscience and developments in drug treatment such as the use of selective serotonin reuptake inhibitors and related drugs in depression and new anti-psychotic drugs (du Mont, Chambers & Collins, 2006). Nurses have also seen an expansion of roles into

prescribing of drug therapy and a move away from a role that focuses on working closely with service users and toward more managerial and administrative duties.

A debate also exists between those advocating the use of what can be described as more mechanistic technique driven cognitive and behaviourally based talking therapies and those based upon a more psychodynamic tradition of talking therapy. To an extent that can be seen as a split in emphasis between behaviourally based approaches tending to focus on the more technical micro interpersonal skills and the more holistic client directed approaches emphasising less tangible macro skills described in chapter one (Hurley, Barrett & Reet, 2006). Most recently this debate has intensified in response to new evidence bases in talking therapy and the development of the Improving Access to Psychological Therapies Programme (Ekers et al., 2011; Richards et al., 2003; Richards, 2007; Richards et al., 2005). Research into the placebo effect of many drugs used in psychiatry (Kirsch et al., 2008) and concerns at high levels of prescribing of some psychiatric drugs, particularly anti-depressants has led to a shift in mental health policy towards talking therapy and particularly those talking therapies with strong evidence bases (Clark et al., 2009; Department of Health, 2011a). This has led to a debate within mental health nursing as to the application of talking therapies. This debate has on one side those who stress the need for development of specific interventions aimed at diagnosed conditions, and see the determinants of mental illness as biologically and genetically determined (Gournay, 1995; Gournay, 2006). The other side of this debate stresses the

importance of nurse client relationships and a holistic view of those clients and their difficulties (Barker, Jackson & Stevenson, 1999; Hurley, Barrett & Reet, 2006; Whitelaw, 2009). A difference in emphasis between gaining of micro and macro interpersonal skills may still exist between these two positions, however the need for skilful interpersonal delivery of therapeutic interventions can provide a common ground for both them built upon the “priorities of service users in the current social context” (Repper, 2000, p.579) (Brooker, 2001; Gournay, 2006).

Peplau and Altschul sought to encompass both sides of this debate in their approach to mental health nursing. They both emphasised the importance of individualised care whilst recognising the nurses role in implementing treatment proscribed in response to specific diagnosis. Indeed the existing sides of this debate vary more in the emphasis they place on the causes of mental illness than in the need for an interpersonal approach in nursing as it is defined in this chapter. Champions of behaviourally based psychosocial interventions (Gournay, Birley & Bennet, 1998; Richards, 2007) can no more deny the need for the ability to work in collaboration with clients and evidence the knowledge skills and attitudes required for effective communication (Chadwick, Birchwood & Trower, 1996) than would the developers of what are often termed holistic approaches, such as the Tidal Model, who highlight collaborative communication as key components of their approach (Barker, 2001). The recent growth of the Improving Access to Psychological Therapies programme has brought the need for both technical and interpersonal skills in using talking as a way of helping and has emphasized that even during brief

therapeutic interventions the interpersonal skills used in delivery are of paramount importance (Bennett-Levy et al., 2010; Roth, Hill & Pilling, 2009).

Authors from both sides of the debate are attempting to provide new and appropriate frames of reference for mental health nursing. In this endeavour no one working in the field can advocate the purely mechanistic application of therapeutic technique no matter how wedded they may be to an evidence base that indicates that a technique has demonstrated efficacy. Neither the positivist scientific or humanistic tradition can therefore minimise the need for nursing interpersonal skill developed within a context of service user involvement and collaboration (Barker, 1998; Barker, 2001; Gournay, 2006; Perkins & Repper, 1996). Mental health nursing has come a long way since Tuke strove to reform an inhumane system of care and treatment. The need for interpersonal skills is established by external policy makers and within nursing itself. The following is a discussion of the current state of interpersonal skill in nursing and the ways it is changing to involve service users.

2.3 - Communication, Interpersonal Skills and Service User Involvement within Mental Health Nursing

Communication is listed as a “core dimension in the NHS Knowledge and Skills Framework (Department of Health, 2004). The Nursing and Midwifery Council (NMC) ‘The Code: Standards of conduct, performance and ethics’ include key components of interpersonal skills such as treating people as individuals and working collaboratively (Nursing and Midwifery Council, 2008).

