Engaging Undergraduate Mental Health Nursing Students in Recovery Orientated Practice Through Service User Involvement: A Mixed Methods Study.

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Declaration

I hereby declare that this material, which I now submit for assessment on the programme of study leading to the award of PhD is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Abstract

Introduction and Background: Current mental health policy is committed to the involvement of service users both in mental health service delivery and in the education of health care professionals. However, this is an under-researched area that requires further attention to understand the potential effect of service user involvement on student's clinical practice and the influence it has on student's perceptions of service users and mental illness.

Aims and Objectives: The aim of the current study was to establish the extent, and examine the perceived effect of service user involvement in undergraduate mental health nurse education in the Republic of Ireland. The objectives were to: (1) establish the national extent of service user involvement in the education of undergraduate mental health nurses; (2) examine students' experiences of service user involvement in their education; and (3) examine service users' experiences of being involved in undergraduate mental health nurse education

Design: The current study adopted a two phased sequential mixed methods design. In phase one a national survey was conducted with all 12 Departments of Nursing in educational institutions in the Republic of Ireland to establish the national extent of service user involvement in undergraduate mental health nursing programmes. In phase two semi-structured interviews were conducted with 18 students and four service users to explore their experiences of service user involvement.

Main Findings: The findings from the national survey indicate that the extent of service user involvement in Irish undergraduate mental health nursing programmes varies to a large degree. Some nursing departments welcome service user involvement not only in the theoretical delivery of their nursing programmes but also in areas of curriculum development and programme evaluations. In contrast, other departments have no service user involvement at any level, with no future plans to incorporate it in any aspect of their programme. The key qualitative findings indicated that the experience of service user involvement shifted the students' focus away from the constraints imposed by a diagnosis, and recognised the service user as a person with a wealth of expertise acquired through their personal experiences. Following the integration of both data sets the following four sub-themes also emerged, 'learning from experiential knowledge delivered through narrative', 'From practical to personal', 'From illness to wellness -a beacon of hope' and 'Progression of practice. The super ordinate theme that emerged was 'Service User Involvement: A Journey towards Recovery Orientated practice'.

Conclusion: This study highlights that service user involvement in undergraduate mental health nurse education has the potential to be an influential factor in student's ability to adopt a recovery orientated approach to clinical practice. Contemporary mental health policy strongly stipulates that recovery orientated practices need to be adopted by mental health nurses. The current study indicates how the vision for recovery orientated practices could potentially be achieved through the involvement of service users in professional education.

Chapter 1 - Introduction

1.1 Introduction

The concept of involvement is associated with 'being included', 'participating', and 'having a say' (Morrow et al. 2012). In many countries across the world, the involvement of service users within health and social care services and in the education of health care professionals has become imperative (Speed et al 2012). In line with international trends, the Department of Health and Children (2006) and the Mental Health Commission (2008) in Ireland called for the involvement of service users in the development, delivery and evaluation of professional education for mental health practitioners. This drive for increased involvement is part of a wider commitment to involve service users in the planning, provision and evaluation of health care services (Department of Health and Children 2001, 2006, Mental Health Commission 2007). In a report on service users' initiatives in professional education, Tew, Gell and Foster (2004) argue that if an ethos of partnership, which recognises and values the expertise of service users, is to underpin service delivery, then such a partnership must also be a core aspect of professional mental health education. Moreover, they stated that the primary reason for involving service users in the training and education of mental health professionals is to produce practitioners capable of delivering improved and more relevant outcomes for service users.

The role of service users in mental health nurse education has historically been passive, with service users the subject of nursing care as the students learn their craft (Hanson and Mitchell 2001). More recently, this passive role is changing. For example, service users now participate in activities, such as classroom teaching (Rush 2008). This provides students with the opportunity to understand the experience of mental distress from the lived experience. Moreover it allows students to engage with

service users outside of the clinical setting. This facilitates a dialogue between the students and the service users that is difficult to replicate in the clinical setting where the power relations are different. Typically students in the clinical setting are there to 'care' for service users, whereas in the classroom students are there to listen and learn from service user expertise. Although there appears to be pockets of small scale activity in relation to service user involvement in mental health nurse education, limited literature exists on service users' involvement in curriculum planning and the development of nursing programmes (Lathlean et al 2006). Those who are keen to promote enhanced service user involvement in the education of mental health nurses claim that there are obvious merits associated with service user involvement. Exposing students to the lived experience of service users can be professionally enriching and ensure a quality curriculum with effective teaching strategies (Rush 2008, Simpson et al 2008). Moreover, service user involvement contributes to a different understanding, and brings new ways of knowing in nursing education (Cowling et al 2006).

Service user involvement in service development had also been considered an essential component for promoting recovery orientated services (HSE 2012). The drive to adopt a recovery-orientated philosophy within mental health nursing has clearly been advocated within contemporary reports (HSE 2012). A recovery orientated philosophy requires a change in both the approach and the beliefs of mental health nurses. Byrne et al (2013) contend that providing real life first-hand examples of recovery is pertinent in order to allow student mental health nurses to truly grasp and internalise the very real possibility that anyone can recover. As a lot of recovery concepts were developed by service users, Gordon (2005) asserts that it must be the lived experience of those that have triumphed and struggled with the experience of stigma, discrimination and social exclusion, and having their voiced silenced because of their mental health struggles, that should inform and direct nurses understanding of recovery. The drive

for both mental health services and mental health practice to adopt a recovery orientation is well documented in mental health literature and policy directives. However there is a lack of meaningful engagement which is problematic (Ramon, Healy and Renouf 2007). Although policy directives are attempting to drive the need for a recovery approach, a lack of training and education is hindering its progression. Having a solid understanding and appreciation of recovery would potentially enhance the application of this orientation, and significant efforts need to be made to ensure that nurses understand recovery and recovery orientated practice,

1.2 Positionality and Rationale for the Current Study

During my childhood and adolescence years I had never experienced a person who had a mental health difficulty or even understood properly the meaning of mental illness, nevertheless I was genuinely intrigued, and in 2003 I began my four year degree programme to train as a psychiatric nurse. Over the course of the programme and the many clinical placements I experienced, a picture was forming, which I believed explained mental illness and the role of a psychiatric nurse. At the end of my degree programme in 2007 I began my career working in an acute inpatient unit.

I can recall the first time I read snippets of the Vision for Change (2006) which was during a night duty shift. I was not exactly absorbing the content of the text, but I remember frequently seeing terms such as ‘service user involvement’, ‘participation’, ‘collaboration’ and ‘expertise of service users’. The words stood out to me, mainly because they were alien concepts, especially in relation to practice. I began to reflect, and to my mind the people with the expertise were the members of the multidisciplinary team, such as doctors, nurses and social workers etc. I believed that I had acquired an expertise through academic education and clinical experience which could help the service user I encountered. It had honestly never dawned on me that service users have an expertise due to first-hand experience of living with a mental

illness, an expertise which has come from the challenge of overcoming stigma, discrimination and having their personal identity eroded because they have a label of a mental illness. I struggled to recall any appreciation for service user's expertise or indeed any meaningful approach to try and involve service users meaningfully in their care, or indeed collaborate with service users in a way that valued or attempted to tap in to the expertise of service users. There was a tokenistic gesture to get service users to sign their care plan, but their involvement in actually devising it was minimal. I thought I was engaging with service users in a meaningful way, but in retrospect my engagement with service users, especially in the early years of my career always had an agenda, which was clinically driven. I wanted to find out how their mood was, their sleep, were they taking their medication, were they suicidal. I realised that I did not engage with the person in the way that I should have. Although I was kind, polite and interested, I engaged with the illness and the symptoms, and sadly lost perspective on the person. There is such an emphasis on risk and risk prevention, that I got caught up in thinking that it was the most important thing.

The overriding view that professionals know best resulted in the views or input from service users being patronisingly rejected, primarily on the grounds of them being "unwell". Despite believing that I had a much more value laden approach to my practice, it was apparent that this view and approach swamped my own practice, and I was narrowly looking at service users through the prisms of their illness. This was the birth of my interest in the area service user involvement and recovery, and I began reading intensely around the topic. To my amazement it seemed like there was a buzzing enthusiasm regarding service user involvement and the potential possibilities it held, especially in the area of professional education. I began looking specifically at service user involvement in professional education programmes in Ireland and it was quickly apparent that there was a dearth of literature. The notion of service user

involvement was certainly appreciated in the literature and in mental health policy directives, but it seemed that it almost stopped at that.

At this point I began to reflect on my training and quickly formed the opinion that service user involvement would have enhanced the programme and perhaps provided me with a more humanistic perception of the human condition, and the catastrophic effect that mental illness can have on all aspects of a person life, ranging from their loss of identity to employment, to living in a society which is largely negative about mental illness. Possibly the experience of service user involvement would have prevented me from believing that my knowledge base was superior compared to that of the service user. I had a genuine interest and passion to carry out research in this area, in the hope that I would establish a picture of service user involvement in undergraduate mental health nurse education in Ireland.

The majority of my educational and personal life experiences, especially my personal experiences in later years, have primarily associated a person with a mental health diagnosis as having a 'mental illness'. My attempt to be mindful of and to communicate my language in a less medical orientated way is a challenge. This is primarily because my experiences are entrenched in a traditional position that looks at mental distress through a 'mental illness' lens, which has directly influenced the language that I use.

Although there is a body of literature, published over many years, relating to service user involvement in mental health services (Hopton 1997, Perkins and Repper 1996, Storm, Hausken and Mikkelsen 2010) much of this literature focuses on the empowerment of service users in planning and controlling their care and on the skills and attributes required of health care professionals (Ion, Cowan and Lindsay 2010, Simpson and House 2002). However there is far less written about the involvement of

service users in the education of health care professionals. Concerns have been voiced regarding the possibility of tokenistic service 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 and Stickley 2004).

The current body of evidence relating to service user involvement in undergraduate mental health nurse education would largely suggest that students view the experiences of service user involvement in a positive light. However, service user involvement should be about much more than simply providing students with a positive learning experience. It should provide a lived perspective that can enlighten students' about the emotional, psychological and social effects that mental distress can cause an individual. Moreover, it should provide a perspective that offers hope about the possibility of re-claiming and re-storing life, a life which is defined by the individual. During their training both in the academic and clinical setting, students are frequently exposed to pathologising of the human condition, where a lot of the focus is on diagnosis, deficits, signs and symptoms. Service user involvement has the potential to humanise the experience of mental distress, and provide a glimpse of how mental illness can impact the human condition, through stigma, discrimination and loss of human rights (Lakeman et al 2012; MacGabhann et al 2010). So the experience of service user involvement should certainly offer more than a positive learning experience, yet there is limited evidence relating to the effect service user involvement has on student's perceptions of suffering, mental illness and their perception of service users. Moreover, there is a lack of evidence concerning the influence service user involvement has in relation to current mental health policy, particularly policy directives on recovery. According to Higgins et al (2011), there is very little evidence to the degree of service user involvement in the educational preparation of mental

health practitioners within Ireland. The current study is warranted as this area of enquiry requires further work in an attempt to address some of the current gaps regarding service user involvement in undergraduate mental health nurse education.

1.3 Aims and Objectives of the Current Study

The aim of the current study is to establish the extent and examine the perceived effect of service user involvement in undergraduate mental health nurse education. This can be broken down in to three specific objectives.

1. Establish the national extent of service user involvement in the education of undergraduate mental health nurses.
2. Examine students' experiences of service user involvement in their education.
3. Examine service users' experiences of being involved in undergraduate mental health nurse education.

1.4 Structure of the Thesis

Chapter 2 - provides a conceptual background and the influential social contexts which influenced the growth and the development of service user involvement, with a particular focus on the service user movement and mental health recovery. The influences of policy directives relating to service user involvement are reviewed. The chapter will also look at the development of mental health nurse education in Ireland.

Chapter 3 - reviews the literature on service user involvement in mental health education. Studies from the disciplines of nursing, medicine, social work and psychology are included in the review. In addition, the benefits and challenges of service user involvement are also considered. Having considered the gaps in the previous studies, a rationale for the current study is established.

Chapter 4 - presents an overview of mixed methods, the rationale for choosing this methodology, the sequence, priority and integration of methods. In addition, a

justification for pragmatism as the theoretical underpinning of the current research is discussed.

Chapter 5 - presents the findings from phase one which involved a questionnaire completed by mental health branch coordinators from each of the Schools of Nursing offering undergraduate mental health nursing degree programmes in Ireland. The aim of phase one was to establish the national extent of service user involvement in the undergraduate mental health nursing programme.

Chapter 6 - provides the findings from Phase 2 which involved individual semi-structured interviews with 3rd/4th year student mental health nurses and service users. A total of 22 individual semi-structured interviews were conducted. Thematic analysis was used to analyse the interviews. The aim of phase two was to examine the perceived effect of service user involvement in undergraduate mental health nurse education

Chapter 7 - presents the integration of the results from phase one and phase two. The super-ordinate theme to emerge indicates a promising and potentially exciting link between service user involvement and a recovery focused approach to clinical practice. Chapter 7 presents a discussion of the super-ordinate theme and the supporting subthemes.

Chapter 8- reviews the aims of the research and how they have been addressed in the current thesis. The study generated new knowledge and considerations relating to the influence of service user involvement in the education of undergraduate mental health nurse education. Based on the findings, the recommendations and implications of the study will be discussed

Chapter 2 - Historical, Political and Theoretical Background to the Research

2.1 Introduction

This chapter will begin by discussing and explaining terminology that will be referred to frequently throughout the thesis. This will be followed by a discussion of the various terms that are used to ascribe meaning to the term 'service user'. A rationale for adopting the term service user throughout this thesis will be provided. Following on from that, key historical events which have been influential in the development of service user involvement will be discussed. These specific events include the development and failure of the psychiatric asylum, the service user movement and recovery. Subsequently, service user involvement and the ideology underpinning service user involvement will be considered. The chapter will also present a discussion on professional knowledge and the experiential knowledge of service users. Following on from that, the developments in mental health nurse education will be discussed. Relevant policy documents which have influenced the development of service user involvement will also be considered, with a particular focus on the UK, Australia, New Zealand, Canada and Ireland.

2.2 Terminology

'Mental health', 'student', 'health care professional', educationalists', 'recovery', 'experiential knowledge' and 'narrative' is terminology that will be referred to frequently throughout this thesis. 'Mental health' refers to a state of mental wellbeing, and 'mental distress' relates to a significant departure from this state. Mental health is about the physical, mental and emotional well-being of a person. Good mental health helps people to deal with the ups and down of everyday living. In contrast, people who are faced with challenges such as violence, discrimination, feeling like they do not belong or not being valued, are at great risk of developing emotional challenges which can impact on their day-to-day functioning and find it a challenge to participate fully in

their work, school, personal and social lives. The term 'student' is used to denote people who have/are receiving training or education at either undergraduate or postgraduate level within an academic institution. It is a term used to describe a novice, beginner, or a learner. 'Health care professional' refers to people who work in a clinical setting, i.e., a nurse, a doctor or a social worker. Health care professionals are involved in the provision of systemic care to communities, individuals and families. Their practice is regulated by a regulatory body to ensure quality and good standards. 'Educationalists' refers to lecturers who are involved in the organisation and delivery of education or training in a third level educational institution. Their role involves an array of activities, ranging from teaching, assessment, research and curriculum development (Tew, Gell and Foster 2004). 'Recovery' refers to a personal journey that involves a change in attitudes, beliefs and skills in order to live a hopeful and meaningful life (Mental Health Commission 2008). 'Experiential knowledge' acknowledges the kinds of knowing that arises from everyday lived experiences (Code 1991). Narrative or a story is an account of an individual's experience in order to make sense of events or actions in their life (Redman 2005). Finally, it is important to note that there is a variation amongst the third level educational institutions in Ireland when referring to 'mental health nursing' or 'psychiatric nursing'. The Nursing and Midwifery Board of Ireland is the statutory regulatory body for nursing and midwifery professions in Ireland. Its primary function is to relate to the promotion of high standards of professional education and training in nursing and midwifery. The Nursing and Midwifery Board refer to 'psychiatric nursing' (An Bord Altranais 2000). However, for the purpose of this study the term 'mental health nursing' will be utilised as it is a more commonly used contemporary term.

2.2.1 Service User

The term 'service user' can have many different meanings depending on the context of its use, and often the terms service user, patient, consumer, survivor and expert by experience are used interchangeable despite having different meanings. Speed (2006) asserts that the term patient, consumer and survivor are imbued with different conceptions of the service user. Wallcraft and Bryant (2003) identify that a challenge is the differing views that service users, consumers and survivors have. Patients may be regarded as passive recipients of care (Barnes and Shardlow 1997), consumers as actively choosing care (Mclean, 2000) and survivors actively resisting care (Crossley, 2004). The different use of terminology can be confusing, but each reflects a slightly different ideology and social status and all of the descriptors commonly used reflect a general distaste for labels like "mental patient" (Misra and Cohen 2001). Being labeled a "patient" turns a human experience into symptoms of pathology. Speed (2002) points out the patient is the construction of the doctor and is offered limited, if any personal agency in terms of their treatment or care. Speed (2002) further argues that the service user as a patient is the embodiment of biomedical practice, meaning that the patient is solely defined through their psychiatric diagnosis and there is no room for the person within the definition. Patients may be regarded as passive recipients of care as patient groups pose no real potential for any resistance against psychiatric authority. Therefore, they passively accept the legitimacy of psychiatric knowledge and diagnosis.

Mental health consumer is associated with the term consumerism and acknowledges the importance of satisfaction with health care. Offe (1984) explains where consumer originated, and reports that it refers to the commodification of the welfare system. This process of commodification has resulted in market principles being incorporated into the health care services. This had a knock on effect, as service users realised that if

they are to be regarded as consumers, then this provided them with the same basic rights as any consumer of purchases would have. Hence, users are increasingly seen as customers who can exercise an informed choice about the services they receive (Tait and Lester (2005). This view is also echoed by Bluebird (2004) and states that the term consumer signifies a choice regarding attending services and receiving treatments. Speed (2002) points out that the service user being a patient or being a consumer represents a crucial difference. Pilgrim, Rogers and Lacey (1993) supports this view and identifies that patients are conceptualised as the object of a clinical intervention, while consumers are conceptualised as a user or consumer of services. Speed (2002) reports that although the term consumer accepts the biomedical basis of psychiatry, it also creates a space within the field for a consideration of the person, so the sole focus is not psychiatric difficulties. The terms "consumer" and "service user" suggests identification with the current mental health system that more radical members of the service user movement would like to reject (McLean, 1995).

The term 'experts by experiences' is a more recently coined term and draws attention to the expertise of people with mental health difficulties gained through virtue of their lived experience, and their expertise about their own mental health. It is used to promote participation and acknowledges a person's ability to work in partnership with the mental health services (McLaughlin 2009). Noorani (2013) asserts that understanding the term 'experts by experience' is in the nature of experiences that it teaches, as it teaches truths not accessible through other forms of knowledge, such as protocols or textbooks. Noorani (2013) considers that one driving force behind 'experts by experience' can be found in the grass roots of self-help and support practices, where individuals who experience mental health challenges experiment with ways of working on their experiences and developing ways of navigating through

periods of distress. In this process, people develop techniques and capacities that are central to expertise by experience.

The user as a 'psychiatric survivor' is linked to the growth, in the early 1970s, of the collective activities of mental health service users. The user as a 'survivor' is chosen to emphasise a positive image of people in distress and the inherent strength required to recover from and survive the mental health system and the accompanying social exclusion. Crossley and Crossley (2001) argues that survivors derive their status from being an active member of various mental health organisations such as Survivors Speak Out, and the Hearing Voices Network and from personal experiences of belonging to an oppressed and exploited group (Tait and Lester 2005). Pilgrim and Rogers (1999) characterise survivors as people who actively resist and reject psychiatric diagnosis and the legitimacy of psychiatric knowledge and have an agenda for social and political change. Speed (2002) argues that survivor is a political statement and the essential point about the term survivor is that the social construction has totally shifted, from a situation where identity is ascribed by a medical expert, to a situation where the person ascribed his or her own chosen identity. Broadly speaking survivors tend to be activists and more challenging of the scientific basics of mental health service.

Taking the previous discussion of the various terms into consideration, the term service user will be referred to throughout the thesis. There are a number of reasons why service user was chosen above the other terms discussed. Involvement in professional education requires people who want to work in collaboration with educationalists and students in a collaborative, constructive and meaningful way; therefore it is important to find a workable solution between activists, resistance and passiveness. Speed (2002) describes service users as working for and driving reform

within mental health. The term service user appears to offer a feasible middle ground between the diverse positions discussed. Also the term service user appears to be a widely accepted term within the Irish body of literature on involvement and it seems to be the most commonly used of the various terms available. The term 'service user' is an amorphous concept which can refer to a diverse variety of groups whether defined by age, colour, race, nationality, gender of disability and will have varied needs and concerns. A further rationale for selecting the term service users is because of its association with the 'user movement'. The service user movement was essentially a liberation movement which gained momentum in the 1970's; it was a political movement of people who had been on the receiving end of oppressive treatment due to mental illness. The movement was a driver for change and restored the voice of people who had been silenced. The 'user movement' was instrumental in the development of service user involvement. In the absence of the service user movement it might not have been possible to have service user involvement in professional education For the purpose of this study the term 'service user' is used to denote people with lived experience of mental distress, who are currently using the mental health services, or who have used them in the past (Tew, Gell and Foster 2004).

2.3 Overview of Key Historical Events and Social Movements Relating to Service User Involvement

Morrow et al (2012) believe that it is important to appreciate and understand that the moves to involve service users have come about due to the culmination of a series of historical events, rather than a one-off policy directive. In other words, a series of historical events and social movements are what makes it possible to talk about service user involvement at this particular instant in time. These societal changes have served to provide some momentum for increasing service user involvement in the area of mental health (Kemp 2010). Key themes contributing to the rise of service user

involvement have been identified and will be discussed in the subsequent sections. These themes include the service user movement and the recovery movement.

Lakeman, McGowan and Walsh (2007) note that protest and resistance within the psychiatric domain has been a response of individuals for as long as others have imposed their treatments on them. The year 1620 is thought to be the first recorded example of people with mental health problems lobbying to improve their treatment. In 1620 patients in the psychiatric hospitals came together to speak out with the 'Petition of the Poor Distracted Folk of Bedlam', and are said to have petitioned the House of Lords complaining about the inhumane treatment by being forced to entertain in public in exchange for clothing and food as well as being physically mistreated and shackled. The forerunner of modern advocacy groups, however, was the Alleged Lunatics' Friend Society, established by John Perceval in 1845. The aim of the society was to protect people against unjust confinement on the grounds of mental illness. This is an early example of groups lobbying against incarceration and exclusion.

2.3.1 The Psychiatric Asylum

Around the year 1840 the care of the mentally ill became a medical responsibility and a subspecialty of medicine called psychiatry was established. Care of the mentally insane was provided in the confinement of 'mad houses', where control was exercised in large institutions known as 'asylums' (Nolan 1993). These 'asylums' or mental hospitals were operational in America and across Europe .Davidson, Raakfelt and Strauss (2010) argue that these asylums had become dumping grounds for anyone in society who was problematic or unwanted by the community, admitting increasing numbers of people with developmental or physical disabilities and the elderly, many without any presenting signs of a mental illness. This wholesale dumping and overcrowding played into asylums becoming little more than warehouses for unwanted human beings.

2.3.2 The Failure of the Asylum

Mental asylums were no sooner built when criticisms were voiced regarding their size, the number of people housed, quality of care and their therapeutic function (Davidson, Raakfeldt and Strauss 2010). According to Rothman (1971), by the early 20th century it became evident that the public mental hospitals thus created had become little more than custodial warehouses, and that hopes for treatment, rehabilitation, and socialisation, which motivated the beginning of the mental health hospital movement, had failed. This view is shared by Foucault (1971), who has documented the undesirable influences of the institutional structures. Foucault argues that emergences of large institutions in which "unreasonable people" were housed was not a progressive medical venture but an act of social exclusion. However noble the intended purpose of the institutions at the time of their creation, they had become inhumane, ineffective, and inefficient. Erving Goffman (1961) was highly critical of the culture of the mental institution and the publication of 'Asylums' marked a dramatic shift in how mental illness and its treatment were viewed. Thomas Szasz's 'The myth of mental illness' was published in the same year and although Goffman did not go nearly as far as to pronounce mental illness as a myth or empty social construction, he was particularly critical of the degree to which mental institutions limited and shaped, if not completely determined a person's own sense of identity. Goffman (1961) further suggested that the bizarre and problematic behaviours of mental hospital patients were the result of processes, practices and the culture in which they were forced to live rather than to any illness which might have triggered their being brought to the asylum in the first instance. Goffman (1961) argues that people did not appear to benefit from their confinement in mental asylums, but rather to lose what resources and strengths they had when they first arrived. This led to the labelling of this phenomenon as 'institutionalism (Wing and Brown 1970).

2.3.3 The Service User Movement

The early survivor movement drew heavily from the intellectual traditions of the anti-psychiatry movement, in particular the works of Ronald Lang and Thomas Szasz. From outside, prolific scholars such as Michel Foucault and Erving Goffman assisted in mounting and promoting a critique of institutional psychiatry (Lakeman et al 2007). Crossley (1998), in his analysis of the anti-psychiatry movement, points out that although it was not a user movement, it did provide an oppositional philosophy which influenced early user organisations. Indeed, the anti-psychiatry movement was a source of inspiration to many who were instrumental in early user organisations (Campbell 1996).

According to Tomes (2006), considering that psychiatry had a long history of patient resistance it comes as no surprise that the mental health field produced one of the earliest and most radical of movements. The service user movement was inspired by other liberation movements of the 1960's and 1970's including Black Power, Women's Liberation and Gay pride. In the 1970's levels of service user activism began to gain momentum (Repper and Perkins 2003). Realising the possibilities for change, service users began to gather periodically in an effort to regain their rights; their common experience became the rallying point of the service user movement. According to Wallcraft and Bryant (2003) in the UK critical groups of psychiatry began to form in the 1970's, groups were formed in response to a wide range of continuous issues, such as improving conditions on psychiatric wards, the closure of long stay psychiatric institutions and giving service users a greater say in choices affecting the quality of their life. Patient-only groups formed at this time included the Mental Patients Union and COPE, which eventually became the Campaign Against Psychiatric Oppression (CAPO). Charities such as Mind and the National Schizophrenia Fellowship (now called Rethink) were also in existence at this time.

Perkins and Repper (1998) argue that within the user movement, there were two distinct trends operating. Firstly, a radical anti-psychiatry movement concerned with the right to reject psychiatric services and provide user run alternatives outside the mainstream psychiatric service. Secondly, a user/consumer movement with a focus on reform and efforts related to improving existing mental health service and campaigning for more involvement and control within them.

Campbell (1996) reports that the climate of the 1980's allowed small independent service user groups to flourish, especially those with a less radical confrontational approach. In 1985, the Mind/World Federation for Mental Health Conference was held. Dutch and US patient groups met UK user/survivor groups for the first time. This event encouraged the growth of the movement, in particular, service user-led advocacy. Four significant user networks, the UK Advocacy Network (UKAN), Survivors Speak Out (SSO), National Voices Network (NVN), and The Hearing Voices Network were formed in the mid-1980s to provide support, to share information, campaign for change and challenge discrimination. By the mid-to-late 1980s, the movement began to use the media to highlight their dissatisfaction about psychiatric services to the general public. For example, the first TV programme made in 1983 by service users/ survivors, called 'We're Not Mad, We're Angry', was a critique of the psychiatric system and described personal experiences of treatment. It was broadcast on Channel 4 during a mental health season. .

Speed (2002) noted that mental health social movement organisation in Ireland has a recent history. Brosnan (2012) argues that the Irish Advocacy Network (IAN), established in 1999, has emerged as a strong presence in the arena of mental health in Ireland. It is a service user run organisation and it provides peer-advocacy services throughout the island of Ireland. It also provides peer-advocacy services with Health

Service Executive (HSE) at approved centres where service users are detained under the Mental Health Act 2001. IAN provides peer-advocates in the community working independently alongside community mental health services. In addition, there has been the development of more radical organisations such as Mad Pride Ireland which was founded in 1998. Mind Freedom Ireland which was established in 2003 and Critical Voices Network which was formed in 2010 have also emerged over the past decade to create spaces of resistance to psychiatric hegemony. Radical organisations are dynamic and creative groups which empower people to challenge and question the dominance of psychiatry. They believe in, and strive for social justice, rights and advocacy. Some groups have reclaimed the word 'mad' but use it as a proud statement of their survival. They empower people to form their own understanding of their experience rather than placing them in a conventional medical framework.

As groups developed stronger voices, their experiential authority as a collective increased. The experiential perspective, wisdom and authority were also being recognised in society. By the 1980's the personal perspectives of people who had lived through various life experiences were recognised and validated as a source of experiential knowledge (Borkman 1999). Watkins (2007) proposes that the service user movement created an influential platform that vocalised and amplified the recovery experiences of people using the mental health services. The social movement described the emergence of different voices outside of the institutional context of psychiatry, this movement facilitated a 'communicative space', within which the voice of service users could be heard and recognised as an important element of the dialogue of psychiatry and mental health care and treatment (Kemp 2010).

2.3.4 Recovery

McCraine (2010) identifies that moral treatment, asylums, psycho-pharmaceutical and community mental health all have been signalled as positive new directions for the

treatment of mental illness. But the reality is that all of these models have fallen short of providing a permanent solution. It was against the backdrop of these unsatisfactory and unsuccessful methods of care, which Frank and Glied (2006) termed “better not well”, that the movement of recovery has taken root in mental health. Although recovery has become the guiding principle in the provision of mental health services in many countries, Davidson at al (2006) asserts that the recovery movement is first and foremost a civil rights movement by and for people with serious mental illness. It is only secondary a movement which has implications for the way mental health practitioners practice. The recovery movement is mainly driven by service users who are trying to achieve systemic change in the mental health system by supporting a psychosocial holistic model that promotes hope, self-determination, empowerment, respect and responsibility to enable people living with mental health problems and illnesses to lead meaningful and productive lives in the community. Peer support plays a major role and sharing personal stories has become a powerful force behind the development of recovery since consumers are considered to be the “experts” by virtue of their lived experience of mental distress (Barker and Buchanan-Barker 2011). One of the most commonly cited definitions of recovery is that recovery is defined as "a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness." (Anthony 1993, P.15). McCraine (2010) argues that there is nothing new about the term recovery for people with mental illness, as it is a term that has been in use for many years. Ramon, Healy and Renouf (2007) suggest that it is perhaps more appropriate to talk about the “rediscovery” of recovery. This opinion is echoed by Davidson, Raakfeldt and Strauss (2010) as they suggest that recovery is simply a

throwback to the days of ‘moral treatment’ when Philipee Pinel employed humane staff and used gentle, supportive and educational interventions to help residents of their asylum overcome their difficulties and resume their normal routines and responsibilities. Silverstine and Bellack (2008) state that recovery has been conceptualised as a vision, a philosophy, a process, an attitude, a life orientation, an outcome and a set of outcomes. Deegan (1988) has suggested that recovery is a process, with a focus on the journey, rather than on reaching its end. Liberman and Kopelowitz (2005) have pointed out that recovery is both a process and an outcome, which indicates the separation of controlling symptoms and cure in the usual medical sense from the business of leading a better life, all of which highlights a fundamental shift in the practice of psychiatry. According to Higgins (2008), recovery should be defined by the individual’s personal contexts, wishes and capabilities.

The Mental Health Commission (2008) assert that because recovery is a unique and individualised process, to fix a definition around recovery in a mental health context is to ignore the key value of individuality which underpins the concept. While the word recovery conjures up the notion of being cured, Harrison (1984) believes that the concept of recovery from a physical illness or disability does not mean that the suffering has disappeared, or the symptoms have been removed, or functioning is completely restored, rather that recovery can occur despite the on-going challenges. Repper and Perkins (2003) believe that recovery puts the spotlight on the issue of human rights, citizenship, advocacy and service user partnerships with professionals. In addition, a recovery approach emphasises the need to change public attitudes, as recovery from the consequences of mental health problems, such as stigma and discrimination, can often be more challenging than recovering from the difficulties themselves. It is apparent that efforts to find a commonly accepted definition have so far been elusive. McCraine (2010) is of the opinion that understanding recovery is

complex. Jacobson and Greenley (2001), Till (2007) and Wallcroft (2005) all hold a similar opinion and argue that the concept of recovery is confusing, poorly understood, difficult to define and therefore open to interpretation. Distinctions that appear in the literature are "recovery in" versus "recovery from" (Davidson and Roe 2007), internal versus external processes in recovery (Jacobson and Greenley 2001), or 'medical' recovery versus 'life' recovery (Deegan 2002). With regards to the internal and the external process of recovery that Jacobson and Greenley (2001) refer to, the key internal conditions are hope, healing, empowerment and connection. The external conditions that facilitate recovery is the implementation of the principle of human rights, a positive culture of healing and recovery orientated services.

Davidson and Roe (2007) distinguish between the meanings of recovery "from" mental illness as more symptom focused with a remission in symptoms and functioning restored, whereas recovery "in" refers to the whole person, and the reclaiming of personhood which allows the person to move ahead with life, even if symptoms have not subsided and continue to persist. Davidson et al (2005) argue that these discourses on recovery are confusing because the language used is rooted in two different philosophies, the biomedical perspective referring to cure from illness, and ideas about 'life' recovery, is a more social model of recovery, generally referring to process of change, empowerment, autonomy and personal growth. These two perspectives are in stark contrast with each other.

It is acknowledged that there are many important promoters of recovery for example; confidence and control, hope, personal resourcefulness, having a voice, relationships, self-determination, positive self-image and identity (Higgins 2008, Le Boutillier et al, 2011). However, Repper and Perkins (2003) believe that empowerment is a core dynamic in promoting recovery. Similarly, Ahern and Fisher (2001) identify

empowerment as the necessary condition for recovery work to be effective. They argue that the healing of severe emotional distress is more effective in an empowerment culture than in the hierarchical, expert-centered culture of the psychiatric system. Watkins (2007) argues that an empowerment culture is one which facilities someone to reconstruct a positive identity from one that has been fragmented by the overwhelming experience of being distressed; one that offers social inclusion and a meaningful role rather than the socially marginalised experience of many mental health service users. McCraine (2010) questions how these concepts relating to recovery become embodied in the interaction between the health care professional and the service user? How do those concepts or practices become institutionalised and embodied in a culture of care which was, and perhaps still is pessimistic about the possibility of recovery?

The medical model drives clinical recovery; clinical recovery reflects a definition of recovery that has emerged from scientific and clinical literature (Slade, Amering and Oades 2008). Clinical recovery is objective and understood to be a return to a former state of health. Outcomes include reduced symptomology, hospitalisation and medication use (Anderson 2003). There are opposing views on whether recovery can occur in a model that requires a return to a former state of health. Critics argue that many service users might not consider themselves recovered under this definition (Ahern and Fisher 2001), and that this view assumes chronicity of psychiatric disabilities (Carpenter 2002). Proponents for the medical model argue that recovery outcomes, such as reduced symptomatology are important to the medical model's recovery orientation (Resnick, Rosenheck and Lehman 2004). A debate has emerged around recovery, the apparent clash between the objectivity and scientific nature of the medical model, and the subjective and personally defined qualities ascribed to the recovery orientation. These two perspectives, their language and values stand in significant tension with one another (Roberts and Wolfson 2004). Kelly and Gamble

(2005) assert that this tension can be understood by looking through different lenses: the medical model focuses on disease and pathology of a person, while recovery emphasises a person's potential for growth. Lakeman (2004) describes a barrier to recovery as the objectivity inherent in the medical model that emphasises and reinforces practitioners' power and the concept of chronicity. Walker (2006) believes that the language of psychiatry is pathologising and deficit-based and is used to elevate the professional above the person who is the subject of a label. Weinstein (2010) argues that language is critical as labelling is counterproductive for recovery. Additional barriers include a lack of emphasis on peoples' strengths, it communicates the idea that a good patient is a compliant patient who should follow instructions about medication, and moreover it defines people according to their symptoms (Carpenter, 2002, Slade Amering and Oades 2008). Walker (2006) contends that within the medical model humans are viewed as something that can be "assessed", "diagnosed" and "treated" much like a machine. These models make distinctions between what is considered "normal" and "pathological". The medical model positions the practitioner as the expert and client as a passive recipient of "treatment. That is not to say the medical model serves no purpose, some people who are unwell might find a diagnosis helpful as they can understand what is wrong with them in the context of a diagnosis. In addition, some people might feel that the prescription of medication is reassuring as it will alleviate symptoms, moreover, many people place great trust and respect the expertise that is associated with the medical professional and therefore believe in the practitioners ability to 'cure' them. In defence of the medical model, Mountain and Shah (2008) assert that the medical model is a process whereby doctors advise on, coordinate or deliver health-improving interventions informed by the best available evidence. Meehan et al (2008) criticise recovery and argue that a recovery approach could generate unreasonable expectations and disheartenment when recovery as a

process becomes confused with recovery as an objective state. Dickerson (2006), a proponent of the medical model, expressed concern regarding the unrealistic expectations that recovery may generate among service users and their carers and families. She suggests that this is because, in relation to mental illness *"our science has not come even close to being able to cure or prevent them"* (Dickerson 2006, p.647). Meehan et al (2006) caution that a recovery orientation may have an impact by devaluing professional help. They suggest that the impacts of this are twofold: one being the people may be discouraged from accessing services that could help them, and the other is that practitioners might potentially lose their focus in relation to their role of assisting service users to achieve functional improvements.

Drawing on some of the key points raised in the previous paragraph it seems that a significant challenge is translating recovery into meaningful and robust changes on the ground. The absence of a succinct or universally accepted definition of recovery is possibly hindering the progression of recovery in practice. Based on the previous explanations and understanding of recovery the reciprocal relationship between the internal and external promoters of recovery are implicit. Whether recovery is the "guiding vision" (Anthony 1993), the "heart and soul of treatment" (Townsend and Glasser 2003) or "old wine in new bottles" (Davidson et al 2005; Pilgrim 2008), there needs to be a shared understanding of its meaning, to avoid practitioners and servicer users equating different meanings to the word recovery. Gosling (2010) believes that service user involvement offers a route to recovery, as it provides an extension from a traditional model, and facilitates a dialogue which can support a transition to new models such as recovery.

2.4 Service User Involvement

Considering the drivers behind the service user movement what has emerged is a history characterised by segregation, isolation and exclusion. The history seems

primarily to be a shared one of oppression, disempowerment and coercion (Beresford and Branfield 2012). The service user movements previously discussed served as a route in the development of both the idea and practice of user involvement. Brosnan (2012) points out that although service user involvement is an important element of the movement's activities, service user groups exist for many other reasons and some choose not to do service user involvement work. Importantly, the service user movement exists independently of its role in service user activities. Barnes and Cotterell (2012) assert that it is important to recognise that service user involvement as both a concept and as a practice, can have multiple meanings. Rose, Fleischmann and Schofield (2009) have identified eight different ways to promote service user involvement: being consulted about staff recruitment, having a role in selection of candidates, being involved in staff performance evaluations, being involved in local mental health services, being involved in research, being involved in professional training programmes and being employed in services as peer-workers. Rose, Fleischmann and Schofield (2009) report that campaigning and anti-stigma initiatives are an additional form of service user involvement.

The concept of involvement has been debated extensively in the literature. Most authors suggest that the term carries an intrinsic association with 'being included', 'participating' and 'having a say' in the issue (Cayton, 2002). Lathlean et al (2006) have described involvement as an active and equitable collaboration between professionals and service users concerning the planning, implementation and evaluation of services and education. According to Tritter and McCallum (2006), service user involvement can be described as the feedback mechanism for the expression of consumer views; it is presented as initiating a constructive dialogue, aimed at reshaping the relationship between service users, health care professionals and educationalists and as a catalyst for more widespread cultural change. Tilley,

Pollock and Tait (1999) have defined service user involvement as the extent to which the service user is involved in defining problems and setting targets that constitutes a plan of care. The WHO (1990) stated that patient involvement would offer a contribution by people to their own health and healthcare, the development of organisational structures that promote participation, and effective empowerment of patients and advocates, so that their voice is heard and not assumed. Hickey and Kippling (1998) believe that there are three main rationales for involving service users in decision making: First, the desire to provide a service that is more responsive to the needs and wishes of service users; secondly, the right users have to be involved in decisions that will affect them; and thirdly, the therapeutic value that being involved in decision-making can have for people with mental health difficulties. Tait and Lester (2005) describe service user involvement as a range of different encapsulating ideas, from active participation at the micro-level of individual decision-making, to more macro-level involvement in service planning and evaluation and increasingly in the arenas of research and training. This study focuses on service user involvement in undergraduate mental health nurse education.

The benefits and challenges of service user involvement have received wide ranging attention from service users, researchers, policy makers and practitioners committed to developing more participatory practices. Beresford and Croft (1993) report that the ideology or intended consequence of service user involvement includes promoting human rights, civil rights, social inclusion and strengthening democracy, all of which point towards the amplification of the service user's voice, thus providing them with the opportunity to have a say on matters that relate to their lives. Kelson (1997) highlights the importance of the service user's perspective in relation to the planning, delivery and monitoring of services and argues that this can result in a better understanding of service user needs and priorities, better relationships between health

care organisations and service users, resulting in the service user having a sense of ownership, partnership and collaboration. From a professional perspective within health care, enhancing practice to account for the views and wishes of service users is viewed as one measure of 'best practice'. However, Oliviere (2001) argues that professionals might present difficulties for involvement by declaring that patients need protecting, and by not recognising the relevance of service user involvement. Beresford and Croft (1993) believe that implementing service user involvement is difficult as it requires changes to traditional ways of working at the level of policy, practice and ideology. Due to the persistent barriers to changing the way practitioners work and think, Barnes and Cotterell (2012) report that practices such as advocacy have been developed to strengthen the voice of the service user in their encounters with service providers. Advocacy is designed to allow service users to have their voice represented in service decision making, even in situations where they are unable to speak for themselves or require assistance to do so.

Repper and Perkins (2003) believe that if service user involvement is to become a reality then a major cultural change is required on the part of practitioners and a shift away from traditional notions of 'professionalism' in which the 'expert' determines what is best for the service user. Professionals tend to believe that they have a specialist body of knowledge that cannot be understood by non-professionals, as they have gained this expertise through academic achievement and clinical experience. Repper and Perkins (2003) contend that such assumptions are probably the greatest impediment to genuine service user involvement. However, the experiential knowledge that service users have by virtue of their lived experienced with mental health difficulties is being recognised as an important resource that can help shape mental health practices, and inform understandings about mental illness, through the lens of a person with a first-hand experience of mental health difficulties.

2.4.1 Experiential Knowledge and Professional Knowledge

The issue of validity of knowledge, which occupies an area of philosophy termed epistemology, is of great importance (Higgs and Titchen 1995). Knowledge in western philosophy has been frequently classified into two main categories: propositional knowledge and non-propositional knowledge. Propositional knowledge is derived through research and scholarship whereas non-propositional knowledge is derived mainly through practice or experience. According to Higgs and Titchen (1995), a hierarchical relationship exists between propositional and non-propositional knowledge, with propositional having a higher status. Schon (1983) reports that in the early 20th Century professionals established their schools in universities with the purpose of gaining prestige. This led to professional activity being conducted in an instrumental problem solving way, which was made rigorous by adopting a scientific theory and technique. An influential epistemological movement during the first part of the 20th Century was logical positivism or logical empiricism. Logical positivists argue that the only source of true knowledge is objective observation and that it has to be based on rational arguments that follow a logical scheme (Carnap 1966). Since then, many scholars have considered scientific knowledge as a supreme form of knowledge, as it utilises objective scientific methodologies and rational arguments. As a result, experiential knowledge was viewed as being invalid due to its lack of objectivity, verifiability, universality or rationality. However, according to Caron-Flinterman, Broerse and Bunders (2005), changes occurred in the thinking about knowledge in the middle of the 20th century, and these insights led to the developments of new, realistic perspectives in relation to knowledge and truth. For example, patient's experiential knowledge may not be deemed as invalid by contemporary scholars, since the existence of one absolute truth is denied, emphasising instead the socially constructed or contextual character of all knowledge, scientific knowledge included. From a

pragmatist's perspective, philosophical concerns about 'how the world really is' is rejected, but recommends the philosophical importance of what is profitable or useful.

