An Evaluation Of A 'User Led' Training Course For Mental Health Nurses And The Effect Of User Involvement Upon Professional Power, Autonomy And Practise.

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By

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Abstract.


This study explores how ‘user led’ workshops for mental health workers were evaluated and subsequent effects upon professional power, practice and partnership working. Research methods involved observation of workshops, semi-structured interviews with course participants and analysis of evaluation forms. A content analysis of the evaluations, interviews and observation notes were interpreted in relation to literature on user involvement, professional power, practice and partnership working, although sub themes emerged during the process including safety and accountability, Care Programme Approach, resources in practice and resistance to change.

The findings reveal that the reaction of nurses to user involvement has been mixed and two groups have emerged. One group are more accepting of user involvement, the user perspective and seek more equality and partnerships with users. They espouse the rhetoric and implement the policy on user involvement and the study reveals a number of changes to their professional practice as a result of the workshop. However even in this group user involvement and partnership may be negated by the need to defer to others or legal and professional imperatives.

In contrast there is a second group who, may also espouse the rhetoric of user involvement and partnership working but nevertheless feel threatened by it. These nurses have been resistant to policy developments, are tokenistic in their acceptance of the user perspective and reluctant to change practice. They do not regard users as equal partners or engage in partnership working. This research has demonstrated therefore that user involvement in education and training can have a beneficial effect upon the working practices of some professionals but there remains a group for whom education alone is less effective.

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CHAPTER 1 INTRODUCTION TO THESIS

Introduction.

This thesis is concerned with professional power, practise and partnership in mental health and the extent to which the practitioners power and autonomy is influenced by the current emphasis within mental health care and services on user participation or involvement in those services. In government policy on mental health care within the National Health Service (NHS) and Social Services there is a prominence given to involving patients and the public in those services and of developing service user involvement and partnerships between professional workers and their patients or clients. This thesis will examine the issues of professional power, partnership and practise in relation to 'user involvement' in mental health education and practise. A service user in this context refers to people who are, or have been, mental health service users and user involvement refers to the extent to which users are involved in their own care, in mental health services or in the education and training of mental health workers.

The focus of this research is upon one training initiative which involved mental health service users but the issues that arise from all forms of user involvement will be utilised both in a review of the literature and in an analysis of the key issues that arise from the research. The subjects who are the main focus of the research are mental health nurses and a group of staff who work in mental health care within the voluntary or non-statutory sector. However examples and literature on power, autonomy, partnership, user involvement and professional practise from nursing and other professional groups will be drawn upon to elucidate the issues. The areas of literature which will be reviewed, that have relevance to this research, surround the issues of user involvement in mental health and the concept of partnership working between mental health workers and service users and the different perspectives and concepts of professional power and authority within the health care professions with particular reference to psychiatric medicine and mental health nursing.


The context in which this study occurred is one in which user involvement in mental health care and services have proliferated in the past fifteen years. This is due in part to changes in government policy in which patient / service user involvement and partnership working between patients / service users and professionals has been encouraged. At the same time there has been the development of a more radical, focussed, articulate and demanding user movement who want structural change and a greater recognition of their own expertise and knowledge of their
illness or problems (Gell, 1987; Campbell, 1996a). Service users also want more power in
decision making with respect to their own care, more partnership working and more
involvement in the development and running of mental health services (Trivedi, 1996; King,
1996). The corollary of these developments is that professional practise needs to change in
order to comply with policy and meet the increasing demands of service users for a more equal
partnership between themselves and the professional workers whom they encounter. Education
and training has been regarded as a means by which changes to professional attitudes and
practise can be effected and service user involvement in professional training is also a feature of
policy in mental health services (DoH, 1994a; NHS Exec, 1997a). This study was conducted in
relation to a training course for mental health staff that involved mental health service users as
trainers so the impact upon the trainees of that involvement is of prime consideration

Policy In Relation To Service User Involvement In Mental Health Care And Services.

Within the National Health Service (NHS) particularly there is increasing importance being
attached to involving service users in a number of ways including involvement in decision
making with respect to their own care and needs, in planning evaluating and delivering services,
in carrying out research and in the education and training of professional staff. The concepts of
service user involvement and consumerism within the NHS have developed simultaneously with
the latter, according to Glenister (1994) being most pronounced in the 1980's when the
effectiveness and cost efficiency of the welfare services was being questioned. The expressed
desire for patient and public involvement has been included in a number of initiatives and
articulated by successive governments in numerous policy documents and has been seen as a
means of redressing the imbalance of power between professional health care workers and
patients and carers. For example one of the intentions of the 'NHS and Community Care Act'
(DoH, 1990a), was to change the influence of services in favour of users and carers. Glenister
(1994) refers to a number of charters and policies between 1989 and 1993, which seek to redress
the imbalance of power and give users and carers more influence and control over the services
that they receive.