The Quality Assurance Agency (Quality Assurance Agency, 2006) includes communication as a key subject benchmark. NMC Standards for pre-registration nursing education include communication as part of an 'essential skills cluster' and communication and interpersonal skills as a progression criterion for student nurses (Nursing and Midwifery Council, 2010). These policies recognise the importance of nursing interpersonal skills. There is also a body of literature focusing on the difficulty in attaining good and effective interpersonal skills amongst nurses (Cormack, 1985; Dickenson, Hargie & Morrow, 1989; MacLeod-Clark, 1988; Telford, 1985).

Nurses are affected by a variety of different mechanisms that can serve to reduce interpersonal effectiveness. As long ago as the 1950s seminal research carried out by Isabel Menzies Lyth (1988) reported on the effect of high levels of stress and anxiety in nursing as being to minimise inter-personal communication between nurse and patient and to foster professional distancing as a way of managing that anxiety. Resistance by nursing staff to the humanistic and interpersonal style required for a form of mental health nursing which is built upon the needs and priorities of its users has been a theme that has been examined through the concept known as "emotional labour" (McQueen, 2004, p 1.).

The idea that nurses feel threatened by the perceived personal cost involved in the humanistic delivery of care is well documented (McQueen, 2004; Phillips, 1996). The concept of emotional labour was originally developed by Arlie Hochschild (1983), and refers to paid work requiring the maintenance of an outward appearance which could conflict with internal

emotional states. This work is carried out to create particular emotional feelings in clients and is in effect a form of acting. Hochschild believed that this way of managing difficult situations could have an ultimately negative effect in that the surface acting required to emotionally manage a difficult situation can become incorporated into a more general style of emotional management. Hochschild called this 'deep acting', in which the individual distances themselves from emotions caused by work situations as a way of coping.

More recently, within nursing, the concept of emotional intelligence first developed by John Mayer and Peter Salovey (1990) has been seen as a vital attribute that should be valued and developed amongst nurses attempting to deliver humanistic care as a way of avoiding the damaging effects of emotional distancing. Ultimately emotional distancing and the related phenomena known as professional distancing exists because of a power imbalance that allows those in positions of power to objectify the individuals in their care, effectively dehumanising them in order to protect themselves from the possibility of emotional pain. This is in the long term a self-defeating strategy as it tends to escalate expressed emotion as those in distress attempt to be heard and to gain a response to their pain from those entrusted with their care.

The impact of emotional distancing and concern at the lack of effective interpersonal skills amongst nurses has been part of wide ranging criticism of services for people struggling with severe mental health problems (Bee et al., 2008; Bee et al., 2005). These services have been criticized for frequent re-

admission, overly restrictive observation based care, poor quality of life, social exclusion and a high suicide rate (Barker, 2000; Department of Health, 2001; Sainsbury Centre for Mental Health, 1998; Standing Nursing and Midwifery Advisory Committee, 1999). A report by the Standing Nursing and Midwifery Advisory Committee, which researched the perceived care deficit in inpatient mental health, identified a “lack of a basic humane response in some of our hospitals” (Standing Nursing and Midwifery Advisory Committee, 1999). The impact of poor practice in mental health services has a direct effect on students during practice placement. Professional socialisation is a well-documented phenomenon in which students and newly qualified nurses feel pressure to conform to bad practice in order to fit in with the prevailing culture in the workplace (Booth et al., 1996; Chant, Jenkinson & Randle, 2002b; du Toit, 1995).