2.4.1.1 Professional Expertise

Higgs (1993) describes a profession as an occupational group that is able to claim a body of knowledge distinctive to itself, whose members are fit to practice competently, autonomously and with accountability, and whose members contribute to the development of the profession's knowledge base. According to Popkewitz (1994), the view of the expert practitioner is that they are the most reliable authority and source of knowledge regarding the nature of the reality it deals with, and assumes that people in society should trust in this expertise without question. In the medical profession, especially in the area of mental health there was, and perhaps the expectation still prevails that patients should passively consume medical diagnosis and advice without posing any resistance to such an expert opinion. Higgs and Bithell (2001) assert that it needs to be recognised that the idea of 'expert' and 'expertise' are socially constructed

The process of professionalisation is the historical and political emergence of occupational groups as professions. This process is one of the main features of today's society, involving the establishment of formal entry qualifications based upon education and examination, and the development of regulatory bodies which can admit and discipline members (Bullock and Trombley 1988). Benner (1984) contends that within the context of professionalisation, expertise implies the possession of an exclusive body of knowledge, and a highly developed level of skill which for the most part is not shared with, or taught to patients or other non-professionals. Expertise carries with it a high degree of status and privileges, and expert judgments are held to be incontestable by others of a lesser status. Professionalisation, as an historical process, reflects an aspiration of professions to attain privilege and status, particularly medicine. In the traditional medical model, the relationship between the health care

professional and service users is one fraught with inequality, in which the service user fulfills the subordinate role of the patient. Patients are expected to place their trust in the professional's judgment and follow the prescribed treatment, any challenge of the professional's opinion is not welcomed, and the patient is often classified as 'awkward' or 'non-compliant' as a result. The authority of expert opinion in health care is no longer unchallenged; service users are challenging paternalistic cultures indicating that there is an additional knowledge base.

2.4.1.2 Experiential Knowledge

Every person has experiential knowledge and draws upon it so some degree, however, the context of this study relates to the particular experiential knowledge of mental health service users. Borkman (1976) describes experiential knowledge as a primary source of truth learned from personal experience. This knowledge or insight is gained from direct participation in a situation. 'Experiential knowledge' denotes a high degree of conviction as it is a primary source of truth learned from first-hand experience. The experiential knowledge of service users challenges the 'specialist knowledge' of professionals, which was once unquestionable. According to Beresford (2003), the concept of experiential knowledge is generally used in relation to service user involvement to mean knowledge that is based in first-hand real life experience. Another term that is sometimes used to describe such knowledge is 'authentic'. Experiential knowledge is thought of as being distinctly different from other types of knowledge that healthcare professionals might draw upon as it is solely based on life experience rather than academic or professional knowledge. Borkman (1976) discusses the major differences between professional and experiential knowledge. In contrast to professional information, experiential knowledge is pragmatic rather than theoretical or scientific. Moreover, the experiential perspective is different from that of the professional knowledge, partly because of the different relationships each has to

the problem. The professional is trained to treat a problem and provide care to the person; in addition, the professional has a financial and career interest. The person experiencing the problem first hand has a different set of interests in the way the problem is defined and the strategies to resolve it. He or she is personally experiencing physical, mental, emotional difficulties with his or her social networks and identity and material interests involved. Beresford (2003, p.22), holds a similar opinion and hypothesises that knowledge originating from this direct experience delivers more reliable knowledge: *'The greater the distance between direct experience and its interpretation, then the more likely resulting knowledge is to be inaccurate, unreliable and distorted'.*

Acknowledging the legitimacy of experiential knowledge promotes the voice and expertise of marginalised groups which have largely been silenced. Feminism, educational, critical theory and emancipatory research are all different perspectives but they are helpful in understanding the relevance of experiential knowledge. The purpose of this section is not to talk about the difference of each of these perspectives, but rather discuss the contribution made by each to experiential knowledge. According to Cotterell and Morris (2012), feminist thought challenges a view of people as singular objects in the way that traditional science can do, and it also sees the development of this 'scientific' knowledge as a means of domination by privileged groups in society. Feminist thought is part of a political struggle with a central debate being about the significance of being a woman and the place of female experience, and the contribution it makes to knowledge. Feminism argues that many individual voices and many forms of knowledge arise and form collective knowledge. Tanesini (1999) suggests that different knowledge sources need to be invited, in a participatory way, so that all experiences are taken into account. Here, the suggestion is that with marginalised knowledge, no one group is claiming that their knowledge is superior;

therefore the groups can move to consider the varied world and the common thread that connects their experiences. Beresford (2003) has highlighted how a history of being marginal, of being unheard and of being discredited takes a great deal of effort to overcome as does seeing one's own experience and knowledge as important and equal to others in more dominant groups. The work of Paulo Freire has been influential in the development of critical inquiry. Freire's (1972) area of interest has primarily been concerned with raising awareness about the empowerment of the oppressed. Cotterell and Morris (2012) report that it can be difficult to access the knowledge that marginalised groups possess, as people in such a position possibly may feel that their knowledge is unworthy and therefore question the legitimacy of articulating their own knowledge. Cotterell and Morris (2012) assert that there is a clear link between the work of Freire and emancipatory research and critical theory, as they both share a common agenda in relation to people's political context, empowerment and equality. Critical theory is 'critical' in relation to its stance in challenging claims made by scientific or traditional knowledge. It aims to unmask beliefs and practices that restrict freedom, justice and democracy in some way. Habermas (1972) has argued that the knowledge interest involved in critical theory is emancipatory and is focused on unmasking ideologies that maintain the status quo by restricting the access of marginalised groups to the knowledge that oppresses them. The aim of critical theorists is to investigate into accepted processes and structures that underpin society and shape everyday lives in an inquiring and critical way. They see knowledge as not only about finding out about the world, but also about changing it (Cotterell and Morris, 2012). Overall, these different perspectives are helpful in understanding the relevance of experiential knowledge and in the promotion of the voice and expertise of marginalised groups.

Professionalism as an ideology embodies appealing values such as autonomy, competency and standards, which are a result of evidence based practice. Higgs and Titchen (2001) believe that if health care professionals solely work from a scientific knowledge base then views of practice, the methods used to problem solve and the criteria adopted to evaluate progress will focus mainly on prevention of illness and objectively measurable outcomes of interventions. Higgs and Titchen assert that the outcome of such an approach may have limited relevance to the individual needs of service users. Prior (2003) acknowledges that patients can have extensive knowledge of their own life and the conditions in which they live but argues that for the most part, lay people are not experts. They are rarely skilled in areas of medical fact gathering, or in the business of diagnosis. In addition, they can be wrong about the causes, course and management of disease and illness. Prior believes that individuals with lay knowledge do have expertise of their own bodies, but they are evidently not experts. Lay knowledge is not sufficient to truly understand the technical complexities of disease causation, its consequence or management, partly because experiential knowledge is idiosyncratic and limited (Prior 2003). Professional knowledge brings an expertise that is evidence based. Evidence based ensures quality and standards in education, and strives towards producing competent practitioners. While acknowledging the considerable contribution of professional knowledge, experiential knowledge can also be an added facet for professional education. The experiential knowledge of service users brings a knowledge that is steeped in the lived experience. This experience can open the student's minds to the social, emotional, psychological and other related human experiences that arise as a result of mental health difficulties. These stories and anecdotes can humanise the experience of mental distress. It can be argued that both professional knowledge and experiential knowledge have a part to play in the education of health care professionals and therefore the contribution of both

should be drawn upon. Faulkner and Thomas (2002) are of the opinion that a marriage of two types of expertise is the essential ingredient of the best mental health care: expertise by experience and expertise by profession.

2.5 Changes in Nurse Education

The discipline of psychiatric nursing has been recognised in Ireland since the introduction of the Nurses Registration Act in 1919. Initially the title used was "Mental Nurse"; however, this was subsequently changed to "psychiatric nurse" by the mental treatment act 1945. Thus, by the first decade of the twentieth century, the asylum system which provided care and treatment to the mentally ill had become firmly established. Changes within psychiatric practice generally, and nursing in particular were occurring in the United States and in parts of Europe throughout the 1950's and the early 1960's. While these changes happened at a much slower pace in Ireland, some changes were occurring. The WHO produced a report which contained specific guidelines relating to the education and training of mental health nurses and even suggested some generic content for inclusion in the syllabus, highlighting the interpersonal aspects of the nurse's role and the need to focus on mental health and measures aimed at the prevention illness. The WHO report resulted in the revision of the mental health nursing syllabus in Ireland which was implemented in 1960. The newly revised syllabus endeavoured to include the recommendations from the WHO report with particular emphasis placed on the inclusion of subjects such as psychology and elements of the nurse's role (Sheridan 2000).

Throughout the 1960's and 1970's the idea of specialisation within mental health became well established and there was a wide variety of courses available to provide training and education. Specialisation occurred in the areas of addiction studies, behavioural psychotherapy, child and adolescent nursing and family therapy. Even

though specialisation was occurring within psychiatric nursing the vast majority of nurses were working within the confines of large institutions. In 1986 An Bord Altranais initiated a review of the psychiatric curriculum which placed particular emphasis on community practice and attempted to address the imbalance of physical versus social science (Sheridan 2006). The role of the nurse as an educator was also highlighted and specific preparation was to be provided to facilitate this new generation of psychiatric nurses to prepare them to work as an equal member of the multidisciplinary team within a hospital and in a community setting. These changes were implemented in 1987 and it was the first time in the history of psychiatric nursing that the actual nursing curriculum was designed and delivered by nurses.

Up until the last decade of the 20th Century, the system of professional training and education of nurses in Ireland was based on the apprenticeship model, and it was only at the start of the 21st Century that the nursing profession in Ireland gained entry to the academy and joined the other graduate professions in healthcare (Fealy and McNamara 2006). The trigger for this reform was the Working Party Report on General Nursing (Department of Health 1980), which called into question the apprenticeship model of training as a suitable model for meeting the education and training needs of nurses. The 1990's also saw development for psychiatric nursing as a profession as nurses continued to consolidate their knowledge and skills and expand their scope of practice. Clinical nursing research became important in psychiatric nursing. Nurses no longer based practice on assumptions and the notion of evidence based practice was being put into practice (Sheridan 2006). The principle of evidence based practice reflects the view that all aspects of the programme: development, delivery and evaluation need to be grounded in evidence (Joyce 2002). In 1994, the report entitled The Future of Nurse Education and Training in Ireland (An Bord Altranais 1994) led to the founding of

links with higher education for the purpose of academic accreditation at diploma level and enhanced training and education for nurses. The transition from the traditional 3 year apprenticeship training to the introduction of a 3 year diploma programme meant that student nurses no longer formed part of the workforce within the hospitals, but had supernumerary status. This change also brought the position of pre-registration nurse education in Ireland (psychiatry, intellectual disability, general) into line with that of the UK, Australia and Canada (Tyrell 1998). In many respects the development of nurse training in Ireland paralleled that of the UK, for example both countries experienced debate regarding the apprenticeship model of training and the merits and drawbacks of graduate entry to the profession. In 2002 recommendations made by the Commission on Nursing (Government of Ireland 1998) resulted in the introduction of a 4-year degree as the sole route of entry to practice. The Commission recommended that from 2002 all pre-registration undergraduate nurse education should be integrated within third-level academic institutions, and only on graduating will students be qualified to register with the nursing board (Government of Ireland 1998). The strategy for a Pre-registration Nursing Education Degree Programme (Government of Ireland 2000) suggested that the mission of this degree programme was to prepare nurses to meet the healthcare needs of a diverse population in an ever changing healthcare environment. However, Gijbels et al (2010) report that there is a lack of evidence relating to the impact post-registration nurse education has on practice and therefore this requires exploration. A review of the undergraduate nursing and midwifery Degree programme in Ireland in 2012 made a number of recommendations regarding the undergraduate nursing programme. One key recommendation was that Higher Educational Institutes (HEI) need to ensure that a person centred philosophy of care underpins all curricula and that educational institutions increase the involvement of service users and carers in curriculum planning, teaching and in the evaluation of the

programme. Opportunities for service users to contribute to the curriculum and participate in student teaching by providing 'patient stories' was strongly recommended by the public interest participants in the consultation process. This is an important recommendation and clearly stipulates the needs for greater service user involvement in the undergraduate nursing programme (HSE 2012).

2.6 Policy Context for Service User Involvement

Internationally there are a number of policy documents that have influenced service user involvement both in practice and in professional education. Reform relating to service user involvement in the UK was brought about by the Health and Social Care Act 2001. This act planned to integrate the views of patients and citizens through every level of the National Health Service (NHS) by bringing the patients voice 'inside' the NHS as opposed to keeping it 'outside' (Department of Health 2001). Service user involvement in the NHS National Institute for Health Research has become a key issue, with the NHS making a national commitment to this. NHS trust policy documents support the involvement of service users. Policy documents such as 'The NHS Plan' (2000) and 'Research and Development funding in the new NHS' (2000) endorse the need for service user involvement. Recently, the aim of the operating framework for the NHS 2011/12 was to strive to improve service's ability to respond to and listen to the patients who use the services. Furthermore the publication 'Real Involvement: Working with people to improve health services' (NHS 2008) helped the NHS to identify what they needed to do in order to have improved involvement practices.

According to Gregory (2007) the importance of service user involvement in healthcare began to be recognised in Australia during the 1990s. The Australian system for service user involvement has taken a different direction than any other country. Service

users are seen as having a valid role at all levels of the health system in Australia. Most states have a consumer council and advisory committees on specific issues such as mental health. Consumer involvement is not treated as an add-on, but as an integral part of the health sector. Within the health sector, involvement is a fundamental part of the government policy development and a statutory obligation for organisations such as the National Health and Medical Research Council (NHMRC) and the Australian Health Ethics Committee (AHEC) (Horey and Hill 2005). In New Zealand important strategies such as its Health strategy (2000) and the Disability strategy (2001) promoted service user involvement. In New Zealand the Health and Disability Commissioner promotes and protects the rights of service users who use health and disability services. The Commissioner is informed by the work of a Consumer advisory group and health and disability representatives.

Canadian health policies have embraced service user involvement and the mental health strategy 'Changing Direction, Changing Lives: The Mental Health Strategy for Canada' was published by the Mental Health Commission of Canada (2012). The experiences of mental health service users were involved in the drafting of this strategy, and the strategy stipulated the need for active involvement of mental health service users in decision making at all levels of the health system in order to promote meaningful change. In America the participation of service users is recognised as being of importance in all aspects of mental health planning, advisory and governance boards and is essential to the effective planning, delivery and evaluation of such services. Service users are seen to have a vital role in the development of policies that serve them. Examples of effective service user involvement include Mental Health planning and advisory councils which are mandated by federal law and service user involvement is strongly advocated by Mental Health America (MHA 2009)

2.6.1 Ireland

In Ireland evidence of a discursive shift towards greater service user involvement is apparent in two major health service policy documents. In 2001 the Irish Government published a new strategy for the health service. Quality and Fairness: A Health System for you (DoHC 2001). The strategy emphasised the significance of patient-centred care. This policy document visualized community involvement in planning through consumer panels and regional forums. In 2004, the Mental Health Commission established a committee to consider the recovery model within the mental health services. A discussion paper, 'A Vision for a Recovery Model in Irish Mental Health Services', was published to encourage and inform debate on establishing a recovery model. The paper discussed the international and Irish experiences in terms of moving towards recovery-orientated services and established the core elements of a recovery based mental health service (Mental Health Commission 2005).

The government policy document on mental health: A Vision for Change recommends service user involvement at every level of the mental health services and initiatives to develop service user run services (DoHC 2006). Essentially the policy document directive highlighted a vision that would essentially strive for equal partnership between service providers and service users; partnership in the relationship was described as fundamental. The document acknowledged that service users do have a unique insight in to the experience of mental illness; hence this expertise of mental distress is very different from the experience of other stakeholders. In addition the policy recommended education programmes to allow service users to represent themselves, and the establishment of The National Service User Executive (NSUE). The NSUE was formed so that service users could have a central role in the planning, delivery and evaluation of mental health services and to be a source of support for service users and carers. A 'Recovery' approach, which prioritises user involvement in

their treatment, is the foundation for A Vision for Change. Attempts at user involvement are recent and until the publication of the Vision for Change policy it lacked guidelines or standards and there was an absence of any coherent policy. The publication of the national strategy for service user involvement in the Irish Health service 2008-2013 (DoHC 2008) aimed to drive service user involvement in the Irish health services. The implementation of this strategy revolves around three levels of engagement: Firstly individual service users involvement in their own care, secondly the involvement of service users at a community level, in local services delivery and development. Finally, a national strategic policy informed through involvement of service user organisations in partnership with health care professionals.

The publication of the HSE's feedback policy to include comments, compliments and complaints is 'Your Service Your say'. The policy is provided to ensure that there is a structured system in place to respond to service user's feedback and complaints (HSE, 2009). This policy supports service user involvement and provides the service users with an opportunity to voice their opinions. The publication of the document titled 'Service User Involvement Methods: A Guidance Document' (HSE, 2009) provides an overview of the range of different methods available for service user involvement, for example, service users panels, surveys, focus groups, consultation: written and online. The scope of the document is applicable to all service users and all professionals within health and social care services. The Health Service Executive (HSE) also published a guideline that strongly advocated for service user involvement. The document was titled 'Best Practice Guidelines for Establishing and Developing a Service user Panel within a health setting'. The purpose of the document is to provide a framework for the establishment and development of a service user panel within a health setting in an attempt to improve delivery and quality of services from the perspective of service users. (HSE 2010).

The 6th Annual report by the independent monitoring group for a Vision for Change (Mental Health Commission 2012) report that some progress has taken place with regards to recovery and service user involvement. For example, the National Service User Executive (NSUE) and service user representatives are active in many national projects led by the Office of the Assistant National Director, Mental Health. Examples include: National Vision Implementation Steering Group, Forensic Reconfiguration Project Group, and Mental Health Act training with external partners (e.g. Gardaí). The role of the Expert by Experience post was independently reviewed and evaluated and the Office of the Assistant National Director, Mental Health and Dublin City University (DCU) has agreed to extend this project for a further 3 years. This decision indicates a commitment to service user involvement in mental health education. The HSE, in association with Atlantic Philanthropies, fund the Genio foundation which supports a number of person-centred initiatives promoting service user participation and capacity building initiatives (Mental Health Commission 2012). Also a key priority of The National Operational Plan was to develop service user and carer partnership by ensuring service user representation on Area Mental Health Management Teams (HSE 2013). It could be argued that this priority is tokenistic and simply ticking the box in terms of 'having' service user involvement. The plan does not outline, or give detail on the role of the service user, it simply states to have service user representation. Service user involvement is about more than simply consulting, service users must be at the centre of decision-making.

A Vision for Change set out to reform the provision of mental health service in Ireland. There is no doubt that the implementation of the Vision for Change is slow, and a number of issues appear to be hampering its progress, namely cutbacks in the public service. It is apparent that steps are being made to strive towards greater service user involvement. However, it seems that policy makers need to recall why there is a

greater drive and need for service user involvement, and that the basic premise of service user involvement is an intrinsic and social right justification. Compared to our international counterparts it has to be acknowledged that there has been limited progress made. Munday (2007) is of the opinion that service user involvement is something of a paradox in that, on the one hand, there is probably greater-than-ever public and policy commitment to increasing service user involvement. But, on the other hand real choice and involvement for service users in rarely available. This seems to be case in Ireland. Service user involvement is largely driven by government policies and imposed from the top down, rather than emerging from the service users themselves. Without meaningful and equal engagement with service users, and a genuine commitment to develop service user involvement, involvement strategies will remain largely disappointing.

2.7 Conclusion

This chapter provides a contextual background for the thesis and discusses the inception of service user involvement. The activities of service user involvement are diverse, and are associated with a wide range of activities, ranging from research, service development to involvement in professional education. Although achieving recovery orientated practice remains a challenge, possibly due to the confusion that exists regarding the meaning of recovery, service user involvement and recovery share a common vision in that they both strive for citizenship, social inclusion, equality and rights. Based on the principles of experiential knowledge and professional knowledge, it would seem that they both have a contribution to make to professional education. In recent years the education of mental health nurses has advanced from a three year diploma to a four degree programme, the drive from policy directives to involve service users in professional education has the potential to be an added facet of the educational programme for mental health nurses and allied mental health professionals.

Chapter 3- Literature Review on Service User Involvement in Mental Health Education

3.1 Introduction

Service users have always had a part to play in education, especially medical education but as illustrations of interesting conditions or as an element of students' experiential learning in the clinical setting. Consequently, service users have had a largely passive role in training and education (Towle et al 2010). However, this passive role has been under scrutiny, resulting in a growing recognition that service users have an expertise gained through living their life faced with mental health challenges (Livingston and Cooper 2004, Skilton 2011). This recognition has resulted in a drive to include service user involvement in professional educational programmes. This drive is being propelled particularly by policy makers, and service users groups who lobby for greater inclusion in an array of activities inclusive of involvement in professional education. Consequently, it is argued that service user involvement has an important place within the structures of professional education.

The review of literature was concerned with studies that looked at the involvement of mental health service users specifically in undergraduate and post-graduate mental health education. This included studies of service user involvement in the education of mental health nurses (18); social workers (2), psychiatrists (1) psychologists (1), and multidisciplinary (5). Studies were primarily identified through searching the electronic databases: CINAHL, MEDLINE and Psych INFO. The terms applied in the search were: 'student', 'college', 'university', 'service user', 'consumer', 'involvement', 'participation', 'psychiatric', 'mental health', 'nurse', 'psychology', 'psychiatrist', and 'social worker'. Additional studies were retrieved from the reference lists of the studies identified through the database search. Both quantitative and qualitative studies were included in the review. Details on the studies discussed in

this chapter are included in Appendix L. The table provides details on which discipline the study is focusing on, the author, aims/objectives, design and data collection, sample, how service users are involved in the study, type of analysis and key findings. The literature is reviewed under the following headings; service user involvement in curriculum design, service user perceptions of their involvement in professional education, educationalists perspectives on service user involvement, training for service users, students' perceptions of service user involvement and the barriers and challenges of service user involvement with a specific focus on training and support, also remuneration and representation.

3.2 Studies on Service User Involvement in Mental Health Education

3.2.1 Service User Involvement in Curriculum Development

Only two studies that featured in the review included service user involvement specifically as a feature of curriculum development (Rudman 1996; Masters et al 2002). In the study by Rudman (1996) a sample of 20 service users were recruited to inform the design of a new preregistration nursing curriculum. The perspectives of the service users were sought in relation to the knowledge, skills and qualities they believed should be inherent in a mental health nurse. In relation to knowledge, the service users identified understanding individual differences as opposed to relying on textbook knowledge, In addition, the importance of understanding, not labelling, while also gaining knowledge of: (i) life/maturity; (ii) local areas and resources; (iii) effects of hospitalisation and (iv) physical care. With regards to desirable skills, interpersonal skills, counselling skills, the importance of being sensitive to non-verbal cues, promoting confidence, avoiding using jargon, providing support and having the ability to take control when required were identified. The qualities that were recognised included caring, being approachable, and professionalism. The study provided no evidence that the research resulted in any change to the nursing curriculum.

Service user involvement in the development of curricula was a challenge for Masters et al (2002) who devised a strategy for service user and carer involvement in a Diploma of Higher Education in Mental Health Nursing. A project management team was formed and evaluation teams comprised of service users, students and lecturers. However the extent of service user involvement in this project is not clear because one service user dropped out and the other did not attend meetings but was provided with updates via phone calls and letters. Eighteen of the 33 questionnaires were returned (only three by service users). While there was also a favoured response to service user involvement in the project, the findings suggested that several difficulties were encountered which affected service user involvement: the payments that the service users received for their contribution interfered with their welfare payments; service users identified the need for training with regards to the education system and curriculum development; some educationalists questioned the means of recruitment as to how and why people were selected to be involved within the teams; and fears of tokenism were also reported.

3.2.2 Service Users' Perceptions of Their Involvement in Professional Education

Three qualitative studies specifically focused solely on service user perspectives regarding their participation in education (Forrest et al 2000; McGarry and Thom 2004; Meehan and Glover 2007). In the study by Meehan and Glover (2007), 11 service users spoke about meaning they give to their involvement. Five themes emerged from the interviews: giving of self; this addresses how the service users can feel vulnerable as result of their personal contributions. Tokenism; service users reported that their contribution was not always valued by educationalists. Learned versus lived experience; service users are of the opinion that their lived experience is not appreciated. Lack of clear expectation; this relates to service users being provided with limited information regarding their involvement in teaching initiatives. Forrest et

al (2000) involved 34 service users to evaluate their perspectives of involvement in mental health nurse education. The service users believed that there was conflict regarding the nursing qualities they valued and the qualities that were being promoted in the educational programmes. Service users valued interpersonal skills while educationalists highlighted symptomology, diagnosis and medicine. McGarry and Thom (2004) conducted three focus groups with five service users in each of them, five themes emerged. (i) reasons for service user involvement; (ii) positive experience, the servicer users reported that engaging with students increased their confidence; (iii) structure of the session, service users identified the need for the sessions to have better structure in order to guide the service users; (iv) contributing to knowledge, service users perceived that they could enhance students' understanding of mental illness; and (v) benefits arising from teaching nursing students, service users are of the opinion that their involvement could deepen students understanding of the needs of service user and this knowledge could be used in practice environments for the benefit of other service users.

3.2.3 Educationalists Perspective on Service User Involvement

In the study carried out by Felton and Stickley (2004) five lecturers providing preregistration nurse education were interviewed regarding service user involvement in nurse education. Five themes emerged: (i) aspects of service user involvement in learning; (ii) service user issues and problems with service user involvement; (iii) education; (iv) role and (v) power. Whilst the educationalists identified service user involvement to be a valuable learning resource, its exact contribution in the classroom still needs to be identified.

Educationalists expressed concerns that due to the nature of a mental illness this could compromise a service user's ability to teach large groups of student nurses.

Additionally, the participants did not want service users to become professionalised as concern was also expressed that service user's involvement would cause a current role to be eroded and they would become glorified markers. Five educationalists participated in focus groups in the study by McGarry and Thom (2004). Three main themes emerged; Experience as a resource, participants identified that user involvement provided students with an opportunity to gain an understanding of the service user's perspective. Careful planning, participants identified concern with tokenistic involvement. The third theme to emerge was support for service users, participants were concerned that service user would use the sessions to verbalise any unresolved issues, also that it would be intrusive for the service users.

The perspectives of educationalists were also referred to in studies by (Anghel and Ramon 2009; Holttum and Hayward 2010; Simpson et al 2008). Lecturers in the case study by Anghel and Ramon (2009) reported that both service users and students required training prior to service user involvement initiatives, as service users needed to understand their role and students needed to be prepared in the event that service users presented them with challenging views of the mental health services

3.2.4 Training for Service Users

Masters et al (2002) and Felton & Stickley (2004) identified the needs for service users to undergo training prior to any involvement initiatives. Masters et al (2002) identified this needs after they had implemented an involvement initiative. Hanson and Mitchell (2001) prepared service users for involvement in education with a 5 day training course over a period of three weeks. Nine service users participated in the training course. The only criterion for their involvement in the course was that they were motivated to use their experiences to help others gain a greater understanding of mental health issues from a service user's perspective. Support was provided to participants during the course. The topics for the course included practical work on

designing, delivering and evaluating a teaching session and each participant had to give a presentation on the final day of the course. On the last day of the course nine participants completed the questionnaire and participated in a group discussion. A post-course evaluation took place 6 months after with the aim of enabling participants to discuss any issues resulting from the course and to find out if the participants used the skills they learned. Overall the participants evaluated the course positively. All the participants agreed that the course had provided them with the skills and confidence to become involved in a variety of activities. Two participants had been involved in classroom teaching with mental health students, two had used their presentation skills at a conference, one had become involved in a 'patient participation group' for their local primary care group and one had provided advice to student nurses on clinical placement.

3.2.5 Student's Perceptions of Service User Involvement in Their Education

Many of the students reported how valuable it was to learn from 'first-hand' experience (Khoo et al 2004; Barnes Carpenter and Dickinson 2006; Rush 2008; Stickley et al 2010; Scheyett and Kim 2004. Rush and Barker 2006; Simpson et al 2008; Byrne et al 2013; Schneebeli et al 2010; Frisby 2001; Happell and Roper 2003). Service users sharing their personal accounts seems to account for students identifying an increase in empathy and understanding (Khoo et al 2004; Scheyett and Kim 2004; Stickley et al 2010; Debyser et al 2011; Rush 2008; Happell and Roper 2003)

The experience of service user involvement helped students to see the person behind the illness and to see service users as people 'just like you and me' (Rush 2008), made the students learning experience 'real' (Anghel and Ramon 2009, Schneebeli et al 2010, Masters and Forest 2010, Rush and Barker 2006), and bridged the theory practice gap (Simpson et al 2008). The findings indicate that service user involvement challenged students' expectations and stereotyping with regards to service users

(Happell and Roper 2003; Rush 2008; Anghel and Ramon 2009, Schneebeli et al 2010). Some were of the opinion that service users were more resilient than they had expected (Scheyett and Kim 2004).

Some studies reported findings that suggest students are more open to working in collaboration with service users (Barnes, Carpenter and Bailey 2000, Khoo et al 2004; Rush 2008, Scheyett and Kim 2004). Students in one study identified that service users were capable of contributing to the process of their own care (Ikkos 2003). Some students valued the opportunity to engage with service users in a classroom setting compared to a clinical setting. Students in the study by Rush (2008) found the classroom to be a more relaxed setting to engage with service users and therefore felt that they could ask questions that they would be reluctant to ask in the clinical setting. In the aftermath of service user involvement some students reported a change in their practice; students reported that this shift is a result of reflecting on past practice and questioning flawed beliefs they had made about service users (Khoo et al 2004, Rush 2008). Students in the study by Wood and Wilson-Barnett's (1999) reported that they used less jargon suggesting a more service user centred approach to practice. Finally, the students in Barnes, Carpenter and Bailey (2000) identified the requirement for shared decision making with service users.

Students reported some apprehension regarding service user involvement in their education (Anghel and Ramon 2009; Ikkos 2003; Khoo et al 2004; Morgan and Sanggaran 1997; Stickley et al 2010; Tew et al 2012). Many of the students felt that the service users had their own agenda which was viewed as unhelpful in terms of the learning needs of the students (Ikkos 2003). The validity and usefulness of service users' feedback was also under scrutiny by some students, who were of the opinion that that their feedback was incorrect, especially when service users were receiving

care at the same time they were providing students with feedback on their performance during clinical placement (Morgan and Sanggarn 1997; Stickley et al 2010). Some of the students in the study by Anghel & Ramon (2009) found the criticisms of the mental health services by service user's quite challenging. Some students questioned how representative were the views of the service users (Khoo et al 2004). Students in the study by Tew et al (2012) would have valued a more medical approach to their education.

3.2.6 Barriers/Challenges to Service User Involvement.

Although the literature highlighted several reasons for service users' involvement, there are also a number of reasons why implementing and sustaining service user involvement may be problematic. The literature highlighted some barriers, for example, the issues of training and support, the necessity for adequate payment, and the issue of representation. Each of these will now be discussed.

3.2.6.1 Training/Support

Many of the studies reviewed raised concern about the lack of training and support provided in service user initiatives. There is a need for training and support for all parties involved; service users, students and educationalists. Service users in the study by Masters et al (2002) identified concern about their lack of expertise and would have favoured training for their role. Service users might also require support due to their specific needs; some are vulnerable or at risk of becoming unwell (Simons et al 2007). Also involvement can remind service users of challenging and difficult times in their life which can result in distress (Frisby 2001). Prior to involvement there is a necessity to provide training and support in order to prepare service user for their role (Masters et al 2002, Rush 2008). Hanson and Mitchell (2001) recognised the needs for training and reported on a study specifically to prepare mental health service users for their work in the classroom. In addition it was acknowledged that training and support may

be needed during and/or after involvement, this could take the form of debriefing and taking the time to reflect on their contribution (Hanson and Mitchell 2001), mentoring or a peer support group (Higgins et al 2011), or pairing an experienced staff member with a service user to maintain consistency in their teaching. Training for service users is not just exclusive to one particular area and depending on their role service users may require training in a variety of ways, such as curriculum development, providing feedback, presentation skills, teaching and student assessment. Involvement in higher education institutions can be quite daunting as service users may feel under pressure to perform consistently at the highest level as a means to silence doubts about their involvement. A solution to this barrier is ensuring that support is a crucial part of any contract with service users.

It was identified in the literature that students might require support in relation to receiving negative feedback from service users (Stickley et al 2010). In the study by Happell and Roper (2003) some of the students reported that the worst thing about being taught by service users was the negative portrayal of psychiatric nursing. It is important that the feedback or information from service users is balanced and constructive so that students actually take note of service users' opinion rather than dismissing them. It is essential that students are allocated some structured reflective time after their engagement with service users to allow them to reflect on the input from service users, and recognise that the approach of the service user might not have been a personal attack, but a way of opening students' minds to the flaws or shortcomings in the mental health system and often in practitioners' practice. As well as training for students and service users, there is a need to provide educationalists with training and support to ensure involvement initiatives are a success for all parties involved. Masters et al (2002) identified that educationalists in the study expressed concern regarding their lack of skills in terms of involving service users and feared

tokenisms. Training for educationalists may be useful in addressing any cultural or attitudinal barriers that might exist. Felton and Stickley (2004) and Simons et al (2007) identified that educationalists can feel threatened by service user involvement for concern that involvement initiatives might erode their role in the classroom, which can result in resistance. Happell and Roper (2003) believe that resistance to service user involvement in education may be a result of the medical model approach, as professionals have the power to define the competency of those with mental health problems, while service user involvement in education is a direct challenge to this.

3.2.6.2 Remuneration and Representation

In order to sustain and develop service user involvement and for service users to feel valued for the contribution they make, it is important that they receive appropriate remuneration and that there are procedures for payment in place. Masters et al (2002) highlighted the importance of developing a payment system that does not have implications or impact on the service user's benefits. If a clear payment policy or payment system is not in place it could prove difficult to attract service users to participate in professional education programmes. Some service users may get involved in a voluntary capacity due to altruistic reasons. For other service users, payment provides them with an important income. If payment is absent, service user involvement could possibly prove very difficult or perhaps even impossible.

The issue of representation was highlighted in the literature. Some educationalists had concerns that there was a lack of diversity of service users (McAndrew and Samociuk 2003), how the service users were selected to participate (Master et al 2002), some students questioned how representative were the service users' experiences (Ikkos 2003) and some educationalists expressed the view that service users become professionalised and distant from their experiences (Felton and Stickley 2004).. In order to develop and promote service user involvement then practical and workable

solutions need to be found in an attempt to address issues such as training, support and payment. If these issues were resolved then more service users with a variety of experiences might opt to be involved which in turn would offer a potential solution for the issue of representation.

3.3Overview

In their review of literature on service user involvement in professional education Repper and Breeze (2007) assert that service user involvement requires a great deal of ongoing commitment and motivation. Seven years on, Happell et al (2014) describe the current body of published work on service user involvement in mental health education as in an embryonic state. Terry (2012) supports this notion and is of the opinion that there is a necessity for further research to be carried out in this area before generalizable results can be achieved. Terry (2012) also notes that studies do not provide adequate detail to allow the reader to assess the quality of the studies, and are perhaps best described as educational evaluations. Happell et al (2014) are also of the opinion that some service user initiatives have not been as successful as their developers may have liked. For instance asking service users who were in receipt of care from students on clinical placement to participate in the assessment of the students work (e.g. Stickley et al 2010), or to provide feedback on students' performance (e.g. Morgan and Sanggaran 1997) seems unfeasible, because they are situations where students have power over service users but at the same time, as the student's assessor, the service user is in a position of power. Happell et al (2014) believe that this dynamic creates an undesirable challenging situation which places both parties in an awkward position. The service users are reluctant to give the student negative feedback, while the student questions the validity of the service user's feedback.

Based on the reviewed studies, it is apparent that there is a tendency to rely solely on or place greater emphasis on students' perceptions as a data source for the evaluation

of service user involvement initiatives. Happell et al (2014) believe that this requires critical consideration as the voice of the student is prominent in the published work. Although service users' voices are in published work and they were participants in some of the studies (Anghel and Ramon 2009; Morgan and Sanggaran 1997; Meehan and Glover 2007; Simons et al 2007), the service users' voice seems weak in the published work as the perspectives of the service users are not always sought. Moreover, the educationalists voice is often heard in the published work. According to Happell et al (2014) often the educationalists is the author of the paper and therefore their voice is heard the loudest. They get the opportunity to construct the arguments for and against service user involvement, they also decide how to report and discuss the findings.

Felton and Stickley (2007) reported that one of the biggest concerns for service users was a need for training and support before and during service user involvement initiatives. Seven years on and the needs for training and support continues to be one of the biggest challenges facing service user involvement. Happell et al (2014) argue that adequate preparation is essential for service users in order to maximise the potential offerings of user involvement initiatives. Preparation of students is as of equal importance and educationalists need to prepare students for service user involvement. Service users can often be critical and challenging of practice and provide emotionally charged criticisms of mental health services and staff. However, students need to be prepared that the views of service user may be challenging. Learning to accept and listen to the criticism of service users is important in good mental health practice, and it may prevent the students becoming defensive and rejecting the involvement of service users.

The quality of research in this area is mixed and methodological limitations are apparent. These limitations are acknowledged by the authors regarding small sample size, single-site studies and a lack of comparison of results. This section will not critique every methodological flaw in each of the studies reviewed but rather discuss exemplar methodological and qualities issues in some of the reviewed studies. The nature of service user involvement in undergraduate mental health nurse education included students hearing service users' stories, engaging in discussion in online forums, service users viewing and participating in student presentations and EBL activities, and facilitating and enhancing sessions relating to the assessment of clinical skills. The majority of the studies were conducted within a single site by educational staff who teach on the mental health programmes. The student's familiarity with the researcher, especially if they were course lecturers, could impact on the results if the students felt obliged to provide positive feedback about service user involvement Simpsons et al (2008) study is described as an exploratory project and states quantitative and qualitative methods were used in order to facilitate triangulation. However, little detail is provided about these methods. Stickley et al (2009) describe a model of service user involvement participatory action research, with service users fully involved at each stage of the study. However, there is limited detail regarding the data analysis, except to say that a service user researcher was involved in the process. This paper appears to have involved service users more in the research process, with the project team abandoning the notion of involvement, stating it inadequately addressed power relationships (Stickley et al 2009). Rush's (2008) provides limited information regarding the data analysis, apart from the mention of a critical friend who coded the transcripts. Limitations are acknowledged relating to the sample size being small, and from one student cohort. However Rush did attempt to establish how students transfer their learning from service users in the classroom into practice. Jones

and Black (2008) report on an initiative and information is given on the service user and students evaluations. However, little attentions is paid to rigour, there is no design or research question stated and the method of analysis is not discussed. Wood and Wilson-Barnett's (1999) study was the only comparative study in the review as they compared students who had, and who had not experienced service user involvement, and is therefore more useful in terms of case comparison. In relation to transferability the sample size is small and a baseline measure of students attitudes and behaviours prior to service user involvement would have been another valuable measure in the study. The study does however include the questions asked of participants, evidence of a combination of data collection methods and reports measures to control bias. For example, suggestions made from classroom observations were confirmed or not by students in group discussion. Frisby's (2001) paper does not include information regarding a study design, sample, data collection or findings although quotes from students' written evaluations are included.

Some literature reviews in related areas have been carried out. Reeper and Perkin (2007) conducted a literature review which evaluated initiatives involving service user involvement in professional healthcare education. Thirty-eight papers were included and most were small-scale qualitative studies. Reeper and Perkins (2007) reported that most of the studies focused on the process of service user involvement rather than the outcome. The review recommended that service user involvement must be developed in partnership with service users across education and service user delivery. Moreover, further research is required to explore the impact of service user involvement in education and training on student's attitudes, practice and behaviours. Terry (2012) reviewed the literature on service user involvement in pre-registration mental health nurse education in the classroom setting. Terry was solely concerned with studies that

focused on service user involvement in teaching and learning initiatives in classroom settings. The paper reviewed a total of eight papers ranging from teaching and learning strategies which included exposure to service users stories, to students being required to demonstrate awareness of service user perspectives in case study presentations, and others involving e-learning and assessment skill initiatives. Although the literature on service user involvement in mental health nurse education is under developed, reports of universities demonstrating good practice in this area is emerging (Terry, 2012). There is much scope to promote the embedding of service user involvement in professional programmes, but with limited direction as how this is best approached or evaluated. Further longitudinal research is required to establish the influence of service user involvement in the classroom on student nurses' attitudes and practices over time (Terry, 2012). Terry (2012) also recommends that a progressive service user involvement group is necessary in ensuring that nursing programmes are meeting requirements and foster involvement in a proactive, ethical and sensitive manner. Terry (2012) further recommends that involvement initiatives should be coupled with academic assignments in an attempt to strengthen the commitment and value placed on service user involvement. Happell et al (2014) carried out a systematic review of the published work on service user involvement in the education of mental health professionals. Twenty- eight papers were included in the review form a range of different mental health professional groups. They identified that service user involvement in the education of mental health professionals is limited and varies across professions, with reported studies on service user involvement most common in mental health nursing. Happell et al (2014) report that numerous basic evaluations have shown that students seem to benefit from the experience of service user involvement. However, adequate preparation is a necessity in order to obtain positive educational outcomes. Moreover, further research is necessary to determine the effect

of service user involvement on the behavior of students in mental health professions. Higgins et al (2011) presented the findings on service user involvement on the educational preparation of mental health practitioners. The findings from this study indicate that the scope of service user involvement is on teaching, with limited involvement in curriculum development or programme development. Higgins et al (2011) argue that service user involvement requires commitment, time, strategic planning as well as financial resources to support the development of such initiatives. Furthermore, the professional bodies responsible for guiding or accrediting curricula in mental health education have an important role in driving the service user agenda forward.

3.4Gaps in the Literature

The existing literature on service user involvement indicates that service user involvement is a feature of undergraduate mental health nurse education, which is a step in the right direction. However, based on the reviewed studies it is apparent that service user involvement in undergraduate mental health nurse education varies to a large degree in terms of the type of service user involvement, the frequency of service user involvement and the programme year in which students are experiencing user involvement. Moreover, the national extent of service user involvement in undergraduate mental health nurse education in neighbouring countries is not known, therefore it is difficult to ascertain the current level of activity relating to service user involvement. The area of service user involvement in professional education is clearly an under-researched area that warrants further work.