A further policy that has emanated in the 1990s, which places an emphasis on user involvement,
is The Care Programme Approach (CPA) (DoH 1990b). This policy provides a set of guidelines
that require professional workers to develop a package of care for their patients that are agreed
with users and carers. One of the purposes of this is to improve the quality of care offered and
subsequently the quality of life for the patient. The government did not prescribe how it would
work, and left it to individual authorities to interpret, implement and develop specific
procedures but they did emphasise elements of good practise and gave some guidelines one of
which was that service users should be fully involved in the development of their own care plans (DoH, 1990b). Subsequent guidelines on how the CPA should be implemented were issued by government all of which emphasised the need for user and carer involvement (DoH, 1994b; DoH, 1995). Government has since reviewed the CPA and some changes made to the policy but the imperative to involve service users and their carers remains (DoH, 1999a). Professional workers in mental health are also required to complete, with the service user, a full assessment of the service user including identifying risks. The process known as risk assessment is often carried out in conjunction with the CPA and like the latter is formally documented. Local authorities were once again left to develop procedures and policies for implementing CPA and risk assessment and this training course was part of the training to be given to professionals about the local procedures and policies to be adopted by them. The policies of user involvement and the issues that emanate from these policy directives will be discussed in the literature review.

The Development Of User Involvement And The User Movement.

In mental health services user involvement in many of its forms has proliferated in the 1990s (Wallcraft, 2003). According to Sayce (1993) the debate is about how, not whether, user involvement should take place. User activists have campaigned for more user involvement in mental health care and services and a greater say in how services are developed and managed. The beginning of the current user movement can, according to Campbell (1996b), be traced to an international conference in Brighton in 1985. Campbell cites a number of influencing factors including the increasing awareness of civil rights in the 1970s and 80s amongst those with mental illness and the policy of de-institutionalisation. The growth and development of user participation and empowerment was also encouraged by the political climate of the 80s and 90s in which the New Right ideology emphasised self-help, minimal state intervention and consumerism (Fraher & Limpinnian, 1999) and the current Labour government have continued the managerialist philosophy and user participation, is now seen as means of monitoring and improving quality of services.

Professional Power And Autonomy.

A number of other policy initiatives including the emphasis on community care, changes to services and ways of working, the consumerist and managerialist philosophies that have been promulgated by successive governments and the prominence of user involvement and partnership, that has emanated from these, have led to the notion that professional power is being eroded. Government philosophy in respect of user involvement is discussed further in the
literature review in the section on the development of user involvement. Mental health service users have comparatively little power in their relationships with professionals when accessing or utilising services and one of the purposes of user involvement is to change the balance of power (Linett, 1999). Some mental health workers including nurses do not want or place a low priority on user involvement (Campbell & Lindow 1997) and this may be because the impetus for user involvement, both from government policy and from user activists, may be seen as a challenge to professional power, authority and autonomy. Therefore the issue of professional power and partnership in the mental health professions is of considerable interest because of the plethora of changes in social policy associated with health and social care not least of which is the importance given to user involvement and partnership working between mental health workers and service users (DoH, 1994a; DoH, 1998a; DoH, 1998b; DoH, 1999b). This notion of partnership working is further discussed in the literature review in the section entitled partnership working between users and professionals.

Nursing has always been subordinate to medicine in the occupational hierarchy despite nurses' attempts to professionalise and become autonomous (Jones, 1994; Gillespie, 1997). The professional status of nursing, and the power and autonomy that nurses can derive from this, is of interest in this thesis firstly because user involvement may be regarded both as another threat to nurses' power and their desire to be autonomous practitioners. Secondly dissonance may occur when they wish to involve users because they regard user involvement as good practise, or they need to follow policy or procedural guidelines that require service users to be involved for example in planning care packages (DoH, 1995; DoH, 1999a). At the same time however, they may have to defer to medical practitioners in decision making regarding service users and furthermore they may have to comply with their own statutory obligations, for example in relation to the mental health act, both of which may run counter to their patients/service users wishes. A discussion on the issue of professional power and user involvement is further developed in the literature review.

Training And Education Of Mental Health Workers / Course Participants / Research Subjects.