Concerns over bad practice particularly in inpatient mental health care have been highlighted by the Chief Nursing Officer who has called for a “values based” approach within nursing and included interpersonal skills as a “best practice competency” for modern mental health nurses (Department of Health, 2006a). ‘Pulling together’ (Duggan, 1997) and the National Service Framework for Mental Health (Department of Health, 1999b) set out an agenda for the core skills, knowledge and attitudes that mental health staff need, and make clear recommendations that in order for this to happen ‘service users and carers’ should be involved in planning, providing and evaluating training for all health care professionals (Gamble et al., 2010). The Commission for Patient and Public Involvement in Health established in 2002

(Florin & Dixon, 2004) was in part created to support this type of involvement. Professional regulatory bodies have begun to produce advice and standard setting publications for service user involvement in education such as the Chief Nursing Officer's Review of Mental Health Nursing (Department of Health, 2006a) and the stipulation by the Royal College of Psychiatrists that postgraduate medical education includes service user involvement (Fadden, Shooter & Holsgrove, 2005). The style and extent of service user involvement is also changing with growing interest in the variety of ways in which service users can be involved and the ways in which educational systems need to change if this is to happen (Tew, Gell & Foster, 2004). The current governments strategy for mental health makes clear links between a civil rights agenda and service user involvement (Department of Health, 2011b). The Mental Health Foundation and organisations such as the PINE project, working directly to promote mental health service user involvement in nurse education have highlighted the importance of the care being taken to ensure that involvement is both appropriate and effective (2011; 2011). Some authors link deficits in the interpersonal nature of mental health nursing to the way in which nurse training has changed. Project 2000 moved all nursing into higher education and gave nurse training a generic core that for some has detracted from the specialist nature of mental health nursing. This could be viewed as part of a trend towards moving mental health nursing away from an interpersonal focus and toward a more complex role in which time spent on interpersonal work has become devalued (Handsley & Stocks, 2009).

In summary the potentially threatening nature of interpersonal communication and the lack of interpersonal skills amongst practicing nurses (Booth *et al.*, 1996; Bray, 1999; Martin, 1998; Menzies Lyth, 1988) and student nurses (Chant, Jenkinson & Randle, 2002b) has made the teaching of interpersonal skills a cause of concern to nurse educators (Ashmore & Banks, 1997; Ashmore & Banks, 2004; Burnard, 1999). A growing consumer 'voice' has had an impact on policy making in mental health (Fox, 2003; Rycroft-Malone, Latter & Yerrell, 2001). The emerging body of policy and advice makes links between the development of interpersonal skills (Bee *et al.*, 2008; Heron, 1990; Speedy, 1999; Watkins, 2001) with the inclusion of service users in a collaborative style of education (Appleby, 2000; Ashmore & Banks, 2004; Bowles, 2000; Burnard, 1999; Department of Health, 2001). However it seems that service user involvement and its impact on the clinical practice of mental health practitioners is far from certain. Indeed there is evidence to suggest that involvement is frequently reduced to procedural implementation that pays lip service to these concepts without adopting their common ethos of humanistic care delivered by interpersonally skilled nurses (Goss & Miller, 1995; Repper, 2000). Below in section 2.4 is a review of the evidence base to support the links between service user involvement and improved interpersonal skills.

2.4 - The evidence base for service user involvement in health education

2.4.1 - User involvement in health education and curriculum development

Even though there is a large body of literature, published over many years, covering user involvement in mental health services (Hopton, 1997a; McIntyre, Farrell & David, 1989; National Institute for Mental Health, 2003; Newnes, Holmes & Dunn, 1999; Perkins & Repper, 1996; Storm, Hausken & Mikkelsen, 2010) much of this focuses on the empowerment of service users in planning and controlling their care and on the skills and attributes required of professionals in practice (Egan, 2002; Heller, 1996; Ion, Cowan & Lindsay, 2010; Simpson & House, 2002). Some literature reports that involvement can be highly conditional in that service users are included in strategic forums as this type of involvement is easy to control and is often reduced to tokenistic involvement (Taylor, 2009).

There is far less written about the involvement of users in the education of mental health professionals. Indeed concerns have been expressed about the possibility of tokenistic user involvement as a way of satisfying policy drivers without challenging established systems of education and without due consideration of the best and most effective form for that involvement (Felton & Stickley, 2004). The small body of research that has been carried out has focused on service user involvement in curriculum design. Qualitative studies of service user views on nurse training report key themes as the need for an eclectic knowledge base for students, that valued difference, recognised the importance of social context, the need for an emphasis on inter-personal skills training and the reduction of professional distancing. Service users also valued professionals' interpersonal and human qualities above the implementation of specific techniques (Forrest et al., 2000; Hogg & Warne,

2010; Rudman, 1996b). These findings are consistent with studies of user preferences regarding nursing approaches (Barker, 1999; Bee *et al.*, 2008; Repper, 2000) and provide some indication of the deficits in educational practice. An evaluation of partnerships with service users in mental health curriculum planning identified a number of issues that need to be overcome in order to meaningfully involve service users in the educational process. These included representation, training for users involved to prevent service user drop out and lack of skill and training on the part of academic staff in managing user involvement (Masters, Forrest & Harley, 2002).