Firstly, the majority of reviewed studies evaluated service user involvement in isolation of, or with little mention of clinical practice. The emphasis was generally about the process of service user involvement rather than trying to determine the

influence it had on the students understanding of mental illness. The purpose of many of the projects was to merely involve service users in mental health nurse education, rather than explore the potential effect it had on student's perception of service users, mental illness or their clinical practice. Furthermore, while many of the studies reported that students viewed service user involvement favourably and that it helped students develop a greater awareness of their skills, it was not established or discussed what the potential outcome for clinical practice could be in light of these findings. Secondly, it is evident from the empirical investigations reviewed that key details regarding the service user initiatives are not always discussed, for example, the frequency of user involvement? Is there a school policy/strategy for user involvement? Will involvement continue to be a regular component? These details are important as they establish the commitment of the Department of Nursing and the educationalists to user involvement. Thirdly, all of the studies reviewed are single-site studies, in that the experiences of service user involvement focus on the experiences of students from one educational institution. This represents a significant gap in the literature as it would be useful to interview students from a variety of educational institutions to determine if the experiences of user involvement would be similar in other contexts and to provide a national picture. Finally, the majority of the studies reviewed apart from Rush (2008) and Byrne et al (2013), did not consider or discuss the effects or implications for students engaging with service users in a specific social context that is different from their usual interface and disrupts traditional power relations. Moreover, how this dialogue between students and service users could potentially contribute to the realisation of recent mental health policy development specifically on recovery has not been explored.

The current study will address the key gaps identified above; firstly the current study will establish nationally the extent of service user involvement in the undergraduate mental health nursing programme in Ireland. Secondly, the adoption of a mixed methods approach will allow educationalists, students and service users' perspectives to be included and integrated. Thirdly, as the majority of the empirical investigations reviewed service user involvement in isolation of clinical practice, the present study will place a particular focus on how the experience of service user involvement potentially influences students' approach to their clinical practice and their perceptions of service users. Fourthly, it is evident from the studies reviewed that students valued the experience of learning from a service user; however it was not established why it is a positive learning experience for students. This study aims to specifically ascertain how learning from a service user differs from a student's typical learning experience, i.e. learning from a lecturer or learning in the clinical setting. Fifthly, the current study will include the experiences of students from a number of different Schools of Nursing which will allow for different perspectives on user involvement from a variety of contexts. Finally, it is important to acknowledge that the current study will be the first to explore in-depth the experience of service user involvement solely in education of Undergraduate mental health nurse education in an Irish context.

3.4.1Aims and Objectives of the Current Study

The aim of the current study is to establish the extent and examine the perceived effect of service user involvement in undergraduate mental health nurse education. This can be broken down in to three objectives,

1. Establish the national extent of service user involvement in the education of undergraduate mental health nurses.
2. Examine students perspectives of the experience of service user involvement in their education

3. Examine from a service users perspective the experience of being involved in undergraduate mental health education.

3.5 Conclusion

The majority of studies reviewed were small scale qualitative studies which focused on service user involvement in single site studies. Based on the studies included in the review, it would appear that service user involvement is more active in mental health nurse education compared to the other disciplines. Bearing in mind that nurses are the group of health care professionals that have the most contact with service users, this may account for what seems to be a greater level of involvement in mental health nurse education. The findings suggest that students' perceptions of service user involvement in their education are by and large similar, regardless of what discipline they are equated to. The challenges associated with service user involvement, namely the need for training/support, and issue of remuneration is problematic across the various disciplines. It would seem that nursing is leading the way in terms of being active and implementing service user involvement initiatives in their educational programmes. While other disciplines are strengthening their efforts to involve service user in their programmes, it appears that they are taking lead from the involvement initiatives in mental health nursing programmes. That said, the literature would strongly suggest that there is a lack of evidence that shows the effect that service user involvement is having on clinical practice, students attitudes towards service users and mental illness. Hence there is a need for further studies to be carried out in all disciplines, including mental health nursing so that the current body of knowledge relating to service user involvement can be advanced.

Chapter 4- Methodology

4.1 Introduction

The chapter begins by re-stating the aims and objectives of the study. Subsequently, a rationale for choosing mixed methods as the methodological approach for this current study, the concepts and characteristics of mixed methods, quantitative and qualitative methods employed in the study, and the steps taken to ensure rigour will be discussed. A critique of the various paradigms underpins the decision to employ a pragmatic paradigm was made. Finally, the sequence of methods, weight of methods and integration of data for the current study will be discussed.

4.2 Aims and Objectives

The study has two aims, firstly to establish the extent of service user involvement, and secondly to examine the perceived effect of service user involvement in undergraduate mental health nurse education. This can be broken down in to three objectives.

1. Establish the national extent of service user involvement in the education of undergraduate mental health nurses.
2. Examine students' experiences of service user involvement in their education.
3. Examine service users' experiences of being involved in undergraduate mental health nurse education

To address the aims and objectives, a two phase, sequential explanatory mixed methods design was employed. Phase 1 involved a national survey of Schools of Nursing to investigate the extent of service user involvement in undergraduate mental health nursing programmes in the Republic of Ireland. Phase two involved semi-structured interviews with students and service users to examine their experience of service user involvement.

4.2.1 Rationale for a Mixed Methods Methodology

Mertens (2005) and Morse (2003) contend that researchers need to evaluate the most appropriate methodology approach to answer specific research questions. Greene, Caricelli and Graham (1989) examined published literature and identified the following five rationales for mixed method studies: (a) triangulation, seeking convergence and corroboration from the result of different methods which are examining the same phenomenon; (b) complementarity, seeking the clarification of the results from one method with the results from the other method; (c) development, which involves using the results from one method in order to enlighten the other method; (d) initiation, which is discovering paradoxes and contradictions that can cause the research question to be reframed; and (e) expansion, which is seeking to develop the range and breadth of the research inquiry by the use of different methods for different inquiry components. Rationale (a) triangulation, (c) development and (e) expansion correspond with the rationale for the use of mixed methods in the study. With regards to rationale (a) triangulation, the results of phase 1 and phase 2 were integrated to establish if the data sets converged, diverged or corroborated. In relation to rationale (c) development, the results of the quantitative phase of the study helped to inform the qualitative phase by establishing the most appropriate sample. With regard to rationale (e) expansion, as phase one wanted to establish the national extent of service user involvement, a quantitative method was required while phase two wanted

to examine the perceived effect of service user involvement therefore a qualitative methods was most appropriate. Hence a mixed methods approach was necessary for the different inquiry components.

A mixed methods approach best suited the aims of the study as the study aimed to examine both the extent and the perceived effect of service user involvement in the education of undergraduate mental health nurses and as mixed methods promotes the integration of findings from multiple perspectives and methods (Creswell and Plano Clark 2007), hence choosing a mixed methods methodology gave the researcher the flexibility to choose research methods that would answer the aims of the study. Using a mixed methods approach added insights and understanding that might be missed if a single method was used. This added to the completeness of the study, as it revealed different viewpoints of service user involvement from the perspective of students, service users and educationalists.

The definition of mixed methods adopted for the current study is that it involves the collection and analysis of both quantitative and qualitative data in a single study in which the data are collected sequentially or concurrently, are given a priority, and involve the integration of the data at one or more stages in the process of research (Creswell 2003). This research employed a two-phase, sequential explanatory mixed method design. According to Creswell et al (2003) sequential explanatory mixed methods design is the most straightforward of the mixed methods designs. It is characterised by the collection and analysis of quantitative data followed by the collection and analysis of qualitative data. The two methods and results are integrated during the interpretation phase of the study. Phase one involved the development and administration of a questionnaire to establish the national extent of service user involvement in undergraduate mental health nursing programmes in Ireland. Phase two

involved individual semi-structured interviews with students and service users. The interviews with the students provided insight into the students' experience of service user involvement in their education. In addition, the interviews provided students' with the opportunity to consider how learning from a service user compares with the typical forms of teaching and learning that they are exposed to. The interviews also established students' perceptions about the influence of service user involvement on clinical practice. The interviews with the service users provided them with the opportunity to discuss the content of their sessions and share their perceptions regarding the potential offerings that service user involvement brings to nurse education. The data from phase one was analysed using descriptive statistical analysis and the qualitative data from the open-ended questions was analysed using thematic analysis. The data from phase two was analysed using thematic analysis.

4.3 Mixed Methods Research

4.3.1 The Issue of Definition

Creswell and Tashakkori (2007) have reported that for almost three decades various scholars have discussed and debated the concepts, methods and the standards of quality of studies that utilize a combination of quantitative and qualitative approaches (Creswell 2003, Greene and Caracelli 1997, Miles and Huberman 1994, Newman and Benz 1998, Tashakkori and Teddlie 2003). This body of literature has been devoted to issues relating to worldview, typology, design, analysis and evaluation of mixed method studies. Given that mixed methods are still evolving, there is still an active discussion in relation to the definition of mixed methods. Cresswell and Tashakkorri (2007) have defined mixed methods as research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches and methods in a single study or programme of inquiry.

The terms used to represent mixed methods vary considerably (Sandelowski 2001; Bryman 2007; Cresswell and Tashakkori 2007). For example, writers have referred to it as multitrait-multimethod research (Campbell and Fiske 1959), interrelating qualitative and quantitative data (Fielding and Fielding 1986), methodological triangulation (Morse 1991), multimethod designs and linking qualitative and quantitative data (Miles and Huberman 1994), combining quantitative and qualitative research (Bryman 1998, Creswell 1994), mixed model studies (Datta 1994), and mixed methods research (Caracelli and Greene 1993; Rossman and Wilson 1991). Although the wording that is utilised to describe mixed methods is diverse, nevertheless, central to all these terms is the idea of combining quantitative and qualitative methods. Creswell et al (2003) argue that the term mixed methods is the most appropriate as the terms 'mixing' provides an umbrella term to cover the multifaceted procedures of combining, integrating, linking and employing multi-methods.

Creswell et al (2003) suggest that an elaborate definition of mixed methods would specify the nature of the data collection. For example, the concurrent or sequential collection of data, the priority of each form of data and the place in the research process where the "mixing" of the data will take place. Essentially, a mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected sequentially or concurrently, are given a priority, and involve the integration of the data at one or more stages in the process of research. However, Cresswell and Taskakkori (2007) argue that as mixed methods is still evolving therefore the discussion of what it actually is should be kept open. Likewise Johnson et al (2007) suggest that the definition of mixed methods will change over time as the research approach continues to grow.

4.3.2 Quantitative Research

Quantitative research has been defined as a formal, objective systematic process in which numerical data are utilized to obtain information about the world (Burns and Grove 1987). The quantitative approach emerged from the branch of philosophy known as positivism. The term positivism was first coined by the founder of positivism, Auguste Comte, the French philosopher who believed that reality can be observed (Mack 2010). Cohen, Manion and Morrison (2007 p.9) claim that "*Comte's position was to lead to a general doctrine of positivism which held that all genuine knowledge is based on sense experience and can be advanced only by the means of observation and experiment".*

Quantitative methodology adopts a deductive approach, meaning that a researcher interested in conducting research within a deductive framework would develop a hypothesis about a phenomenon and the researchers work is directed towards establishing whether that hypothesis is supported by the data gathered (Streubert and Carpenter 2003). So deductive research is designed to test or refine prior knowledge and assumes that a working theory exists in the mind of the researcher beforehand. Investigations in quantitative research are carried out under carefully controlled conditions in order to prevent the findings being affected by variables or influences that are not a component of the research study. The researcher remains separate from the phenomena being studied and approaches the research objectively and systematically. Research methods associated with positivist methodologies include structured observations and various kinds of measuring instruments such as attitude questionnaires. Quantitative data is generated, and the data is analysed using descriptive and/ or inferential statistics (Creswell 2007). The study used questionnaires to gather quantitative data in phase one of the study

4.3.2.1Questionnaires

Questionnaires are design to elicit information through written responses of subjects; questionnaires are structured so that each respondent is faced with exactly the same questions, and in the same order. When a questionnaire is used in a study the researcher is employing a strategy which facilitates the participants to use self-report to exercise their attitudes, beliefs and feelings towards a topic of interest (Teddlie and Tashakkkori 2009). The structure within a questionnaire can range from closed-ended questions to open-ended questions or a mix of both (Barker 1996 cited in Cormack). Closed ended questions invite the respondents to choose from pre-assigned categories of response. An advantage of closed ended questions is that they speed up the answer rate, thereby reducing respondent fatigue. However, a drawback of such questions is that the multiple choice questions can help respondents recall or clarify events, beliefs or feelings. There is danger that the set of optional responses might suggest that such experiences have occurred or that such views have been or are held (Barker 1996). Open-ended questions are structured to allow the respondents to answer in their own words. The main advantage of open ended questions is that the respondents are allowed to define their own frame of references in relation to the area of inquiry. The open ended questions allows the researcher to assess what the respondent thinks or feels and also what the respondent knows about the subject. There are a number of drawbacks associated with open-ended questions for example; the respondents may answer at great length thus making analysis difficult.

There are a number of advantages associated with questionnaire. Firstly, it provides a useful method of obtaining information in a structured format, and it can be administered without the direct support of a researcher (Wilson and McClean 1994). They are less costly than interviews in terms of time and energy. Questionnaires are appropriate for participants geographically distant from the researcher. Disadvantages

associated with questionnaires include poor response rates. Also some respondents may ask someone else they feel is appropriate to complete the questionnaire, thus prejudicing the sample (Carr 1994).

4.3.3 Qualitative Research

According to Creswell (2009) qualitative procedures demonstrate a different approach to scholarly inquiry than methods of quantitative research. Qualitative inquiry employs different philosophical assumptions, strategies of inquiry and methods of data collection, analysis and interpretation. The qualitative paradigm has its roots in cultural anthropology and American sociology (Kirk and Miller, 1986). The tradition arose due to the fact that quantitative research methods were unable to fully describe human values, culture and relationships. Krasner (2000 p.70) states that the early philosophers "argued that human phenomena could not be reduced to mathematical formulas". According to Speziale and Carpenter (2003), since early times human scientists have been concerned with describing the fundamental patterns of human thought and behaviour. Descartes' ideas were grounded in an objective reality and supported the idea that cause and effect could explain all things. Descartes view of science was hailed as the only approach to new knowledge. Kant is attributed with questioning the fundamental nature of reality and opened up the discussion about human rationality. According to Hamilton (1994), Kant proposed that perception was more than the act of observation and for him all reality was not explainable by cause and effect. He raised the issue that supported the notion that nature was not independent of thought or reason. Therefore, what was observed was not the only reality. The concept of scientific versus practical reason was derived from Kant's ideas. Kant's ideas were advanced to explore reality as it is perceived rather than an observational phenomenon only. Scientists questioned whether empiricism was the only way to gain knowledge. Philosophers such as Husserl furthered Kant's propositions, and eventually, the

German School of Philosophy supported and advanced the ideas about self, self-consciousness, reality and freedom. The early debates about the science and reality resulted in the foundations of the qualitative paradigm being established, a paradigm used by many social scientists use today (Speziale and Carpenter 2003). According to Denzin and Lincoln (1994), qualitative research offers the opportunity to focus on finding answers to questions centred on social experience, how it is created and how it gives meaning to human life. The intent of qualitative research is to understand a particular social situation, event, role group, or interaction (Locke, Spirduso and Silverman 1987). It is largely an investigative process where the researcher gradually makes sense of a social phenomenon by contrasting, comparing, replicating, cataloguing and classifying the object of study (Miles and Huberman 1984). Marshall and Rossman (1989) suggest that this entails the researcher entering the participants world and seeking their perspective and meanings.

4.3.3.1 Interviews

An interview is a research strategy that involves one person (the interviewer) asking questions of another person (the interviewee). The questions can be either closed ended or open ended or both. Interviews are an excellent data collection strategy because they facilitate one to one interaction between the researcher and the interviewees. Interviews provide an opportunity for researchers to learn about social life through the experience, language and perspective of those living it. Participants are given the opportunity to share their story, pass on their knowledge and provide their own perspective on a range of topics (Hesse-Biber and Leavy 2006). Boeije (2010) asserts that in order for the interview to be a success it is crucial that a number of factors be adhered to: (1) the questions fit the interviewee's frame of reference and the questions match the research topic exactly as it was introduced by the interviewer and to which the participant has agreed to participate; (2) the topic is of concern or interest to the

participant and the questions are posed in language that is understandable; and (3) the researcher creates an atmosphere of trust and openness by showing respect for what the participant has to say. Morse and Field (1996) believe that it is paramount that the interviewer accommodates to some degree the participants need to spend more time on certain issues, listens with interest, and does not interrupt the flow. Jumping from one question to another, irrespective of what has been before, is detrimental to the interview. An advantage of interviews is that they provide ample opportunity for interviewers to ask for explanations of vague answers or to provide clarification if a question is not clear (Teddlie and Tashakkori 2009). There are however disadvantages associated with face-to face interviews. For example, interviews are a costly method of data collection and are time consuming as the researcher may have to travel considerable distances to the geographical areas where the participants are based. In addition there is the risk that the researcher's presence may bias responses.

Since qualitative researchers are often looking for a true understanding of what is happening, the interviews are usually not entirely pre-structured in relation to the content, formulation, sequence and answers. Neither are they left entirely open. Rather, thorough preparation results in a list of topics and or questions to be asked. This type of interview is a 'semi-structured' interview (Boeiji 2010). Face to face semi-structured interviews was the method of qualitative data collection used in the study. The rationale for choosing this method was to explore the area of enquiry from the participant's perspective by providing them with an opportunity to share their ideas and opinions. Thus allowing detailed and rich information to be collected.

4.3.4 Mixed Methods

The collection and combination of both quantitative and qualitative data in research has been influenced by several factors. Unquestionably, both quantitative and qualitative data are increasingly available for use in studying social science research

problems. As limitations exist with all methods of data collection, the use of multiple methods can neutralise or cancel out some of the disadvantages of certain methods. Furthermore, mixing qualitative and quantitative methods facilitates each complementing the other, allows for a more robust analysis and takes advantage of the strength of each (Creswell et al 2003; Miles and Huberman 1994; Tashakkori and Teddlie 1998; Ivankova, Creswell and Stick 2006). Therefore there is a vast consensus that mixing different types of methods can strengthen a study. In addition as social phenomena are so complex, different kinds of methods are required to best understand these complexities (Greene and Caracelli 1997). Mixed methods studies can access knowledge or insights unavailable to a quantitative study and a qualitative study undertaken independently (O'Cathain, Murphy and Nicholl, 2007a). Mixed methods research is an attempt to legitimise the use of multiple approaches in answering the research question, rather than restricting or constraining the researchers' choice, hence why it is seen as an expansive and creative form of research and not a limiting form of research. It suggests that the researcher takes an eclectic approach in relation to method selection. What is most fundamental is the research question, that is, the research method should follow the research question in a manner that offers the best chance to obtain useful answers (Johnson and Onwuegbuzie, 2004). Gaining an understanding of the various strengths and weaknesses of quantitative and qualitative research puts the researcher in a position to mix methods and to utilise the fundamental principles of mixed methods research (Johnson and Turner, 2003). Maxwell and Loomis (2003) argue that when mixing methods within a single study, the intention is not to homogenise the research methods but rather to synthesise and preserve the unique qualities and advantages of utilising both quantitative and qualitative methods. According to this principle, researchers should collect multiple data using different strategies, approaches and methods in a manner that the combination of methods is

likely to result in complementary results with no overlapping weaknesses. According to Johnson and Onwuegbuzie (2004) using this principle effectively is a justification for mixed methods research as the result will be superior to monomethods.

4.4 Research Paradigms: Theoretical Perspective and Philosophical Underpinnings

The term worldview can be defined as *"a basic set of beliefs that guide actions"* (Guba, 1990 P.17). Others have called them paradigms (Lincon and Guba, 2000). Creswell (2009) describes worldviews as a general orientation about the world and the nature of research that a researcher holds. He also argues that world views are shaped by the discipline area of the researcher. Theoretical perspectives aid to provide a philosophical underpinning for the methodological approach and the methods adopted in research. Morgan (2007 p 47) defines a paradigm as *"the set of beliefs and practices that guide a field".* World view, theoretical lens and paradigms are terminology that is used interchangeably throughout the literature (Doyle et al, 2009). Distinct elements which define paradigms include epistemology (how we know what we know), ontology (nature of reality), axiology (values) and methodology (the process of research) (Hanson et al, 2005). Essentially paradigms will influence the question that the researcher will pose and the methods that are utilised in order to answer the question (Morgan. 2007).

According to Crotty (1998) and Hughes and Sharrock (1997), philosophical issues need to be discussed from the outset in order to ensure that valid, consistent and logical choices are displayed throughout the research According to Bryman (2006) the different epistemological and ontological assumptions underpinning quantitative and qualitative research methods have resulted in a clash between positivism and post-positivism). Guba and Lincoln (1988) argue that the paradigms are not compatible as it is not possible to combine ontological and epistemological stances of both traditions.

According to Sandelowski (2001) traditionalists would argue that these paradigms are different therefore a combination of the two is simply not possible. Consequently, the debate about quantitative and qualitative research at the epistemological level became known as the paradigm "wars". The term stemmed from the perception of quantitative and qualitative research being distinct and competing paradigms which were based on fundamentally different principles (Bryman, 2006).

According to Bryman (2006), researchers in social and behavioural sciences can be roughly categorised in to three groups (a) quantitatively orientated researchers working with the post positivist tradition and primarily interested in numerical analysis, (b) qualitatively orientated researchers working within the constructivist tradition, such researcher interest lies in the analysis of narrative data, and (c) mixed methodologists working within other paradigms for example pragmatism or transformative-emancipatory paradigm, and are interested in both quantitative and qualitative data.

4.4.1 The Postpositivist Worldview

The postpositivist assumptions represent the traditional form of research, and these assumptions are associated with quantitative research. This worldview is often referred to as the 'scientific method'. This method is called positivist/postpositivist research, empirical science and postpostivism. Postpostivism represents the thinking after positivism and challenges the notion of an absolute truth and recognised that being positive about claims of knowledge when studying human behaviour is not possible (Philip and Barbules 2000).

Bryman (2004) described the central ideas of positivism as the notion that only observable phenomena can count as knowledge, and can inform us of the social world, the notion of objectivity and value-neutrality within research, the extraction and testing of hypotheses from theory and the adoption of methods from the 'natural' sciences to

observe and measure the social world. Positivists believe that there is a single reality and therefore seek to identify the casual relationships through objective measurement and quantitative analysis (Firestone 1987). In the positivist's paradigm the researcher is considered independent and objective using larger samples to test carefully constructed hypotheses and puts aside values to avoid bias in a process of inquiry (Doyle et al, 2009).

Postpositivists believe in a deterministic philosophy in which causes probably determine effects or outcomes. Therefore, the problem studied by postpositivists reflects the need to identify and assess the cause that influences outcomes, such as the outcomes found in experiments (Creswell 2009). It is also reductionist, which means that the intent is to reduce the ideas into small, discrete sets of ideas to test, such as the variables that comprise hypotheses and research questions. This knowledge that develops is based on cautious observation and measurement of the objective of reality that exists "out there" in the world. As a result, developing numeric measures of observations and studying the behaviours of individuals becomes vital for a positivist (Creswell 2009).

Phillips and Barbules (2000) provide a concise understanding of the key assumptions of this position, such as:

1. Knowledge is conjectural which means that the absolute truth is impossible to find. Hence, the evidence established in research is fallible. Hence, why researchers state that they do not prove a hypothesis, they indicate a failure to reject the hypothesis.

2. Data evidence and rational consideration shape knowledge. In practice the researcher collects information on instruments which are based on measurement which the participants complete or by the researchers' recorded observations.
3. Researchers try to develop truthful relevant statements that can explain the situation of concern or that describe the relationship of interest. In quantitative studies, the researcher advances the relationships among variables and poses this in terms of questions or hypotheses.
4. Objectivity is a vital aspect of competent inquiry. Therefore, researchers must examine methods and conclusions for bias. Hence, why standards of validity and reliability are significant in quantitative research.

4.4.2 Constructivism Worldview

The qualitative paradigm is sometimes described as the naturalistic inquiry, post positive, constructivist or interpretative approaches (Creswell 1994). Constructivism emerged as a competing vision to the positivist form of inquiry (Schwandt 2000) and was borne out of resistance to the 'positivist orthodoxy' (Hughes and Sharrock 1997, Crotty 1998). Qualitative and quantitative scholars are committed to different styles of research, different epistemologies, and different forms of representation. Qualitative researchers use ethnographic prose, historical narratives, first-person accounts, life histories and biographical and autobiographical materials, among others. Quantitative researchers use mathematical models and statistical tables and graphs (Denzin and Lincoln 2005).

Guba and Lincoln (2000), Nueman (2000) and Crotty (1998) are more recent writers who have talked about the constructivism position. Social constructionists believe that individuals seek understanding of the world in which they live and work. Individuals develop subjective meaning of their experiences which is directed towards certain

objects or things. For constructivists, understandings of reality are constructed both individually and socially These meanings are varied and multiple which lead the researcher to look for the complexity of views rather than narrowing meaning into a few categories or ideas (Crotty 1998).

The notion of objectivity within research is rejected by constructivism. Snape and Spencer (2003) argue that the research process is interactive and inevitably influences the perspective and values of the researcher. According to Appleton and King (2002), researchers who work within the constructivism paradigm strive to illuminate the reality of others through the process of detailed descriptions of their experiences. The constructivist researcher relies on the participant's views of the situation in order to gain the participants insight into the meaning of the situation. The researcher listens carefully to what people say or do in their life setting. The constructivist researcher often addresses the process of interaction among individuals. They also focus on specific contexts in which people work and live so that they can gain an understanding of the historical and cultural settings of the participants. It is the researcher's intent to understand the meanings others have about the world (Crotty 1998).

Crotty (1998) has identified several assumptions:

1. Human beings construct meaning as they engage with the world they are interpreting. Qualitative researchers usually use open-ended questions to enable participants to share their views
2. Humans engage with their world and make sense of it based on their historical and social perspectives. Thus qualitative researchers try to understand the context or setting of the participants through visiting the context and gathering the information personally

3. The basic generation of meaning is always social, which arises in and out of interaction with a human community. Qualitative research is largely inductive with the researcher generating meaning from the data collected.

4.4.3 The Pragmatic Worldview

Pragmatism is a philosophical movement that began during the latter decade of the 19th Century by the American philosopher Charles Sanders Peirce. This distinctly American philosophy was elaborated on by James, Mead and Dewy (Cherryholmes 1992). Recent writers include Rorty (1990), Murphy (1990) and Cherryholmes (1992). These pragmatists rejected certain traditional assumptions in respect of the nature of knowledge and truth and the nature of inquiry. These pragmatists disputed the notion that social science was able to access the 'real world' solely by virtue of a single scientific method (Maxcy 2003). Pragmatism as a worldview arises out of actions, situations and consequences. Morgan (2007) and Patton (1990) convey its importance for focusing its attention on the research problem in social science research and then using pluralistic approaches to derive knowledge about the problem.

Hall (2011) argues that paradigm issues are a major concern in mixed methods research and choice of an appropriate paradigm is seen as a necessary step to justify the use of mixed methods. Pragmatism has gained considerable support as a stance for mixed methods research (Feilzer 2010, Johnson and Onwuegbuzie 2004, Maxcy 2003, Morgan 2007). Pragmatism offers a set of assumptions about knowledge and inquiry that underpins a mixed methods approach and distinguishes the approach from purely quantitative approaches that are based on the philosophy of positivism and from purely qualitative approaches that are based on the philosophy of constructivism (Johnson and Onweubuzie 2004, Maxcy 2003). According to Denscombe (2011) pragmatism provides a fusion of approaches that complements the philosophy of mixed methods.

Cherryholmes (1992) maintains that researchers should be concerned with applications, with what works. In light of this the use of both quantitative and qualitative methods can help to best understand the research problem. Pragmatism is not committed to any one system of philosophy and reality. This applies to mixed method research in that the inquirers draw liberally from both quantitative and qualitative assumptions. Pragmatism allows researchers to have freedom of choice. In this way researchers are allowed to choose methods, techniques and procedures of research that best meet their needs and purposes.

Pragmatists do not see the world as an absolute unity. This is similar to the way that mixed methods researchers use many approaches for collecting data and analysing data rather than subscribing to only one way, for example qualitative or quantitative. Johnson and Onwuegbuzie (2004) believe that the project of pragmatism has been to find a middle ground between the philosophical dogmatism and scepticism and to find a workable solution. Two major characteristics of pragmatism are the rejection of the dogmatic either-or choice between constructivism and post positivism and the search for practical answers to questions that intrigue the investigator. In that sense pragmatism allows the researcher to be free from the constraints imposed by the *"forced choice dichotomy between post positivism and constructivism"* (Creswell and Plano Clarke 2007, p. 27), In addition, researchers do not have to *"be the prisoner of a particular method or technique"* (Robinson 1993, p. 291). The obvious commitment to pragmatism has become a way of rationalising the conjoint use of quantitative and qualitative research. Maxcy (2003) suggests that pragmatism appears to have emerged not only as a research method of inquiry but also as a device for settling the debates between research purists and the more practically minded scientists.

4.5 Rationale for a Pragmatic Approach in the Current Study

Some researchers believe that mixed methods are possible but they must be kept as separate as possible so that the strengths of each paradigmatic position can be realised (Brewer and Hunter 1989, Morse 1991). On the other hand, Maxwell and Loomis in Tashakkori and Teddlie (2003) do not believe in purely qualitative or quantitative research paradigms. They argue that each of these two generic positions has a number of separate and distinct "components". They argue that qualitative and quantitative components can be put together in multiple and legitimate ways as the two research paradigms are not pure to begin with. Guba and Lincoln (2005) have argued that it is possible to combine qualitative and quantitative, however, others Sale, Lohfeld and Brazil (2002) have continued to argue it is not possible to mix methods as they are rooted in different paradigmatic assumptions.

One of the chief manifestations of the pragmatic approach is the significance that is given to the research question. Teddlie and Tashakkori (2003) argue that pragmatic researchers view the research question to have greater importance than the method that is used. Erzberger and Kelle (2003) hold a similar view and argue that the selection of adequate methods should not be made on the basis of sympathies towards a certain methodological position, as methods are tools for answering research questions and not vice versa. Miles and Huberman (1984) argue that pragmatists ascribe to the philosophy that the research question should drive the method(s) used, stating that epistemological purity does not get the research done. According to Onwuegbuzie and Leech (2005), researchers who ascribe to epistemological purity ignore the fact that methodologies are merely tools that are designed to aid our understanding of the world. Bryman (2006) believes that this debate about quantitative and qualitative research prioritises the research question and relegates epistemological and ontological

debates to the side line. By doing so, it clears the path for research that combines quantitative and qualitative research methods. Ultimately, pragmatism over looks that quantitative/qualitative divide and ends the paradigm war by raising an important question, whether the research method has helped to find out what the researcher wants to know (Hanson 2008). Denscombe (2008) argues that pragmatists do not "care" which methods they use as long as the chosen methods have the potential to provide answers to the research question. It is acknowledged, however, that pragmatism is not an excuse for sloppy research and it does require the researcher to have a good understanding of quantitative and qualitative methods and analysis.

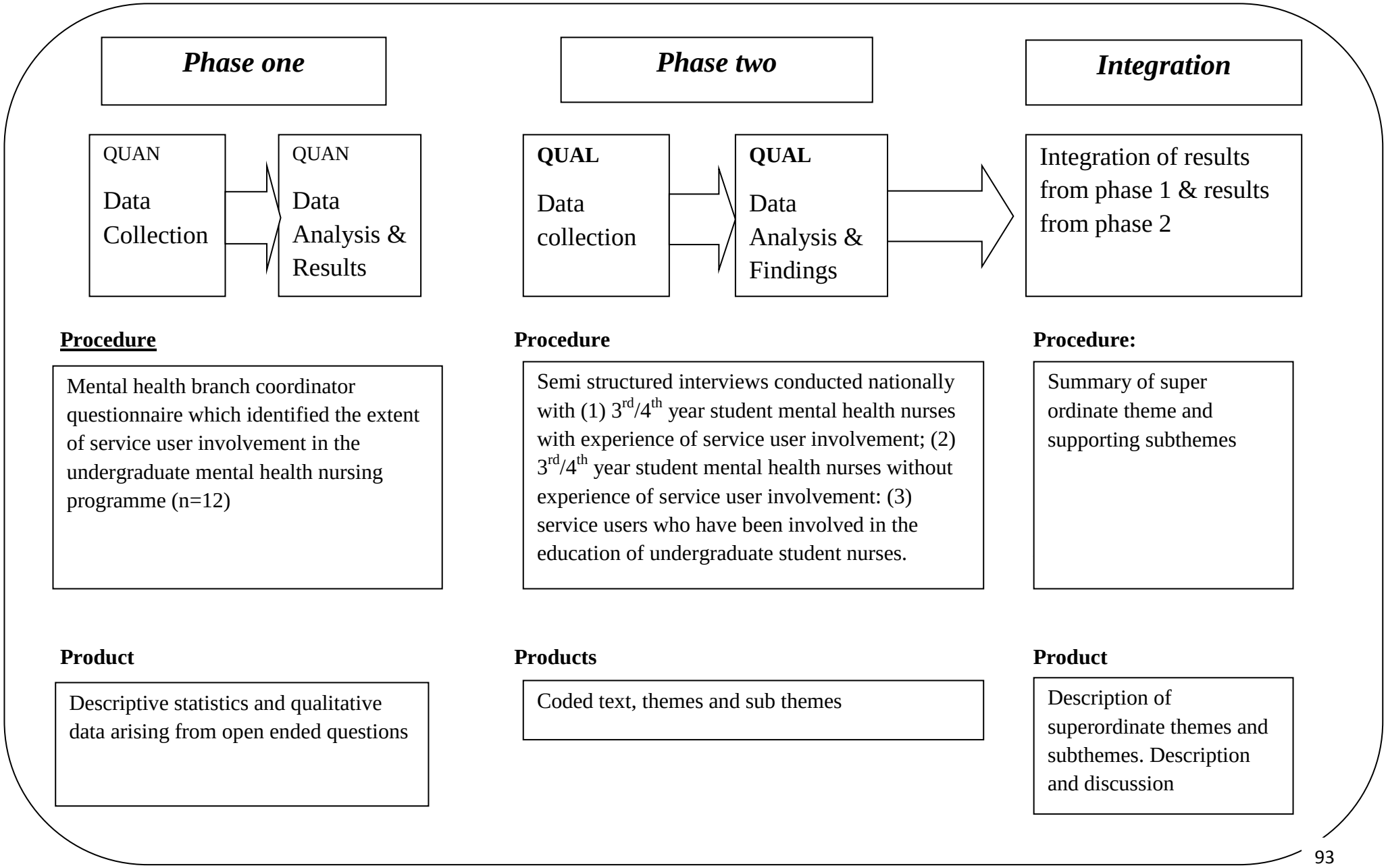
Taking the previous paragraphs in to consideration it is apparent that being a pragmatic researcher is advantageous. Firstly, it allows for flexible investigation techniques to address a range of research questions that arise (Onwuegbuzie and Leech, 2005). Tashakkori and Teddlie (1998), Morgan (2007) and Patton (1990) convey the importance of pragmatism as it focuses attention on the research problem and uses pluralistic approaches to derive knowledge about the problem. According to Miles and Huberman (1994 P.40) *"at bottom, we have to face the fact that numbers and words are both needed if we are to understand the world".* According to Tashakkori and Teddlie (1998) pragmatism presents a practical and applied research philosophy. As previously stated, pragmatist researchers consider the research question to be more important than either the method used. Tashakkori and Teddlie (1998) refer to this as "dictatorship of the research question". They also suggest that; "*study what is of value to you and what interests you, study it in the ways that you deem appropriate, and utilise the results in ways that can create positive consequences within your value system"* (Tashakkori and Teddlie, 1998 p96). In adopting a pragmatic approach, it is possible to focus on 'what works' in terms of the most appropriate way to answer the research question. As the current study is mixed method research, pragmatism opens

doors and provides the researcher to have the freedom of choice. In this way, pragmatism facilities the use of multiple methods, different assumptions, as well as different forms of data collection and analysis (Creswell 2009).

4.6 Sequence of Methods

This study involved two phases of data collection: (1) Questionnaire establishing the national extent of service user involvement in undergraduate mental health nurse education and (2) student mental health nurse and service user individual semi-structured interviews. It is a mixed methods sequential explanatory design which consists of two distinct phases: quantitative followed by qualitative. A sequential explanatory strategy is characterised by the collection and analysis of quantitative data in the first phase followed by the collection and analysis of qualitative data in a second phase that builds on the results of the initial quantitative results. The next section will provide a fuller discussion of how the qualitative phase builds on the initial quantitative phase. (Creswell et al 2003). See Figure 2, which is based on Ivankova et al.'s (2006) guideline for visual models of mixed methods studies.

Figure 1: Visual Diagram of the Research Design



4.7 Priority of Methods

Priority refers to which approach, quantitative or qualitative (or both) a researcher gives more weight or attention to throughout the data collection and analysis process in a mixed methods study (Creswell 2003). Creswell (2009) argues that weight or priority given to quantitative or qualitative methods within a particular study is an important factor when designing mixed methods studies. In some studies the weight might be equal; in other studies, it might emphasise one or the other. Reportedly it is a difficult decision to make and might depend on the interest of a researcher, the audience for the study, and/or what a researcher seeks to emphasise in the study (Ivankova et al 2006). In Figure 1, the use of capital letters (QUAN) and (QUAL) signifies that both phases of the research were given equal priority. Both phases had specific research aims and objectives and collectively both phases provided an important and therefore equal contribution to the overall study.

Phase one was important as it indicated the current extent of service user involvement in each of the Schools of Nursing in third level institutions in the Republic of Ireland. It also indicated the context to which service user involvement is occurring and importantly the frequency with which students are experiencing service user involvement. The questionnaires also highlighted where service user involvement is not currently active. The quantitative phase also provided qualitative data relating to the educationalists perspectives of service user involvement as the questionnaire contained open-ended questions. . However, both the educationalists and students perceptions will provide a different viewpoint, therefore, it was anticipated that the study will be richer for including both. As previously mentioned, the study was not just concerned with finding out the extent of service user involvement, but wanted to explore the perceived effect that service user involvement had on nurse education and on clinical practice. Moreover, the semi-structured interviews with both students and

service users who have been involved in teaching student mental health nurse provided additional information to correspond with, expand on or contradict the findings from the mental health branch coordinator questionnaire. Phase 1 provides an important context of the type and nature of service user involvement which is important in informing our understandings of students' and service users' experiences in phase 2. This is particularly pertinent when it is considered that the students' and service users' in phase 2 are educated/involved in this context and the service user involvement experiences that they discuss are embedded in this context.

4.8 Analysis and Integration of Findings

Mixed methods data analysis allows the researcher to use the strengths of both quantitative and qualitative analysis to understand the phenomena better. The ability to "get more out of the data" provides the opportunity to generate more meaning thereby enhancing the quality of the data interpretation. A parallel mixed methods data analysis was used in this study. This involves two separate processes, firstly the quantitative data is analysed using descriptive statistics, and qualitative analysis of the data using thematic analysis. Although the two sets of analyses are independent, each provides an understanding of the area of enquiry by answering specific research objectives. The quantitative data analysis generated inferences (conclusion, interpretations) relating to the quantitative orientated questions, while the qualitative data analysis was used to generate inferences regarding the qualitative orientated question.

An inference is a conclusion or an interpretation in response to a research question, which is made on the basis of the results of the data analysis (Teddlie and Tashakkori 2009). Inferences made on the basis of the results from each strand are then integrated or synthesised to form-meta inferences at the end of the study. These meta-inferences or superordinate themes are conclusions that are generated through linking, combining

or integrating the inferences that were obtained from the quantitative and the qualitative phase of the study.

Integration is a key element of mixed methods research. Creswell, Fetters and Ivankova (2004) report that the unique contribution of mixed methods research is that integration between methods occurs within a single study. According to Creswell et al (2004) and Tashakkori and Teddlie (2003), integration is a key aspect of mixed methods research. According to Lewin, Glenton and Oxman (2009) and O'Cathain, Murphy and Nicholl (2007b) recent empirical studies of mixed methods research in health show a lack of integration between qualitative and quantitative components, consequently the amount of knowledge generated from mixed methods studies is limited. Without integration, the knowledge yield is equivalent to that from a quantitative and a qualitative study carried out independently (O'Cathain, Murphy and Nicholl, 2010). The issues of integration and the integration strategy adopted in this study will be discussed and explained at start of the integration chapter of the thesis.

4.9 Rigour

According to Graneheim and Ludman (2004) research findings should be as trustworthy as possible and every research study must be evaluated in relation to the procedures used to generate the findings. The use of concepts for describing trustworthiness differs between the qualitative and the quantitative research traditions. Within qualitative research, credibility, dependability and transferability have been used to describe various aspects of trustworthiness (Lincoln and Guba 1985; Polit and Hungler 1999). In quantitative research, validity, reliability and generalizability are used to ensure quality. Qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures (Creswell 2009). In the

subsequent chapters the steps taken to ensure rigor in each phase of the research will be discussed.

Teddlie and Tashakkori (2009) discuss the issue of quality in mixed methods research and they assert that given the inconsistency between the standards for assessing the quality of inferences derived from quantitative and qualitative designs, assessing inference quality in mixed methods research is a challenge. A crucial stage of a mixed methods study is the integration, which involves comparing, contrasting or linking the two sets of inferences generated by the two strands of the study. Teddlie and Tashakkori (2009), identify that when assessing the quality of a mixed methods study many of the standards are the same as assessing the quality of quantitative and qualitative approach, however it is important to assess the quality of the design in a mixed methods study. Teddlie and Tashakkori discuss specific areas of design quality that should be assessed. In relation to design suitability, Teddlie and Tashakkori ask; are the methods of the study appropriate for answering the research question? Do the strands of the mixed method study address the same research questions, or closely related aspects of questions? With regards to design fidelity; are the quantitative and qualitative procedures (e.g. sampling, data collection procedures, data analysis procedures) implemented with the quality and rigor necessary for capturing the meanings? In terms of within-design consistency; do the components of the design fit together in a seamless manner? Do the strands of the mixed methods study follow each other in a logical manner? With regards to analytic adequacy; are the data analysis procedures/strategies appropriate and adequate to provide possible answers to research questions? Are the mixed methods analytic strategies implemented? The current study adhered to the above strategies to ensure the quality of this mixed methods study.

4.10 Conclusion

This chapter has provided an overview of mixed methods research with a specific focus on a rationale for choosing mixed methods as the methodological approach for study. The chapter illustrated that quantitative and qualitative method are required in order to meet the specific aims and objectives of the study. A discussion of the various paradigms highlighted how a decision to adopt a pragmatist's perspective was chosen. Finally key components of mixed methods research, that is priority of methods and integration of findings, were discussed.

Chapter 5- Phase 1 - National Survey of Service User Involvement

5.1 Introduction

The quantitative phase of the study utilised a questionnaire to address the specific objective of phase one of the study. The aim of the current study is to establish the extent and examine the perceived effect of service user involvement in undergraduate mental health nurse education. Phase one addresses objective one and establishes the extent of service user involvement in undergraduate mental health nurse education in Irish third level institutes in the Republic of Ireland. This chapter begins by discussing the design and development of the questionnaire. Subsequently the sample, ethics, procedure and data analysis are discussed. Next the chapter presents and discusses the result of phase one.

5.2 Method

5.2.1 Questionnaire Design

The fundamental aim in designing the questionnaire is to communicate with the respondents and ensure useful and relevant information is gathered. A well designed questionnaire requires thought and effort and needs to be planned and developed in a number of stages; therefore design issues such as language, frame of reference, information level, nature, sequence and form of questions require careful consideration (Barker 1996).