It was against this background of the policy changes in the CPA, risk assessment, the statutory imperative to involve mental health service users in all aspects of care and services and the development of user groups that the service providers in Warwickshire commissioned a training course for its mental health staff. The training course referred to in this study is concerned with providing training to professionals on implementing the CPA policy and risk assessment and is entitled 'Implementing the new CPA, providing quality in mental health services' (Konzon, 2001) The course was a two day multi agency programme on the implementation of the new
integrated CPA, following the government review (DoH 1999a), based upon what the
commissioners refer to as a holistic approach to risk assessment and care planning. The course
was aimed at all members of staff who had not received previous CPA training and staff from
the independent and voluntary sectors. A number of these courses were delivered across the
county over a period of eighteen months and staff were required to attend one of them. Details
of the course, subjects and service user trainers can be found in appendix 3.

The course was commissioned by Warwickshire Social Services Staff Development
Commissioning Unit who has the responsibility of providing training now for all mental health
workers including those in social services and the NHS. They employed an external consultant
to carry out this training but asked him to include within the course one sessional workshop
from local service user organisations. The purpose of this workshop was to involve local
service users in the training of mental health workers in order to give a users perspective on the
care planning process. The workshop was entitled ‘Promoting Partnership: Involving Users In
Their Care Plans’ (UETC, 2001; SWUF, 2001). The workshops that the service users delivered
then were part of a two-day course but the evaluations referred to in this thesis, and which are
one of the data collection methods used, are concerned only with their particular input into this
course. The nature of the evaluations that were conducted is discussed in the data collection
methods section of the research methods chapter. Two different service user groups from
within the county were used to deliver this session, dependent upon the geographical location of
the training. They were South Warwickshire User Forum (SWUF) and User Empowerment
Training Consultancy (UETC). Both groups were given the same brief by the commissioners
and they attended a one-day training course to prepare the service users for their input into the
CPA training. The service users themselves have all used mental health services at some stage
in their lives and had previously undertaken training in how to be user trainers.

Concepts And Terminology Used In This Thesis.

A number of terms and concepts are used in this thesis that are central to an understanding of
the different perspectives, beliefs and practises of professional workers and those who are the
recipients of their services. If professional workers for example regard those people that they
serve or treat simply as patients with medical conditions then that may influence their own
beliefs about the nature of the relationship and who has the authority power and expertise within
it. It may influence how they regard those individuals, their acceptance of their opinions and
how they practise especially in relation to working in partnership with them. Similarly if mental
health service users regard themselves as survivors of a repressive system as opposed to patients
being treated then their perspective on the power relationship is likely to be very different from
that of the professional and they are likely to demand more from the professional, in terms of
equality in decisions over their own care. Those who use the term consumers will also have pre
conceived ideas about what this term implies and again that may well affect the power
relationship and an acceptance by the professional, of the consumers own expertise and
opinions.

Users, Survivors, Patients, Clients Or Consumers.

The terms users, survivors, patients, clients and consumers are all used synonymously by
different people at different times. There is no clear consensus as to the most appropriate term
to refer to those who are the recipients of mental health care and services and there is no
consensus as to the most workable definition of users in the context of mental health care.
Categories of users could include the general public, current or past users of services, carers or
representatives of service users and representatives of specific user groups. In Britain the term
'user' of mental health services has generally become common in recent years although many
former service users prefer the term survivor. The terms user and survivor have different
connotations that reflect the different meanings that individuals ascribe to them with the latter
being adopted by people who regard themselves as having survived the psychiatric system
(Crepaz-Keay et al, 1997) and who in many cases belong to more radical or activist movements
but terminology is important as it is concerned with the subjective meaning that people give to
their experience of the mental health system.

Professional workers more often use the terms patients and clients with the former being used
by those, mostly doctors and nurses, who espouse or practise a more medical approach to care.
The term clients is frequently used by community psychiatric nurses who may have coined the
term in an attempt to break away from the more narrow medical approach to care. A further
way of conceptualising psychiatric patients, or those that use mental health services, is as
consumers of services, which is a relatively new ideology, brought about by the health care
policies of the 1980s (Pilgrim & Rogers 1999). Practitioners, or service users themselves, who
may regard themselves as reluctant consumers in many cases, rarely use the term and this
concept appears more as an ideology in official documents. It is this conceptualisation of
mental health service users as consumers, clients, service users or patients that may be key to
understanding or explaining differences in the response of professional workers to the user
movement and user involvement, specifically in relation to changing their practise and / or
working in partnership with service users.
Although one of the user trainers who conducted the training workshops that this research is concerned with prefers to use the term survivor most of them refer to themselves as service users or user representatives and not by terms such as consumers or even patients. Therefore notwithstanding the ideological, philosophical and personal meaning given to language, for the purposes of this study the term service users is preferred except where other terms are expressly used specifically by the literature and / or where a direct quotation is being used.