2.4.2 - Measuring the Impact of Involvement

In addition to the literature focusing on curriculum design some authors have attempted to describe and directly measure the impact of user involvement in the teaching and learning process though research of this type is scarce (Hamilton, 2009). It has been reported that the involvement of service users in professional education has a variety of positive effects (Simpson & House, 2002; Tew, Gell & Foster, 2004). Results from studies in this area are however mixed. A 1999 study compared the impact of service user facilitated discussion with lecturer facilitation (Wood & Wilson-Barnett, 1999). Results indicated that user involvement led to a more user centred approach and a reduction in professional distancing. Similarly Barnes *et al* (2006) evaluated the impact of service user involvement in postgraduate interprofessional mental health training and reported a beneficial effect from user involvement.

Some studies have reported problems linked to service user involvement. University staff expressed concern over levels of accountability for the impact of service users personal accounts of mental health difficulty on students (Repper & Breeze, 2007a). Simons et al (2007) studied the impact of a service user academic appointed to a mental health nursing teaching team. A qualitative evaluation found that the appointment impacted positively on student attitudes and helped to integrate service user involvement into the curriculum. It also highlighted problems with unintended discrimination caused by organizational and structural factors with higher education. A qualitative study of mental health nurse lecturer's perceptions of user involvement identified barriers to involvement including role identification and power imbalances as key themes (Felton & Stickley, 2004). Consistency of summative and formative feedback from service users has been identified as a potential problem effecting reliability in assessment(Felton & Stickley, 2004; Morgan & Jones, 2009; Wilkinson & Fontaine, 2002).

2.5 - User Involvement in Interpersonal Skills Teaching

This area is looked at in greater depth in the systemic review chapter. Below is a summary of some policy opinion and research of a more general nature than that covered by the review that is restricted to mental health professional education in interpersonal skills rather than all types of educational activity. There is a body of research, across a variety of health professions, which specifically considers mental health service user

involvement in teaching (Biehn & Molineux, 1979; Greco et al., 2002; Merkel, 1984). However a Cochrane review of the effects of training for health care providers aimed at promoting patient-centred approaches, found only two studies that included any such training for staff working with people experiencing emotional or psychiatric difficulties and none of the studies reviewed appeared to have included any service user teaching input (Lewin et al., 2001).

Within medical education the involvement of service users, including those with mental health difficulties often includes an element of interpersonal or communication skills teaching. Those involved are usually termed expert or standardised patients and are often but not exclusively service users. This type of involvement is often part of a problem based learning approach, in assessing or providing feedback on the interpersonal skills of medical students and doctors. Assessment usually involves the use of standardised assessment tools used to measure technical skill, empathy, person centeredness and attitudes (Mead & Bower, 2000). An evidence base supports this style of involvement though this is not extensive (Greco & Powell, 2002; Livingston & Cooper, 2004; Wykurz & Kelly, 2002). Within medical education an evidence base has been developed which offers some support for the use of service users as standardised patients in a problem based learning environment (Eagles et al., 2001; Spencer et al., 2000). This style of user involvement could be viewed as disempowering as the role of standardised patient tends to place the service user in a less powerful position than the role of “Expert by experience” that is advocated by service user

organisations and has developed as an emerging component of a recovery model of mental health (Repper & Breeze, 2007b).