The use of mixed methods began in this stage of the study as a mixed methods questionnaire was developed. According to Teddlie and Tashakkori (2009) a mixed methods questionnaire includes both open-ended and close-ended items. The closed-ended questions might have a pre-planned response format and the open-ended questions allows the participants to share elicit candid information. The various stages

of the questionnaire development outlined by Rattray and Jones (2007) will be discussed in the subsequent section.

5.2.1.1 Question content

This is an essential stage of the questionnaire design as it relates to the questions that will feature in the questionnaire. As there was no pre-existing questionnaire available which established the extent of service user involvement in the undergraduate mental health nursing programme many of the questions were influenced by the literature review and were formulated by the researcher. Some of the questionnaire content was influenced by Higgins et al (2011). For example; the inclusion of questions that are relevant to the programmes that do not have service user involvement. Tew, Gell and Foster (2004) report that it is important to consider certain issues when assessing the quality of service user involvement initiatives in professional education. A document written in the UK by Tew, Gell and Foster (2004) on behalf of Mental Health in Higher Education (MHHE) was useful in establishing the content of the questionnaire. The guide was devised to assist in the development of service user involvement initiatives in higher education. The document highlights specific factors to take in to consideration when assessing good practice in service user involvement initiatives. Factors such as the spectrum of service user involvement, the programme years that service user initiatives spans across, the planning and evaluation of service user involvement, and a strategy/policy for service user involvement. Taking these points on board and considering the research objective of phase 1 many of these factors were seen as relevant in addressing the research aim.

5.2.1.2 Question Sequence and Layout

The questionnaire was devised ensuring the phrasing and layout was clear and the order of questions was appropriate and comprehensible. The questions were numbered and questions on a particular aspect of the topic were grouped together to ensure a

coherent and logical flow for the respondent. The respondents were provided with clear instructions in relation to the completion of the questionnaire.

5.2.1.3 Issues of Validity and Reliability

At the time of the study there were twelve third level educational institutions in the Republic of Ireland providing undergraduate mental health nurse training and as the study aimed to survey all of these, a pilot study of the questionnaire was not conducted so that all of the programmes could feature in the final results. However the initial draft of the questionnaire was reviewed by a panel similar to those in the target population comprising mainly of academics, however service users and students also contributed. The purpose of this was to consult with experts to ascertain their opinions whether all relevant issues had been addressed and if the questions had been formulated in an understandable way, also if the questions coincided with the aim of the questionnaire. They offered their expertise on the appearance, content, structure, comprehensiveness, clarity and appropriateness of the questionnaire, and highlighted areas of confusion. This ensured the face validity and content validity of the questionnaire. The expert panel made some recommendations and suggested that some questions be eliminated as it was questionable if they served a meaningful contribution to the research. The panel also recommended adding additional question, for example; questions relating to the evaluation of service user involvement and the continued involvement of service users in the undergraduate mental health nursing programme. The suggestions were taken on board and any amendments highlighted were made. The panel reviewed the questionnaire after the suggested amendments had been incorporated, it was proposed that adding some open-ended questions would provide the participants with an opportunity to answer in their own words with no influence of specific alternatives provided as in the close ended question. Issues of internal

consistency and test-retest reliability are less relevant for a questionnaire which will be analysed on an item by item basis and is not purporting to be a scale.

5.2.1.4 The Final Questionnaire

The questionnaire was five pages in length and had a total of 18 questions. The questions were relevant to the subject matter and it predominately had closed-ended questions with the exceptions of two open-ended questions. Close ended questions are advantageous because it provides the respondent with an easy method of indicating their answer without having to think of an articulate way to word it. The closed-ended questions were carefully worded and mutually exclusive response options were clearly identified. The final draft of the questionnaire was clear and comprehensive which ensured ease of completion. Table 1 below lists the questions that featured in the questionnaire will be discussed and a rationale of their inclusion will be provided. A copy of the questionnaire is included in Appendix A.

Table 1: Rationale for the inclusion of each questionnaire item

<table>
<tr><th>Item</th><th>Rationale</th></tr>
<tr><td>Q1. Is there service user involvement on the BSc undergraduate mental health nursing programme?</td><td>To establish if service user involvement was a component of the undergraduate mental health nursing programme</td></tr>
<tr><td>Q2. If service users are NOT currently involved with the course, is there a plan in the near future to involve service users in any of the following ways? Please tick all that apply
Part of the BSc programme
Curriculum design
Regular teaching on the course
Sessional teaching on the course
Provide workshops
Student assessment
Other please specify</td><td>To establish if the department had a future agenda to incorporate service user involvement as a component of the undergraduate programme, indicating their future commitment to developing service user initiatives as part of the undergraduate programme.</td></tr>
<tr><td>Q3. If service users are NOT currently involved with the course, please state some of the reasons why service users are not current involved in the undergraduate mental health nursing programme? Please expand on your answer at the end of the questionnaire / add further comments if necessary
Negative past experience
Inability to provide remuneration
Not a priority
If other, please provide detail</td><td>To establish some of the reasons why service user involvement is not a feature of the undergraduate programme</td></tr>
<tr><td>Q4. If there is service user involvement in the undergraduate mental health nursing programme please tick what year/years of the nursing course that this applies to</td><td>To establish each year or years of the programme that service user involvement is occurring</td></tr>
<tr><td>Q5. How frequently do students have service user involvement per year? Please tick all students that are exposed to this
<table>
<tr><th></th><th>1st Yr</th><th>2nd Yr</th><th>3rd Yr</th><th>4th Yr</th></tr>
<tr><td>More than once a week</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Once a week</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Two or three times a month</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Once a month</td><td></td><td></td><td></td><td></td></tr>
<tr><td>A few times a year</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Once a year</td><td></td><td></td><td></td><td></td></tr>
</table></td><td>To establish how frequent the students are experiencing service involvement across each of the four years</td></tr>
</table>

Less than once a year					
Q6. How are service users involved with the course? Please tick all that apply. BSc programme team Curriculum design Course evaluation Regular teaching on the course Sessional teaching on the course Workshops Student evaluation If other, please specific					To find out the various ways in which service user are involved in the undergraduate mental health nursing programme and establish if involvement initiatives expand beyond the scope of teaching activities.
Q7. Who plans the session(s) that are going to be delivered to the students? Lecturer Service user Collaboration of both If other, please specify					To find out who plans the service user sessions and establish if the ethos of 'involvement' was being fostered by having service users actively involved in the planning of the session(s)
Q8. What is the topic/context of the teaching session(s) that the service user delivers to the students? Please tick all that apply User experience Clinical practice skills Research Alternative knowledge/evidence If other, please specify					To establish the topic of the service user session(s) that is being delivered to the undergraduate student mental health nurses
Q9. Is the content of the sessions linked to the overall module aims? Q10. Is the content of the session linked to the overall programme aims? Q11. Is there a school policy/strategy for involving service users in the undergraduate mental health nursing programme? Q12. Is service user involvement evaluated? Q13. If yes who is it evaluated by? Please tick all that apply Student Service user Lecturer Course team If other, please specify Q14. If service user involvement is NOT evaluated; please specify why this does not take place					To establish the commitment of the school/department to service user involvement in the undergraduate mental health nursing programme. Moreover, establish if service user initiatives will continue to be a part of the undergraduate programme going forward.

Q15. Will service user involvement continue as a regular component of the undergraduate mental health nursing programme?	
Q16. Please state which of the following statements best captures the impact that service user involvement has had on nurse education? I strongly agree that it has a positive impact I agree that it has a positive impact Neither agree or disagree that it has a positive impact I disagree that it has had a positive impact I strongly disagree that it has had a positive impact Q17. Please expand on what you think the impact of service user involvement has had on service user involvement Q18. Please share any further comments in relation to service user involvement on the BSc mental health nursing programme	To provide respondents with the opportunity to share in their own words their perceptions or any comments they might have relating to service user involvement in undergraduate mental health nurse education.

5.3 Identifying a Sample

As the study was solely interested in service user involvement in undergraduate mental health nurse education, the inclusion criteria included lecturers with extensive knowledge of the timetables and modules of the undergraduate mental health nursing curriculum. Hence the mental health branch coordinator, who is the designated lead for the mental health branch of the undergraduate degree in nursing in each School of Nursing, was seen as the most appropriate person to complete the questionnaire. Part of the role of the mental health branch coordinator also involves teaching duties on the programme. In the Republic of Ireland, the undergraduate nursing programme comprises a four year honours degree programme. At the time of the study twelve educational institutions in the Republic of Ireland offer an undergraduate mental health nursing programme; six out of the twelve educational institutions are Universities, and the remaining six are Institutes of Technology. The training and education of student mental health nurses comprises an academic taught element and clinical placements during each year of training. Practice placements are an integral component of the

programme. In 3rd/4th year of the programme students have an internship, which is for a period of 9 months; during this time students are a paid member of staff but remain supernumerary.

5.4 Ethics

Ethical approval was granted by Dublin City University Research Ethics Committee. All participants were over eighteen years of age and capable of informed consent. Participants were not requested to sign a consent form. Consent was assumed by the completion and return of the questionnaire. All participants were provided with the contact details of the researcher should they have any concerns or require additional information about the study. This ensured that confidentiality was maintained. An e-mail was sent thanking all of the branch coordinators after the questionnaires had been returned. No unforeseen ethical issues presented that required consideration or attention during this phase of the study.

5.5 Procedure

Once ethical approval was granted a letter was sent to the head of department in each School of Nursing inviting their school to participate in the current study (See appendix B). Once the head of department agreed to participate in the study, approval was granted to access the mental health branch coordinator. The head of department provided the names and contact details of the mental health branch coordinator. A cover letter, information sheet, questionnaire, and a freepost envelope with which to return the questionnaire were posted to the branch coordinator in each School of Nursing in the Republic of Ireland which provides an undergraduate mental health nursing programme. The questionnaire was posted to the participants to allow them time to complete the questionnaire at their own convenience. The majority of the respondents returned the questionnaire within a timely manner. A reminder letter and second copy of the questionnaire was sent via post to any respondents who had not

returned the questionnaire within three weeks of the questionnaire being distributed. All 12 questionnaires were returned. Each returned and completed questionnaire was given a unique identifier so that no data could be attributed to a specific educational institute or individual5.6 Data AnalysisThe data was analysed using Statistical Package for the Social Sciences (SPSS). The datasets were set up by the researcher and all data were analysed by the principal investigator. The data obtained from the completion and return of the questionnaires were analysed using descriptive statistics. Descriptive statistics are procedures to summarise numeric data in easily interpretable tables, graphs or single representation of a groups of scores. The goal of descriptive statistics is to be able to understand the data and detect patterns and relationships and better communicate the results (Teddlie and Tashakkori 2009).There was a 100% response rate as all twelve questionnaires were returned. The aim of this phase of the study was to establish the national extent of service user involvement in the undergraduate mental health nursing programme. Considering the small sample size and the content of the questionnaire, for this reason descriptive statics was chosen so that the data could be clearly interpreted and presented. The open-ended questions were analysed using thematic analysis. An example to demonstrate the steps taken to analyse the qualitative data can be seen in the appendices (Appendix C). Thematic analysis is essentially a method for identifying and analysing patterns in qualitative data (Merton 1975). Braun and Clarke's (2006) versions of thematic analysis has been employed. This method of analysis has five key stages; Familiarisation with the data: This involved reading the data and becoming very familiar with the content. This involved reading and re-reading also making notes of initial thoughts and ideas.

1. Coding: This involved going through the data and manually coding it by writing words that applied meaning to the data. This helped to identify any patterns emerging.

2. Searching for themes: At this stage the codes were organised by grouping similar topics together. This was done by cutting out all the codes and putting related codes in a pile together.
3. Reviewing themes: This process involved taking each theme and subtheme and examining it with the original data and the codes, this was to ensure that the theme/subtheme represents the meaning of the data accurately.
4. Defining and naming themes: During this stage the finial names of the theme and subtheme were chosen. The names chosen were concise and informative in order to illustrate the meaning of the data to the reader.

5.6 Results

The following results are based on 12 questionnaires.

5.6.1 Service User Involvement on the BSc Undergraduate Mental Health Nursing Programme

Two-thirds (8 out of 12) of the Schools of Nursing have service user involvement in the undergraduate mental health nursing programme, while one-third (4 out of 12) do not have service user involvement.

5.6.2 Future Plan for Service User Involvement

From the 4 out of 12 Schools of Nursing that do not have service user involvement; none of them plan on having service users as part of the BSc programme. 3 plan on having service users involved in the curriculum design. 4 reported that service users would not be involved in regular teaching on the course. 2 plan on having service user involved in sessional teaching. 1 plan on service users providing workshops and 4 said that service users would not be involved in student assessment.

5.6.3 Reasons for Service Users not Currently Being Involved

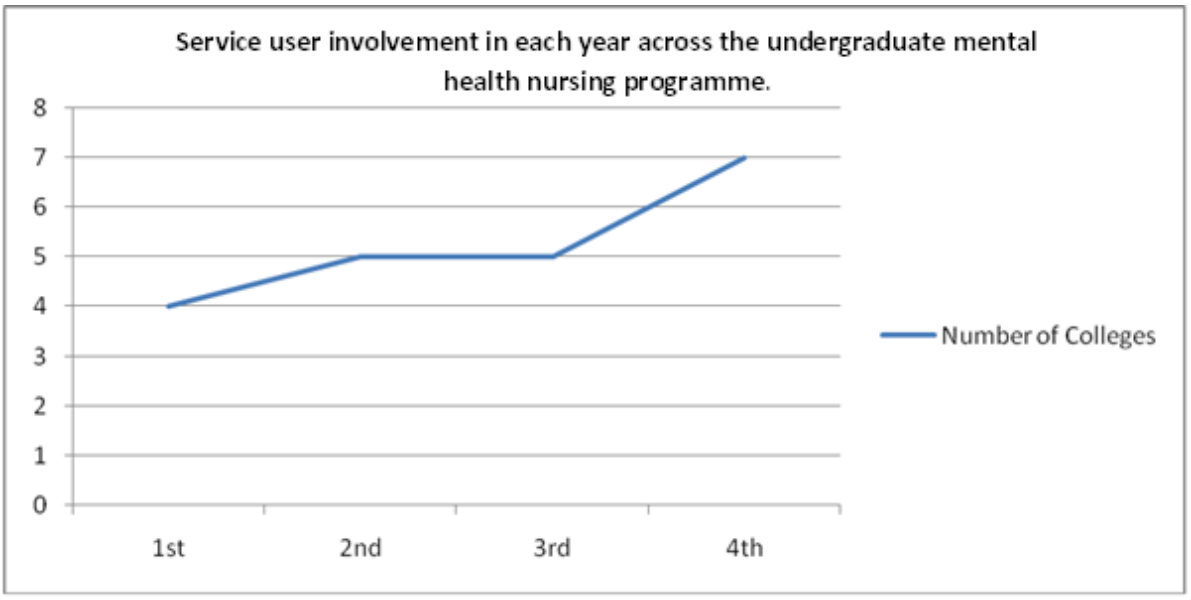
From the 4 out of 12 Schools of Nursing that currently do not have service user involvement on the BSc undergraduate mental health nursing programme, 1 said that

this was because of negative past experience, whilst 3 reported that service users were not currently involved due to an inability to provide remuneration.

5.6.4 Service User Involvement from 1st to 4th Year

From the 8 out of 12 Schools of Nursing that currently have service user involvement in the undergraduate mental health nursing programme, 4 have service user involvement in 1st year of the programme, 5 have service user involvement in 2nd year, 5 have user involvement in 3rd year and 7 have service user involvement in 4th year. Only one school has service user involvement across all years. See Figure 2 for a graph of service user involvement across each year of the undergraduate degree in mental health nursing.

Figure 2: Service User Involvement across each Year of the Undergraduate Mental Health Nursing Programme

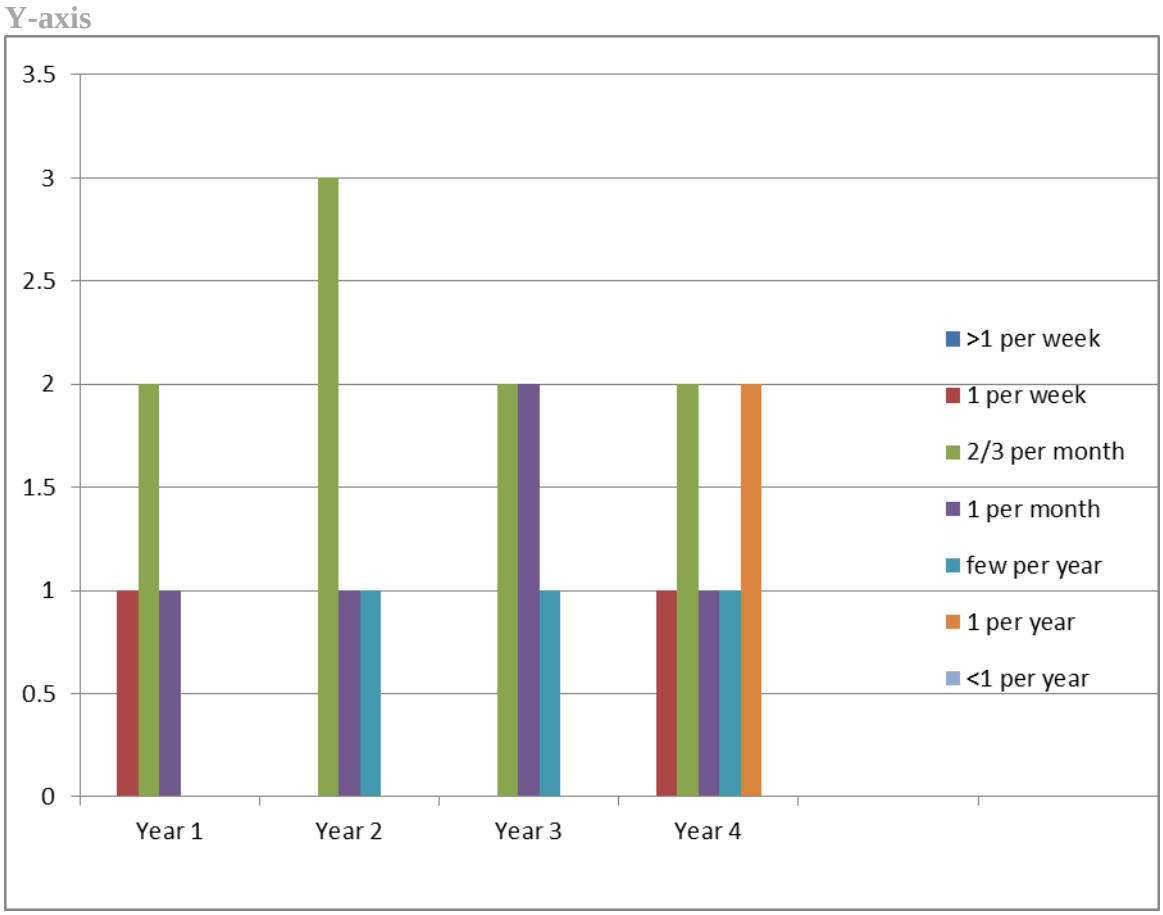


5.6.5 The Frequency of Service User Involvement during 1st to 4th year of the Programme

The following results are based on the schools of nursing who currently have service user involvement on the undergraduate mental health nursing programme (8 out of 12).

See figure 3 for a graph of frequency of service user involvement across each year of the undergraduate degree in mental health nursing.

Figure 3: The Frequency of Service User Involvement From 1st to 4th year

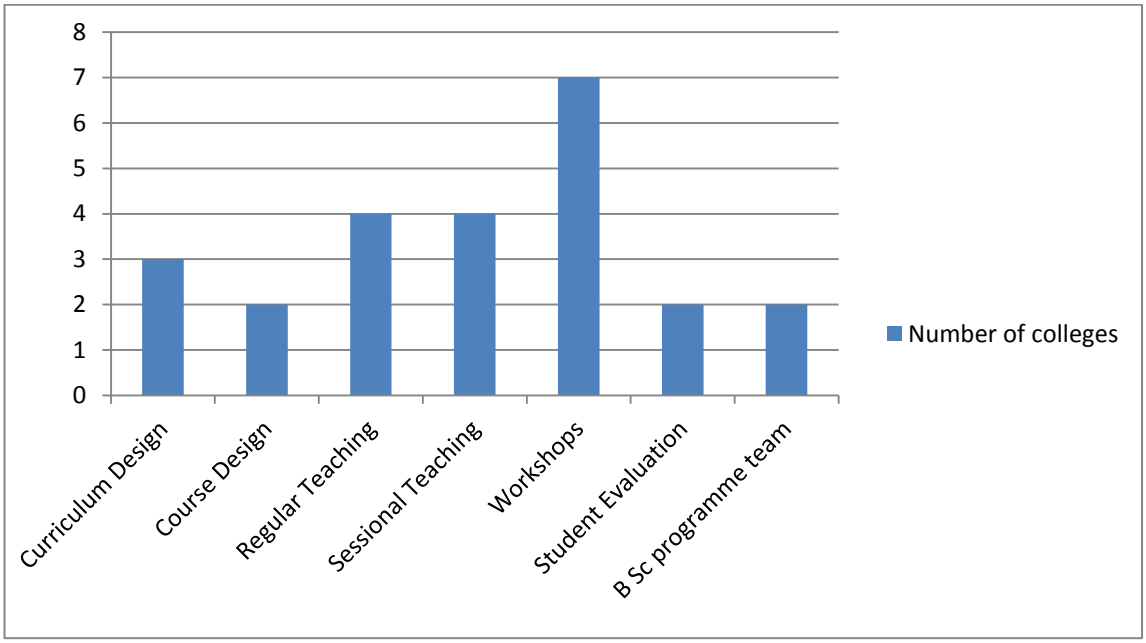


Four Schools of Nursing have service user involvement in year 1 of the programme Once a week (1); 2-3 times per month (2); Once a month (1). Five Schools of Nursing have service user involvement in year 2 of the programme (2-3 times per month (3); Once a month (1); A few times a year (1). Five Schools of Nursing have service user involvement in year 3 of the programme. (2-3 times per month (2); once a month (2); a few times a year (1). Finally, seven Schools of Nursing have service user involvement in year 4 of the (once a week (1); 2-3 times per month (2); a few times a year (1); once a month (1); once a year (2).

5.6.6 How Service Users are Involved with the Undergraduate Mental Health Nursing Programme

From the 8 out of 12 Schools of Nursing that currently have service user involvement on the undergraduate mental health nursing programme, 2 of the Schools of Nursing have service users involved in the BSc programme team, 3 have service user involvement in the curriculum design, 2 have user involvement as part of the course design, 4 have service user involved in regular teaching, 4 have service users involved in sessional teaching, 2 have service users involved in student evaluation and finally, 7 have service user involvement in workshops. One School reported an additional way that service users are involved in the course; this consisted of service users participating with student nurses in undertaking project work. See Figure 5 for a graph of how service users' are involved in the undergraduate degree in mental health nursing.

Figure 4 - The context in which service users are involved in the undergraduate mental health nursing programme



5.6.7 Planning the Service Users' Sessions

From the 8 out of 12 Schools of Nursing that currently have service user involvement on the undergraduate mental health nursing programme, 2 report that the lecturer plans

the session(s) that the service user is going to deliver to students, 1 report that the service user plans the session(s), and 6 report that it was a collaboration of both the lecturer and the service users. One participant ticked two boxes hence why the total adds up to nine. Two Schools of Nursing reported two additional ways in which the service user session(s) are planned, which included Health Service Executive (HSE) staff involved in the planning process and clinical nurse managers participating in the planning of the session. Also, on commencement of the first session students and service users identify personal learning needs together.

5.6.8 The Topic/Context of the Teaching Session

From the Schools of Nursing who currently have service user involvement in the undergraduate mental health nursing programme (8 out of 12), 8 of them said that the topics for the service users session(s) that is delivered to students is based on user experience. One respondent indicated that the sessions are based on clinical practice skills, 4 indicated the sessions are based on alternative knowledge/evidence and 3 said it is based on research. Two of the Schools of Nursing identified further topics which the service user delivers to the students. One reported that ethics was the topic for the session(s) with a particular focus on patient rights. Another stated that the topic for the session is based on enduring health issues and recovery.

5.6.9 Sessions Linked to Module and Programme Aims

All 8 reported that session(s) are linked to the module aims whereas 7 said that the session(s) are linked to the programme aims.

5.6.10 Policy/Strategy and Evaluation for Service User Involvement

From the 8 Schools of Nursing who currently have service user involvement, 7 said that there was a policy/strategy to involve service users and 6 said that service user involvement in the undergraduate mental health nursing programme is evaluated. 4 said that students evaluate service user involvement, 6 said that a service user

evaluates it, 3 indicated that the lecturer evaluates the service user involvement and 3 indicated that the programme team carries out the evaluation.

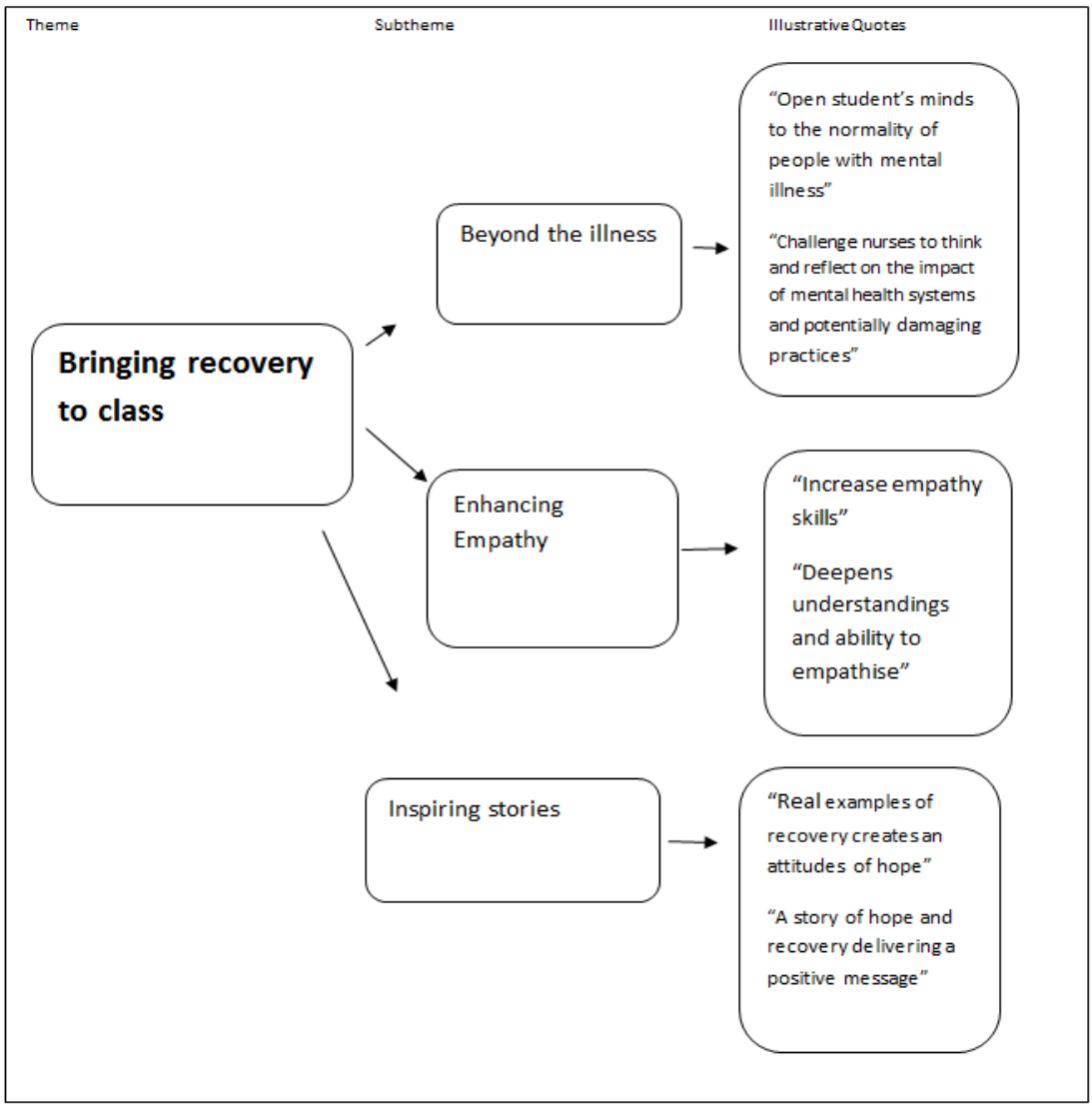
5.6.11 Service User Involvement as a Regular Component

Of the Schools of Nursing that currently have service user involvement, 7 reported that it will continue as a regular component of the undergraduate mental health nursing programme

5.6.12 Results from Open-Ended Questions

The educationalists had the opportunity to answer two open ended questions at the end of the questionnaire. The questions asked the educationalists to give their opinion on the impact service user involvement has had on nurse education and also to share further comments in relation to service user involvement on the undergraduate mental health nursing programme. Six educationalists answered the open ended questions while the remaining six left no comments. Three of the responses came from Universities, while the remaining three came from Institutes of Technology. The responses were thematically analysed, and one main theme and three subthemes emerged. The main theme that emerged from the open ended questions was ‘Bringing Recovery to Class’. This theme seemed fitting as the subthemes ‘beyond the illness’, ‘enhancing empathy’ and ‘inspiring stories’ are all facets of the recovery concept. These findings are visually displayed in figure 5 with illustrative quotes to support the subthemes.

Figure 5: Themes from the open ended questions in the Questionnaire



As a result of service user involvement the educationalists felt that having service users in the classroom setting would be 'Bringing Recovery to Class'. Seeing service users out of the mental health setting, where students are typically in contact with patients, would enable students to see past the label often attached with having mental illness, thus allowing students to see 'Beyond the Illness' and the normality of people with a mental illness. One of the educationalists believed that it would challenge students and therefore make them more mindful of potentially damaging practices within the mental health system. The educationalists reported that hearing service users' 'Inspiring Stories' of recovery would provide students with a positive message of hope about the possibility of recovery. Moreover, as a result of hearing the stories of recovery students

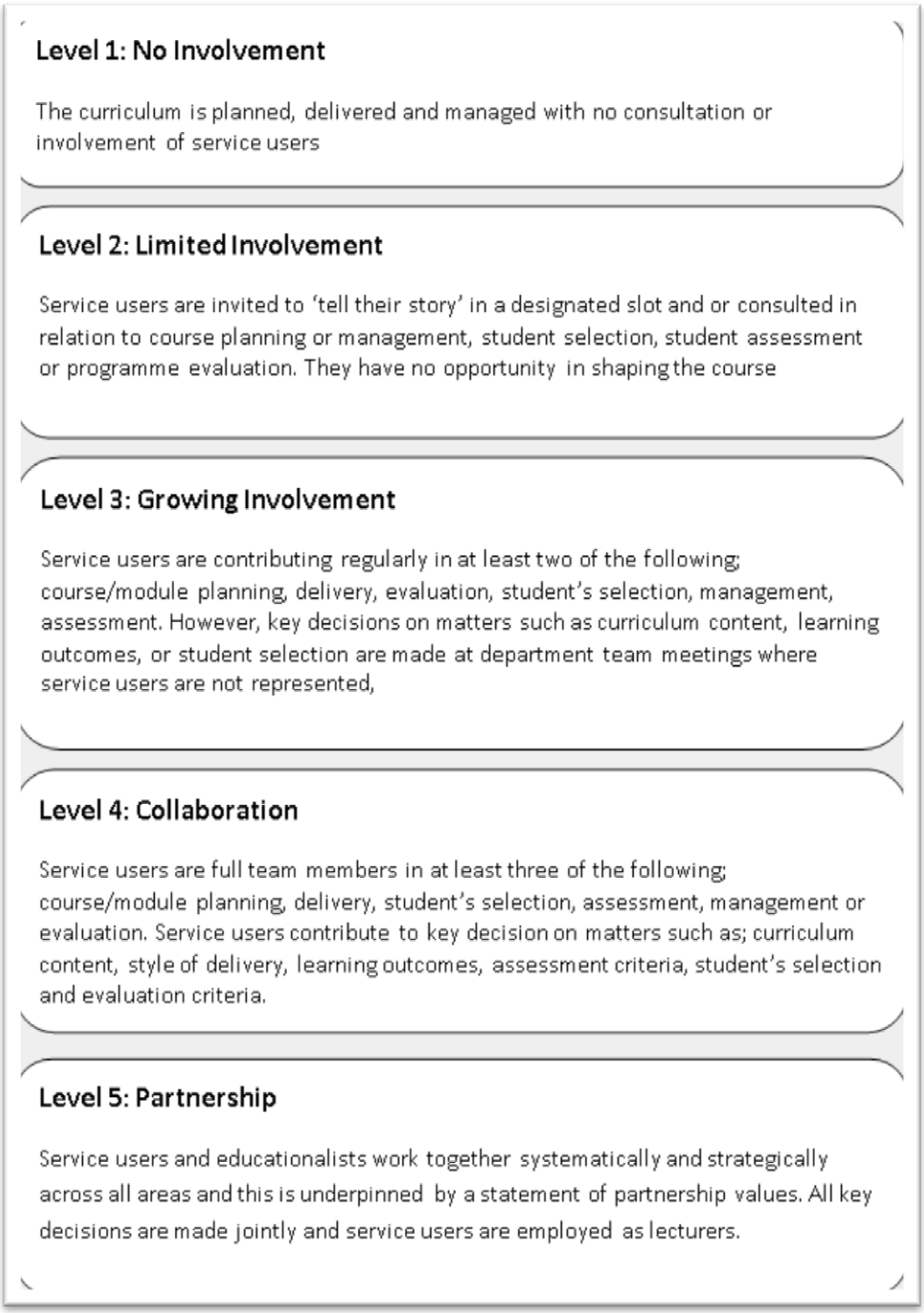
would be aware of the journey that service users have endured, hence 'Enhancing Empathy'.

5.7 Discussion

The findings from phase one are discussed with reference to the "Ladder of User and Carer Involvement" (Gross and Millar 1995). Gross and Millar (1995) clarified the term 'involvement' by using a "ladder of user and carer involvement". Since then the ladder has been adapted by educationalists, service users and policy makers in an attempt to move from no involvement to partnership. For example, Forrest et al (2000) used the ladder of involvement as a guide to frame part of a discussion on a study on service user involvement in preregistration nursing curriculum development. The ladder of involvement also underpins the evaluation processes set out in the National Continuous Quality Improvement Tool for Mental Health Education (Northern Centre for Mental Health 2003). In their report on reviewing mental health teaching on behalf of the Mental Health in Higher Education Programme, Tew, Gell and Foster (2004) suggest that the ladder of involvement might be helpful to rate the progress of service user involvement in educational programmes.

This ladder of involvement was used as a guide to rate the level of service user involvement the current study. This serves a useful purpose as it provides further meaning to the results and establishes where the current level of service user involvement in undergraduate mental health nurse education is situated on the ladder. This will help inform what steps need to be taken to advance future service user activity. A visual image of the ladder is displayed in Figure 6 to highlight the various levels of service user involvement. The figure is based on Tew, Gell and Foster's (2004) adaption of Gross and Millar's framework (1995).

Figure 6: The Ladder of Service User Involvement (Tew, Gell and Foster 2004) adapted from Gross and Millar (1995)



It is evident based on the results that the extent of service user involvement in schools of nursing in the Republic of Ireland varies to a large degree. Students most frequently experienced service user involvement in the 4th year of the programme. The most

common way the service users are involved is through the delivery of workshops. From the 8 schools that currently have service user involvement in the undergraduate mental health nursing programme, only 2 schools have service user involvement in the BSc programme team, while 3 have service user involvement in the curriculum design, 2 have service user involvement as part of the course design, and 2 schools have service users involved in student evaluation.

The main focus of service user involvement is delivering teaching to students and service users were less involved in other aspects of educational developments. This finding is consistent with the findings of the study by Higgins et al (2011) which presents the findings of a study on service user involvement in the education and training of all professionals working within Irish mental health services. While Higgins et al (2011) did not specifically focus on service user involvement in undergraduate mental health nurse education, the findings of that study showed that of the 50 courses that service users are involved in, 90% of their involvement focused on providing inputs or teaching about their experience and were far less involved with other aspects of education, with 34% (17) included in course design, 30% (15) in course evaluation and 22% (11) in course management. Higgins et al (2011) focused on undergraduate and post-graduate education and looked at all mental health professional groups. The findings from phase one in the current study builds on what is already know about extent of service user involvement in undergraduate education from Higgins et al (2011) study by solely focusing on service user involvement in undergraduate mental health nurse education and providing a more complete picture in terms of the activity and context of service user involvement within Schools of Nursing in the Republic of Ireland. The current study established the content of service user sessions, the planning and evaluation of the sessions, the frequency of service user involvement across all four years of the programme, the inclusion of service user involvement in school

policy and whether service user involvement will remain a component of the undergraduate mental health nursing programme.

Based on the results of the current study and using the Ladder of Involvement as a guide, 'growing involvement' is the most common level of service user involvement in the undergraduate mental health nursing programmes in the Republic of Ireland. According to the Ladder of Involvement, 'growing involvement' is when service users are regularly involved in at least two of the following: planning, delivery, student's selection, assessment, management and evaluation. As 7 of the Schools of Nursing have service user involvement in workshops and 6 reported that it was a collaboration of both the lecturer and the service users who plan the workshops that are delivered to the students, this shows that service users are involved in aspects of both planning and delivery, which would indicate 'growing involvement'. It is important to note that two Schools of Nursing appear to have greater involvement as service users are involved in the BSc programme team. According to the Ladder of Participation, having service users involved as a team member signifies collaboration, which is level 4 on the ladder (Tew, Gell and Foster 2004).

The Northern Centre for Mental Health (2003), in their ladder of participation, refers to level 3 'growing involvement' as 'token involvement'. 'Token involvement' is generally seen to be ad hoc and that service user involvement is being treated as a 'box ticking' exercise (Beresford 2002). Forrest et al (2000) argue that the challenge of achieving true involvement in the curriculum, rather than tokenistic consultation, is a mammoth task. Rush (2008) contends that the term 'growing involvement' is perhaps more encouraging for educationalists than 'token involvement'. Allott and Holmes (1993) suggest that while tokenism is unacceptable, it may possibly be interpreted in a positive way, as at least the concept of service user involvement has been recognised.

The current extent of service user involvement in professional education in Ireland is limited. According to Tew, Gell and Foster (2004), in some instances, especially when establishing a new programme, it may be possible to embed full-scale service user involvement in all areas from the start pending the infrastructure necessary to support this. However, more usually especially when developing involvement within existing educational programmes, it may be more realistic to start with smaller scale initiatives and work progressively towards greater service user involvement. This point should be given some consideration, as based on the results of the current study and using the ladder of participation as a guide, it appears the current level of service user involvement is 'growing involvement' rather than 'token involvement', as service user involvement in professional education in an Irish context appears to be in its infancy. Four schools currently have no service user involvement; two of the schools have a future plan to involve service users, while two have no future plan to incorporate it as part of the undergraduate mental health nursing programme. Seven of the Schools of Nursing reported that there was a policy/strategy to involve service users and seven of the schools who currently have service user involvement reported that it will continue as a regular component of the undergraduate mental health nursing programme. Despite the need to move the agenda of service involvement forward, this indicates a potentially promising future for service user involvement in the undergraduate mental health nursing programme in the Republic of Ireland.

The results showed that from the Schools of Nursing who currently have service user involvement 5 reported that service user involvement is evaluated. According to McOwens et al (2009) programme evaluations should be multi-dimensional combining subjective and objective data to obtain comprehensive information on the teaching processes and learning outcome. Porter et al (2011) believe that obtaining students' evaluation is crucial, as the knowledge gained from the evaluation process might

highlight where improvements are required and therefore potentially play a role in the delivery and content of the course. In addition, evaluation helps educationalists to clarify and re-examine their purposes for having service user involvement, and to see more concretely the direction in which they are advancing or not. If service user involvement is not evaluated then changes/suggestions cannot be taken on-board by educationalists and used to advance the current level of service user involvement. Also students' perspectives will remain unknown. Moreover, if evaluation is not high on the educationalists list of priorities, then students might begin to question the merits of user involvement.

Tew, Gell and Foster (2004) argue that in order to reflect on the level of service user involvement in relation to what has or has not been achieved and what could be the next stage in its development, it is important to evaluate progress in a systematic manner. Evaluation should be a constructive process of dialogue and discussion within course teams and more widely with service users and students in order to see how relevant it is in relation to meeting the challenges of preparing students to work in a modern mental health system. Lack of evaluation suggests that educationalists are looking to merely 'tick the box' in terms of service user involvement. The finding from the current study questions some of the educationalists' commitment to service user involvement, and therefore the relevance that is placed upon it. It is recommended that Schools of Nursing use the ladder of involvement as a means to establish their progression, or not of service user involvement.

From the 8 Schools of Nursing who have service user involvement, all of them reported that the topic for the service user session(s) is based on the user's experience. Yet only one of the Schools of Nursing reports that the service user's sessions are based on clinical practice skills. Tew, Gell and Foster (2004) report that service users

have a unique contribution to make to training in core professional skills, such as listening, communication, empathy and advocacy. Without guidance and feedback from service users students may fail to learn what is important in establishing therapeutic partnerships from the perspective of a service user. Moreover, for the 8 Schools of Nursing who currently have service user involvement, the majority of the students are experiencing service user involvement in the 4th year of the programme, 7 of the schools had it in 4th year compared to 4 schools in 1st year, 5 schools in 2nd year and five schools in 3rd year.

Fisher (2002) is concerned that due to the negative public attitudes and stereotypes regarding the mentally ill, health care students could potentially be influenced by these attitudes. Consequently the first clinical placement in a mental health setting could be fraught with apprehension and fear. According to Bower et al (1994) and O'Brien (1994) the negative attitudes and feelings of fear and anxiety can block effective student learning and the development of rapport, empathy and a therapeutic relationship with the client. The literature has suggested that service user involvement in the early years of training is beneficial as it can destabilise common myths and stereotypes about mental illness before students have their first clinical placement (Ion and Beer 2003), yet the results of the current study show that students are less likely to experience service user involvement in year one of the programme.

The findings from a study by Rush (2008) indicated that students found it refreshing to see service users in recovery which brought feeling of hope that recovery from mental illness is possible. Moreover, students in studies by Morgan and Sanaggran (1997) and Masters and Forrest (2010), reported that service user involvement helped them to relate to service users as people, rather than in terms of their mental health problems. Taking these results into account, it would suggest that having service user

involvement early in the programme has a positive influence on student learning and the formation of attitudes relating to mental illness. This is an area that warrants further attention by Schools of Nursing offering undergraduate mental health nursing programmes.

According to Campbell et al (1994) the influence of nurse clinicians as role models in the clinical setting has been recognised as crucial to students, as students spend a lot of time on placement shadowing their preceptors. Therefore, students are vulnerable to accepting the professional behaviours of clinicians as 'the norm'. This has potential implications for the student, particularly if this behaviour is less than optimal. This has implications for service users in terms of how students develop attitudes and skills in engaging and establishing therapeutic relationships. However, by ensuring that students are exposed to multiple perspectives throughout their training inclusive of educationalists, clinical staff and service users, this will potentially provide students with the opportunity to look at mental illness from a variety of different angles, giving a broader and a more informed perspective. Moreover, as clinical placement is one of the few opportunities that undergraduate nursing students get to work intensively with people who have a mental illness, by threading service user involvement throughout the nursing programme and particularly in 1st year, this provides students with the opportunity to engage with an additional perspective and alternative insights regarding the experience of mental illness.