User Involvement / User Participation / Partnership Working.

The concept of user involvement is also difficult to define because it depends upon meanings ascribed to words, perceptions and ideological considerations. Ashworth et al (1992) argue that participation requires a mutual stock of knowledge or understandings which are necessary for social cohesion but Glenister (1994) is critical of this as he points out that patient participation often occurs when there is conflicting ideologies for example the psychiatric and lay perspectives. As Anthony and Crawford (2000) note 'user involvement', 'negotiated care', 'patient participation' and 'person centred care' all frequently appear in nursing literature and their meanings become blurred and synonymous. Similarly Peck et al (2002) note that the terms user involvement, participation and empowerment are used interchangeably and simple definitions appear unavailable. There is also an issue as to the degree of participation and differing perspectives as to what constitutes participation, which varies in its minimalist form from service users asking questions and receiving information to service users delivering services. Peck et al (2002) provide a useful matrix of user involvement that ranges from users just being recipients of information through to users being in control of and running services.

Like user involvement the concept of partnership between service users and professionals has been articulated in a number of government policy documents (DoH 1994a; DoH 1998a; DoH 1999b; DoH 2001a) and the concept is often referred to alongside user involvement. Partnership is regarded it seems as an essential ingredient for mental health services. The importance of nurses working in partnership with their patients was emphasised in the recommendations of the review of mental health nursing (Butterworth & Rushworth, 1995) and this review further recommended that people who use the services, and their carers, should participate in teaching and curriculum development. The term or concept of partnership also has differing meanings and interpretations and the concept is frequently referred to in the literature in discussions of involvement, equality, power and empowerment which leads Barnes et al (2000) to conclude that partnership is a more realistic concept than empowerment because of the inequalities in power between service users and mental health workers. The concept of partnership and the associated policy is discussed further in the literature review.
In this research the terms user participation and user involvement are also used synonymously, with the term user involvement being preferred except where a direct quotation is used, although it is recognised that they may have slightly different connotations. Interviewees were asked to comment upon what partnership meant to them, how equal they felt the partnership to be and in what ways they would involve or consider service users as partners in care.

Professionalism / Professional Practise.

These terms refer to what professionals actually do and how they operate. What constitutes good or bad practise is often a subjective judgment although service users themselves are often clear what they want from professionals (Read, 1996, Lindow, 1996) but this does not always coincide with what professionals actually do. Good practise may be defined by adhering to procedures or guidelines as described by specific policies such as the CPA and / or by compliance with stated principles such as user involvement, but the latter of course may be subjective as the ways and the extent to which user involvement is part of professional practise is a matter for the individual practitioner.

One of the prime purposes of this training was to improve or change professional practise to ensure that service users have full involvement in the development of their own care plans and have copies of them. Hitherto, and one of the reasons for the government review of the CPA (DoH 1999a), there had been criticism from service users and documented evidence that CPA was not being carried out properly and there was little evidence of user involvement in the care planning process (North, C., Ritchie, J. and Ward, K. 1993, Wolfe et al 1997). There have also been a number of initiatives within mental health services (Higgins, 1994; Maza, 1996; Wolf, 2001; Kehoe & Haigh, 2003) and education (Ramon & Sayce, 1993; Clinton, 1999; Wood & Wilson-Barnett 1999; Happell & Roper, 2003) to involve service users, with the latter often concentrating upon trying to change the attitudes, perceptions and subsequently the practise of some professionals towards the mentally ill. However despite the popularity of user involvement the reality in practise is at best inconsistent (Anthony & Crawford, 2000). This research seeks to examine whether any examples of changes to attitudes or practise of the nurses who undertook the course could be attributed to the effectiveness of the user led workshop.

Power / Empowerment.

The importance of user empowerment like user involvement has developed in the last two decades probably because of a combination of the pressure of radical groups in mental health
and the political climate which enabled this and developed a more consumerist ethos in service delivery. The terms power and empowerment often appear together in the literature but they have different meanings. Perkins & Repper (1998) provide a useful distinction. Power according to them is a political term and refers to structural conditions and power relationships between groups of people which in the context of mental health and this research applies to power between service users and professionals with the former having much less power due to structural factors. Empowerment on the other hand is a psychological concept wherein an individual feels that they have power. Professionals can seek to work in an empowering way by encouraging, supporting and emphasising service users strengths and resources but this is more than likely done within structural constraints and nurses often work in a disempowering way (McDougall, 1997) and maintain powerlessness of service users (Campbell, 1998).