There is evidence within nurse education that service users have been consulted about the importance of interpersonal skills training and the way in which it should be carried out (Breeze & Repper, 2007). These developments frequently focus on the provision of formative feedback on the use of interpersonal skills (Frisby, 2001). Wood and Wilson Barnett (1999) and Frisby (2001) researched service user involvement in assessment training for mental health nurses. The study by Wood and Wilson Barnett (1999) included a mixed methods approach, triangulating quantitative and qualitative results. A measurement tool to measure student user centeredness was developed as part of this study, this does not appear to have been tested for reliability or validity. Analysis involved counting and tabulation. Results indicated more frequent and more empathic understanding in nurses that received service user intervention at an earlier stage in their training than a comparison group. The study by Frisby was wholly qualitative but did not appear to adopt a recognized qualitative methodology or any clear procedures to ensure rigor. Results indicated that user involvement promoted deeper understanding of the impact of nursing interventions. Anxiety at being judged on role played performance and issues of accountability were also raised.

The quality of research in this area is very mixed. There are few comparative studies of the effectiveness of user involvement in mental health services in all areas including therapeutic involvement, service development and education (Simpson & House, 2002). In the course of this literature

search no comparative studies were found that used standardised instruments to assess the impact of service user involvement on nursing students though this is common practice in medical education (Biehn & Molineux, 1979; Greco et al., 2002; Merkel, 1984).

Nursing studies of the impact of user involvement in the classroom have shown some efficacy in bringing about change in nursing students in key areas associated with good interpersonal skills (Repper & Breeze, 2007b). Some studies have raised concerns regarding service user involvement. The reliability of assessment and feedback from service users to students has been questioned. Also the impact of personal emotionally charged material introduced by service users and the accountability of teaching staff for the impact of such material on students. A range of problems in increasing service user involvement in the traditional structure of higher education have been discussed in the literature including tokenism and the provision of payment for service user trainers (Repper & Breeze, 2007a).

2.6 - Summary

The studies set out in this thesis seek to contribute to the limited evidence base that focuses on user contribution to student interpersonal skills education. This chapter sets the context for a study of the impact of service user involvement in teaching in interpersonal skills. This context is established through an exploration of the gradual shift from a medical perspective to a more psychosocial approach to care within mental health nursing, highlighting

the influence of Altschul and Peplau. Whether one subscribes to the science of mental health practice (Newell & Gournay, 2000) or the artistry of mental health care, (Barker, 2001; Watkins, 2001) a common theme is that nurses need to engage with their clients using effective interpersonal skills. Interpersonal skills feature in most policy and advice covering mental health nurse competence, including, the Chief Nursing Officers Review (Department of Health, 2006a) and the NMC Standards for pre-registration nursing education (2010a). Demands for interpersonal competence are greater than ever as the evidence base for talking therapies grows. However bad interpersonal practice is a very real problem. Nurses are subjected to workplace pressures due to the emotional nature of their work and the changing nature of their role. In order to produce an interpersonally skilled workforce interpersonal skills training needs to be efficient, effective and evidence based.

Interpersonal communication could be characterised as the point of delivery for the main components of interpersonal skills including the macro skills required for the formation of therapeutic relationships and the micro skills needed for the delivery of specific evidence based techniques. Service user involvement may be an important step in preparing interpersonally competent mental health nurses in the use of both micro and macro skills. As discussed above there is policy but little research that links competent practice with a clear evidence base for either the overall effectiveness of user involvement in mental health nursing education, or for their specific involvement in interpersonal skills teaching. Interpersonal skills training is

complex and expensive. In modern mental health nurse education large groups are the norm and running key components of interpersonal skills teaching such as skills rehearsal exercises requires extra staff and resources such as larger rooms and longer sessions. The addition of service user input is a further layer of complexity and expense. To justify such an investment, and to make a case for service user involvement within this type of teaching, a clearer evidence based indicating the efficacy of service user involvement is required.

To this end this research has sought to investigate the effect of user involvement in the process of teaching interpersonal skills to mental health nurse students. The chapters that follow set out the following: a systematic review of the research into the impact of service users on mental health nursing students in their first year of training, a mixed methods study of the impact of service user teaching in interpersonal skills on these students, the development of a third party observation scoring inventory for peer assessment of macro and micro interpersonal skills of mental health nursing students. This broad range of study types addresses a range of deficits in the current evidence base.