The theme that emerged from the analysis of the open ended question 'bringing recovery to class', indicates that from the educationalists' perspective service user involvement provides students with the opportunity to see recovery in the classroom setting and brings a message of hope to the students. A similar view is supported by A Vision for Psychiatric/Mental Health Nursing (HSE 2012). This report identifies that

recovery principles and values must be reflected throughout national undergraduate and post-graduate professional education programmes. The involvement of service users is one way to achieve this. According to Byrne et al (2013) only those with a lived experience can truly explain the process of recovery. In the education of mental health nurses, providing individual examples of recovery is pertinent in order to allow the student an opportunity to truly grasp and internalise the very real possibility that anyone can recover.

5.8Conclusion

The findings from phase one of the current study have established the national extent of service user involvement in the education of undergraduate mental health student nurses. It is unclear how the activity of service user involvement in undergraduate mental health nursing compares internationally, as no other known study has looked at the extent of service user involvement at a national level. All of the studies in the literature review primarily focused on service user involvement in single site studies, with the focus on the actual process of service user involvement. These results of phase one of the current study is the first known national study of service user involvement in undergraduate mental health nursing programmes.

Although service user involvement is evident within the programmes, some Schools of Nursing have advanced further their level of service user involvement, and have service user involvement high on their agenda. Moreover, some of the educationalists give greater credence to the benefits of service user involvement in undergraduate nurse education. Based on the results of the questionnaire and using the Ladder of Involvement as a tool to interpret the data, it is evident that the extent of service user involvement in the undergraduate mental health nursing programme currently represents as level 3 on the ladder which is ‘Growing Involvement’. This indicates that there is regular contribution from service users. It is important that evaluation of

service user initiatives remain a priority for educationalists, in order to monitor the progression of service user involvement, but also to gauge how receptive students are to the experience. The results show that students are more likely to experience service user involvement in year four of their training, considering that this is essentially the final stage of training, considerable efforts and consideration needs to be given to the implementation of service user involvement in the 1st year of training. This is to ensure that the service user perspective is threaded throughout students training and that the potential effect this has on students' understanding of mental illness and therefore their approach to clinical practice is maximised.

Chapter 6 – Phase 2 - Interviews with Students and Service Users

6.1 Introduction

This chapter examines students' and service users' experiences of service user involvement in undergraduate mental health nurse education. The phase of the study employed an exploratory design. The sample, recruitment of the sample, formation of the interview guide, ethics procedure and data analysis are discussed. The chapter also presents and discusses the result of phase two. This phase of the study had two specific objectives to address.

1. Examine students' experience of service user involvement in their education.
2. Examine service users' experiences of being involved in undergraduate mental health nurse education.

6.2 Method

6.2.1 Design

The qualitative phase of the study employed an exploratory design. Teddlie and Tashakkori (2009) report that the objective of exploratory research is concerned with gathering information that will help yield important insights in the hope of generating information about a particular phenomenon.

Phase one of the study established the extent of service user involvement in undergraduate mental health nurse education in third level institutions in the Republic of Ireland. While the first phase of the study played an important role in establishing the national extent of service user involvement, it also provided important information regarding the nature of service user involvement in third level educational institutions. However, the current study was not solely concerned with the extent of service user involvement but also the perceived effect of service user involvement in mental health nurse education from the perspective of service users and mental health nursing students. The second phase of the research employed individual interviews to explore

student mental health nurses' experiences of service user involvement in their education. Student nurses who had not experienced service user involvement were also interviewed. This was to provide them with the opportunity to discuss the potential effect of service user involvement in nurse education. Service users who were involved in teaching the students participated in interviews to discuss their personal experience of being involved. For this phase of the study it was decided that adopting a qualitative approach would provide important insights, and allow the specific experiences of students and service users to be comprehensively explored. It is anticipated this will add to the completeness of the study, by bringing together a more comprehensive account of the area of inquiry as individual interviews will allow the participants to describe what is meaningful or important to them regarding their experience or perceptions of service user involvement using their own words, therefore giving them the freedom to answer how they wish. Individual interviews provide the participants with the opportunity to express their experiences, feelings and attitudes on a particular topic or area of inquiry. This provides the researcher with a deeper understanding of participants' viewpoints, as interviews unfold the meaning of peoples' experiences (Fielding 1994).

6.2.2 Interview Guides

In order to address the aims and objectives of phase two of the study, interview guides for students with service user involvement, students without service user involvement and service users were developed (Appendix G,H,I). The questions were guided by the extensive literature review conducted. Ice-breaker questions such as talking about their experience of service user involvement, and the topics were included to ease the participant in to the interview, and establish their experience to date regarding service user involvement. I noticed that often students in other studies were not asked how service user involved had influenced their practice. I considered this an important

question to ask, as there is limited evidence relating to the effect of service user involvement on practice. Furthermore, I had an interest in the ideology of experiential knowledge and I was interested to see if students' were able to identify this type of knowledge from their engagement with service users, so I included a question relating to that. The same sets of questions were asked to each student and service user. Occasionally the opportunity arose to ask unanticipated questions that were relevant to the research; this allowed the opportunity to explore certain areas in greater depth.

6.2.3 Pilot Study

In keeping with Kvale (2007), a pilot test was conducted to identify any flaws or weaknesses within the interview design and if necessary to make necessary revisions prior to the implementation of the study. As a pilot test should be conducted with participants similar to the sample that will feature in the study, two service users and two student nurses participated. After I initially developed the interview schedule I met with the pilot participants who were participating in the pilot and I explained the nature and purpose of the study. The pilot participants read each of the interview questions and commented on the wording and structure of the questions. They recommended that I simplify the language that I had used in some of the questions. In addition, they recommended that I added questions that they believed to be of relevance. For example, they recommended that I include a question asking if service users should continue to have an active role in teaching. Furthermore, as students were in receipt of service user involvement they were best placed to identify other useful ways to involve service users, and recommended that I offered the participants the opportunity to identify alternative ways that service users could be involved in education. The pilot study served a very useful purpose and helped in the refinement of the interview schedule by reconstructing the questions so that they were clear, understandable and appropriate to answer the research question.

6.2.4 Sample and Method of Recruitment

Inclusion criteria comprised:

- 3rd/4th year undergraduate mental health nurses.
- Mental health service users who have been involved in teaching on the undergraduate mental health nursing programme.

Purposeful sampling a strategy which deliberately selects participants for the information that they can provide that cannot be gotten as well from alternative choices (Patton 1990), was used in this study. Phase one identified that students were more likely to experience service user involvement later in the programme. For this reason 3rd/4th year student mental health nurses were the target sample in Phase 2. Also, it was expected that the students would have had sufficient clinical exposure at that stage in the programme, thus enabling the students to contextualise their experience of service user involvement, in terms of the perceived effects, if any on their clinical practice. Drawing on the information from the questionnaires in phase one, which mapped out the extent of service user involvement in the undergraduate mental health nursing programme, participants were sought from all of the 12 Schools of Nursing in the Republic of Ireland which provide undergraduate mental health nurse education. This included six Universities and six Institutes of Technology.

A number of processes occurred to secure this sample. Firstly, the mental health branch co-ordinators were asked if they would circulate a recruitment letter which explained the nature and purpose of the research (Appendix D, E). All mental health branch co-ordinators agreed. The recruitment letter invited them to participate in an individual interview. The letter stated that if participants were interested in participating in the study they could contact me directly. Although the majority of the participants contacted me directly, some of the participants expressed an interest

directly to the mental health branch co-ordinator who subsequently passed on their contact details to me. The recruitment of participants was a lengthy process and took a number of months. At the time of recruitment some students were on clinical placement and consequently they were not checking their email as frequently. Four weeks after the initial recruitment letter was circulated, the branch coordinator sent a reminder about the study.

It is important to acknowledge that method of recruitment via the mental health branch co-ordinator might have had some potential drawbacks. As the mental health branch co-ordinators circulated the recruitment letter and information regarding the nature of the study to the students and service users, therefore there is a possibility that the participants might have felt obliged to participate in the study, rather than express a genuine interest of their own accord to participate. A further issue to be mindful of was the mental health co-ordinators may have been selective in who they circulated the letter to. However, this may have been countered by highlighting to them the importance of including participants with a range of experiences and diverse viewpoints. Considering that the branch co-ordinators are employees of Institutes of Education and familiar with the ethical practices regarding the conduct of research, it is assumed that the branch-coordinators adhered to the ethical protocols. All four of the service users' who participated sent their replies directly back to principal investigator, and although the majority of the students' sent their replies directly back to the principal investigator, the contact details of six of the students' were passed on to the principal investigator via the mental health branch coordinator. A total of 18 students and four service users volunteered to participate in the study.

All Schools of Nursing in the Republic of Ireland participated in phase 1 of this study. In Phase two of the study, a total of eighteen students were interviewed; 16 female and

2 male. Fourteen of the students had experience of service user involvement and four of the students had not experienced user involvement. A total of six 3rd year students and twelve 4th year students participated. As the students were either in 3rd/4th year of their training they had all been exposed to clinical practice settings in each academic year of their training. At this stage in training, students would have been exposed to a wide variety of mental health settings ranging from; acute care in hospital settings, psychiatry of old age, child and adolescence, to community setting i.e. day hospitals, day centres, high support hostel or placements with community mental health nurses.

The fourteen students who had experienced service user involvement represented seven institutions (four universities and three institutes of technology). The four students who had not experienced service user involvement represented two institutions (one university and one institute of technology) and the four service users represented three institutions. Overall, out of the twelve Schools of Nursing in the Republic of Ireland, interviews were conducted with people from nine of the educational institutions. Three out of the twelve Schools of Nursing are not represented in this phase of the study. Out of the three not represented, one was a University and two were Institutes of Technology

Four service users were also interviewed. These service users were male. Out of the four service users who were interviewed, three of the service users were employed by the educational institution and are involved in nurse education. Of these, one service user was employed in an 'expert by experience' role and therefore their role expanded beyond the scope of classroom teaching sessions. The remaining service user was basing his experience of involvement on a single session with students.

It is evident from the results that emerged from phase one, that the involvement of service users has evolved at different rates in the various educational institutes. Three out of the four service user that voluntarily participated in an interview were employed by the educational institution. Considering the statistics relating to the experiences of mental difficulties, the World Health Organisation (WHO 2003), reports the following information in relation to mental health in Europe. In Europe, one in five persons will develop a depressive episode during their lifetime. Bearing this in mind, there is the chance that a lecturer is in fact a service user who could share their personal experiences of mental illness with students. However, they would be operating from a different agenda compared to a service user or an 'expert by experience', as they are employed and contracted as a mental health lecturer. They have gained their position as a lecturer through both clinical and academic qualifications and achievements. On the other hand, the service users who are employed as 'experts by experience' have gained their position primarily because of their lived experience of mental illness, not because of academic or clinical success. The justification for employing 'experts by experience' in an academic environment is to bring real life experience to aid in the understanding of mental health difficulties from the perspective that is steeped purely in the lived experience.

6.2.5 Relationship Between the Interviewer and the Interviewee

According to DiCiggo-Bloom and Crabtree (2006) the process of establishing rapport is an essential component of the interview. Essentially, rapport involves trust and respect for the participant and the information that he or she shares. It is also the means of establishing a safe and comfortable environment for sharing the participant's experiences and attitudes. Therefore it is necessary for the interviewer to rapidly develop a positive relationship with the participant. I had established a rapport with the participants prior to the interviews as I had spoken to them over the phone to arrange a

time and place for the interview. Rhodes (1994) is of the opinion that the place of interview can influence the power dynamics. Therefore, the strategy that I adopted was to give the participants the choice of venue for the interview in an attempt to allow them feel comfortable in the surroundings of their choice.

I was mindful that participants might feel that a power structure existed as on the one hand, I was a doctoral student and on the other hand I was a qualified nurse. To overcome the potential power dynamics between myself and the participants a number of strategies where employed during the interview process. The first strategy was to make known my research to participants. I gave a brief introduction to the aim, research and the areas covered at the beginning of the interview, so as to provide the participants with a general framework for my research. I explained to the participants that I might take notes briefly during the interview; this was to give the participants prior warning and avoid them feeling like they were not being listened to. Prior to commencing the interviews I asked the participants if they had any questions relating to any aspect of the study of the interview process. Bearing in mind that the participants might have felt initially apprehensive, I began the interview with a broad and open-ended question that was non-threatening and reflected the nature of the research. This allowed the participants to build up confidence and rapport. During the interviews I remained as neutral as possible, and did not show a strong emotional reaction to their responses. I maintained good eye contact and listened intently to show my genuine interest. At the end of each interview I asked each participant if they would like to add anything that was not covered in the interview. I asked this to allow participants the opportunity to share something that might not been directly asked in the interview or to share a thought that was relevant to an earlier question that just dawned on them. I thanked the participants for taking the time to participate in the research and acknowledged the value of their contribution based on their experiences

in relation to the topic of inquiry. I explained to the participants that they had the option of participating in 'member checking' once the interview had been initially analysed. I explained to the participants this meant that they could comment on whether or not I had accurately interpreted what they were saying during the interview. I explained that this would to help improve the accuracy and validity regarding the content of the interview and avoid false information being presented.

The majority of the interviews were conducted in the Schools of Nursing where the students and service users were affiliated. However, some of the interviews were conducted in alternative places, which was convenient for the participants. I ensured that the participants had read and understood the information sheet provided (Appendix F). The interviews typically lasted up to 30 minutes, depending on the individual. The interviewer was not acquainted with any of the participants before the study.

6.2.6 Ethical Approval Procedure

Ethical approval for the study overall was granted by the Research Ethics Committee at Dublin City University. Subsequent approval to access students was granted from the Research Ethics Committees in the educational institutions.

6.2.6.1 Confidentiality and Informed Consent

All participants were asked to sign a consent form indicating their willingness to participate in the research (Appendix J). All participants were informed that they could withdraw from the study at any time without reason. The participants were assured that confidentiality and anonymity would be maintained at all times throughout the research process. In transcribing the data from the interviews, participant's individual identities were not linked to the data provided. All identifying information was

removed from the transcripts. All interviews were digitally recorded with the consent of the participants. In addition, the recordings, hard copies of the questionnaires and consent forms are being stored in a locked cabinet which only members of the research team have access to. The transcripts were inputted directly onto the researcher's computer, which is protected with a password. In keeping with ethical approval, data will be disposed of safely five years after completion of the study.

6.2.7 Rigour

Long and Johnson (2000) assert that it is essential that there is a clear imperative for rigour to be pursed in qualitative research so that findings may carry conviction and strength. Specific strategies were adopted to address rigour in this phase. At the outset of the study the researcher was articulated in order to approach the topic honestly and openly. By identifying my bias I was more aware of the potential judgements that might occur during data collection and analysis and that the interpretations of the findings was shaped by my background. Being aware of my biases enhanced the credibility of the research. This ensured quality in the interview collection and analysis and ensured the validity of the findings. The use of 'member checking' was also used to ensure the credibility and dependability of the findings. This involved determining the accuracy of the findings by taking specific descriptions of themes back to participants to determine whether the participants feel that they are accurate. It was explained to the participants that they had the option of participating in 'member checking' once the interview had been initially analysed in order to confirm the credibility of the findings. Ten of the participants opted to participate in member checking, this included 8 students and 2 service users. The purpose of this procedure was to allow the participants to confirm if the reported findings represented their experiences accurately. The participants were contacted via phone by the researcher

after the interviews had been transcribed to explain initial codes and ideas; this was to ensure they accurately reflected the participants' opinions. The participants were contacted a second and final time after themes had been developed. The participants concurred with the themes and were of the opinion that they reflected their views. This step contributed to the credibility and dependability of the findings as the participants confirmed that the researcher's interpretation represented their experience accurately. In addition the accuracy of the transcripts was reviewed and read by an external person with experience in the field of research, this was to ensure that mistakes were not made during transcription. Sample selection, methods of data collection and data analysis strategies have been reported in detail in order to provide a clear and accurate picture of the methods used in the study; this also strengthens the credibility and trustworthiness of the research.

6.2.8 Data Analysis

The tapes were transcribed verbatim, and thematic analysis was employed to analyse the data. Thematic analysis is a method for analysing and reporting patterns or themes within the data (Braun and Clarke 2006). According to Boyatzis (1998), a theme is a pattern found in the data which describes and organises potential observations or interprets aspects of the phenomenon in question. According to Elo and Kyngas (2008), thematic content analysis is commonly used in nursing studies, but there has been a limited publication of the actual analysis process and generally they only provide a brief description. However Braun and Clarke (2006) have provided comprehensive guidelines on the process of applying thematic analysis. These guidelines have been followed in the present study and are discussed below.

Ryan and Bernard (2000) contend that thematic analysis is a process performed within 'major' analytic traditions, such as grounded theory, rather than a specific approach in

its own right. However, Braun and Clarke (2006) contest this and argue that there are two types of qualitative analytic methods. Within the first, there are those stemming from a particular theoretical or epistemological position, such as Interpretative Phenomenological analysis; IPA. Second, there are methods that are essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches. Braun and Clarke (2006) argue that thematic analysis is positioned in the second perspective, and is compatible with both essentialist (universal truth, not dependent on context) and constructionist (where truth is constructed by our social worlds) paradigms.

As thematic analysis facilitates a flexible approach when analysing data, according to Braun and Clarke (2006) it is important to recognise that qualitative analysis guidelines should be applied in a flexible manner to suit the data and the research question. Boyatzis (1998) reports that thematic analysis is flexible, meaning that and what researchers do with the themes once they uncover them differ based on the intentions of the research and the process of analysis. Many researchers use thematic analysis as a way of getting close to their data and developing some deeper appreciation of the content. Therefore, thematic analysis was chosen as it offers an accessible and theoretically flexible approach, which has the potential to provide a rich and complex account of the data (Braun and Clarke 2006). In the process of thematic analysis there are two ways to identify themes or patterns. Firstly, an inductive approach means that the themes identified are strongly linked to the data. Secondly, a theoretical deductive approach is when the structure of the analysis is influenced by researcher's theoretical or analytic interest (Braun and Clarke 2006).

According to Braun and Clarke (2006) another important decision for the researcher is the level at which the themes are to be identified: at a semantic or explicit level, or at a

latent or interpretative level (Boyatzis 1998). With a semantic level the themes are identified within the explicit or surface meanings of the data, which means that the researcher is not looking for anything beyond what a participant has said. In contrast, at a latent or interpretive level, the researcher begins to identify or examine the underlying ideas or assumptions, and concepts that are theorised as shaping or informing the semantic content of the data. The present study tends to analyse the data in an inductive interpretive level. The inductive approach, in this study, refers to an approach that primarily uses detailed reading of raw data to derive concepts, themes, and models, through the researcher's interpretations of the raw data (Strauss and Corbin 1998).

Braun and Clarke (2006) suggest six steps to follow when doing thematic analysis. The six steps suggested by Braun and Clarke (2006), are employed when doing thematic analysis regardless of a semantic or interpretative level of analysis being adopted. A visual diagram to illustrate the steps takes to analyse the data may be seen in Figure 6.

Step1: Familiarising self with data: I transcribed each of the interviews to ensure full immersion and connection with the data. I continued to immerse myself in the data, through repeated reading and listening to the transcripts in order to search for meaning and patterns. I also took copious notes of initial thoughts and ideas

Step 2: Generating initial codes: Following on from this initial stage, I generated an initial list of ideas about what was in the data. This phase involved the production of initial codes and building on the notes and ideas generated through transcription and data immersion. I began at the beginning at each transcript and systematically worked my way to the end. The data were manually coded by writing initial notes/words in the

texts, and highlighting key words. This helped to indicate potential patterns. The codes identified features of the data that I felt were central to the research question.

Step 3: Searching for themes: This step involved sorting the codes into potential themes. By this stage I had a long list of codes. To help me with this step I manually cut out all of the codes and laid them out on the floor. All similar codes were sorted and grouped together in to separate piles to form initial themes. At this point any themes that did not have enough data to support them were discarded. At the end of this phase I had a collection of themes and subthemes.

Step 4: Reviewing themes: During step 4 I re-read all of the data extracts and checked the themes against the data extracts. This was to ensure that themes reflected the meaning of the data,

Steps 5 & 6: Defining and naming themes: In this phase I wanted to ensure that I had captured the essence of what each theme was about. After on-going analysis and continuous revisions of the themes, they were given final names. Suitable quotations from participants were identified to reflect the focus of the theme.

6.3 Results of Phase Two

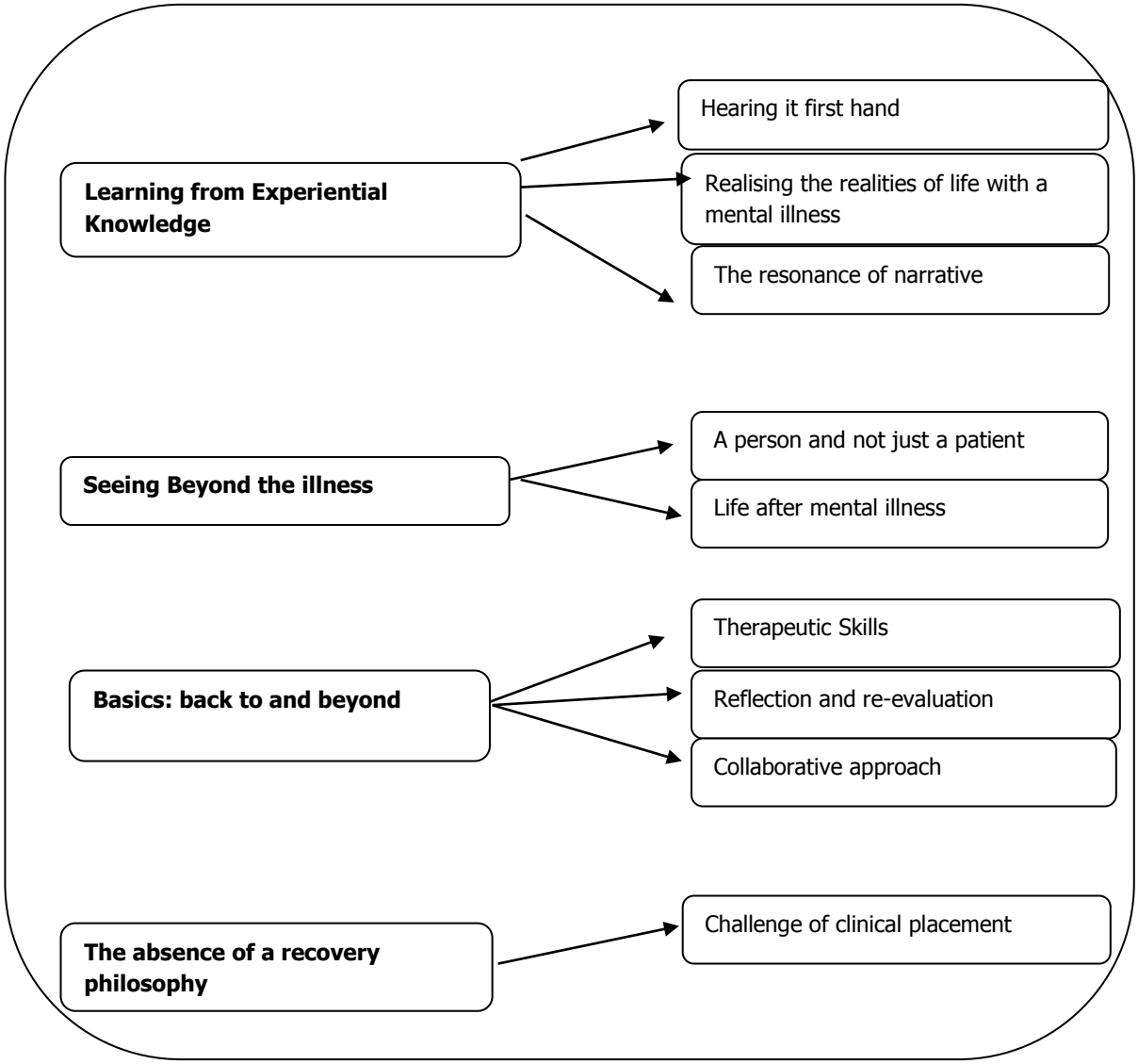
The results will be discussed in three sections. The first section concerns the students who had experienced service user involvement. The second section relates to the interviews with the students who did not have service user involvement, and finally the third section documents the interviews with service users. The themes from students who had experienced service user involvement are as follows 'Learning from Experiential Knowledge', 'Seeing Beyond the Illness', ' Basics: back to and beyond',

and ‘The Absence of a Recovery Philosophy’. The theme that emerged from the interviews with the students who had not experienced service user involvement is ‘Hearing it First Hand’. Finally, the themes from the service user interviews were ‘The Real Experience of Mental illness’, ‘Uniqueness of Recovery’, ‘Restoring Hope’, ‘Alternative Approaches’.

6.3.1 Students with Service User Involvement

The themes and sub-themes which arose from the analysis of the interviews with student mental health nurses are presented in figure 7. Extracts from the interview data are presented throughout as evidence to support the identified themes and sub-themes.

Figure 7: Themes and Sub Themes from the Interviews with Students with Service User Involvement



Learning from experiential knowledge

The first theme to emerge is related to the student's recognition that the experiences shared by the services users are a source of knowledge that can immensely help in understanding the true complexities of life when living with a mental illness. The subtheme 'hearing it first-hand' related to the students comparing the experience of learning directly from a service user compared to learning from a lecturer or from a textbook. 'Realising the realities of life with a mental illness' indicates how learning from service users created a greater awareness among the students about the actual

realities of life when faced with mental health challenges. The third subtheme 'The resonance of narrative' refers to the credence that the students placed on hearing the service user's story. Many of the students reported that the service user story stayed in their memory, long after the experience of service user involvement.

Hearing it first hand

Hearing service users' experiences of mental illness helped a number of the students to realise the benefits of hearing and learning about mental illness from a primary source. Students made comparisons between a primary source of information and secondary source, i.e. learning from books.

> Student 9: I suppose if you're learning from lecturers, they are reading notes or from books or from stories on the internet, whereas this is actually life experience coming from somebody. They are the ones who are experts on their tablets. There're the ones who experiences recovery …they know better than anyone really

> Student 8*:* I don't think any of us, unless we suffer a mental illness, can really have a clue what it's like. It's a service user who has been through it. It's more real. I guess you stand up and listen more because there's a big difference from reading it from a book and listening to someone who has actually experienced it.

> Student 6: In the lectures, they would give examples of their experiences… I know senior staff have so much experience behind them but they don't actually know themselves what its (mental illness) is like. So first-hand experience was really good.

As a result, some of the students are seeing the life experiences of service users as a source of knowledge

> Student 11: Say the lecturer is so evidence-based; its theory, whereas a service user is pure experience…their experience is knowledge.
>
> Student 10: They've been there, they've done it. They've got the experience. What they're saying is true-not that it's made up, but that there're not reading from textbooks, they've lived it. What they say is the truth.

Realising the realities of life with a mental illness

As a result of hearing service users' talk about their personal experiences, some of the students seemed to gain a greater realisation of what life is like with a mental illness.

> Student 2:well I find when we're in class it's all fine and well reading from a textbook but it doesn't put theory into practice, if you know what I mean?. Whereas seeing someone with an actual illness telling their story, it really puts it into practice for us…I felt we really got a feel for what it's like, for the patient living with the illness. I feel that I've learned more from service user involvement than I would from a textbook or theory in class.
>
> Student 5: It absolutely doesn't compare, because unless you hear someone's story first-hand, it's ok sitting and talking and lecturing 'and this is what a person feels like when they are depressed'. Unless somebody stands there and tells you, and how he felt on the dark days, when he couldn't function, couldn't get out of bed… it seemed more real. You could have read all the journals of the day, it was just when somebody was

> expressing their entire emotions and what was good for them, what was bad, what worked for them, what didn't; compared to looking at something in black and white.

One student was more mindful of the difficulties that patients can experience.

> Student 6: You were thinking after (service user session), 'God it must be so hard to concentrate when you have not only one but two or three voices talking to you at the same time'. You could understand a bit more when you are doing a care plan or interventions; they might not have the concentration-span.

The Resonance of Narrative

The third sub-theme to emerge is the resonance of narrative. Many of the students discussed how hearing the service user's story really stayed with them. They reported how hearing a personalised account/story left an indelible impression.

> Student 2*:* when we have speakers (service users) coming in and talking to us, we really learn from that and it's always something that's going to stick with us and that we'll remember, whereas a lot of theory can be overwhelming. It's not something that going to stick with us… but if we were sitting in an exam and there was a question on bipolar then that lady would always come back. In my head, I would think 'well this is how she explained her story'. I think that real life story tends to stick with you more than something in theory and I think that is the way forward.

> Student 7*:* I had one experience of a man from schizophrenia Ireland coming to see us, and his stories never left me, about how he coped with hearing voices, how he heard voices while walking down the street, he used

to take out his mobile and respond to the voices, pretending he was on his mobile. The story never, ever left me.

Student 12: it's a better learning experience, I suppose because no matter how many slides or lecturers your hear, you won't remember it as well as somebody standing up in class and telling their story… you remember their face, you remember exactly what they said-whereas, if a lecturer tells you something on a slide, you're not really as interested.

Student 13: it's very personal and they're telling you stories about when they were in hospital and 'this happened me, this is how I felt at the time'… you seem to remember quicker, they were saying 'well, I was tired all the time and they were giving me a high dose in the morning and I'd be tired for the rest of the day… just things like that stick with you when it's their own personal account.

Seeing Beyond the Illness

The second theme that emerged as a result of the analysis was seeing beyond the illness. This incorporated a subtheme of students seeing beyond a diagnosis, looking at other dimensions of the patient, and not just focusing on the clinical signs and symptoms. A second subtheme is realising that there is life and hope after the experience of mental illness.

A person not just a patient

There is recognition from the students, that the experience of service user involvement helped them to realise that service users are not solely defined by their mental illness, are more than a patient and that there is a person under the clinical diagnosis and symptoms.

Student 1: I suppose it makes you treat every client more individually, rather than being on a ward and looking at their illness. You try and see the person, what's behind them, what makes them tick, what makes them happy, even stuff not to do with their illness, even talking to them about soccer, if they're into soccer. Or another example, a gentleman who I cared for, was really into sport and he was in there (hospital) for depression and was on medication, he was doing far better, but he was almost being neglected because he was doing a lot better. In the end he decided to take up cycling, so I got him into a cycling club and that…It makes you more aware of their point of view. Ok, we can go in and do our job, but our job sometimes is treating the illness and not the person and often the person is neglected because of the illness.

Student 9: I definitely think I'll remember more about a service user being a person than a client, as opposed to just a patient on the ward from them coming in and giving their experience.

Student 5: you can relate to the person more. There was another speaker in and he spoke about his gambling addiction. How he hid it and put his family in jeopardy, and his home in jeopardy, and whenever you hear of someone going to the bookies you think ' oh Jesus, waste of space, waste of time'.. If you came across somebody you would ask 'how is it for you'?

Life after mental illness

A number of students reported that hearing the service user experience, and seeing them in recovery, brought them a feeling of hope and optimism.

> Student 7*:* service user involvement was a great way for me to see that people can recover, and to see, that people can move on with their lives and go back to being successful, just like everybody else.

> Student 2*:* It showed us as student nurses that there is hope for people.

One student reported how the feelings of hopefulness can be instilled into others.

> Student 8: that there is hope if people do have a problem, and they do maintain a good life...If you feel there is hope, you can instil that into someone else.

Basics: Back to and Beyond

The third theme to emerge from the analysis is 'Basics: back to and beyond'. This theme refers to the students developing a greater realisation of the importance of basic nursing skills in their interaction with service users, such as therapeutic skills. In addition, the experience of service user involvement has helped the students to critically reflect on their practice, which has challenged their approach to care. Moreover, students are more mindful of adopting a collaborative approach to care and working in consultation with the service user in the clinical setting.

Therapeutic Skills

Students reported how they have a heightened awareness of the importance of therapeutic skills; these skills are an essential aspect in the nurse-patient relationship.

> Student 8*:* As a student nurse, there's not very much I can do as in changing treatment. But I suppose listen more, to be a bit more empathetic, and not be

so worried about what maybe the clinical side of it, and more interested in how the person is feeling.

Student 9: the mother of the two service users said that sometimes when she is in a meeting with a doctor, a family meeting in particular, she felt that they were talking over her sons and not talking to them. I'm more cognisant to the fact that they are there beside you and you can involve them in conversations.

Student 10*:* when a patient first comes on the ward, to greet them and settle them in. I'm very aware of the first meeting I have with them, they meet me and I am the first contact they have with the hospital. They're very scared and looking for someone to trust. So I try and make them at ease and tell them what's going to happen and ease them into it.

Student 11: If I had a client that was really, really, upset, a simple little hand on the shoulder just to show the reassurance, whereas before (service user involvement) I would have thought that to be slightly inappropriate.

Reflection and re-evaluation

Participants reported adopting a more critical and reflective approach towards their practice as a result of having service user involvement. Moreover some of the students re-evaluated their perspectives and their approach to service users and their clinical practice.

Student 11: Having the service users come in and talk to you gave you a critical way of how you practice, different ways you wouldn't have thought of before, simple things like respect and listening to them. You would do that before they even say it, but you don't realise how much of an impact it

has on them and after they come out of services, how much they value it and how much they respect those who listen to them, respect them.

Some of the students reported that the experience of service user involvement challenged them to adopt an alternative approach than what they previously would have done before user involvement.

> Student 11: it makes you think about a critical approach, and how you would practice. Instead of telling Joe 'Take the medication you have to', maybe find out the reasons why he doesn't want to take the medication.

> Student 13: making you think (about practice) 'well is that right? Is there a better way of looking after patients and treating them'?

Collaborative approach

Students reported that the experience of service user involvement resulted in them collaborating with patients in care planning and tapping in to the expertise of patients.

> Student 9: I'm asking service users more questions about what worked for them in the past, instead of just suggesting interventions in their care plan and asking what worked previously…something that they could identify as working.

> Student 7: in terms of nursing, stuff like individualised care plans, those things are so important, and nurses need to get a concept of how these people, how people with mental illness have got coping skills of their own… and to integrate that into their care plans.

> Student 13: It (service user involvement) has changed the way I've thought…I would ask the patients now 'when you were psychotic, how did you feel? What help makes you come around? What way of talking to you

helped?' so on that level, I think I can talk more openly about it and you know more from the patients level, or their view.

The Absence of a Recovery Philosophy

The fourth theme to emerge is 'the absence of a recovery philosophy'. Findings suggest that some students are being socialised into negative attitudes towards practice and labelling of service users while on clinical placement. Some of the students highlighted that this is a challenge of clinical placement. Hence why some of the students identified that learning from the service user in the classroom setting is better when compared to the clinical setting.

Challenge of clinical placement

Some of the students spoke about the challenges that one can be faced with in the clinical setting, and how this can influence their attitudes, and how it impacts on their interactions with service users.

> Student 1: There is a massive difference and wrongly (learning in the classroom than on placement). But if you're on the ward and somebody is telling you "you're doing nothing for me", there're just automatically labelled as 'difficult' or 'troublesome. Whereas you see someone who is recovered and they tell you "well you did nothing for me while I was in there, I done it myself", and then you've got to ask why. There's a massive difference between meeting someone in clinical placement and meeting someone out of it. I suppose, and wrongly, you take someone out of it (hospital) a bit more seriously because you don't have people telling you they are difficult.

> Student 7: when you spend a lot of time on placements in hospitals, you can't help but fall into that perspective, that stereotype of someone who is

> mentally ill-somebody who wouldn't be successful in all aspects of their life.
>
> Student 8: On placement, especially in a hospital, you become very institutionalised-that is the way the day pans out, and whether you get to talk to a service user about their experience of mental illness…I just think it's different. Maybe it's the clinical setting and the college setting, you look at things very differently when someone comes in.

One student discussed how on placement it can be difficult to hear patients' experiences as they can be unwell. Also patients can be afraid to share their experience because of potential consequences.

> Student 5: whenever we meet people (patients) on placement, they are severely unwell, sometimes you're on placement for such a short space of time that you don't get to see them well, or hear their experiences, and they don't volunteer because they are afraid to have a chat, to say I did hear voices because "I might not get out of here".

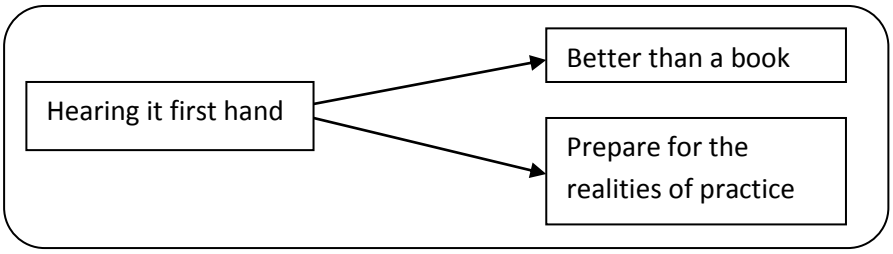
One participant reported that the idea of recovery for patients is not always promoted in the clinical setting.

> Student 7: It was (service user involvement) a great way to see the recovery process work because you get taught it in college. When you're in the hospital, the concept of recovery isn't as important.

6.3.2Results of Student interviews without Service User Involvement

No known previous empirical investigations known have looked at student's perspectives that have not experienced service user involvement. Students who had not experienced service user involvement were invited to participate in an interview in order to examine from their perspective the potential effect of service user involvement in mental health nurse education. Figure 8 shows the link between the theme and the sub-themes.

Figure 8: Theme and Subthemes from Interviews with Students without Service User Involvement



Hearing it first hand

One main theme emerged from the analysis, with two subthemes supporting the main theme. 'Hearing it first-hand' was the main theme. The two subthemes were 'better than a book', and 'prepare for the realities of practice'. Even though the students interviewed had never experienced service user involvement in their undergraduate programme, they believed that the experience of hearing and learning about mental illness first-hand from someone with personal experience would be a valuable learning experience.

Better than a book

The students interviewed considered that the experience of service user involvement would provide them with a learning experience that learning or reading from a book could not replicate.

> Student 15: I think it'd be great to have service users teaching us, just to get a hands-on, first-hand experience. I know myself, sometimes the books- you can read everything in a book but just to get first-hand experience and different things. Stuff you read in a book, sometimes that's not exactly what happens out there.
>
> Student 16: I think it would give students a better insight, rather than reading from a book and taking it from there.

That student continued to say, that service user involvement would show the emotion that mental illness can cause, which could not be obtained from reading.

> Student 16: when're you're reading it from a book, that's fair enough, but when you get someone telling you what they've gone through, it gives you a better grasp of their emotions and what they're feeling. You can really get that from what written on a page.

One of the students felt that learning about mental illness from a service user would have a greater staying power in your memory.

> Student 18: Instead of reading if from a book, you'd have to go over it, like study it, whereas you can go back in your head and see the person that said that. And that sticks in your head more…I think you'd remember it easier, where you can associate that with the persons face in your mind and you're face to face.

Furthermore, the student believed that service user involvement would retain the student's attention.

> Student 18: I think it would stay in your mind more. Because you are coming into your classroom and they're sitting in the same classroom and the lecturer puts up the notes and you go through it. I think you would pay attention more if... You see your lecturers face a lot, so I think seeing a new face, getting a new perspective would just stick in your head more.

Prepare for the realities of practice

Students believed that if they had experienced service user involvement they would be better prepared for the realities of clinical practice.

> Student 15: well, service users are the ones who are availing of our services… so their involvement would be very important, just to get their point of view of what services are like.

Furthermore, students argued that service user involvement would potentially ease anxieties prior to clinical placement.

> Student 15: I suppose if service users had taken part in the course from the very start, we might not have felt as anxious going out (on clinical placement).

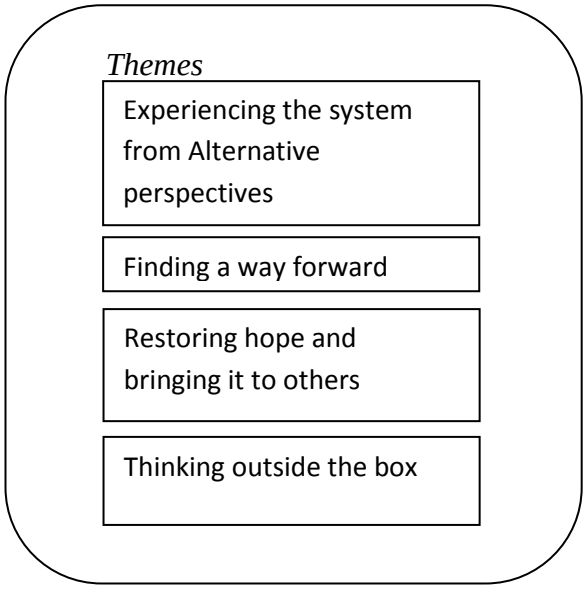
> Student 16: it would show us the patient, what they are suffering from, and you get to see that in practice, again it would give the student more grasp and an approach when they are going out there (clinical practice) and doing it.

6.3.3 Results of Service User Interviews

The aim of the interviews with the service users who have been involved in teaching undergraduate mental health nurses was to examine from the service user's perspective what they feel they can offer students in their learning alongside other forms of

teaching/learning. Four main themes emerged from the analysis; the themes are displayed in figure 9.

Figure 9: Themes from the Interviews with Service Users



Experiencing the System from Alternative Perspective

This theme relates to the service user sharing their personal experiences of coming through the system and imparting the very real possibility to students that people can recovery and transition forward in life.

> SU 2*:* I spoke to them, told them about my experience, and told them about the hell that I was in – I mean, I was close to suicide – I didn't want to... It wasn't because I wanted to die, I didn't want to live and I didn't want to live in the way that I had, and I just felt stuck. So I gave them the whole experience – what it was like to be stuck. I was a person who was getting severe panic attacks, severe anxiety, that I went through something like sixteen weeks without any sleep, so where do you turn to? I didn't know where to turn to; I didn't know what to do. I was married with two children. I was trying to keep my life on. I was trying to work and I found that I was

> in a very severe mentally ill state and I didn't know what direction to go, and that's a very scary place to be. Eventually, I went to hospital, I spoke to them about that experience and what it felt like at the start when I was there.

One service user talked about opening students up to the relevance of lived experience, and the importance of understanding how the service user experiences has shaped their life.

> SU 3: suppose in many ways part of what I do is bring them into the realisation of the real experience of people rather than the text from a book or a PowerPoint presentation on theory. It's about getting into that experience and understanding it. So it's probably a different style of involvement…There's no point in having that sort of theory or practice if you have no deeper understanding of people's experiences and what they make of those experiences – how they understand those experiences, how they are able to live with them, own them and have power over those experiences. So primarily mine would come from those experiences, the sort of life that has developed from them.

The service user reported how they shared an alternative perspective with the students; the experiential perspective, which they hope will inspire a fresh perspective and understanding for the students

> SU 4*:* I shared with students my personal experience of mental illness. That's coming from a different perspective…and bringing them the experiential perspective...its steeped in the lived experience and bring students a new perspective... a new way of thinking about mental illness.

> SU1: I suppose from my point of view, as a service user who has come through the system myself, I have a lot of experiential knowledge from being in public and private psychiatric service user since I was 15 years of age, and now 15 years out of it. So I suppose I have a deep historical experiential knowledge of being somebody who was classified as a mental health patient in those years and then coming through that and becoming part of a recovery movement, part of a healing, therapeutic community outside of the services.

> SU 2: When you bring it into daily layman's terms and an awful lot of the stuff I have acquired and I kind of put the whole thing together in the sense of, like in an easy, understandable way – just to share with them my experience and my way out of it and they can look at me and see that it's living proof that it works.