Power and authority are vested in professional workers by the state and a hierarchy of power occurs within the welfare professions. Power may be defined as the ability of individuals or groups to get others to do what they want and authority as a form of power that is seen as legitimate (Iphofen & Poland, 1998) and it is these concepts that are the focus for this research as developing social policy and user involvement may be seen to threaten or undermine the power and authority of professional workers.

Conclusions.

This research focuses upon a training course for professional workers that had been developed in response to changes in government policy on care planning and risk assessment. It was incumbent upon the commissioners of this course to involve service users in the training as government policy (DoH, 1994a; NHS Exec, 1997b; DoH, 1999b) also requires service users to participate in all aspects of service delivery including training. This thesis therefore is concerned with how user involvement and partnership is perceived by professional workers and the extent to which the power, authority and autonomy of mental health workers may be eroded or threatened by this impetus for service user involvement in mental health care and services. The thesis also examines how professional practise may change as a result of the user involvement on this training course and the apparent differences between staff in their conceptualisation of service users and their acceptance of the concept and rhetoric of user involvement.
The Development Of These Concepts And Issues In This Thesis.

Introduction:

This chapter has provided an introduction to the thesis, the context in which this research was completed, a discussion of the conceptual framework and a description of the training course that was used as the subject of the research including a description of the course participants and course trainers. The thesis is comprised of four other chapters: a literature review, a chapter on research methods used, a chapter that presents an analysis of the findings and a final chapter devoted to conclusions and recommendations. The contents of these chapters will be discussed in the following sections.

Chapter Two: Literature Review.

This chapter will review the literature on two main areas, user involvement in mental health care and services and professional power and concepts of power and authority. A number of themes emerge from the literature on these issues that are of relevance to this thesis. The literature on user involvement will be reviewed with particular reference to the mental health service user. The history and development of service user involvement in mental health will be examined in light of policy and political developments. The benefits and problems of user involvement will be examined followed by a review of evidence of service user involvement in training and education. The review will also examine the issue of partnership working between service users and professionals, the effect of user involvement on professional practise and finally the issue of user involvement and professional power.

In relation to professional and power there will be an examination of the concepts of professions and professional power with particular reference to medical power and how medicine has dominated the health and welfare professions. There will be a critique of medical power and a discussion of how nurses have attempted to professionalise, control their own work and become autonomous practitioners. The theoretical literature on power will be reviewed briefly with examples of how professionals maintain power over patients/service users. Finally, in relation to power, a review will be conducted of some of the theoretical, political and practical ways in which professional power may have become eroded.
Chapter Three: Research Methods.

This chapter will provide an explanation of the research design and why it was chosen. There will be a discussion of the research paradigm and the methods of investigation that were used including the strengths and limitations of these methods and this approach including issues of validity and reliability. Ethical issues will be explored along with the background and potential influence of the researcher upon the subject matter under investigation. The chapter will also include a description of the subjects being studied and an explanation of how access to the research was gained and will conclude with an explanation of how the data is to be analysed.

Chapter Four: Presentation And Analysis Of Findings.

This chapter will be used to present the findings and analysis of the research. A thematic approach will be used following the broad themes that have been included in the literature review. A number of other themes emerged from the data collection and analysis and these will also be presented and analysed under the appropriate headings.

As the research is qualitative in nature a content analysis will be used related to the themes in the literature and the research questions. Therefore the data will be presented in the form of quotations or statements made by respondents followed by a discussion of the relevant concepts and issues.

Chapter Five: Conclusions And Recommendations.

This chapter will draw together the threads of the study to arrive at some general conclusions that address the research questions. A retrospective evaluation of the research and its contribution to the field of knowledge on user involvement will be included. Recommendations for the future of user involvement in education and training will be made and a discussion on the implications for professional practise with particular reference to nursing. This chapter will also identify new directions for further research and a synopsis of the limitations of this study.

The following chapter will review the literature in relation to the conceptual framework and key issues referred to in this introduction and two broad areas of literature will be reviewed. The first area of literature relates to user involvement and the concept of partnership working between mental health workers and their clients / patients, or service users as they will be referred to in this study. The second area of literature to be reviewed is the perspectives and
concepts of professional power and authority within the health care arena, with particular reference to the position of nurses within the occupational hierarchy.
CHAPTER 2 LITERATURE REVIEW

Introduction.