The systematic review sets out to synthesise existing published review and research literature in service user and interpersonal skills. This approach to reviewing interpersonal skills teaching is new and links the phenomena in a way that provides a context for further research in this area. The mixed methods study sets out to test the use of mixed methods in this field, to measure the effect of involvement and to gain a depth of understanding of the

processes involved in the effects of service user involvement. The instrument-testing chapter describes the development of a valid and reliable tool for students and teachers to engage in formative assessment of interpersonal skills. It was developed in collaboration with service users. The variety of different research approaches used in this study hopefully provides an original and valuable contribution to the evidence base. The discussion and conclusions chapter attempts to synthesise the results of the different research approaches using the principles of mixed methods research set out in the methodology and research design sections.

A SYSTEMATIC REVIEW OF THE EVIDENCE ON SERVICE USER INVOLVEMENT IN INTERPERSONAL SKILLS TRAINING OF MENTAL HEALTH STUDENTS

The discussion in sections 2.4 and 2.5 identifies that there is policy but little research that links competent practice with a clear evidence base for either the overall effectiveness of user involvement in mental health nursing education, or for their specific involvement in interpersonal skills teaching. Policy recognises the importance of nursing interpersonal skills and there is also a body of literature focusing on the difficulty in attaining good and effective interpersonal skills amongst nurses (Cormack, 1985; Dickenson, Hargie & Morrow, 1989; MacLeod-Clark, 1988; Telford, 1985) Those studies that have focused on interpersonal skills training have often looked at consultation rather than active involvement (Breeze & Repper, 2007). Some research is being carried out into the actual involvement of service users in teaching, though this activity is recent and has yet to be reviewed (Simpson & House, 2002).

As a starting point for a wider investigation into the efficacy of service user involvement in interpersonal skills teaching this systematic review set out to appraise and synthesise existing published review and research literature

in this area. This synthesis aimed to fill what appeared to be a gap in the evidence base as no other systematic review could be found that focused on this type of research synthesis.

This review has been undertaken with a common research purpose that runs through the aims and conduct of the different research studies; systematic review, instrument testing and mixed methods that are included in this thesis. This common purpose within all the studies aims to provide a basis for the evidence based involvement of service users in mental health nurse education. The systematic review contributes to this by providing an overview of the evidence base for involvement (see 3.2.1 - Review aims and objectives -Systematic Review aim 1.) by focusing on studies that compare traditional teaching methods with the effect of service user teaching (see 3.2.1 - Review aims and objectives - Systematic Review aims 2&3). Quantitative, qualitative and mixed methods studies are reviewed and this then provides a context for the research methods used in the studies set out in chapters three, instrument testing, and four mixed methods. The systematic review also provides an examination of the quality and findings of existing research in this area and its recommendations (see 3.12) underpin the aims set out for the instrument testing and mixed methods studies. This has been discussed in more detail in section 1.1.1 The aims for the different research approaches.

3.1 - Background

3.1.1 - Defining Interpersonal Skills and interpersonal skills teaching¹

This review uses the definition of interpersonal skills set out in chapter one. In summary interpersonal skills can be defined as including all the basic skills of communication in conjunction with the communicators' attitudes and ability to empathise with others (Bennett-Levy, 2006; Noble et al., 2007). These are frequently divided into micro skills often linked to the delivery of specific and evidence based techniques such as cognitive behaviour therapy and macro skills linked to the formation of therapeutic relationships. Using the definition set out at the Kalamazoo conference as a framework the functional components of this definition are set out in table 1 Chapter 1. (Duffy *et al.*, 2004).

This definition of interpersonal skills has been used as part of the selection criteria for inclusion in this review (see screen 2 below section 3.4.2). Interpersonal skills teaching can be viewed as any educational activity that focuses on attitudes, empathy and communication skills. This type of teaching often includes examples from practice and possibly the personal stories of people who have experienced services. It will also often include demonstration exemplars through the use of video or live demonstration of

¹ The variety of different approaches in this study means that to an extent the same literature base is covered in different chapters. This is particularly true of the introduction and systematic review chapters. The way in which the evidence base is used is however contextually different within the different chapters.

techniques using role players. Skills rehearsal in which students practice skills under peer or expert supervision role-playing clients for each other is also a common component. From what is already known about the literature in this area there is a great deal written and some research into the effect of service user involvement of the attitudes of mental health professionals. There appears to be much less written and possibly no research that examines the involvement of service users in teaching the more technical aspects of interpersonal skills. Some studies do involve the facilitation of role-play by service users particularly in medical education.