Finding a way forward

The second theme that emerged was finding a way forward where the service users talked about how they moved their life forward in the aftermath of a crisis. One service user talked about the specific approaches he used to help himself. One talked of their experience of transitioning life forward after a crisis, and how this is an individual experience for everyone. Another service users emphasised how he hoped that students would realise that life can still be positive even if symptoms continue to persist.

> SU 3: For me it isn't recovery, my experience is a little different to everybody I've ever met. So it's the uniqueness of those recovery stories that need to be understood rather than clumping it all into one heading and saying it's 'Recovery' when it's not… It's totally unique for each because for me, what brought me into using the language of a mental health crisis

> are probably different to everyone else because it was my own unique life journey and instances and things that happened that brought me into crisis. Now there are parts of other people's life stories that may mirror or may be part of the same crisis experience but how they live through the crisis or how the crisis builds up around them is totally different.
>
> SU 4*:* I hoped my story would help students realise that recovery doesn't mean that the symptoms of illness are gone, but that life can still be great even with symptoms…what helps recovery is very different for each person… there is no one plan that works.. It's so individual.

One service user explained to students the actual approach that he adopted to help his recovery journey. He discussed the experiential knowledge that he gained while on that journey, and the importance of sharing that knowledge with others.

> SU 2: I just took them with the journey that started with doing exercise; that started with discovery of meditation and the discovery of the whole importance of diet. And then the rigorous approach of, and constantly how to apply these things and how my life gradually began to improve. So I shared that.
>
> SU 2*:* A lot of the doctors have zero knowledge of [this], because I know from talking to them that they really don't know what it's like and again, talk more to the people who have the condition and people who have found a way out of it.

One service user gave students the theory behind recovery and the application of it in practice

SU1: well, I gave them the core principles and competencies of recovery, how recovery is used in practice

Restoring hope and sharing it with others

The third theme to emerge from the analysis is restoring hope and sharing it with others. Service users wanted to enlighten students to realise that there is hope after mental illness and the importance of instilling this hope and optimism into the lives of patients they come in contact with in the clinical setting.

SU1*:* hope it's interesting for the students to see that when they actually are working, that there is a lot of hope, that a lot of service users experience that if they are diagnosed for life, psychiatry says you can be treated, but can't be cured, all this kind of stuff- it might be interesting for nursing students to think that when they are dealing with a very difficult life situation, just to keep in mind the recovery principles and I'm not being glib here, but there is hope, there are ways where people can actually get better, have a quality and fulfilling life. Nursing is caught in this clinical world; it's kind of divorced from reality.

SU 2: That having a mental health condition doesn't have to be the end, in fact, it can be the beginning.

SU 4: Students need to bring a belief in recovery into their practice and they need to be reassuring and share this… they need to talk about recovery with belief.

One service user discussed how the process of recovery brings a feeling of hope and optimism for the future.

> SU 3*:* With me, I tend to start at the very start, what brought you into crisis? How did you come here to this point? And then start to work your way through the middle part and then straight through to the very end. The very end being hopefully moving on to their recovery, having a deeper understanding of what it was that got them there in the first place and enables them and gives them the tools to be able to take ownership of it and move on, leaving the past in the past, and build whatever sort of future they want to build for themselves.

Thinking outside the box

The service users wanted to challenge the students and their assumptions, to encourage the students to reflect and think outside the box in terms of practice and the values that underpin their practice, and to not just passively consume the professional's perspective. Moreover, the service users hoped that their involvement would inspire the students to engage with service users in a meaningful way.

> SU 3: get involved in dialogue with them around where they are at now, what they believe in, especially the hearing voices stuff, getting them practically involved in being able to experience a hearing voices session, working their way through it and trying to find solutions, overcoming different perceptions they might have and trying to bring them into the experience.

> SU 4: I tried to challenge the students and get them to pay attention to the person and what's gone on for that person…don't just accept the medical interpretation…getting nurses to reflect on their own values and their own kind of biases possibly, and to try to widen their understanding of people and their problems.

In addition, they challenged the student's perspective, and their understanding of a diagnosis of schizophrenia.

> SU 3*:* For argument, my experience would be around the diagnosis of schizophrenia, which for me is highly questionable. That's the main part of what I do – to make them question the whole need for diagnosis, or try to de-myth what schizophrenia is and how people live, survive and fight their way through it.

One of the service users discussed with the students about the importance of realising that there are alternative ways of achieving recovery and that the strategies he adopted helped his recovery, hoping that it might encourage students to think outside the box.

> SU 2: So if I can talk to them with conviction that it does work then it might get them to look at it from another angle that they mightn't have thought… as far as I understand it, the medical system, is to apply care that works. And if I'm telling you that this works, do I not have an obligation as a human being to say, hold on a minute, there is a better way?

The earlier sections discussed the findings that emerged from the interviews with students and service users. The subsequent section will discuss significant findings in relation to relevant literature

6.4Discussion

The findings of this study offer exciting and interesting findings regarding the experience of service user involvement in undergraduate mental health nurse education in the Irish context. Learning from experiential knowledge' emerged as a theme from the analysis of the interviews from the students who had experienced service user involvement. Many of the students who had experienced service user involvement valued the opportunity to engage in dialogue with service users. Typically in mental health courses, mental health student nurses learn about the experience of mental illness through a labyrinth of terms, classification systems, symptoms and treatment modalities (Byrne et al 2013). The experience of service user involvement humanised the experience, and brought students in to the world of service users by providing them with 'real-world' examples of mental distress, stigma, social isolation, feelings of inadequacy and hopelessness, rather than learning it from a traditional lecture, reading a book or from clinical staff. The students reported that it opened their eyes to the realities of life when living with a mental illness. Moreover, the students felt that hearing the service user's story had left a lasting impression, in that they could recall specific details of the story long after the experience of service user involvement.The second theme to come out from the interviews with the students who did experience service user involvement was 'seeing beyond the illness'. Hearing the service user telling their story appears to have been an immensely powerful experience for the students. The experience of service user involvement has helped them to see the person behind the diagnostic label, and recognise the very real possibility that anyone can recover. Service user involvement provided a platform which gave students an additional perspective, one which appears to have challenged their perceptions and beliefs regarding mental illness and service users.

The third main theme to emerge from the students who had experienced service user involvement was 'basics: back to and beyond'. The experience of service user involvement has helped the students to be more mindful of their therapeutic skills in their interactions with patients. In addition, they are critically reflecting on their approach to practice and adopting a more collaborative approach with service users in the clinical setting. The final main theme from the interviews with students who had experienced service user involvement is 'the absence of a recovery philosophy' Some of the students identified that learning from service users in the clinical setting can be challenging due to staff's attitudes, and the hospital setting not always realising the possibility for recovery.

With regard to the perspectives of those students without experience of service user involvement in their undergraduate nursing programmes, it is interesting to note that their expectations tallied with the actual experiences of those students with service user involvement. The main theme to emerge was 'hearing it first-hand' where students proffered that hearing service users' first-hand experience of mental illness directly from people who had personal experience of mental illness would be 'better than a book' and would 'prepare them for the realities of practice', giving them an understanding of service user expectations, and potentially easing anxieties prior to clinical placement.

The key findings from the interviews with service users showed that they wanted to bring students into the 'real world' in terms of understanding the difficulties and challenges an individual experiences when their mental health is in crisis. They wanted students to recognise the personal resourcefulness that they have. Moreover, that this resourcefulness is used to help people find ways of recovering despite the adversity they faced. In addition, they wanted to highlight to the students that the journey of

recovery is a unique process, and what helps or hinders recovery is individual to all. Moreover, the service users wanted to bring hope to students that recovery from mental illness is possible and for students to share this positive message to service users they come in contact with in the clinical setting. Additionally, the data from the service user interviews showed that service users hoped that their involvement would stimulate students to challenge their own assumptions and beliefs in relation to their practice and the mental health system rather than just passively consuming academic knowledge.

The findings of this study are in keeping with the findings of previous studies relating to service user involvement in mental health education. Learning from experiential knowledge' emerged as a theme from the analysis of the interviews from the students who had experienced service user involvement. Many of the students who had experienced service user involvement valued the opportunity to learn about the experience of mental distress from someone with first-hand experience compared with a traditional lecture or reading a book. The students reported that it opened their eyes to the realities of life. Moreover, the students' felt that hearing the service user's story had left a lasting impression, in that they could recall specific details of the story long after the experience of service user involvement. These findings are consistent with the studies by Khoo et al (2004); Barnes and Carpenter (2006); Rush (2008); Stickley et al (2010); Scheyett and Kim (2004). Rush and Barker (2006); Simpson et al (2008); Byrne et al (2010); Schneebeli et al (2010); Frisby (2001); Happell and Roper (2003), Felton and Stickley (2004).For example, Stickley et al (2009) recognised the significance of service user's experiences being first hand and Rush and Barker (2006) reported that service user involvement facilitated better learning than reading a journal or book.

The second theme to come, 'seeing beyond the illness, is reminiscent of a finding in a study by Masters and Forrest (2010) where the students remarked on remembering that clients are human and that their experience are important. Similarly, the students in the study by Rush (2008) commented that it was refreshing to see service users in recovery phase and to see service users as people 'just like you and me'. A similar view is echoed in the studies by Anghel and Ramon (2009) and Schneebeli et al (2010).

The third main theme to emerge, 'basics: back to and beyond', is mirrored in studies by Stickley et al (2009) where the students reported that they had greater empathy as a result of service user involvement, Simpson et al (2008) who reported an improvement in communication, Wood-Wilson Barnett (1999) in which students indicated that they were adopting a user-centred approach to care, Rush (2008) where students were more reflective as a result of service user involvement and Khoo et al (2004) where students identified the merits of working in collaboration with service users Indeed, service users in the studies by Rudman (1996), Forest (2000) and Masters and Forrest (2010) placed values on nurse's qualities and ranked interpersonal skills and good human qualities as of great importance.

6.4.1 Learning from the Lived Experience of Service Users

The findings of the present study add an exciting contribution to the area of inquiry from the Irish context. However, some of the findings are particularly interesting, and therefore warrant further consideration and discussion. Based on the findings it would seem that engaging with the service users' in the classroom setting provides students' with the opportunity to hear about the experience of mental distress being talked about in a different language. This language conveyed hope and demonstrated resilience and was defined by the person themself. This language is in contrast with the language that

students' are often exposed to; the students' familiar language is couched and shaped by the organisation culture of psychiatry. A culture which is steeped in behaviours often underpinned by pessimistic beliefs, values, attitudes and assumptions all of which can influence working practices, and can hinder the diffusion of innovation and change. Often in practice, practitioners believe that they are primary agents of change and therefore a hierarchical relationship can exit. The experience of service user involvement seems to have heightened students' awareness to the relevance of working in collaboration with service users, and the merits of tapping into experiential knowledge of service user's. This approach to practice demonstrates a working alliance which supports service user's autonomy, and is favoured by a recovery ideology.

'Seeing beyond the illness' was a theme that emerged from the interviews with the cohort of students who had experienced service user involvement The findings of the current study suggest that the experience of service user involvement in the classroom setting prompted students to reappraise their perceptions of service users and re-evaluate their approach to practice. Many of the students commented on how their experience of service user involvement served as a method of helping them to reflect and re-evaluate their stereotyped perceptions of service users, and enabled them to appreciate service users as experts in their own experience, a source of expertise that they felt cannot be replicated by educationalists, clinical staff or obtained from reading a book.

The opportunity to engage with service users in the classroom seems to have served as a mechanism which prompted the students in this study to reconsider their perceptions of service users. The emergent insights and perceptions indicate the importance of engaging with service users in an alternative environment outside of the traditional

clinical setting that supports the psychiatric paradigm. Samociuk and McAndrew (2005) raise the question as to what is the difference about hearing the service users experience in the University setting as opposed to listening to service users whilst on clinical placement, as one would assume that students were listening to service user's accounts of their illness, day in and day out. However, Samociuk and McAndrew (2005) suggest that the university setting adds veracity to service users' accounts in that it is seen to be valuing their input in the same context as research and theory. Bearing in mind that the medical model has dominated psychiatry since its inception (Stickley and Timmons 2007), students have been widely exposed to the traditional medical model practices of psychiatry and are exposed to service users within the mental health system, where patients are passive recipients of care and defined by diagnostic labels. These labels can be stigmatising and can influence how people are perceived and the degree to which equal relationships can be achieved (Edwards 2005). As Repper and Perkins (2003) point out, the mental health system has focused on deficits and dysfunctions. The students in the current study reflected on the difficulties they often experience engaging with service users in the clinical setting. It would appear that in the clinical setting, there are factors that diminish the reality and significance of the service user experience to the point that their stories may not even be sought (Samociuk and McAndrew 2005). The experience of service user involvement provided an opportunity for face to face interaction with service users without many of the distortions that the structure of professional practice frequently impose. Based on some of the students' comments the clinical setting is a place of organisational pressures and dominant professional roles. Scott (2003) comments that this can result in student nurses becoming discouraged from questioning practice, and as they progress to qualified nurses, they lose motivation to resist the confining and debilitating habitus of professional practice. However, service user involvement in the

classroom setting provided students in this study with an opportunity to engage with service users outside of the restrictive socialisation processes that takes place in the professionally structured clinical practice environment.

For many students in this study their previous experience of service users was solely within the clinical setting, often when service users are experiencing a period of crisis or heightened distress which arguably skews the student's perceptions of people who have mental health difficulties. This perception of mental illness is coupled with the influence of a professional culture whose 'expertise' has dominated the practice of psychiatry. Keeping this in mind, the findings indicate that the opportunity to engage with service users outside of the professionally structured practice environment was seen to be of high potential value for the students' learning experience. As all of the students were in either third or fourth year of the programme, it could be assumed that the students would already have had these insights and understanding regarding service users. However, the findings would suggest that it was the engagement with service users in the classroom setting that made it possible for the students to reflect and gain insights and understandings that are not accessible in the clinical setting.

The findings suggest that the experience of service user involvement during their undergraduate mental health nursing programme helped students to recognise that service users are a person and not just narrowly defined in terms of their mental illness. Stickley and Timmons (2007) are of the opinion that when student nurses enter higher education to commence their nurse training it is expected that they would hold lay beliefs of mental health and mental illness. According to Anderson (2003), lay beliefs regarding mental illness are virtually identical to the medical model beliefs and are largely influenced by the media portrayal of mental illness. Walker (2006) asserts that the vocabulary of the medical model uses language that focuses on deficits; one of the

traditional rationales for diagnosing is to have a shorthand way of communicating with other professionals. One thing that gets communicated is a cluster of "symptoms" under the heading of the "diagnosis. Furthermore, he argues that the hierarchical relationship and the deficit focused context are also communicated. Thornicroft et al (2010) describe the mental health system as a powerful blemish on a person's identity. Beecher (2009) believes that the medical model deflects the focus away from the person and favours focusing on the illness. In contrast, the experience of service user involvement helped the students in this study to relate to the human experience of mental distress and mental illness, which enabled them to see the person behind the illness.

Experiential knowledge emerged as an important component of the experiences of service user involvement in the classroom. For example, it was evident that being exposed to experiential knowledge played a role in stimulating the students in this study to reflect on past practices and to challenge the assumptions they had previously made about service users. According to Kemp (2010), service user involvement provides a 'third sphere' of learning in nurse education alongside the 'theory' and 'practice' elements of their training. Kemp describes this third sphere of learning as essentially the provision of learning opportunities for students in the form of direct face-to face engagement with service users outside of the clinical setting which provides an opportunity for learning that is neither readily available in practice nor accessible in conventional theory-based classroom learning. The experiential knowledge of service users and their stories of recovery provide a valuable form of learning. Kemp believes that involvement is more than simply including service users or an added extra to enrich the course. The inclusion of service users is a fundamental necessity for student learning, in terms of understanding the service users' experiences,

how mental illness impacts on the human condition and the resilience that service users have. Moreover the application of this knowledge has the potential to influence how students approach practice and their interactions with service users. The service users who participated in interviews hoped that their involvement would enable students to understand the actual realities of having a mental illness, and more importantly understand the real possibility of recovery.

Typically students are exposed to service users' personal accounts in the clinical setting. However, Barker (2003) asserts that the purpose of the story is to provide the necessary materials for the psychiatric formulation, and the consequent medical intervention. Frequently, this begins with the requirement that the person abandons his or her own interpretation of their story in favour of the professional perspective, which is generally framed by the diagnosis. In contrast, the experience of service user involvement provided students in this study with the experience to hear the service user story entirely in the person's own voice, rather than translated into a third person account, or into professional language. Hearing the story first-hand allowed students to witness the emotion that mental illness causes and the difficulties that a person experiences when faced with the reality of a mental illness. The emotive details of the personal account are not replaced by cold clinical diagnostic language. This may account for the student's ability to engage empathetically with the service user story. This represents the relevance of the human experience in the learning process. It could be argued that reading a personal account from a service user or watching a documentary based on a service user's experiences could replicate the same experience as the physical presence of the service user in the classroom in terms of the learning experience for students. However, the findings of the current study would suggest that the actual presence of the service user in the classroom was at least partly responsible

for the positive outcomes that the experience had on student learning. Kemp (2010) identifies that having service users in the classroom appears to create a 'communicative space' where the service users and students can engage in critical dialogue away from the constraints of the clinical environment where they usually encounter each other. In the current study the presence of the service users provided students with the opportunity to engage with service user's face-to face in a situation where the power dynamics between them were reversed. The service users were there in a lecturer/ facilitator capacity, which projects an important message to students in terms the capabilities of service users and importantly about the relevance of the service user's experiential knowledge. Engaging with service users in the classroom meant that the students were disengaged from clinical practice and the organisational influences that structure student's interactions and their relationships with service users in practice. There is an expectation that students provide care to people who are unwell while they are on clinical placement, therefore they must adopt a professional role (Kemp 2010). Engagement with service users in the classroom brought students and service users together for a different purpose and therefore with a different expectation. The service users were present in a situation which placed them in the position of 'expert'. The physical presence of the service user potentially plays a key part in challenging the students' perspectives and triggering a response which resulted in a revised identity of service users.

The findings of the current study suggest that the experience of service user involvement made students mindful of the relevance and importance of adopting a collaborative approach with service users in their clinical practice. The experience of service user involvement and hearing the service user stories of recovery highlighted to students the knowledge base and wisdom that service users have by virtue of their

personal experience of mental illness. Students report that they are mindful of tapping in to this wisdom, as it is an important resource in the care planning process. This indicates that students recognise the merits of working in collaboration with service users. In addition, the experience of service user involvement heightened student's awareness of the importance of good communication and the relevance of listening to the service user's story. These aspects are also conducive for a collaborative approach to practice. The student's collaborative approach that values shared knowledge and expertise, and promotes personal growth is in contrast to the paternalistic, authoritative ways of knowing that is typically associated with the medical model. This demonstrates a shift in the power relations that is often evident between practitioner and patient, where usually things are done 'for' the patient, rather than 'with' the patient. Moreover, a collaborative approach is one of the underpinning values of recovery orientated practice. The collaborative partnership between the nurse and the service user is an integral component of the recovery process. The findings of a study by Cleary and Dowling (2009) found collaborative skills to be the most important factor influencing service user's recovery.

There is a growing recognition that collaboration with service users is a good idea for the progression of mental health services due to the knowledge, insight and problem solving skills that service users can contribute (Mental Health Commission 2005, Higgins 2008, MacGabhann et al 2010). According to Gottlieb, Feeley and Dalton (2005), there is a general agreement that collaboration is illustrative of the shift away from the traditional paternalistic and authoritative ways of illness treatment and towards more mutually respectful systems of person-centred care that considers the knowledge and expertise held by both partners within a relationship. According to Higgins (2008), open communication, respect for each other's opinions and a sense of equality between parties are fundamental facets of a collaborative relationship.

O'Connor (1999) writing from a service user perspective, believes that collaboration means cohesiveness, respect for each other's points of view, clarity of purpose and a shared vision. For O'Connor, true collaboration can only be achieved if a respectful and trustful relationship exists. Service users in a study by McCloughen et al (2011) identified that successful collaboration was conditional on nurses recognising and valuing service user's expert knowledge in relation to the experience of mental illness, and in turn, supporting and encouraging service users to share their experience. The study by McCloughen et al aimed to identify if service users and nurses shared common understandings, attitudes, values and experiences of a collaborative relationship. Both service users and nurses in the study acknowledged that the collaborative relationship required active input from both sides, indicating shared participation. They specifically identified that effective communication was essential to developing and maintaining a collaborative relationship. Goodwin and Happell (2006) found that both nurse and service users considered respect as an integral facet to forming a collaborative relationship.

The importance of recognising power within the collaborative relationship has also been identified. Gottlieb, Feeley and Dalton (2005) report that a fundamental aspect of sharing power and expertise is the pursuit of mutually agreed person centred goals. McCloughen et al (2011) believe that for power sharing to occur, it is essential for nurses and service users to recognise and be agreeable to give up traditional dominant and passives roles, in order to identify the potential contribution of each other's knowledge and skills, and to actively work on co-constructing the purpose, process and outcomes of their relationship.

The findings of the present study indicate that students' recognise the importance of adopting a more collaborative approach in their interactions and relationships with

service users in the clinical setting. The experiential knowledge of service users appears to have served as a method of helping students to realise that service users are generally best placed to identify what helps or hinders in their recovery. It appears that students are respecting the knowledge and expertise that is generated from the actual lived experience and consequently they are not adopting a dominant paternalistic approach towards relationships with service users in the clinical setting. The students are more aware of the merits of working in collaboration with service users rather than just assuming they know what the best course of action is.

The service users in the current study hoped that their involvement and sharing their stories of recovery would provide students with a belief in recovery. Moreover, they hoped that students would instil this positivity into the lives of service users they encounter in the clinical setting. The students in the current study acknowledged that they feel more positive about the possibility of recovery as a result of service user involvement. Hearing the service user stories of recovery instilled a sense of optimism regarding the outcome of mental illness, in that the possibility of living a happy and fulfilling life is possible even in the depths of mental distress. If students can bring this belief into the lives of service users in the clinical setting, it has the potential to have positive outcomes for service users and for nurse's attitudes towards recovery, as Russinova (1999) believes that hope is the starting point of recovery.

Allott et al (2002) report that historically, people who experienced mental health difficulties were not expected to recover. In the 19th century, this negative expectation was reflected in "degeneracy" theories of mental disorder (Kraeplin 1919). People with a diagnosis of schizophrenia were seen as having a poor prognosis and there was an expectation of a downwardly spiralling course. Deegan (2002) believes that psychiatry placed people in a position of 'learned helplessness' due to the negative beliefs and the

attitudes that provided little or no hope. Moreover, the term 'chronically ill' is attached to people whose illness have become long term, and as a result long periods in hospital may occur (Allott et al 2002). It is a term that offers very little hope of recovery. Topor (2001) argues that we must recognise that chronicity is a product of the life style, and influenced by association with psychiatry. The development of the recovery movement and its association with human rights and empowerment of disadvantaged groups occurred to prevent and challenge these very beliefs and instil a positive message of hope in to the lives of people with a mental illness.

According to Higgins and McBennett (2007), universal in all the writings of recovery are the issues of hope and optimism. In the context of recovery, service users and health care professionals are increasingly acknowledging the importance of hope as a major factor facilitating the recovery process. Understanding how people remain optimistic in the face of difficult circumstances and how professionals can instil and maintain hope in service users is crucial for optimising recovery (Russinova 1999). Anthony (1993) emphasises the relational aspect of hope and its connection to recovery: hope emerges when there is a person one can trust, a professional who believes in better outcomes, even when service users do not believe in themselves. Deegan (1988), writing from a consumer's perspective, describes the process of recovery as a transformation from despair, anguish and pessimism to a new hope that life can be different, a hope born out of the presence of another person ready to provide support and care. According to Bonney and Stickley (2008) hope and optimism are fundamental components of recovery. Roberts and Wolfson (2004) believe being met with hope and optimism, and care been provided in an atmosphere of hope is central in many peoples' accounts of recovery. The findings of a study in an Irish context by Kartalova-O'Doherty (2010) identified that a belief in recovery needs to be shared by both service users and professionals. The findings of the present study suggest that the

involvement of service users in undergraduate mental health nurse education triggers a belief in the possibility of recovery. It is possible that students are exposed to feelings of hope in the clinical setting as they witness service users being discharged from hospital and becoming well. However, service user involvement in the classroom adds a further dimension, as it not only provides a sense of hope about recovery from, or a reduction is the symptoms of a mental illness, it provides hope about recovery of the person. Service user involvement provides hope that the person can recover their sense of self, despite mental illness often eroding that sense. Service user involvement challenged the students to see beyond the clinical diagnosis and recognise that service users have additional angles to them as people. The findings indicate that service user involvement not only provided students with a sense of hope about recovery from the symptoms of mental illness, but it also highlighted to them that recovery of self and identity is also possible. Considering the finding from the study by Kartalova O'Doherty (2010) and bearing in mind the findings of the current study, the current study contributes that service users should have active involvement in professional education, as it would potentially provide health care professionals a belief in hope of recovery from the symptoms of mental illness and a belief in the person's ability to recover their sense of self.

6.5 Conclusion

Phase two of the current study provides findings related to service user involvement in undergraduate mental health nurse education from a variety of different perspectives inclusive of interviews with students who had experienced service user involvement, students who had not experienced it and service users who had experience of involvement in undergraduate education. Considering the findings that have emerged from phase two, it is argued that the experience of service user involvement facilitated a constructive dialogue between the students and the service user which previously did

not exist to the same extent. Service user involvement appears to have amplified the service user's voice and opened the student's minds to the generation of knowledge that this personal experience brings. This experience seems to have re-shaped the way students think about the needs and capabilities of service users. The emerging themes such as 'Learning from experiential knowledge', 'Seeing beyond the illness', and 'Basics: back to and beyond', have an association with recovery when looked at collectively. Typically, students' experience of recovery in the clinical setting would be looked at through the lens of symptom reduction and treatment outcomes. The findings indicate that service user involvement in the classroom has a part to play in humanising the personal experience of recovery for the students. When the students are on clinical placement it can be easy to overlook what may be important from a service user's perspective when the routine of their day is driven by duties or tasks such as the daily handover, medication, patient checks, paper work, covering break times etc. In the context of the current study, service user involvement seems to have triggered a response in the students which indicates a shift towards a more recovery orientated way of thinking. Service user involvement humanised the experience of recovery, which prompted the students to consider and appreciate perspectives that they might otherwise not have thought of. The findings show that students want to engage with service users in a collaborative way that both values and seeks to understand their world and reality. Students in this study report that the experience of service user involvement has helped them to be mindful of respecting and listening to service user's experiential knowledge, also the relevance of tapping in to their resourcefulness and working in collaboration in order to achieve positive outcomes. The students state that they are now more optimistic about the possibility of recovery and report that they are aware of bringing this hope into their interactions with service users they encounter in the clinical setting. The students' reported that they feel more

empathetic, which suggests that hearing the service user's story attuned the students to the emotional dimension of the person's experience. The findings indicate that the experience of service user involvement seems to have re-focused the student's attentions on to the person and shifted their approach from predominately focusing on the practical aspects of their clinical practice.

Overall, the findings from Phase 2 indicate that service user involvement triggers a response where students re-evaluate their perception of service users and the knowledge base they have by virtue of their personal experience of mental illness. Seeing the service users' out of the clinical context can raise students' awareness and challenge their frame of reference, resulting in them moving their gaze away from the body as a label, a diagnosis and an object of care that requires interventions to a person living a life. Such findings have implications for undergraduate mental health nursing education and the way in which a deeper understanding of the service user's experiences can be promoted.

Chapter 7 Integration and Discussion of Results from Phase 1 and Phase 2

7.1 Introduction

This chapter begins with a discussion of integration in mixed methods research, and explains and gives a rationale for the method of integration used in this study. The super-ordinate theme and the subthemes arising from the integration of the findings from phase one and phase two will be discussed. A super-ordinate theme is the conclusion generated from integrating the results of the quantitative and qualitative phases of the study (Tashakkori and Teddlie, 2003). 'Service User Involvement: A journey towards recovery orientated practice', emerged as the super-ordinate theme. The sequencing of the subthemes starting with 'learning from experiential knowledge delivered through narrative', and ending with 'progression of practice' proposes the journey of development that occurs in students which they indicate was influenced by their experience of service user involvement.

7.2 Integration

According to Creswell et al (2004) and Tashakkori and Teddlie (2003), integration is a key aspect of mixed methods research. O'Cathain, Murphy and Nicholl (2010) have outlined techniques that help researchers to integrate data or findings in their mixed methods studies. Of relevance to this study are the integration techniques where researchers use qualitative and quantitative methods to examine different aspects of the research question. In this study, the purpose of phase one was to establish the extent nationally of service user involvement in mental health nurse education, while phase two was to build on these results by creating an understanding of the experience of service user involvement from the perspective of the students who had experienced service user involvement, and from service users who were involved.

The techniques outlined by O'Cathain et al (2010) include triangulation where data is collected and analysed separately for each component to produce two sets of findings, combining these findings is sometimes referred to as the process of triangulation. Morgan (1998) described this type of integration as the "third effort" as it occurs after the analysis of the qualitative and quantitative components. According to Sandelowski (1995), the term triangulation can be confusing because it can have two meanings. It can be used to describe corroboration between two sets of findings, or to describe a process of studying a problem using different methods to gain a more complete picture. According to O'Cathain, Murphy and Nicholl (2010) the latter meaning is commonly used in mixed methods and is the meaning that applies here.

In the current study integration is occurring at the stage where the data from phase one and phase two have been analysed separately. The two data sets were brought together to combine the two sets of findings. There is little direction within the literature regarding the nature or shape that the analytical process should take, therefore integration remains one of the biggest challenges in a mixed methods study (Farmer et al 2006). According to Bryman (2006) integration can occur at different stages of the research process, from the formulation of the research questions; sampling; data collection; and data analysis. Integrated methods has been described as the greatest level of integration in mixed methods research; this involves integration from conceptualisation and threaded through the research process and onwards to the final reporting of the research (Moran-Ellis et al, 2006). However many mixed method studies may be operationalized with some distance from the other methods of data collection and analysis, consequently the datasets may be brought together and integrated at the point of interpretation or theorising.

Considering that phase one and phase two used two different samples, and were addressing different research aims they therefore operated with some distance from each other for these reasons interpretative integration was chosen as the approach to integrate the data sources in the present study. Interpretative integration is an approach termed by Moran-Ellis et al (2006) as 'separate methods, separate analysis and theoretical integration'. This integrative approach is when the data generated from the different methods are integrated after all data has been analysed. This particular approach does not combine methods or analysis, but rather takes each set of findings or datasets and brings them together into one explanatory framework (Moran-Ellis et al 2006). This integrative approach was used by Green (2003); the study utilised a mixed methods approach that integrated quantitative survey data and qualitative data from interviews and personal narrative to look at the application of labelling theory and the experience of stigma in families of children with disabilities.

By integrating the findings from phase one and phase two there is the potential for various outcomes: convergence (where all data sets produce the same finding on a theme); complementary or divergence (where all the data sets feature a theme but have alternative perspectives on that theme); silence (where one data set uncovers a theme for example whereas the other data set is silent about it); and discrepancy (where the data sets have conflicting findings on a theme (Farmer et al 2006). There was no evidence of discrepancy between the data sets.

Super-ordinate themes are located within a qualitative approach and they are themes that encompass the principal metaphor in the data as a whole. According to Attride-Stirling (2001) a super-ordinate theme is like a claim in that it is a concluding or final tenet. A super-ordinate theme presents an argument, position or assertion about a given reality. As such, they are macro themes that summarise and make sense of cluster/sub-

themes/ lower order/ themes abstracted from and supported by the data. Thus super-ordinate theme tells us what the texts as a whole are about within the context of the analysis. They are both a summary of the main theme and a revealing interpreting of the data. Arriving at a super-ordinate theme starts with basis findings and works inwards towards the super-ordinate theme. Once a collection of basis themes has been established they are classified in relation to the underlying story they are telling and this becomes a subtheme/ organising theme. Subthemes are then reinterpreted in light of their basis findings and are brought together to illustrate a single conclusion or interpretation know as a super-ordinate theme.

Qualitative findings and quantitative findings were integrated to provide a fuller and more nuanced understanding of the area of inquiry. As there was a significant amount of qualitative data, it is presented in a visual diagram for ease of understanding and to demonstrate fluidity and to emphasise the interconnectivity. The quantitative data is integrated in the text throughout the discussion. Using integration in this way it was possible to use the relevant parts of the datasets to deepen understanding, to support findings and to elaborate on the findings emerging. As displayed in Figure 10 below, there were both complementary and convergence findings.

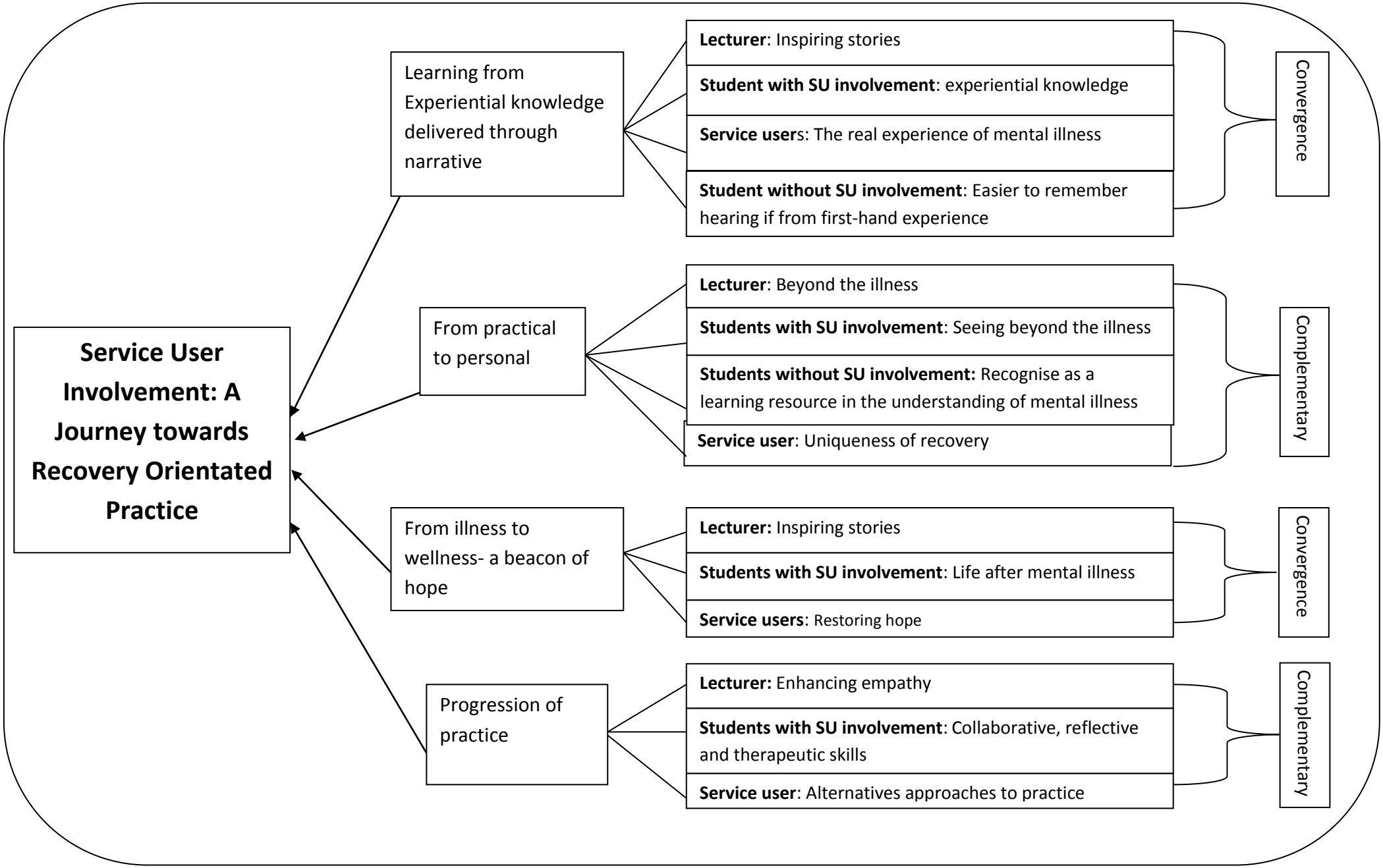


Figure 10: Superordinate theme, Subthemes Supporting findings

7.3 Super-Ordinate Theme: Service User Involvement: A Journey Towards Recovery Orientated Practice

The findings from the data sources suggest that service user involvement in undergraduate mental health nursing programmes has brought the students on a 'journey'. The word journey conjures up the idea of progress from one stage to another. In the current study the journey begins with the recognition and realisation of service users' first-hand experience as a source of knowledge. Moreover, this knowledge is perceived to be a greater learning resource in comparison to learning from books or lecturers in terms of understanding the actual complexities of life with a mental illness. Hearing the service users' stories of recovery gave the students a positive message of hope. Some students recognised that hope and a belief in the possibility of recovery can be instilled in to the lives of patients. In addition, the students reported that they are seeing beyond the typical limitations and labels so frequently associated with mental illness, in that they are recognising that service users are not merely defined by their clinical diagnosis and presentation. Students reported that they are more empathetic and reflecting on their own practices, which is a result of hearing the service user's stories. Also, they reported that they are adopting a more collaborative approach with patients, as they recognise that patient's personal experiences can be a valuable resource and source of knowledge in the care planning and recovery.

The super-ordinate theme is supported by four subthemes, which all have an association with recovery. 'Learning from experiential knowledge delivered through narrative', 'from practical to personal', 'from illness to wellness-a beacon of hope', and 'progression of practice'. In the following sections each of these subthemes will be discussed. The super-ordinate theme will be discussed following the discussion of the subthemes.

7.3.1 Learning from Experiential Knowledge Delivered Through Narrative

The lecturers reported that service user involvement would afford students the opportunity to hear the real experience of mental illness from a first-hand perspective. The students who had not experienced service user involvement believed that learning about mental illness from a personal experience perspective would be easier to remember as the person who had personal experience of mental distress would be the story teller. Indeed, the students who had experienced service user involvement reported that service user involvement was a better learning experience, as it involved hearing and learning about mental illness directly from someone with first-hand experience. The service users wanted to bring to students the real experience of people with mental health difficulties thus helping the students to gain a deeper understanding of their experiences. The students report that service user involvement did provide them with this realisation. Moreover, hearing the service user's story seems to have opened the students' mind to the realisation of the service user's expertise. Four out of twelve schools have service users involved in regular teaching, four have service users involved in sessional teaching, and seven have service user involvement in workshops. Taking into consideration each of these findings, it is apparent that the decision by educationalists to have involvement in classroom based teaching initiatives is a positive way to introduce students to service user involvement, and the qualitative findings from students support this decision. Despite the enthusiasm amongst students to hear first-hand of the service users' experiences, this involvement could be deemed as tokenistic. When mapped against the 'Ladder of Involvement' it would be characterised as limited involvement (level 2). Given the positive appreciation that students have for service user involvement, and the relevance of the service user sessions for students, all schools should be encouraged to involve service users in teaching

and related activities, for example, curriculum design as only 3 out of the 12 schools have implemented service user involvement in curriculum design.

Typically students would initially hear the service user's story in the depersonalised clinical setting during the assessment process, where the primary focus would be on severity and frequency of symptoms and management of those symptoms. Service user involvement provided an opportunity for students to hear service users articulate their story for a different reason and in a different social context from their usual interface. Hearing the service user's story in this way appears to have been instrumental as it challenged students to reconstruct their view of service users. Furthermore, many of the students believed that service user involvement had heightened their awareness and realisation of the knowledge base of service users. Moreover, this knowledge base has enhanced their understanding of the complexities of life with a mental illness. Hearing the service user's stories of recovery enabled students to see the emotional distress that mental illness causes, which appears to have enhanced student's ability to empathise. Indeed, service users sharing their personal experience was the preferred content of service user sessions in eight schools. The qualitative results support this finding as both educationalist and students recognise the merits of service user sessions being based on the service users personal experiences and sharing their stories of mental distress. Moreover, sharing these personal stories provided students with the opportunity to hear personal testimonies of recovery, thus helping students feel more hopeful about the prospect of living a happy life despite the turbulence that mental illness can cause.

According to Buchanan-Barker and Barker (2006), in traditional practices, the service user's story is usually translated into a third-person, professional account, for the purpose

of psychiatric formulation. Thus, the service user's story becomes the professional's view of that story. Often professionals are primarily interested only in what is "wrong" or in pursuing particular lines of professional inquiry, i.e. seeking signs and symptoms. Borkman (1999) describes how professional knowledge or "truth" differs in purpose and relationship as compared to experiential knowledge about a problem. She described professional knowledge as grounded in logical positivism concerned with truth finding. In contrast, she noted that experiential knowledge conveys meaning and human condition. Hence, service user involvement in the classroom as part of the undergraduate mental health programme could provide students with a completely different learning experience. The experience of mental illness was heard entirely in the person's voice, rather than translated into a third person account expressed via professional jargon. This allowed students to witness the service users as experts in their own experience, and as a result recognise that they have developed a powerful storehouse of wisdom, conveyed through the enactment of their life story.

Buchanan-Barker and Barker (2006) assert that professional's stories about service users are traditionally framed by the arcane nature of professional jargon with a focus on treatment. Professionals rehashing the service user's story with the use of clinical jargon can potentially cause professionals to become desensitised. In contrast, many of the students reported that the service user's story had made a lasting impression. The use of language is an additional factor for consideration in relation to the influence of service user involvement on students' learning. The language of the story, complete with its natural grammar and personal metaphors is the medium for expressing the abstract of the service user's story of recovery, allowing students to hear and see the emotions evoked as a feature of mental illness, as opposed to merely classifying and categorising the clinical

features (Buchanan-Barker and Barker, 2006). Lakeman et al (2013) report that that is an emotional subtext inherent in personal narratives. In the current study the findings imply that the students were moved by the emotional content of the service user's story.

Both lecturers and students recognised the specialist expertise that service users bring to mental health nurse education. This type of specialist expertise has been termed experiential knowledge (Borkman 1976). Experiential knowledge is wisdom gained from working through one's personal experience; therefore it is grounded in an individual lived experience. The experiential knowledge of the service users was viewed as highly credible in the eyes of the students, which validates the beliefs associated with experiential knowledge. Experiential knowledge provides knowledge that is gained from personal participation. The wisdom and know how tends to be concrete, commonsensical and personal as it is specific to an individual's experience (Borkman 1976). Many of the students reported that learning from service users was a superior learning experience, in comparison to learning from lecturers or books. It provided students with a first-hand perspective, in relation to the realities of life with a mental illness. This challenges the hierarchical culture of professional education and its association with 'expert knowledge'. Moreover, it challenges the oppressed identity and competencies of mental health service users, an identity which has been eroded by the profession of psychiatry.

Historically mental health care was provided during an era in which large psychiatric asylums where the basis of service provision. Those environments were separate and closed-off from the ordinary life in the community. Pilgrim (2009) reports this long-term warehousing of those with a diagnosis of mental disorder was what defined their personal identity. According to Foucault (2001) when the first asylum was opened in the early

nineteenth century, the figure of the doctor focused on power, authority and respect. He was the power of reason over a madness that had to be tamed and had little accountability for his treatment methods. Moreover, Roberts (2005) contends that the diagnostic and therapeutic practices of contemporary mental health care rest upon, and are informed by a 'body' of psychiatric expertise. Foucault (1991) argues that such bodies of knowledge are essential to the manner in which human beings are 'made subjects', meaning that human beings are said to be made subjects to others by 'control and dependence' (Foucault 1982, p. 212). Psychiatric knowledge is thoroughly enmeshed within the history of a culture where people who were mentally unwell were deemed to be incompetent and cast away into these asylums where they were merely passive recipients of care. According to Foucault (1982) the psychiatric discourse and their associated practices can therefore be seen to produce a person's 'subjective identity', in so far as those discourses and practices serve to transform and delimit who or what a person understands themselves to be and, importantly, who or what others understand that person to be. Link et al (1987) hold a similar opinion, that the psychiatric label sets a cultural stereotype about mental illness that is applied to the person by others. As a result these powerful psychiatric diagnoses can saturate a person's identity, moreover such an identity or label was used to legitimatise explicit forms of psychiatric power and control (Roberts 2005). In addition, to label a person as 'mentally ill' is to subject the person to a variety of beliefs that are associated with the concept of 'mental illness'; presuppositions that characterise that person as needy or dependent and effects a person's ability to act in an autonomous manner. As such, it is often suggested that acts of paternalism in psychiatry are sometimes necessary to govern a person, who because of a diagnosis of a mental illness, is unable to govern themselves (Thompson, Melia and Boyd 2003).

In the context of the current study it is evident that service user involvement has challenged these notions. Students would usually be in contact with service users in the clinical setting, where they are primarily viewed as a patient in a sick role. According to Parsons (1978), the sick role incorporates the expectation 'of seeking help' from an appropriate 'technically competent' health professional and co-operating with them in the process of recovery and returning to social functioning. According to Rush (2008), the implications of sick role theory for service users is to accept, rather than to challenge an imbalance in power between professionals and service users. However, the students in the current study recognised the experience of the service users as a source of knowledge, which deepened their understanding of the realities of life with a mental illness. Some of the students called them 'experts', and gave precedence to the service users session over their traditional lecturers. Rose et al (2003) assert that the experiential knowledge of service users may be valued for its authenticity but when set beside forms of knowledge that can claim the status of 'evidence' that authenticity occupies second place. Furthermore, Tew (2005) believes that a power laden dichotomy exists between 'us' and 'them', and it is the professionals who are seen as having the monopoly on knowledge and expertise, while the insights and understandings of service users are often ignored or devalued. The current study challenges these beliefs, as many of the students gave credence to the service user sessions over their lecturers.

According to Secker, Grove and Seebohm (2001) the recovery approach requires a different relationship between service users and professionals. Roberts and Wolfson (2004) have characterised this as a shift from staff that are seen in a position of expertise and authority, to someone who behaves more like a coach or trainer, offering their professional skills and knowledge, while learning from and valuing the patient, who is an

expert by experience. The students in the current study recognised and placed high regard on the experiential knowledge of service users, delivered through narrative. Students were more focused on the person rather than the illness, as a result of service user involvement. Indeed Kottsieper (2009) believes that first-person stories are an important and constructive part of education and training as they challenge the beliefs that people with serious mental illness do not recover. Moreover, these stories depict unique experiences that can teach practitioners something that is all too often forgotten, which is the person behind the illness.

7.3.2 Seeing Beyond the Illness

Some of the lecturers in the study believed that service user involvement would enable students to recognise the normality of people with a mental illness. Many of the students reported that service user involvement helped them to be more mindful of the person behind the illness, and not primarily focus on the clinical signs and symptoms. Moreover, the students were aware of the valuable contribution that the service user's experiential knowledge had provided them with. The students saw service user involvement as a means for understanding mental illness. Thus, students were seeing past the illness and valuing them as a learning resource. Students who had not experienced service user involvement believed that it would be a valuable learning resource in relation to enhancing their understanding of mental illness. In that regard, these students were able to see past the illness, and realise the important contribution that service user involvement would make to their training and education. The service users in the current study anticipated that sharing their stories of recovery would assist students to see beyond the limitations so frequently associated with mental illness.

According to Happell, Robins and Gough (2008) student nurses commence their mental health nursing studies with preconceived ideas about mental illness, and these ideas are likely to be further shaped or altered as a result of clinical exposure. Nieswiadomy et al (1989) report that the clinical experience in a psychiatric setting seems to be one of the most anxiety-provoking of all clinical experiences for students, due to the stereotypes associated with mental health patients and psychiatric facilities. Therefore, preceptorship has been identified as one strategy that assists and supports nursing students in overcoming their fear and apprehension towards people with a mental illness, and therefore enhances the development of a positive attitude (Mullen and Murray 2002). Kragelund (2011) believes that such learning environments provide students with the optimum condition to obtain the most out of their clinical experience. However, Rungapadichy et al (2004) reports that there is some research to suggest that, preceptors sometimes act as poor role-models for student nurses. Some student nurses observe what they termed 'alleged malpractice', where the nurse did not get involved with the patients, lacked skills, and showed a negative approach to care. Moreover, according to Campbell et al (1994) the influence of nurse clinicians as role models in the clinical setting has been recognised as crucial to students. Therefore students are vulnerable to accepting the professional behaviours of clinicians as 'the norm'. This has potential implications for the student, particularity if this behaviour is less than optimal. Morrissette (2004) argues that student's opportunities to interact and develop therapeutic relationships can be hindered by learning opportunities on the ward.

In the current study students have primarily been in contact with service users in mental health settings. In these clinical settings, the decisions affecting patient care are usually governed by the consultant psychiatrist, where the focus of recovery is the illness. Barker

and Buchanann-Barker (2011) argue that the nurse's primary function remains much the same as a Century ago: to keep people safe; to express medical treatment as prescribed by the doctor; and in the hospital setting to 'manage' the physical and social environment.

In the current study, students recognised service user's expertise or experiential knowledge and were able to see them as a person, and not just in terms of their mental illness. Seeing service users outside of the clinical setting might account for this realisation. Typically students' experiences with service users are in the clinical setting, where professionals are seen as the 'experts', where they claim authority and power by reference to a body of knowledge (Williams and Lindley 1996). Moreover, students see service users within a social context, where a deep rooted assumption about the capabilities and competencies of service users exist due to the psychiatric label. Seeing service users away from this setting appears to have challenged some of their deep rooted assumptions about the knowledge base of service users and potential for recovery, regardless of a diagnosis of mental illness. The results suggest that students seeing service users outside of the typical psychiatric paradigm, appears to have changed how students engage with that paradigm.

Service user involvement afforded students the opportunity to see service users outside of the clinical setting, away from the 'sick role' label, a label which often results in service users merely being passive recipients of expert wisdom. Hence students saw them in a new light, where they are a person on a personal journey of recovery. Higgins and McBennett (2007) describe this journey as not just overcoming the illness, but a process of recovering from the internalisation of stigma associated with a diagnosis of mental illness, the negative impact of social exclusion perhaps due to missed opportunity for education,

employment and relationships, the loss of rights that often ensue from being labelled mentally ill and the iatrogenic effects of disempowering practices and treatment. The students paid homage to the service user's experiential knowledge and recognised it as the voice of experience. Moreover, they recognised that service users are without question the expert when it comes to understanding the true complexities of mental illness. In addition, being exposed to service users in a teaching role allows students to see service users in a valued role where their specialist knowledge contribution is being respected, resulting in an elevation of their social positioning. 'Seeing beyond the illness' plays an important role in changing attitudes and beliefs and challenging stereotypes. Furthermore, as Borg and Kristiansen (2004) report, a reciprocal relationship between practitioner and service users requires seeing the service user as a person and fellow human being, not as an ill individual.

7.3.3 From Illness to Wellness- A Beacon of Hope

Lecturers, students and service users all believe that service user involvement brings a positive message of hope about the possibility of recovery from mental illness. For the students, the service user's stories of recovery provided them with a belief and a sense of optimism. According to Shepherd, Boardman and Slade (2008), the process of recovery is fuelled by hope. Similarly Roberts and Wolfson (2004) report that being met with hope and optimism, and care being provided in an atmosphere of hope is central in many people's accounts of recovery. Repper and Perkins (2003) have described hope as the catalyst of the recovery process.

Carpenter (2002) believes the concept of hope and its association with recovery is in contrast to the medical model, where the possibility of recovery from mental illness is extinguished, as a paternalistic and illness-orientated approach is utilised. Shepherd,

Boardman and Slade (2008) acknowledge that professionals are often poor at making accurate predictions of what is and is not likely to be possible for a given individual in a specific area of their life. As a result of these low expectations of people's capabilities, they can all too easily become self-fulfilling prophecies. Demonstrating a belief in the service user's strengths and capabilities can take the service user out of the 'sick role'**.** Therefore the professional's belief in the person's capacity to recover and develop personal resourcefulness, regardless of the diagnosis, symptoms or problems is of central importance. However, proponents of the recovery model argue that it is exactly this sort of hope that is extinguished by the medical model (Deegan 1996).

Chen et al (2012) commented that health care professionals need hope as well. Given the nature of mental illness, relapse often occurs. Therefore, having a feeling of hope can play a part in the prevention of health care professionals becoming disillusioned and retaining a belief in the possibility of recovery despite the diagnosis of a mental illness. In the current study, service users wanted students to realise that recovery from mental illness is truly possible. It is evident that student's recognition and belief in the possibility of recovery was influenced by service user involvement and their stories of recovery. This belief supports the recovery model and potentially students will bring this positive message to their interactions with patients in the clinical setting. It is particularly noteworthy that while students in previous studies identified that service user involvement provided them with a feeling of hope, the concept of hope as a fundamental facet of recovery and service user involvement in undergraduate mental health nursing programmes instilling this hope that contributes to a recovery focused approach has not been previously discussed.

7.3.4 Progression of Practice

Lecturers believed that service user involvement would enhance student's ability to empathise with patients in a therapeutic sense. Service users hoped that students would take alternative approaches to their practice and stimulate them to think outside the box in relation to typical beliefs and assumptions about mental illness. The students who had experienced service user involvement reported that they are more empathetic as a result of their involvement; in addition they are more mindful of their communication skills during their interactions with patients in the clinical setting. Some of the students reported that they are working more collaboratively with patients, as they are mindful of the fact that service users are best placed to identify what works for them in terms of their recovery. The students identify that this approach to practice is influenced by their experience of user involvement in the classroom. Six of the eight schools with service user involvement report that the service user session(s) were planned in collaboration between the servicer user and the educationalists. This collaborative relationship between the educationalists and the service user may have conveyed to the students a positive message regarding the relevance and merits of working collaboratively with service users and the educationalists. The qualitative findings would suggest that experience of service user involvement stimulated the student's interest to work in collaboration with service users, and seeing the educationalists and service user come together collaboratively further strengthens this positive message.

Borg and Kristiansen (2004) reported that service users valued human qualities and a collaborative approach to care as important qualities of a recovery orientated professional. According to Henderson (2011) the relationship between health care professionals and service users is an important aspect of recovery, and is well documented within the

literature. Mancini et al (2005) has also identified supportive relationships for service users as a catalyst of recovery. Moreover, the findings from a study by Aston and Coffey (2012), which collected data from two focus groups, one with service users and one with nurses about the meaning of recovery, indicated that a more collaborative approach to care was an important element for recovery practice. In the context of the current study, service user involvement has made students more mindful of the importance of their therapeutic skills in their interactions and relationships in the clinical setting and has provided a greater awareness of the importance of adopting a collaborative approach to care. The students in the current study reported that they are tapping into the knowledge base of patients in the care planning process and working in a more collaborative approach. The experience provided them with the realisation that service user can be a vital resource in the care planning process, as the service users have a wealth of first-hand experience and are therefore best placed to identify what helps and what hinders. Buchanan-Barker and Barker (2006) identifies that the client's story contains many examples of what has worked in the past, or beliefs about what may work in the future. These represent the primary tools that need to be used to unlock or build the story of recovery. According to Higgins and McBennett (2007) the collaborative partnership and working alliance between the nurse and service users is an integral component of the recovery process. Shanley and Jubb (2007) suggest that recovery-orientated nurses aim to tap into the coping mechanism of service users, assisting them and identifying how they cope with difficult situations. This minimises the power imbalance, eases communication and places control in the hands of the service user. These insights gained as a result of service user involvement, may a positive influence on patient care and have the potential to progress the students towards a recovery orientated practice.

7.4 Service User Involvement: A Journey Towards Recovery Orientated Practice.

'Service user involvement: a journey towards recovery focused practice' emerged as the super-ordinate theme from the integration of the findings from phase one and phase two in the current study. The super-ordinate theme transpired in response to the subthemes which are 'learning from experiential knowledge delivered through narrative', 'From practical to personal', 'From illness to wellness-a beacon of hope', and 'progression of practice'. It is evident from the findings that there is a link between service user involvement and recovery. The findings suggest that user involvement brought the students on their own journey of discovery and development. The students report that these insights are influenced by their experience of service user involvement.

7.4.1 Recovery

The main impetus of 'recovery' originated from the consumer/survivor movement in the 1980's and was based on self-help, empowerment and advocacy. It provided a challenge to traditional notions of professionalism, power and expertise which pervade mental health services and arguably still do (Secker, Grove and Seebohm 2001). Providing recovery-orientated services has become a focus of mental health systems (Chen, et al. 2012). Moreover, international mental health policy is advocating for a recovery-orientated approach to practice (HSE 2012, Higgins 2008; Higgins et al. 2012). According to Williams and Tufford (2012) the growing consensus regarding the importance of recovery has been accompanied by efforts to establish practice guidelines and competencies to guide professionals in the work of promoting recovery. According to Chen et al (2012) the development of recovery competencies has been used in mental health as a way to alter health care professionals' way of thinking and working. Recovery competencies are attitudes, knowledge, skills and behaviours. These competencies define how providers are

expected to treat and interact with service users. These competencies are grounded in a recovery philosophy and are characterised by prioritising value, attitudes and service user participation. Higgins and McBennett (2007) report that there is no clear consensus as to what constitutes a recovery approach, but there are skills and competencies which are components of good practice in recovery-orientated mental health nursing.

Higgins and McBennett (2007) contend that within mental health, the person experiencing mental distress does not have to experience a traditional 'cure', where all the signs and symptoms have subsided. For health care professionals recovery is an approach to care. It is evident that a recovery approach requires a different relationship between service users and professionals. A medical model of recovery may be seen as overly negative using terms of diagnosis, symptoms and illness (Aston and Coffey 2012). In the current study, the findings have suggested that students have experienced an internal change in attitudes and question the negative stereotypes of diagnosis and psychiatric labels. The shift in the student's attitude towards a recovery approach was reportedly as a result of service user involvement.

Hope and optimism are seen as fundamental components of recovery (Bonney and Stickley 2008). Lakeman (2010) argues that it is essential that mental health practitioners themselves believe that recovery is possible. Students in the current study reported that hearing service user's stories of recovery provided them with hope that recovery from mental illness is possible. Some of the students felt that this hope could be instilled into the lives of service users they meet in the clinical setting. Anthony (1993) in his seminal paper on recovery, stated that a crucial component of the recovery process seems to be

having at least one trusting relationship, where the people who experience distress have someone else who is there for them and believes in them.

Lakeman (2010) identified from service users in an online Delphi survey, the most important professional competencies that support recovery. The top five rated competencies are

1. A competent mental health worker recognises and supports personal resourcefulness of people with mental illness.
2. To work in a recovery focused way mental health workers need to reflect a belief that recovery is possible.
3. Thirdly, mental health workers need to be able to listen to what service users are actually saying and respect their views.
4. Fourthly, to work in a recovery focused way, mental health workers need to reflect respect for the expertise and unique knowledge gained as a result of having experienced mental health problems.
5. Finally, a competent mental health worker helps the person develop self- belief, therefore promoting their ability to help themselves.

As a result of their experiences of service user involvement and as discussed previously, the students in the current study appear to have possibly adopted the recovery competencies that service users in the study by Lakeman (2010) would rank as being important for health professionals. The students in the current study attribute these new insights and approaches as an outcome of the service user involvement in their undergraduate mental health nursing programme.

In Ireland, 'The Vision for Change' (Department of Health and Children 2006,) the blueprint for mental health policy, recommends that mental health services adopt a recovery perspective. This policy directive broadly defines the principles of recovery as a belief that people with mental health problems can recover their self-esteem and regain control of their lives despite their illness (Department of Health and Children 2006). In 2007, the 'Quality Framework for Mental Health services in Ireland' enshrined recovery as a guiding principle in the design, development, delivery and evaluation of Irish mental health services (Mental Health commission 2007). However, the 6th annual report from A Vision for Change monitoring group reported that the progress regarding the implementation of a recovery approach is worryingly slow. Moreover, a national implementation plan focused on the transformation process required to embed recovery principles is urgently required, if the agreed vision regarding recovery is to succeed (HSE 2012). The findings of the current study are an optimistic and exciting indication of the potential links between service user involvement in undergraduate mental health nursing programmes and recovery orientated practice. As the voice and experience of service users is recognised as a core tenet of recovery, therefore this finding warrants further consideration in relation to the role and the potential influence that service user involvement could play in recovery training and education.

According to Lakeman (2010), mental health recovery is a concept that has been championed by mental health service users. Slade et al (2008) assert that a valid understanding of recovery must be grounded in lived experience. The current study argues that the student's adoption of a recovery focused approach is as a result of the learning from the service user's experiential knowledge, which is grounded in their lived experience. The student's high regard for the service user's experiential knowledge, and

the effect of hearing the service user's stories of recovery, appears to have acted as a catalyst for the other elements of recovery being adopted by the students. The very presence of the service users in the classroom and hearing their stories of recovery appeared to have moved the students emotionally. Students report that as a result of service user involvement they have adopted a new perception of service users and new approaches to clinical practice. The Mental Health Commission (2005) contends that movement toward recovery principles fundamentally requires a change in heart and mind. Service user involvement seems to have provided students with the opportunity to re-establish the identity they attribute to service users, and not just view them narrowly in terms of their mental illness, but rather as a person with other dimensions to them.

A recovery orientation for professionals means a reorientation from being an expert on other people's lives towards supporting individuals in their own ways of dealing with problems and struggles (Borg and Kristiansen 2004). Students in the current study placed high regard on the service user's knowledge base. The recovery approach emphasises the wealth of expertise service users have accumulated by virtue of their lived experience with mental health difficulties. In order to promote a genuine recovery focus, respecting service users' experiential knowledge as a source of wisdom and insight is essential in understanding the experience of mental illness (Mental Health Commission 2005). Students reported that hearing the service user's story made lasting impressions and really opened up their eyes to the realities of life with a mental illness. Moreover, it helped them to see beyond the service user's illness and recognised them as a person and not just defined by their illness. The recovery literature places high regard on the service user's personal narratives and the meaning these narratives have for people. It enables them to reclaim a lost voice; therefore having an emancipating value (Mental Health Commission

2008), as it allows the service user to talk frankly about their experiences and feelings. Recovery focuses on the person rather than the illness (Barker 2001). It focuses on other aspects of the person's life and sees beyond the limits imposed by a diagnosis. Students in the current study reported that hearing the service users' stories of recovery instilled a sense of optimism that recovery from mental illness was possible. Glover (2002) calls on professional helpers to take seriously their role as "holders of hope". The ability to act as holders of hope for those who cannot hold it themselves and being able to look forward to a better future ahead is essential for recovery. Many of the students reported that after the experience of service user involvement they were more mindful of working collaboratively with service users as they had their own insight in terms of what helps or hinders in terms of recovery. Collaboration is one of the underpinning values of recovery, a good working alliance between the nurse and the service user is essential. Also open communication and respect for each other's opinions supports a collaborative ethos (Higgins and McBennett 2007).

It is important to consider the potential reasons for students establishing these new insights, or why the experience of service user involvement in the undergraduate mental health nursing programme enabled the students to see the service users in a different light, considering that the students are frequently in contact with service users. Lakeman (2012) suggests considering the mental health system as cultures of care into which mental health practice is embedded. When students are on clinical placement the approach to clinical care is influenced by the medical model. The medical model is associated with the possession of 'specialist knowledge', where the health care professional 'knows what's best' because of their 'expertise'. As a result patient's autonomy is dismissed thereby

limiting their contribution to their own care and they become passive recipients of care. Moreover, the use of diagnostic labels erodes a person's sense of identity and imposes limitations that are typically associated with having a mental illness. In addition, service users' stories are not heard. Doctors take histories for diagnostic and treatment purposes (Mountain and Shan 2008). Barker (2001) argues that traditionally the medical model has served as a means of deflecting attention away from the lived experience of the person, translating this unique, subjective account, into the paralanguage of the medical model.

As students are so accustomed to the approaches of the medical model, Stacey and Stickley (2012) assert that students expect an educational programme which is in line with a medical model. This includes detailed descriptions of diagnostic categories and medication management as the primary mental health nursing intervention. Moreover, students who have had the experience of working within mental health services may have observed practices which contradict the experience of service user involvement. Hence, service user involvement provides a way forward for educational programmes in terms of providing learning opportunities for students which challenges the medical model, thus providing students with a more informed perspective prior to the influence of the clinical setting.

Stacey and Stickley (2012) acknowledge that there is a lack of literature on the implications of the recovery concept for pre-registrations nurse education. Stacey and Stickley believe that one way of appreciating the contribution that recovery might make to nurse education is to frame it as a threshold concept into mental health theory. Cousin (2006) reports that a threshold concept is transformative as new understandings are assimilated into who we are, how we see the world and how we feel. This depth of

learning requires both a conceptual and ontological shift. Threshold concepts are considered irreversible as once the learner has grasped the concept they are unlikely to forget it. Cousin (2006) adds that the depth of learning required to grasp the meaning of recovery represents the intellectual and ontological shift discussed previously. Once this shift has taken place the students is unlikely to view mental health nursing practices and their position within it in the same way.

Stacey and Stickley (2012) assert that a recovery approach to practice requires the students to recognise the service user as an expert of their experience. This contradicts the concept of professionals as experts and challenges the medical model which has been historically defined by the possession of specialist medical expertise. The findings of the current study indicate that the involvement of service users has acted as a catalyst for students adopting a recovery focused approach to service user and to their clinical practice. As service user involvement and recovery operate in tandem with each other, if service user involvement became embedded in nursing curricula this could help establish recovery as a concept within nurse education and nurse theory.

7.5 Conclusion

As a result of service user involvement, students are mindful of the knowledge base of service users, and see the sharing of their experiences as a vital learning resource in their understanding of mental illness. Students report that as a result of service user involvement they are more empathetic and reflective on their interaction with patients in the clinical setting. Moreover, that they are aware of tapping into the knowledge base of service users and consequently adopting a more collaborative approach to care. The findings suggest that as a result of service user involvement, their experiences brought students on their own journey of professional development, resulting in a re-valuation of

service users and of mental illness. The journey had different stages and began with 'learning from experiential knowledge delivered through narrative', 'Looking at the person', 'from illness to wellness-a beacon of hope', and ended with 'progressions of practice'. Each stage of the student's journey is an important element of mental health recovery, highlighting the connection between service user involvement and recovery.

The findings of the current study add some new and exciting considerations and insights in relation to the outcomes of service user involvement in undergraduate mental health nurse education. The overall finding of the super ordinate theme of the current study signifies that the experience of service user involvement in undergraduate mental health nurse education potentially plays a role in the student's ability to adopt a more recovery orientated approach to service users and to their clinical practice. Educationalists, service users and student in the current study all identified concepts that collectively suggest a link between service user involvement and recovery orientated practice. The findings suggest that engaging with service users in a different social context has positive implications in terms of how students view service users. The students were able to recognise service users' experiences as a source of knowledge and see them as a person, and not just in terms of their mental illness. Seeing service users outside of the clinical setting might account for this realisation. Typically students' experiences with service users are in the clinical setting, where professionals are seen as the 'experts', where they claim authority and power by reference to a body of knowledge (Williams and Lindley 1996). Moreover, students see service users within a social context, where a deep rooted assumption about the capabilities and competencies of service users exist due to the psychiatric label. Seeing service users away from this setting appears to have challenged some of their assumptions about the knowledge base of service users and potential for

recovery, regardless of a diagnosis of mental illness. The results suggest that for students seeing service users outside of the typical psychiatric paradigm has changed how they engage with that paradigm. Moreover, seeing service users outside of the clinical setting, away from the influence of the medical models approach to practice appears to have provided them with a forum where they were able to deconstruct their assumption of service users and changed how they engage with the psychiatric paradigm. The new insights gained by students are grounded in a recovery philosophy and characterised by prioritising values, attitudes and service user involvement, and a new appreciation for experiential knowledge in the learning process. This demonstrates a potential shift away from traditional psychiatric practices, which are professional specific and focus on clinical knowledge skills. As a result of the experience students have become more recovery orientated and less illness focused.

Allot et al (2002) assert that recovery has been described in many different ways, as a process, an outlook, as a vision and as a guiding principle. Common to all these descriptions is a key shift of emphasis; instead of focusing on symptomology and relief from symptoms, recovery supports individuals in their own personal development and places an emphasis on hope, inspiring relationships, re-establishing personal identity, discovering and reclaiming social roles, and an appreciation of the experiential knowledge of service users. Repper and Perkins (2003) believe that an understanding of the process of recovery is essential to the development of effective support; this can only be gained from the experiences of people who have faced the challenge of recovery. Service user involvement provided students with insights and understandings relating to personal experiences of recovery.

The findings signify that service user involvement triggered a response in the students which shifted their awareness to a recovery focused approach in their clinical practice. Recovery orientated practice is not simply about doing something tangibly different for service users. Adopting a recovery approach requires a shift in thinking and vision. In the current study, the findings indicate that the students revised their thinking regarding the capabilities and knowledge base of service users by virtue of their personal experience of mental illness. This revised perspective offers hope that perhaps the students are adopting a more recovery focused approach to both service users and clinical practice. Mental health recovery places the person at the centre of its vision, and the experience of service user involvement has re-focused the student's attention back to the person and away from the current model of mental distress which focuses primarily on illness. In essence, developing a true recovery-orientated approach to practice requires a significant paradigm shift both in relation to people's conceptualisation of mental distress, and thinking about how people who experience mental health problems should be cared for. Service user involvement heightens the student's awareness of recovery and recovery principles. Considering the findings of the present study, service user involvement in undergraduate mental health nurse education provides a promising and exciting potential in relation to the adoption of the recovery vision into practice.

Chapter 8 Conclusions

8.1 Introduction

A detailed review of previous research in the area of service user involvement in the education of undergraduate mental health nurse education identified that although service user involvement is placed in high regard, and educational and policy directives rank service user involvement high on their agenda, it is evident that there is a paucity of previous research into this area of interest. These identified gaps are addressed in the current study whose overall aim was to establish the extent and examine the perceived effect of service user involvement in undergraduate mental health nurse education. A mixed methods design was adopted to address this aim. The findings from this research can be used to inform mental health education, clinical practice and further research not only on service user involvement in mental health nurse education, but in the wider field of service user involvement in the education of mental health practitioners.

This study generated new knowledge relating to the extent and perceived effect of service user involvement in the education of undergraduate mental health nurses. This chapter discusses how the aims of the current study were addressed and answered. Furthermore, based on the study findings presented, the educational, clinical, research and practice recommendations arising from the study will be discussed. The strengths and limitations of the research will also be discussed.

8.2 Revisiting the Research Aims and Objectives

The aim of the current study was to establish the extent and examine the perceived effect of service user involvement in undergraduate mental health nurse education. This was broken down in to three specific objectives.

1. Establish the national extent of service user involvement in the education of undergraduate mental health nurses.
2. Examine students' experience of service user involvement in their education.
3. Examine service users' experiences of being involved in undergraduate mental health nurse education.

Objective 1 - Establish the national extent of service user involvement in the education of undergraduate mental health nurses

The results of phase one established the national extent of service user involvement in the education of undergraduate mental health nurses in the Republic of Ireland. Based on these results it is evident that the extent of service user involvement varies between educational institutions. The students most frequently experienced service user involvement 2-3 times per month and most frequently in the 4th year of the programme. The most common way the service users are involved is through the delivery of workshops. From the 8 schools that currently have service user involvement in the undergraduate mental health nursing programme, only 2 schools have service user involvement in the BSc programme team, while 3 have service user involvement in the curriculum design, 2 have service user involvement as part of the course design, and 2 schools have service users involved in student evaluation.

It is evident that the main focus of service user involvement is delivering teaching to students and service users were less involved in other aspects of educational developments. Based on the results of the current study and using the Ladder of Participation as a guide, it is argued that the level of service user involvement is between 'growing involvement' and 'collaboration'. While 'growing involvement' is the most common level of service user involvement in the undergraduate mental health nursing

education in Ireland, two Schools of Nursing have greater involvement as service users are involved in the BSc programme team. According to the Ladder of Participation, having service users involved as a team member signifies collaboration. Despite the on-going need to continuously move the agenda of service involvement forward, this indicates a potentially promising future for service user involvement in the undergraduate mental health nursing programme.

Objective 2. Examine students' experiences of service user involvement in their education.

The experience of service user involvement seems to have triggered a response which challenged the students to reform their perspective of their clinical practice. The students were prompted to consider issues that they might otherwise not have thought of and identified that the experience of service users was responsible for their altered perspectives/approaches. The students report that service user involvement encouraged them to reflect on their clinical practice and challenged them to consider alternative or better ways of working with service users. The findings indicate that the students address clinical practice situations from different angles that incorporate the service users' perspectives. The students identified that they are mindful of tapping in to the experiential knowledge of service users and utilising the service users' strengths and resources in the care planning process, signifying a collaborative approach to care. Moreover, they acknowledge that service user involvement opened their minds to the possibility of recovery, which instilled a sense of hope and optimism. The students recognize that it is important to share this hope regarding recovery with the service users they encounter in the clinical setting.

Service user involvement helped to undermine stereotyped perceptions and enabled the students to appreciate the service users as firstly as a person rather than a 'patient' and not defined just by the limitations imposed by a clinical diagnosis. Moreover, students appreciated that service users have families, careers and can speak articulately and insightfully regarding mental health practices as well as about their own personal lived experience. Service user involvement heightened student's awareness to the possibility that service users have their own resources, are capable of living a 'normal' life and that recovery despite a mental illness is indeed possible.

The findings also indicate that service user involvement opened students mind to the experiential knowledge that service users have by virtue of their lived experience with mental illness. Students reported that service users' experiential knowledge is a better learning resource than the typical forms of teaching or learning that the students are usually exposed to during their training. Service user involvement served as a method of helping the student to appreciate users' perspectives and expertise in a way that is difficult to do by other means. The students recognised the authenticity of the service users' experiential knowledge and reported that due to the personal nature of these experiences they left a greater impression. Therefore, the students acknowledged that the sharing of these experiences conveyed the service users' perspectives more powerfully than the traditional ways that students learn about mental illness. The students reported that the narratives shared by the service users was a source of knowledge that conveyed the actual realities of life when living with a mental illness more aptly than a lecturer, text book or a nurse in the clinical setting. The students reported that the physical presence of the service user in the classroom setting sharing their personal narratives were more interesting, and therefore kept their attention focused compared with a lecturer teaching from a power

point presentation or reading an article or book. In addition, the students identified that the clinical setting does not always provide the most optimum learning environment and identified a significant difference in relation to interacting with service users in the clinical setting compared to the classroom. The findings suggest that the experience of service user involvement facilitated the students to gain insights and understanding that are not accessible in the clinical practice setting perhaps due to organisational pressures and professional roles. Moreover, service user involvement in the classroom setting created a unique communicative space promoting interaction and critical dialogue,

Objective 3. Examine service users' experiences of being involved in undergraduate mental health nurse.

The findings from the interviews with the service users indicated that they found the experience of being involved in undergraduate mental health nurse education to be a positive experience. Service users anticipated that their involvement would enable students to recognise the expertise that service users have by virtue of their personal experience of living with a mental illness. In addition, they anticipated that students would embrace the possibility of recovery and instil this hope regarding recovery into the lives of service users they encounter in their clinical practice. Moreover, the service users hoped that their involvement would challenge the students to be mindful of their clinical practice and consider alternative approaches to their practice that could potentially have greater outcomes for service users.

Overall, this study makes a unique contribution to the existing literature on service user involvement in undergraduate mental health nurse education. The experience of service user involvement challenges how students engage with the psychiatric paradigm. The

super ordinate theme that emerged from the integration of the findings from phase one and phase two 'service user involvement: a journey towards recovery-orientated practice' suggests that the experience of service user involvement triggered a response in the students which resulted in them adopting a recovery focused approach to their clinical practice. Collectively the supporting subthemes that emerged such as 'Learning from experiential knowledge delivered through narrative', 'From practical to personal', 'From illness to wellness- a beacon of hope', and 'Progression of practice' all have an association with recovery. The findings indicate that the students have revised their perceptions of service users and altered their approach to clinical practice. These new found insights and practices which resulted from service user involvement have an associated with recovery-orientated practice. The findings of the present study offer some exciting and potentially promising pointers which could have a positive contribution in terms of how the vision of recovery orientated practice can be meaningfully achieved through service user involvement.

8.3 Recommendations

Recommendations are discussed under four headings: education, clinical practice, research and policy.

8.3.1 Educational Recommendations

- The extent of service user involvement varies to a large degree across educational institutions in Ireland, with some of the educational institutions not including service users in any aspect of the undergraduate mental health nursing programme. Higgins et al (2011) argue that professional bodies with responsibility for guiding or accrediting curricula in mental health education have an important role in promoting service user involvement and should include service user involvement

as one of the criteria for accreditation thus showing a demonstrable commitment to service user involvement and achieving a culture of true participation across higher education providers. In addition to this, the current study recommends that in order to ensure a genuine commitment to service user involvement is fostered and that service user involvement becomes embedded in nursing curricula specifically, it is necessary that clear criteria and guiding principles for service user involvement in undergraduate mental health nursing education are developed, agreed upon, clearly explicated and implemented consistently across the educational institutions in Ireland. These criteria would identify what constitutes a minimum acceptable level of service user involvement in undergraduate mental health education and the minimum acceptable range of service user involvement activities such as involvement in programme team, curriculum development, evaluation of modules and teaching. Educationalists, service users, clinical staff and students should contribute to the drafting of such guidelines.

- It is recommended that educational institutions strive to ensure that service user involvement is not just a priority in undergraduate education, but it also is an integral component of post-graduate education programmes. This is to ensure that service user involvement in threaded throughout all educational experiences at both undergraduate and post-graduate level thus heightening student's awareness to the importance and merits of service users' involvement.
- All educational institutions need to ensure that there is a clear written statement of service user involvement in their programme philosophy. This should contain an explicit objective to work towards developing service user involvement in all aspects of the programme ranging from course management, curriculum planning

evaluation, student assessment and teaching, thus ensuring that the programme is underpinned by an explicit statement which supports service user involvement.

- Finally, from an educational perspective, it is recommended that each institution develops partnerships with service user organisations/service user groups. This form of networking would potentially develop links between educationalists and service users and work as a recruitment strategy to encourage service users to get involved in mental health nurse education. Moreover, it would create a communicative space where issues such as educational preparation, support and payment for service users could be addressed.

8.3.2 Clinical Recommendations

- Based on the perceived effect that service user involvement has on student learning and potential practice, service user involvement should become part of on-going in-service training for students and qualified staff, so that the potential effect of involvement experienced in an academic setting can be replicated within the clinical setting.
- Appropriate education and training opportunities incorporating service user involvement should be an integral component of continuous professional development programmes for clinical staff. This will provide nurses and other disciplines an opportunity to experience and recognise the merits of service user involvement. Moreover, it will provide nurses with insights in to the educational experiences that students experience in the academic setting.
- Considering the potential effect that service user involvement has in relation to students adopting a recovery orientated approach to clinical practice, service users should be actively involved in appropriate educating and training opportunities on

recovery orientated practices in order to support nurses to work in a recovery orientated way.

- The involvement of service users in student clinical evaluations should be considered as this strives to ensure that the service user perspective is threaded through the student's education experience.
- Consideration should be given to the involvement of service users in the development of clinical documentation, such as care plan packages and clinical guidelines. Again this will help to ensure that these documents are tailored to the service user's needs, thus more recovery focused.

8.3.3 Research Recommendations

Further research is required to address particular questions that arise from this study. The study has identified some of the existing gaps in service user involvement in undergraduate mental health nurse education in Ireland. These gaps warrant attention and further exploration and it would be helpful to explore this developing field further.

- Longitudinal research is required to establish the impact of service user involvement in the classroom on students' attitudes and practices over time. In addition, research is required to establish the effects of professional socialisation once students qualify, particularly if they have grasped the importance of recovery in the classroom, only to find that putting this into practice as a qualified nurse is not without its difficulties and potential resistance.
- Future research is required to explore the difference in values, attitudes, knowledge base and practices of students who have experienced service user involvement versus students who have not experienced service user involvement.

- Future research is needed in order to compare and contrast the difference in values, attitudes, knowledge and practices of students who experienced service user involvement in first year of the programme in comparison to students to experience it at a later stage in the programme. McLaughlin (1997) indicated that classroom theory, prior to clinical placement, can positively change student nurses attitudes towards people with mental illness, which was not contradicted by later clinical experiences. Therefore, classroom learning is a potential vehicle for change in breaking down stereotypes about people with mental illness. This implies that there may be significant gains from service user involvement in the classroom at an early stage of student's training.
- Future research is required to review the extent of service user involvement in undergraduate mental health nurse education. There needs to be a continuous review of service user involvement in order to assess if the extent of service user involvement is progressing beyond classroom teaching and filtering into other areas such as programme design and curriculum development as currently the scope of service user involvement is on teaching. Moreover, on-going review is important in terms of ascertaining that service user involvement is a priority on the educational agenda.

8.3.4 Policy Recommendation

- Mental health policy makers should consider the results of the current study and ensure that recovery training for health care professionals is delivered by service users, as service user involvement has the potential for the adoption of recovery orientated practice. .

- Educational policy makers should ensure that service user involvement becomes a compulsory aspect of the undergraduate mental health nursing programme and ensures that their involvement is threaded through the programme from first to fourth year. It is also important, that involvement initiatives are not restricted to classroom teaching initiatives, that service involvement is an active part of all elements of the programme.

8.4 Strengths and Limitations of the Study

In terms of limitations, it is recognised that it would have been useful to interview all of the service users who had been involved in undergraduate mental health nurse education, in an attempt to establish a wider perspective from service users in relation to their experience of involvement in mental health nurse education. Despite efforts being made to recruit them, only four service users opted to participate, and three out of the four were employees of the educational institution. In addition, considering the number of undergraduate mental health nurses nationally only a small purposeful sample of students was interviewed and therefore the generalisability of the study findings to a larger population is questionable.

The strengths of this mixed methods study outweigh the limitations. The current study included all Schools of Nursing in the Republic Of Ireland, which for the first time has provided a national perspective on the extent of service user involvement in undergraduate mental health nursing education. Moreover, the findings of the current study are inclusive of educationalists, students and service users' perspectives. This allowed the area of service user involvement to be addressed from a variety of different perspectives, thus adding to the overall completeness of the data. In addition, the study interviewed students

who had not experienced service user involvement to allow them to discuss what they believed to be the potential effect of service user involvement. The students who had experienced service user involvement confirmed the expectations of students who had not experienced it to be true.

All of the previous investigations on service user involvement in undergraduate mental health nurse education focused on the experiences of students from one educational institution. The present study included the perspectives of students from eight educational institutions, thus providing a wider perspective on service user involvement.

It has been widely acknowledged that the principles and values of the recovery approach need to be adopted within mental health services, moreover that mental health nurses need to provide care that supports a recovery orientated approach. However it has been identified that mental health nurses remain unsure about the meaning of recovery and the applications of recovery principles into their clinical practice, and therefore the need for training on recovery is warranted (HSE 2012). The findings of the current study suggest how the recovery vision can be meaningfully adopted by mental health nurses and the role service users play in this understanding of recovery. This is a major strength of the current study and supports current policy directives, as adopting a recovery approach is an aspirational goal of current mental health policy. Moreover, it offers a way forward in terms of how the recovery vision could be meaningfully adopted. The findings suggest that the involvement of service users has the potential to instigate a recovery orientated approach to practice.

The study adopted a mixed methods approach, which involved the combination of qualitative and quantitative research methods. In the present study using both qualitative

and quantitative data produced a more comprehensive understanding of service user involvement in undergraduate mental health nurse education as the area was looked at in a number of ways and was inclusive of a number of different perspectives. In addition, the uses of multiple data sources enabled the process of triangulation. Triangulation allowed the researcher to look for convergences and divergence between the data sources which helped to increase the dependability of the findings of the study and confidence in the interpretation of the data gathered.

8.5 Reflexive Summation

When I reflect on the thoughts and feelings that I experienced throughout this process, I can certainly say that it was an emotional, time-consuming and intense period of my life. Nevertheless, my genuine interest, and belief in my research area of interest remains. This PhD is something that is so close to my heart, largely because the idea to carry out the research was my own. This was not a PhD project that had been planned out and with a full research scholarship. I self-funded this research out of a genuine interest in my area of inquiry, and curiosity about a future career in nurse education. I struggled with having different identities throughout the research, this was challenging because I was not a full time researcher. I was working as a community mental health nurse on a part-time basis, and doing my PhD during the other half of my time. I had strong links with the clinical setting and worked closely with service users, and frequently my role required me to be a preceptor to student mental health nurses. Hence it was difficult to be a detached, neutral and objective researcher. Therefore, I had to locate and be mindful of my position regarding the research, in an attempt to retain boundaries between the participant interview and my interpretation of the findings. As I had such a personal interest in the topic, at times when I was conducting the interviews with the students and the service

users, it was a challenge to remain neutral, and not ask leading questions. However, I really did not want my own thoughts and knowledge to prevent me from hearing the reality of the participants. When it came to interpreting the data I made every effort to examine it without being influenced by my epistemological and ontological influence. This for me was the biggest challenge, and at times I could see how my background and personal experiences led me to a particular way of 'seeing' and 'hearing' during the data analysis. I could see how the influence of my clinical experience and working under the medical model, was clouding my interpreting of the data. For example, I was interpreting the data as having an association with 'mental illness,' even though a reference to 'mental illness' was not obviously apparent in the transcript. In the event of this happening I would reflect and critically scrutinise my own location and conceptual filters to ensure that my experiences were not causing me to misinterpreting the participant's data.

Having carried out this research I can now see that a researcher's experiences play a large role in the way that a research project is undertaken, the interactions with participants and the understanding and analysis of the data. Although at times it has been difficult, and there have been many challenges along the way, but as a novel PhD student, I believe that utilising my experiences was ultimately beneficial to this research project and it propelled my momentum to complete the PhD.

8.6 Conclusion

This is the first study to specifically examine in depth service user involvement in undergraduate mental health nurse education in Ireland. The findings will enable international comparison and situate the Irish context in relation to policy and best practice of service user involvement. Furthermore, the findings of the study offer an opportunity

for third level educational institutions to examine and where appropriate revise their curricula. Although this study is focusing solely on undergraduate mental health nurse education, the methods and findings will prove useful for further studies with other nursing programmes and other mental health professional disciplines. The findings of the present study provide baseline findings that other nursing programmes and other professional disciplines can use as a comparison to gauge how activities of service user involvement compare or how progressive service user involvement is in other courses.

The findings of the current study suggest that the experience of service user involvement triggered a response which challenged the students to re-evaluate their perceptions of service users, mental illness and indeed their approach to their clinical practice. The findings have an association with recovery. Moreover, as a direct result of the experience, students appear to have revised their previous assumptions about the capabilities and knowledge base of service users, and recognised the importance of listening to, and respecting service users' experiential knowledge. If the students are able to maintain their beliefs and introduce this approach in their clinical practice, students will be working in a more recovery focused way, which has the potential to have a positive effect on patient care. This is a potentially encouraging outcome of service user involvement, as adopting a recovery orientated approach is at the heart of current mental health policy.