User involvement in education takes place across a broad range of health care professions including mental health (Gmc, 1993; Morgan & Jones, 2009; Rummery, 2009; Rush, 2008; Tew, Gell & Foster, 2004). This has been reflected in increased levels of activity in involving service users in education in a range of institutions (Repper & Breeze, 2007b) and published policies and guidelines from different professions (Gmc, 1993; Mhna, 2005; Tew, Gell & Foster, 2004). The literature in this area since the 1990's has tended to focus on user involvement in curriculum planning with several reviews of different structures and approaches being published (Repper & Breeze, 2007a; Townend *et al.*, 2008). Service users have identified interpersonal skills as amongst the most desirable qualities of mental health professionals (Playle & Bee, 2008; Rudman, 1996b; Whittaker & Taylor, 2004).

As involvement has progressed there has been a growing recognition of deficits in the interpersonal skills of some health professionals. This has led to increased interest in the way professionals are trained in interpersonal skills

(Campbell, 2005; Department of Health, 2006a; SNMAC, 1999). There is some evidence in the wider literature on health education that service user involvement in teaching interpersonal skills is increasing and has a beneficial effect on students (Morgan & Jones, 2009; Warne & McAndrew, 2005). However despite the existence of some reviews, descriptive articles and empirical research (Beresford, 1994; Cook, Jonikas & Razzano, 1995; Repper & Breeze, 2007a) until very recently little published material and research activity has focused on the actual involvement in teaching mental health students and still less on the involvement of teaching students effective interpersonal skills. There has over the last few years been an increase in literature and research activity seeking to evaluate the impact of initiatives in service user involvement in teaching mental health professionals. Some of this activity involves the direct involvement of service users in teaching. Researchers' evaluating specific programmes of involvement have identified both benefits and difficulties including both positive and negative effects on students (Costello & Horne, 2005; Dogra *et al.*, 2008; Rush, 2008).

This review appraises and synthesises the research that has been carried out in this area, as this does not appear to have been the subject of a previous review. A review focusing on service user involvement in interpersonal skills teaching also provides a starting point and basis for the mixed methods study set out in chapter 5. The need for such a review was confirmed through a presentation and subsequent consultation with peer academics at a quarterly meeting of Mental Health Nurse Academics UK

(Perry, 2011) where the review was well received and the author was encouraged to seek publication on completion.

3.2 - Review method

3.2.1 - Review aims and objectives

Aims

The aims of this review are to answer the following questions:

1. What can the current evidence base reveal about the effects of mental health service user involvement in the teaching of interpersonal skills to mental health students?
2. What are the effects of this type of involvement in comparison with more traditional methods of teaching?
3. What were participants' experiences of this type of involvement?
4. Does mental health service user involvement in the teaching of interpersonal skills to mental health students have negative effects?

Objectives

1. A review of Interventions and outcomes of interest in studies of mental health service user involvement in the teaching of interpersonal skills
2. An assessment of the evidence on the positive and negative educational effects and experiences of mental health service user involvement in the teaching of interpersonal skills to mental health students. To make a selective quality appraisal of the evidence base supporting the involvement of service users in teaching interpersonal skills
3. To summarise research findings
4. To make recommendations for future research activity

These aims have been met through the identification of both published and grey literature on the involvement of service users in the delivery of interpersonal skills training for mental health students. The review

describes approaches taken to involvement of service users in interpersonal skills training. Evidence of the benefits, negative impacts and ethical implications of these types of involvement and the methods used to evaluate involvement are reviewed and discussed. The final part of the chapter discusses the gaps remaining in the evidence base on service user involvement in interpersonal skills training. Differentiating between studies that focus on interpersonal skills teaching and other forms of educational intervention is not a simple or straightforward process. Many interventions used in studies are poorly defined. For the purposes of this review only studies that demonstrate that the content of teaching and measurement of outcomes includes components of interpersonal skills as defined in the elements of interpersonal skills list above are included. This includes studies that are less clearly focused in intent i.e. not necessarily billed as interpersonal or communication skills teaching but have measured outcomes that include major components of these phenomena.