Adopting a recovery orientated approach to clinical practice is in contrast to the traditional medical model approach. Moreover, recovery operates within the dynamics of the partnership between the mental health nurse and service user. This partnership is based on collaboration and negotiation. Within this partnership each person is seen as bringing their own expertise. Nurses are encouraged to recognise that service users are in the best

position to know their own experiences and concerns and should see the service user as a whole person and not just defined by their illness. Service user involvement provided students with the opportunity to see service users outside the remit of the traditional medical model. If these new found attitudes and values are meaningfully incorporated in to their practice, the students approach to practice will be in contrast to the traditional accepted practices of psychiatry, resulting in a positive change in their clinical practice and in their perspectives. This is a significant clinical contribution as providing care that supports recovery orientated practice is at the forefront of policy and practice agenda in Ireland.

The findings of the present study provide a promising and exciting contribution to the area of inquiry relating to service user involvement in undergraduate mental health nurse education. Stacy and Stickley (2012) believe that recovery should be a threshold concept in mental health nurse education. The current study indicates a link between service user involvement and recovery orientated practice. Therefore, if service user involvement becomes a compulsory aspect of undergraduate nurse education then the aspiration for the adoption of recovery orientated practice can potentially be achieved.

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Appendix A

Questionnaire for BSc mental health branch coordinators establishing the extent of service user involvement in the undergraduate mental health nursing programme

My name is Siobhan Russell and I am a PhD student in the school of nursing in Dublin City University. This questionnaire is designed to find out if student mental health nurses are having service user involvement in their education and to find out in what context is this involvement happening. Absolute confidentiality can be assured for participants. No data will be attributed to specific educational institutes or individuals.

The title of the research project is:

A mixed method study to explore the perceived effect of service user involvement in the education of student mental health nurses

Could you please state what educational institution you are associated with

_____

Please choose an answer that best represents your view by placing a tick in the appropriate box

1. **Is there service user involvement on the BSc undergraduate mental health nursing programme?**

   Yes 1 ☐
   No 2 ☐

2. **If service users are NOT currently involved with the course, is there a plan in the near future to involve service users in any of the following ways? Please tick all that apply**

Part of the BSc programme	1	☐
Curriculum design	2	☐
Regular teaching on the course	3	☐
Sessional teaching on the course	4	☐
Provide workshops	5	☐
Student assessment	6	☐
Other please specify	7	

   _____

3. **If service users are NOT currently involved with the course, please state some of the reasons why service users are not current involved in the undergraduate mental health nursing programme? Please expand on your answer at the end of the questionnaire / add further comments**

Negative past experience 1 ☐
Inability to provide remuneration 2 ☐
Not a priority 3 ☐
If other, please provide detail
4 _____

4. **If there is service user involvement in the undergraduate mental health nursing programme please tick what year/years of the nursing course that this applies to**

1st 1 ☐
2nd 2 ☐
3rd 3 ☐
4th 4 ☐

5. **How frequently do students have service user involvement per year? Please tick all students that are exposed to this**

	1st Yr	2nd Yr	3rd Yr	4th Yr
More than once a week				
Once a week				
Two or Three times a month				
Once a month				
A few times a year				
Once a year				
Less than once a year				

6. **How are service users involved with the course? Please tick all that apply.**

BSc programme team
Curriculum design 2
Course evaluation 3
Regular teaching on the course 4
Sessional teaching on the course 5
Workshops 6
Student evaluation 7
If other, please specific 8

_____

7 Who plans the session(s) that are going to be delivered to the students?

Lecturer 1
Service user 2
Collaboration of both 3
If other, please specify 4_____

8 What is the topic/context of the teaching session(s) that the service user delivers to the students? Please tick all that apply

User experience 1
Clinical practice skills 2
Research 3
Alternative knowledge/evidence 4
If other, please specify 5_____

9 Is the content of the sessions linked to the overall module aims?

Yes 1
N0 2

10 Is the content of the session linked to the overall programme aims?

Yes 1
No 2

11 Is there a school policy/strategy for involving service users in the undergraduate mental health nursing programme

Yes 1 ☐
No 2 ☐

Please expand to provide further detail

_____
_____
_____

12 Is service user involvement evaluated?

Yes 1 ☐
No 2 ☐

13 If YES who is it evaluated by? Please tick all that apply

Student 1 ☐
Service user 2 ☐
Lecturer 3 ☐
Course team 4 ☐
If other, please specify 5 ☐

_____

14 If service user involvement is NOT evaluated, please specify why this does not take place

_____
_____
_____

15 Will service user involvement continue as a regular component of the undergraduate mental health nursing programme?

Yes 1 ☐
No 2 ☐

16 Please state which of the following statements best captures the impact that service user involvement has had on nurse education?

I strongly agree that it has a positive impact 1 ☐
I agree that it has a positive impact 2 ☐
Neither agree or disagree that it has a positive impact 3 ☐
I disagree that it has had a positive impact 4 ☐

I strongly disagree that it has had a positive impact 5

17. Please expand on what you think the impact of service user involvement has had on nurse education.

_____
_____
_____

18. Please share any further comments in relation to service user's involvement on the BSc mental health nursing programme (CONTINUE ON THE BACK IF NECESSARY)

_____
_____
_____
_____
_____
_____

Your cooperation in filling out this questionnaire is greatly appreciated, thank you.

Appendix B

Letter of Invitation to the BSc Mental Health Branch Coordinator

Siobhan Russell
School of Nursing,
Dublin City University,
Ballymun Road,
Dublin 9.

Siobhan.russell5@mail.dcu.ie
Tel: 01-700-7934

Dear

Re: Invitation to participate in a study to explore the extent and effect of service user involvement in the education of student mental health nurses

My name is Siobhan Russell. I am a mental health nurse and currently doing a PhD in Dublin City University. The study is being conducted on a national level and has received ethical approval from Dublin City University ethics committee. I have also received permission from your university/institute ethics committee.

Phase 1 of the study asks the branch leader for the undergraduate psychiatric Nursing Programme to complete a brief questionnaire about service user involvement. As branch leader, I would be grateful if you could fill out the questionnaire and return it to me please.

Phase two for the study involves individual interviews with 3rd/4th year student mental health nurses on service user involvement. Would it be possible for you to email the attached recruitment letter to students which will inform them of the nature of the study? If students are interested in participating in the study, they can contact me then directly. In addition, Phase two involves individual interviews with service users who have been involved in teaching student mental health nurses. If you have had service user involvement in the mental health nursing programme would it be possible for you to pass on my details to the service user or ask them if I can make contact with them to discuss participating in the study?

You might find the attached plain language statement useful in explaining the study further. Your help is greatly appreciated. If you wish to discuss any aspects of the study do not hesitate to contact me.

Yours sincerely

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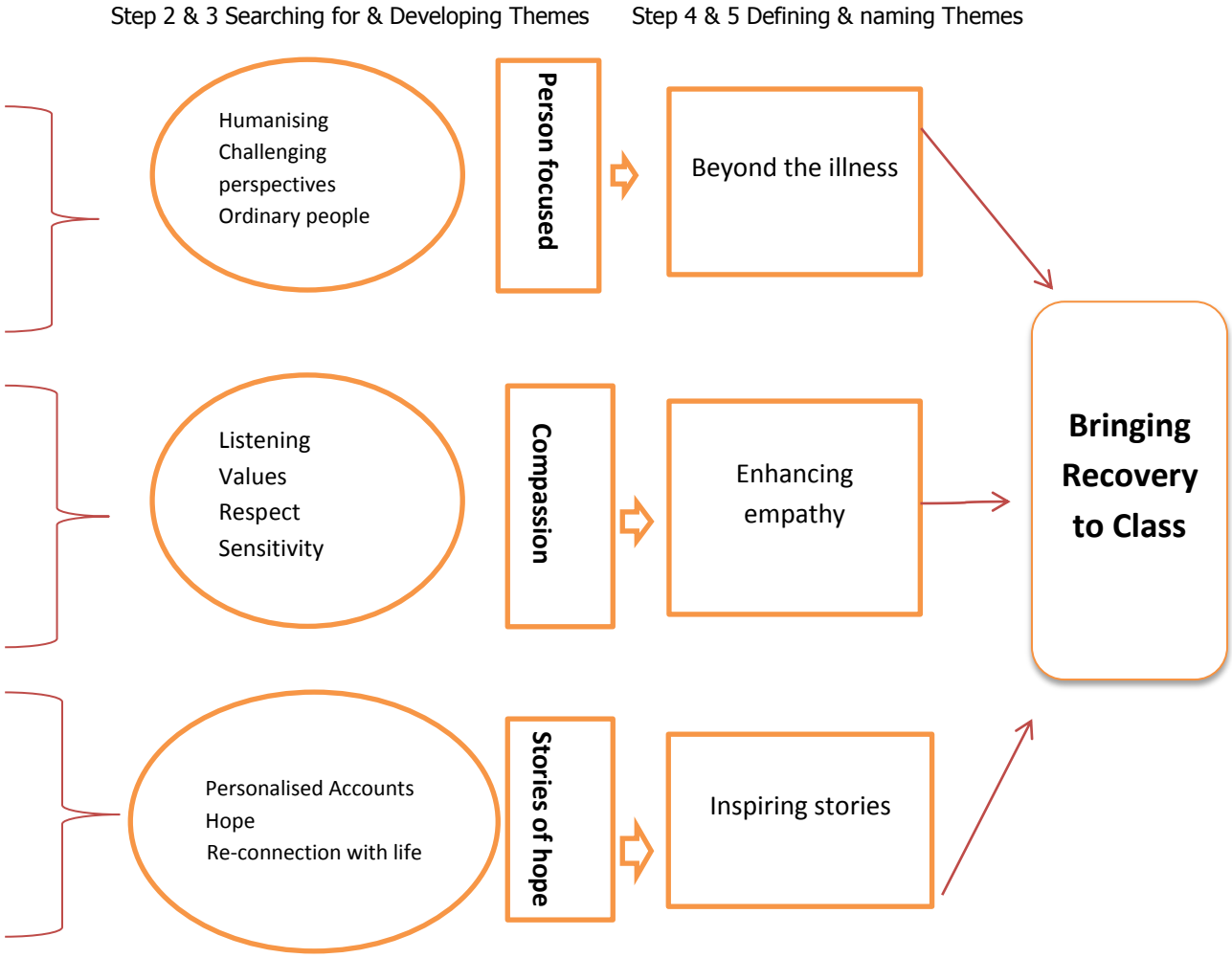
Appendix C- Example of steps taken to analyse the qualitative data from phase 1

Step 1 coding

Data Item	Initial Codes
Open students minds to the normality of people with mental illness	Ordinariness Non-judgemental Humane Identity Label
Challenge nurses to think and reflect on the impact of mental health systems and potentially damaging practices that exist	Ponder Cultures of care harmful
Listening to service users in the classroom provides an opportunity for students' to think about the challenges that people face… this is required to increase empathy skills	Heeding Ponder Difficulties Understanding Values
Listening to the service users' experience can help to deepen understanding and ability to empathise with people in distress	Heeding Identification Appreciation Rapport
Service user involvement in nurse education provides students with real examples of recovery which can create an attitude of hope	Genuine Restoration Optimism
Service user involvement brings a story of hope and recovery which delivers a positive message to the students about the possibility of recovery	Narrative Optimism Restoration



Appendix D

Letter of Invitation to student mental health nurses

Siobhan Russell
School of Nursing,
Dublin City University,
Ballymun Road,
Dublin 9.

Dear Student,

Re: invitation to participate in a study to explore the extent and the effect of service user involvement in the education of student mental health nurses

My name is Siobhan Russell. I am a mental health nurse and currently doing a PhD in Dublin City University. The aim of the study is to explore the extent and the effect of service user involvement in the education of student mental health nurses and the influence this has on their clinical practice. The project has received ethical approval from DCU research ethics committee.

The literature has highlighted that service user involvement in nurse education has the potential to enhance students' understanding of mental illness as they are learning directly from a person who has personal experience of mental distress. This research project will look at the education of undergraduate mental health nurses in Irish third level institutes.

Phase one of the project required BSc mental health branch co-ordinators to complete a questionnaire which highlighted the extent of service user involvement in the mental health nursing programme. Phase two of the project requires you the student mental health nurses to participate in individual semi-structured interviews. It is anticipated that the interviews will allow an opportunity to explore the student's perspective on service user involvement in their education also explore the perceived effect that it has on clinical practice. Students who have not experienced service user involvement are also invited to participate and explore the perceived impact that service user involvement would have on nurse education. It is expected that the duration of the interviews will be approximately 30 minutes.

Your participation would be greatly appreciated and will make a difference to the outcome of the study. If you require any further information or clarification on any issues relating to this study, or you would like to participate please contact me at the following number 086-333-1651 or email: Siobhan.russell5@mail.dcu.ie

Yours Sincerely

_____

Appendix E

Letter of Invitation to service users

Siobhan Russell
School of Nursing,
Dublin City University,
Ballymun Road,
Dublin 9.

Dear,

Re: invitation to participate in a study to explore the extent and the effect of service user involvement in the education of student mental health nurses

My name is Siobhan Russell. I am a mental health nurse and currently doing a PhD in Dublin City University. The aim of the study is to explore the extent and the effect of service user involvement in the education of student mental health nurses and the influence this has on their clinical practice. The project has received ethical approval from DCU research ethics committee.

The literature has highlighted that service user involvement in nurse education has the potential to enhance students' understanding of mental illness as they are learning directly from a person who has personal experience of mental distress. This research project will look at the education of undergraduate mental health nurses in Irish third level institutes.

Phase one of the project required BSc mental health branch co-ordinators to complete a questionnaire which highlighted the extent of service user involvement in the mental health nursing programme. Phase two of the project invites you the service user who has been involved in the experience of nurse education to participate in individual semi-structured interviews. It is anticipated that the interviews will allow an opportunity to explore the service user's perspective of their experience of being involved in undergraduate mental health nurse education. It is expected that the duration of the interviews will be approximately 30 minutes.

Your participation would be greatly appreciated and will make a difference to the outcome of the study. If you require any further information or clarification on any issues relating to this study, or you would like to participate please contact me at the following number 086-333-1651 or email: Siobhan.russell5@mail.dcu.ie

Yours Sincerely

_____

Appendix F

Participant Information Sheet

Introduction:

You are being invited to take part in a study. Before you decide to take part or not, it is important that you understand why the study is being done and what it will involve. Please read the following information carefully and discuss with others, if you wish. If you require further information, or would like to ask any questions, please contact Ms. Siobhan Russell, the school of Nursing, Dublin City University on 01-700-7934 or by e-mail **Siobhan.russell5@mail.dcu.ie**

As service users have firsthand experience of mental illness it is believed that they are experts by experience. Therefore students understanding of mental illness and mental distress could be enhanced by having active service user input in their training and education. However, in Ireland there has been no research on service user involvement in mental health nurse education to date.

The overall aim of the research is to look at undergraduate mental health nurse education and find out the extent of service user involvement, to learn more about the student's' experience of user involvement in their education, and to explore the service user's perspective about their experience of being involved in the education of mental health student nurses.

Procedures:

Phase 1 of the project will involve a questionnaire based survey which will be sent to the mental health branch co-coordinators in the various educational institutes. The survey will focus on finding out if students have service user involvement in their education and to inform the research team o the context in which user involvement happening.

Phase 2 of the project will involve semi-structured interviews with students from the various educational institutes who have had service user involvement. The service users who were involved in teaching the students will also be interviewed in order to find out what this experience was like for them and to explore from their perspective what they believe they have to offer students in their learning compared with other forms of learning/teaching. This phase also aims to explore from a student's perspective if they valued the input from the service user and was it a beneficial experience in terms of enhancing their clinical practice.

Benefits:

There are no direct benefits from taking part in this study. However, the information that will be collected will find out the extent of service user involvement in their education of undergraduate mental health nurses. This information will capture the students' perspective and highlight if this experience is enhancing their understanding of mental illness and impacting on their clinical practice. The study will also explore the service user's perspective who have been involved in teaching mental health student nurses

Risks:

This project does not envisage that participants will be exposed to any risk. The study team does not foresee or anticipate any direct risk to you.

Exclusion:

- Non undergraduate mental health nurse students
- If you are a service user who has not been involved in teaching undergraduate mental health student nurses
- If you are not the mental health nursing branch coordinator.

Confidentiality:

If you agree to take part, all information collected will be kept strictly confidential and within the limitations of the law.

Voluntary participation:

You have volunteered to take part in this study. You may withdraw your participation at any time. If you decide not to participate, or if you quit, you will not be penalized. There will be no penalty for withdrawing before all stages of the research study have been completed.

Permission:

The research project has been approved by Dublin City University Research Ethics Committee

Further Information:

If you need more information about your participation in the study, your rights, or answers to your questions about the study, contact Siobhan Russell from the School of Nursing in DCU on 01-700- or by E-mail Siobhan.russell5@mail.dcu.ie. You can also write to Siobhan at the school of nursing, DCU, Dublin 9.

If participants have concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Tel 01-7008000

(Appendix G)

Semi-structured interview guide for student nurses who have experience with service user involvement

Thank you for agreeing to take part in this interview. I would like to assure you that, as stated on the plain language statement, your responses will remain anonymous, as no records of the interview will be kept with your name on it.

1. Can to tell me about your experience to date of service user involvement in nurse education?
2. Can you tell me about the sessions in the classroom?
3. What were the topics?
4. To what extent have the sessions influenced/changed your practice in any way?
5. How did learning from service users compare with other forms of learning/teaching that you are exposed to?
6. Would you recommend that service users continue to have an active role in teaching mental health student nurses? Follow response with WHY?
7. Can you tell me about any other ways that service users could be involved in student nurse education?
8. Can you think of any other aspects relating to service users being involved in your learning that has not been covered in this interview?

Appendix H

Semi-structured guide for student nurses who had not experienced service user involvement

Thank you for agreeing to take part in this interview. I would like to assure you that, as stated on the plain language statement, your responses will remain anonymous, as no records of the interview will be kept with your name on it.

1. Can to tell me what your understanding of service user involvement in nurse education is?
2. To what extent do you think service user involvement would potentially influence/change your practice?
3. How do you think learning from service users would compare with other forms of learning/teaching that you are exposed to?
4. Would you recommend that service users have an active role in teaching mental health student nurses? Follow response with WHY?
5. Can you tell me about any other ways that service users could potentially be involved in student nurse education?
6. Can you think of any other aspects relating to service user involvement that has not been covered in this interview?

Appendix I

Semi-structured interview guide for service users

Thank you for agreeing to take part in this interview. I would like to assure you that, as stated on the plain language statement, your responses will remain anonymous, as no records of the interview will be kept with your name on it

1. Can you tell about your experience of being involved in nurse education?
2. Can you tell me about the teaching sessions/session?
3. Who choose the topic for the sessions?
4. How was the content of the sessions delivered to the students?
5. What do you feel you have to offer students in their learning compared with other forms of teaching/ learning that they are exposed to?
6. Would you like to continue being involved in teaching mental health student nurses?
7. Can you think of any other ways that service users could be involved in students nurse education?
8. Can you think of any other aspects of your experience of being involved in the education of student mental health nurses that have not been covered in this interview?

Appendix J
Participant consent form

This study and this consent form have been explained to me. The researcher has answered all my questions to my satisfaction. I believe I understand what will happen if I agree to be part of this study.

I have read, or had read to me, this consent form. I have has the opportunity to ask questions about the consent form and all the questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, which respect my legal and ethical rights. I am aware that I may withdraw at any time, without giving reason, and without this decision affecting me in any way. I have received a plain language statement.

Participant – please complete the following (Circle Yes or No for each question)

Have you read or had read to you the Plain Language Statement?	Yes/No
Do you understand the information provided?	Yes/No
Have you had an opportunity to ask questions and discuss this study?	Yes/No
Have you received satisfactory answers to all your questions?	Yes/No
Are you aware that your interview will be audio taped?	Yes/No

Participant's name:

Participant's signature:

Date:

Date on which the participant was first given this form

Statement of investigators responsibility:
I have explained the nature, purpose, procedures, benefits, risks of, alternatives to, this research study. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Investigator's signature:
Date:

Appendix K

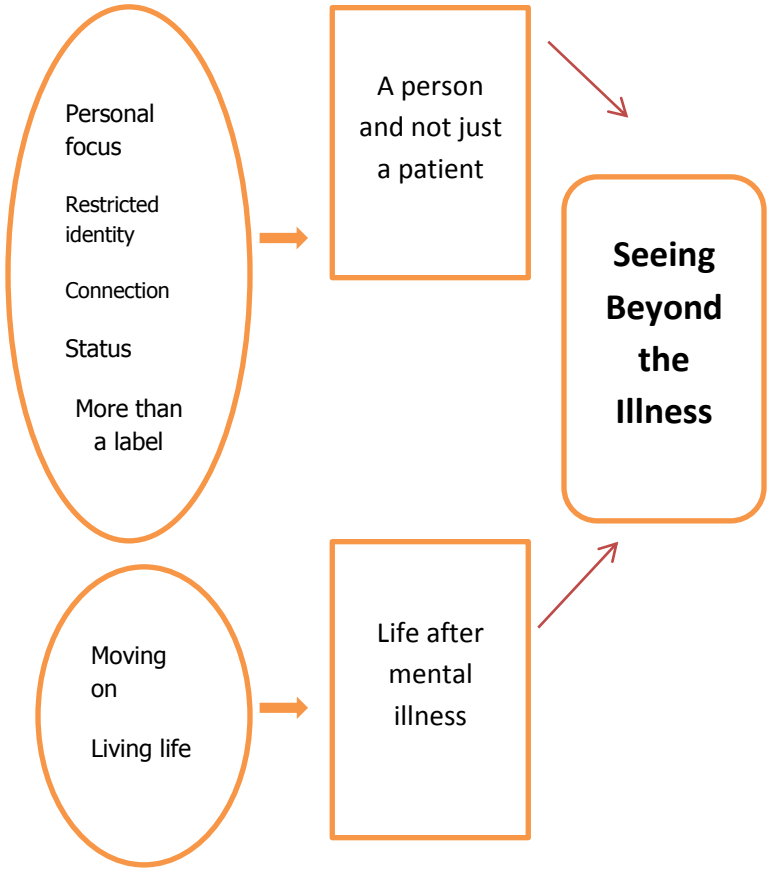
Figure 11: Example of steps taken to analyse the qualitative data from phase 2

Step 1 Coding

Data Item	Codes
(S1)I suppose it makes you treat every client more individually, rather than being on a ward and looking at their illness. You try and see the person, what's behind them, what makes them tick, what makes them happy, even stuff not to do with their illness, even talking to them about soccer, if they're into soccer…. Ok, we can go in and do our job, but our job sometimes is treating the illness and not the person and often the person is neglected because of the illness.	Personal Narrow focus An individual Interests Narrow focus Label Neglect identity
(S9)I definitely think I'll remember more about a service user being a person than a client, as opposed to just a patient on the ward from them coming in and giving their experience.	Personal Narrow focus Label Neglected Identity
(S5) you can relate to the person more. There was another speaker in and he spoke about his gambling addiction. How he hid it and put his family in jeopardy, and his home in jeopardy, and whenever you hear of someone going to the bookies you think ' oh Jesus, waste of space, waste of time'.. If you came across somebody now you would ask 'how is it for you'?	Connect Personal Challenges Judgemental Empathy
(S7)service user involvement was a great way for me to see that people can recover, and to see, that people can move on with their lives and go back to being successful, just like everybody else	Renewal Progression living Normality
(S8)that there is hope if people do have a problem, and they do maintain a good life...If you feel there is hope, you can instil that into someone else.	Optimism Living well

Step 2 &3 Developing Themes

Step 4&5 Defining and naming themes



Appendix L - Studies Reviewed in the Literature Review

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Psychiatry/Junior doctors	Ikkos (2003) UK	To engage service users as teachers of psychiatrists in training for the purpose of enhancing doctors understanding of service users views.	**Design:** Not clear **Data Collection:** An anonymous questionnaire	**Sample**: 34 Junior Doctors **SUI:** Service users contributed 2/3 of sessions including leading 2 sessions.	**Analysis:** No method of data analysis described. **Finding**s: 87% reported personal or professional benefits from service user involvement. Perceived benefits: Personal value, greater awareness of issues that have impacted on service users. The representativeness of service user's views was questioned.
Trainee Clinical Psychology	Holttum and Hayward (2010) UK	To examine staff and trainee ratings of service user involvement.	**Design**: Quantitative approach **Data Collection:** A questionnaire sent out at 2 time-points, I year apart.	**Sample:** 44 Doctoral trainees and 81 staff. **SUI:** Lack of description of how service users are involved. Simply states they increased the number of service user teaching sessions	**Analysis:** SPSS, but no specific details given. **Findings:** There were significant improvements of the ratings of service user involvement in the areas of teaching, decision making and trainee research from the students' perspective. In relation to SUI in student selection the relevance of the initiative was acknowledged and it highlighted qualities that were desirable in a trainee candidate(good communication, willingness to disclose personal experiences)
Undergraduate social worsk tudents	Anghel and Ramon (2009) UK	To evaluate the involvement of SU and carers in the training of an undergraduate degree programme.	**Design:** Case study research. **Data Collection:** Questionnaires and interviews.	**Sample:** 167 Students in year 1 and 22 students in year 2. 15 SU and 13 Lecturers **SUI:** 18 SU were involved in the course over 2 years. 6 were specifically mental health SUs. Involvement included SU providing personal testimony and co assessing student presentations, suggesting questions for admission interviews.	**Analysis: Thematic Analysis** **Findings:** Most students valued SU involvement. Some found it difficult hearing SU negative feedback about social work. SU enjoyed working with students but identified a lack of briefing and debriefing problematic. Lecturers reported that SU involvement was positive but identified a need for training for both SU and students.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Social work and Nursing (Multidisciplinary)	Tew et al (2012) UK	Involve nurses and social work in a joint learning initiative with service users	**Design:** A collaborative learning initiative. **Data Collection:** Questionnaire with open ended questions.	**Sample:** First cohort = 10 nursing and 19 social work. Second cohort= 15 nursing and 25 social work. **SUI:** 6 service users and carers were involved through a 4 day face to face learning and involved in the production of teaching videos.	**Analysis:** No method of data analysis described **Findings:** No significant differences emerged between the two groups. Findings from most students indicated that they had gained a deeper understanding of the experience of mental illness. Some students would have preferred a more traditional approach to learning in this area.
Post-Graduate social work students	Sheyett and Kim (2008) UK	To facilitate dialogue between service users and master's level social work students with a goal of positively shifting students' attitudes towards service users	**Design:** Quantitative and qualitative design **Data Collection:** Pre and post questionnaires and qualitative interviews	**Sample:** 10 social workers at masters level **S.U.I** 10 Service users were involved in a one-day, six hour event. .	**Analysis:** SPSS was used to analyse descriptive statistics and the pretest and posttest comparison .ATLASti, a qualitative analysis program, was used to explore themes and patterns in the post-dialogue interviews. **Findings**: Students' attitudes towards consumers, as measured by their need for social distance, perception of dangerousness, and affective response, had a significant positive shift. In addition, the follow-up interviews revealed that all students were able to identify at least one way they would change their practice based on the insights they gained from the dialogue.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Nursing	Stickley et al (2009) UK	To question from an emancipatory service user perspective in what ways does service user involvement in nurse training affect the perceptions of student nurses and users involved.	**Design:** Participatory action research **Data Collection:** 4 focus groups before. 5 focus groups after. Individual interviews with service user trainers. Post session questionnaires completed by students. Researcher's diaries. Minutes of project group meetings.	**Sample:** 50 student nurses and service user trainers. Exact sample not known. **SUI:** 16 service users participated in the development of 4 educational themes. A number of service users were assigned to teaching sessions.	**Analysis:** No method of analysis described. **Findings:** Prior to teaching students were positive about the idea of service user involvement, but some had concerns that service users would have their own agenda. The service users felt confident because of their preparation. After service user involvement students report that they found the experience enjoyable and insightful and gained insight into the reality of being a service user. They believe the experience would impact on their practice.
Nursing	Schneebeli et al (2010) New Zealand	To evaluate SU involvement in mental health nursing	**Design:** Qualitative **Data Collection:** An anonymous questionnaire with 5 open ended questions	**Sample:** 30 student nurses **SUI:** SU provided class room teaching and facilitated small group tutorials.	**Analysis:** Thematic analysis **Findings:** Students found the normalization of mental health experiences helpful and valued the hearing of personal experiences. Students reported that SUI challenged myths and stereotypes about mental illness and identified the need for more SUI.
Nursing	Stickley et al (2010) UK	Assessment of SUI in the practice assessment of student nurses	**Design:** Participatory action research. **Data Collection:** Focus groups and individual interviews.	**Sample:** 15 student nurses. 16 service users who were receiving treatment. **SUI:** 16 SU who were receiving treatment, who were selected by the students and who performed assessments of the students work.	**Analysis:** Content analysis. **Findings:** Students adopted strategies to reduce the risk of critical feedback (eg selection of SU). Some students dismissed critical feedback as being incorrect or influenced by SU mental illness. Students who declined to participate anticipated inaccurate negative feedback from service users.
Nursing	Rush (2008) UK	To investigate the impact of SUI in the classroom on student nurses' practice and the underpinning mechanisms and contexts	**Design:** A realistic evaluation. **Data Collection:** semi structured individual interviews and 1 focus group.	**Sample:** 26 Student nurses. 12 service users. 7 students attended focus group. **SUI:** Services users taught students in the classroom	**Analysis:** Transcripts analysed using NVIVO software. **Findings**: The reversal of roles enhanced student learning. The students identified positive learning from SU stories and the emotional impact of the sessions. They developed new insights as a result of SUI.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Nursing	Simpson et al (2008) UK	To evaluate an online discussion forum involving mental health service users in the education of nursing students	**Design:** An exploratory project using both qualitative and quantitative methods **Data Collection:** Semi structured interviews with 25 questions. Quantitative data was collected by recording participant activity on the project site.	**Sample:** 35 student nurses and 12 service users. **SUI:** 12 service users were recruited to participate with students in the online forum.	**Analysis:** No method of data analysis described **Findings:** Over a period of 6 weeks, 20 students read messages posted on the forum while 15 students posted messages. On average students read 7.1 messages while SU posted on average 14.8 messages. Some students who were interviewed reported gaining an appreciation for SU experiences in relation to admission to hospital mental illness, and their interactions with staff. The contribution of SU was viewed positively. However in group presentations 2 groups showed minimal influence of SUI.
Nursing	Rush and Barker (2006) UK	To evaluate the involvement of mental health SU in nurse education through enquiry based learning	**Design:** No research design described **Data Collection:** Written student evaluations	**Sample:** 26 first year student nurses. **SUI:** A 3 day SU enquiry based learning experience. SU presented and discussed information with students.	**Analysis:** No method of data analysis described. **Findings:** Students identified that the sessions stimulated thinking and were motivating. They identified that the material was presented in an accessible manner. The students said SU input strengthened the EBL process.
Nursing students	Wood and Wilson-Barnett (1999) UK	To explore if SUI would enable students to adopt a more user centered approach to mental health assessment and evaluate the influence of SUI on student learning	**Design:** A comparative study. **Date Collection:** Field notes of class observation. Pilot group tested video. Student questionnaire. Focus group discussion.	**Sample:** 29 nursing students, n=15 experienced service user involvement and n=14 did not. **SUI:** Service users involved in the classroom.	**Analysis:** Thematic content analysis. Triangulation with user centred questionnaire. **Findings:** Three themes emerged (1) use of terminology and Jargon (2) empathetic understanding (3) an individualized approach**.** Results showed that students who had exposure to SUI in the classroom were less likely to use defensive language and were more likely to show greater empathy towards people with mental distress than others students who did not have service user experience.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Nursing	Jones and Black (2008)	To involve service users sharing personal experiences of illness with nursing students	**Design:** Qualitative approach. **Data Collection:** Feedback of service users presenting stories to the classroom.	**Sample:** 30 student nurses **SUI:** 11 SU presenting their stories.	**Analysis:** No method of data analysis described **Findings:** 28 out of 30 students reported the sessions had impacted on practice. All 30 reported that user involvement had an important contribution in the mental health curriculum. 8 out of 11 service users reported feeling empowered and felt the experience had a positive impact on their mental health.
Nursing	Frisby (2001) UK	To raise students' awareness of clients centered perspectives. Service users review of student presentations regarding mental health assessment.	**Design:** No research design described **Data Collection:** Written student evaluation	**Sample:** Unknown sample **SUI:** Exact means of SUI unclear. Simply informed that users from local mental health representative organisations attend a series of college based sessions to evaluate student presentations.	**Analysis:** No method of data analysis described **Findings:** Students report that the experience of SUI enabled them to identify how nursing interventions can affect the lives of service users. The findings identified the need for training for service users prior to involvement.
Nursing	Byrne et al (2013) Australia	To present the views experiences and perceptions of nursing students having been taught by an academic who has personal experience of mental health difficulties.	**Design:** A qualitative exploratory approach **Data Collection:** 1 face to face in-depth interview and 11 telephone in-depth interviews.	**Sample:** 12 student nurses **SUI:** A service user was involved in teaching about recovery for mental health nursing practice.	**Analysis:** Analysis involved 4 stages based on the method proposed by Colaizzi (1978). **Findings:** Two main themes were identified: 1.'looking through fresh eyes'- what it means to have a mental illness and 2. 'It's all about the teaching.' The experience was received positively; students reported positive attitude and increased self- awareness. Moreover, they identified an appreciation of the impact of mental illness on the individual person.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Nursing	Forrest et al (2000) UK	To elicit service users views about the knowledge, skills and attributes they considered mental health nurse should have.	**Design:** Qualitative **Data Collection:** Focus group using a semi structured technique.	**Sample:** 34 Service users **SUI:** 34 Service Users participated in 5 focus groups	**Analysis:** Thematic analysis **Findings:** Four themes emerged (1) the issue of conflict (2) the issues of representativeness (3&4) the issue of involvement versus tokenism. The findings also suggested that service users should be engaged in the planning and development of teaching materials from the start and not simply invited to provide a "talk on the service user side of things".
Multidisciplinary	Hanson and Mitchell (2001) UK	To evaluate the success of a 5 day course aimed at preparing service users for their role in the classroom.	**Design:** No research design described **Data Collection:** Questionnaire and nominal group technique. 6 month evaluation post course.	**Sample:** 9 **SUI:** 9 service users completed the course.	**Analysis:** No method of data analysis described **Findings:** Overall the participants evaluated the course positively. They agreed they had gained confidence which enabled them to become involved in a variety of service user initiatives.
Nursing	Felton and Stickley (2004) UK	To explore mental health nurse educators' perceptions of the involvement of service users in preregistration nurse education	**Design:** Qualitative **Data Collection:** Semi-structured interviews	**Sample:** 5 lecturers **SUI:** N/A	**Analysis:** Thematic analysis Findings: Five key themes emerged, (1); experience of service user involvement in learning; (2) service user issues; (3) problems with service user involvement in education; (4) role; and (5) power. The findings suggest that the current situation of involving service users at the research site was ineffective. The concepts of 'role' and power relationships were used to explore the reasons for this. The development of SU involvement in education is complex and requires further research.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Mental health staff (Multidisciplinary)	Meehan and Glover (2007) Australia	To establish from the perspective of service users their experience of being involved in training and education of mental health staff	**Design:** Qualitative Phenomenological approach **Data Collection:** Interviews	**Sample:** 11 Service user educators **SUI:** 11 service user educators were interviewed	**Analysis:** Phenomenological approach **Findings:** There should be greater integration of the lived experience into the overall teaching experience. 5 keys themes emerged from the interviews: giving of self; tokenism; learned verus lived experience; voyeurism; and lack of clear expectation.
Nursing	Happell, Pinikahanna and Roper (2002) Australia	To examine the postgraduate nursing students views on the service user participation in mental health service delivery and psychiatric nurse education.	**Design:** Quantitative **Data collection:** Questionnaire on first day of the course.	**Sample:** 25 postgraduate nursing students **SUI:** Service user academic position.	**Analysis:** SPSS **Findings:** That most students are in favour of a high level of service user participation but that this is limited to specific areas of treatment planning and delivery. Furthermore, the students demonstrate some level of ambivalence regarding the value and necessity of the service user academic role.
Nursing	Masters et al (2002) UK	To devise a strategy for user and care involvement in pre- registration curriculum and evaluate the development process	**Design:** Quantitative included open-ended questions **Data Collection:** Two Questionnaires. Type A included 18 closed questions about issues surrounding involvement the remaining questions were left open. Type B was a 12 item questionnaire comprising 3 closed ended questions and 9 open ended questions	**Sample:** 33 questionnaires were sent out. 17 type A and 16 type B. A total of 18 questionnaires were returned, 11 type A and 7 type B questionnaires. **SUI:** The extent of SUI is not clear because one SU dropped out and one did not attend meetings.	**Analysis:** Thematic analysis for open ended questions and the responses to the closed questions were collated. **Findings:** The key themes that emerged are (1) The issues of 'representation' and 'representativeness' (2)Satisfaction and importance: support and training (3) A powerful experience: issues of identity, (4) Status and power (5) Feeling involved, feeling left out of the process (6) A fragile or a durable policy? (7) Time, energy and limited resources (8) The 'process' of involvement**.** Respondents identified a need for training and education. Lecturers also identified a similar need for training. Participants identified personal benefits in terms of learning new skills, increased self-confidence and a feeling of empowerment.

Discipline	Authors and Country	Purpose/aims	Design and Data collection	Sample and Service User Involvement (SUI)	Analysis and Findings
Multidisciplinary	Barnes , Carpenter and Bailey (2000) UK	To assess learners reactions to service users trainers and establish any change in knowledge, attitude, skills and organizational practice.	**Design:** Mixed methods **Data Collection:** Participant observation and group interviews	**Sample:** 23 individual participant observations. 18 group interviews with students and their managers (n=13) and they have self-report questionnaires **SUI:** Service users were involved in the commissioning, management, delivery, participation and evaluation of the programme.	**Analysis:** Qualitative data was analysed by NVIVO computer software package and analysed thematically. Quantitative data was analysed using SPSS. **Findings:** Students report positive learning outcome associated directly with service user involvement. They report the value of partnership working with service users in interprofessional education.
Multidisciplinary	Khoo et al (2004) UK	To evaluate the involvement of service users in the postgraduate mental health education and establish if it enabled students to be innovative in their practice.	**Design:** Quantitative and Qualitative **Data Collection:** Two phases. Phases 1.Questionnaires were sent to all past and present students. Phase 2. Semi-structured interviews lasting no longer than 45 minutes.	**Sample:** Phase 1. 26 out of 41 were returned. Phase 2. Of the 26 respondents 10 were chosen at random for a more detailed interview. **SUI:** Service users and ex users and representatives of user led organisations led seminars and discussion sessions. They contributed to over half of the seminars on a module about 'Innovations in Mental Health'	**Analysis:** Descriptive statistics and by content/thematic analysis. **Findings:** 79% were very enthused by the user contributions; none considered their involvement were poor. A majority (87%) felt that that they had benefited personally and professionally from the involvement of SUs in the programme. Many had implemented user-focused initiatives in their practice as a consequence of undertaking their studies.

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Nursing	McGarry and Thom (2004) UK	To explore stakeholders' experiences of user and carer participation in nurse education. To highlight the key issues that arise for participants involved in the process. To identify pivotal issues to inform the development of practice in this area	**Design:** Qualitative **Data Collection:** 3 focus groups	**Sample:** 5 service users, 6 nursing students and 5 lecturers. **SUI:** 5 service users participated in a focus group.	**Analysis:** Used NUD*IST Version 4, a software package designed to undertake qualitative data analysis. **Findings:** Show that to achieve meaningful involvement of users and carers in nurse education is not simply a matter of including them in the process. Rather-it is a task that can be accomplished only through careful consideration and partnership at every stage of the development process. A number of key issues (e.g.ndividual expectations, planning and support) need to be explored further if user and carer participation in nurse education is to achieve its optimal value in health care provision.
Nursing	Simons et al (2007) UK	To evaluate the development of an innovative Service User Academic post in mental health nursing in relation to student learning and good employment practice in terms of social inclusion.	**Design:** Case study design **Data Collection:** Group discussion and interviews	**Sample:** 6 service users, 10 educators and 35 students (post and undergraduate students) **SUI:** Delivering course to students as part of a service user academic role.	**Analysis** Framework approach. **Findings:** The evaluation revealed tangible benefits for the students and the wider academic community. Most important was the powerful role model the Service User Academic provided for students. The post proved an effective method to promote service user participation and began to integrate service user perspectives within the educational process. However, the attempts to achieve socially inclusive practices were inhibited by organisational factors. The expectations of the role and unintended discriminatory behaviors had an impact on achieving full integration of the role. Furthermore, shortcomings in the support arrangements were revealed.

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Nursing	Debyser et al (2011) Belgium	It had 3 research questions. 1. What conditions supported the gathering of meaningful service user feedback to enhance the students learning process and service user well-being. 2. Does the use of the practical model for service user feedback lead to positive experiences. 3. To what extent is service users' feedback consistent with the feedback with a student's nurses mentor or teacher	**Design:** Qualitative exploratory design. **Data Collection:** Semi structured interviews	**Sample:** 7 service users. 4 students, 2 nurses and 2 educationalists. **SUI:** Participated in the assessment of a student.	**Analysis**: Thematic analysis using NVIVO analysis software **Findings:** The findings were discussed under the following heading' (1) The practical model (2) The meaning and value of feedback (3) What did clients value in students (5) Client feedback as a vital component of the overall assessment**.** Service user feedback generated a learning experience for the students which helped the students recognise the vulnerability of a service user. The mental health nurse plays a key role in supporting service users in the assessment of students.
Nursing	Morgan and Sanggaran (1997) Australia	To report on the impact of mental health service user involvement in student assessment and student performance.	**Design:** Quantitative and qualitative **Data Collection:** 3 Questionnaires with open ended-questions	**Sample:** 43 Nursing students and 74 service users **SUI:** The service users within the mental health facilities gave constructive feedback on students' performance and discussed their feedback in a facilitative forum.	**Analysis:** Method of analysis not clearly described **Findings:** Many service users and students believed that there was a role for service users providing feedback on learning. However over half the students indicated that gaining this feedback did not contribute to their learning.

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Nursing	McAndew and Samociuk (2003) UK	To involve service users and students to jointly reflect upon mental health issues.	**Design:** Evaluative case study **Data Collection:** Pre attitudinal and reflective sessions.	**Sample:** 5 service users and 5 students **SUI:** Service users participated in 2 hour sessions for a total of 10 sessions during student's clinical placement. Themes for the sessions were medication, communication, stigma and labeling, being hospitalised, roles and relationships.	**Analysis:** No method of analysis described **Findings:** Results are not clearly discussed but pre attitudinal test highlighted that service users could offer real life experiences. 3 students expressed concern and hoped that service users would not have their own agenda.
Multidisciplinary	Higgins et al (2011) Ireland	Establish the degree of service user involvement in the educational preparation of mental health practitioners.	**Design:** Quantitative **Data Collection:** Questionnaire	**Sample**: 149 questionnaires were returned by course coordinators/Directors**.**	**Analysis:** SPSS **Findings:** 63% of the courses are planned and delivered without consultations or input from service users, while service users are involved in 37% of the courses. Out of the 29 courses designed for mental health nurse training, 19 (66%) had service user involvement Four (80%) out of the five professional courses in social work have service user involvement, compared with only one (25%) of the four courses in psychology. Of the 50 courses that service user were involved in, 90% of their involvement focused on teaching about their personal experiences.