3.2.2 - Population

Mental health professionals undergoing mental health education

3.2.3 - Interventions

Any educational activity that involves teaching by people that have experienced mental health problems. This excludes programmes that included role-playing of standard scenarios or where service users were

asked to act as “standardised” or “simulated” patients.

3.2.4 - Outcomes

Any educational outcome, including (but not restricted to) changes in skill, beliefs, attitudes, behaviours, empathy and negative effects.

3.2.5 - Study design

Much of the research into mental health service user involvement in teaching interpersonal skills adopts mixed methods. Mixed methods are often used in this area, involving a combination of quantitative and qualitative methods rather than a formal adoption of mixed methods as a paradigmatic underpinning of the research process (Cresswell & Plano-Clark, 2007). Guidelines for the conduct of systematic reviews that are commonly used in health care research, such as the guidelines for quality appraisal set out in the University of York Centre for Review and Dissemination (CRD) (Khan, 2001), do not adequately cover the review of mixed methods approaches or the less formal adoption of a mixed quantitative qualitative approach. In order to allow a reasonable appraisal and synthesis of the research covered in this review a composite study design was adopted using elements of the CRD guidelines such as the approach to summarizing studies for quality appraisal. Also the approach adopted to quality appraisal developed by Walburn et al (2001)

which was in itself developed from CRD guidelines and the Critical Appraisal Skills Programme (CASP) tools for appraisal developed by the Public Health Resource Unit (2006). The approach adopted by Walburn was used as it was designed to appraise a range of studies similar to those reviewed in this review and has been employed by other reviewers where a range of quantitative, qualitative and mixed methods studies are being appraised (Besenius et al., 2010; Waddell & Taylor, 2009). The CASP appraisal tools are commonly used in health research as a systematic approach to qualitative appraisal (Dixon-Woods et al., 2007).

Randomised controlled trials (RCTs), controlled trials, quasi-experimental designs and prospective / cohort studies. Qualitative and mixed methods studies are included where the qualitative methods used are rigorous in approach and use a recognizable qualitative methods such as focus group studies, grounded theory based designs, ethnographic designs

3.3 - Search Strategy

Table 3 - Sources used for searches

| Databases Searched |
|---|
| ASSIA - Applied Social Sciences Index and Abstracts |
| BNI - British Nursing Index |
| British Education Index |
| British Medical Journal (Clinical evidence) |
| CINAHL - Cumulative Index to Nursing and Allied Health Literature |
| Cochrane Library |
| Database of Education Research |
| Embase |
| Higher Education Empirical Research Database |
| Index to Theses |
| Medline |
| National Research Register |
| OTDbase - Occupational Therapy Database – no access – used OT seeker instead |
| PEDRO - Physiotherapy Evidence Database – no access |
| Proquest |
| Psycinfo, |
| Scopus |
| Social Care Online |
| Web of science |
| ZETOC - British Library's Electronic Table of Contents |
| Other internet sources |
| EPPI-Centre Evidence Libraries |
| Current Educational Research in the United Kingdom (CERUK) |
| Intute – Websites for study and research |
| NMAP - Nursing, midwifery and allied health |
| OMNI – Medicine and dentistry |
| SOSIG – Social sciences |
| Department of Health |
| National Library for Health – archive |
| INVOLVE - Promoting public involvement in NHS, public health and social care research |

Terms are combined in various ways (see figures 1 - 4) in order maximize coverage of relevant literature using the method described by Haig and Dozier (2003) in their paper on systematic searching, and including the use of an adapted form of the PICOS framework (see table 4). This consists of components grouped under the headings: *population, intervention,*

comparison, outcome and study design. This framework is commonly used in health related searches for evidence. Initially the terms under students, teachers and type of involvement are used. The ways in which these terms are combined have been determined by the number of hits obtained and relevance of results. For instance a keyword search obtaining thousands of hits of low relevance was refined by restriction to tile or title plus keyword search to increase relevance by reducing the number of irrelevant hits. Other relevant terms or descriptors were used to refine searches further as required. They were also used to develop new searches as emerging findings revealed new themes or relevant areas of publishing activity that do not fit within the framework.