This review will examine the literature relevant to professional power, and user involvement within the context of the health and welfare professions and with particular reference to mental health care and services. This thesis is concerned with how service user involvement in mental health affects the individual practitioners power, autonomy and professional practise and the degree to which individual mental health nurses feel threatened by the growing involvement of service users in their own care and in mental health services generally. The key concepts that are the subject of this research are the power and authority of professionals, how this power and authority may be eroded or threatened by user involvement, partnerships between service users and mental health nurses and the influence that user involvement in training has on professional practise.

Consequently the main areas of literature that will be reviewed, which have relevance to this research, are: -

1) User involvement in mental health and the concept of partnership working between mental health workers and their clients / patients.
2) Perspectives and concepts of professional power and authority within the health care professions with particular reference to psychiatric medicine and mental health nursing.

The focus of this research is upon mental health nurses and their power and autonomy in health care practise. Nurses’ power is related to where nurses are in the occupational hierarchy and how nurses professional practise is influenced by these factors. Concepts of power and authority are of relevance because mental health service users often feel powerless and disempowered in their relationships with professionals and it is necessary to examine the theoretical perspectives on power to understand how power is mediated in society and the health care sector. For the purposes of this research, how professional power is being challenged by changes in health and welfare, and more specifically by service user involvement, will also be considered. The issue of professional power and medical dominance in the welfare professions is of considerable interest because of the plethora of changes in social policy associated with health care. Examples of these include: changes to roles, the emphasis on community care and the consumerist and managerialist philosophies that have been promulgated by successive governments and which it may be argued have enabled service user involvement to flourish. A major change in health care policy, and one that is the subject of this research, is in the
emphasis given to user involvement and working in partnership with service users. This has developed alongside a burgeoning service user movement and so the main area of literature that will be reviewed is that of user involvement in mental health.

A thematic approach to reviewing the literature will be used. A review of the literature on user involvement, that is relevant to this research, reveals that a number of common themes emerge including: the history and development of user involvement; benefits and problems associated with user involvement; evidence of user involvement in education and training; the effect of user involvement upon professional practise; partnership working between users and professionals; and finally user involvement and professional power.

From the literature on professions and professional power the themes that will be covered include: perspectives and concepts of power and authority; medical power and medical dominance in psychiatry; nurses power, autonomy and the professionalisation of nursing and the notion that professional power is being eroded or under threat by societal and National Health Service (NHS) policy changes including user involvement.

**USER INVOLVEMENT IN MENTAL HEALTH CARE AND SERVICES.**

**The History And Development Of User Involvement.**

The user movement is relatively new in this country and user participation in services has developed in an ad hoc way (Maza, 1996). The beginning of the current user movement can, according to Campbell (1996b), be traced to an international conference in Brighton in 1985. He suggests that at this conference evidence of such movements from other countries was revealed and highlighted the fragmented and underdeveloped nature of user activity in this country. From that conference the first patient council was developed in Nottingham (Gell, 1987), as was one of the most influential groups 'Survivors Speak Out' whose main aim was to change the mental health system (Bell, 1987) and from a small number of radical anti-psychiatry groups in the 60s and 70s there are now over 900 user led groups many of whom just want better services, information and support (Wallcraft, 2003). Activity by service users both in the statutory and voluntary services, as well as in their own organisations, has been very diverse and the debate about service user involvement has moved on from whether service users have a right to be involved, or have anything useful to contribute, to one of how and when to involve users Campbell (2001).
A number of factors including the increasing awareness of civil rights in the 1970s and 80s amongst those with mental illness have influenced the proliferation of user involvement. The policy of de-institutionalisation meant that the mentally ill were now in a better position to campaign and assert themselves against the hitherto monolithic professions in psychiatry and at the same time a number of radical workers within the psychiatric professions were also becoming influential Campbell (1996a). These radical workers were part of what was known as the anti-psychiatry movement. Ramon & Sayce (1993) assert that, although the current user movement shares some of the anti-psychiatry approach, many service users are not content to be represented by professionals but wish to be empowered and informed themselves and many want structural change.

However, the growth and development of user participation and empowerment has not been achieved just by the pressure of radical groups. It was also encouraged by the political climate of the 80s and 90s in which the New Right ideology emphasised self-help, minimal state intervention and consumerism (Fraher & Limpinnian, 1999). The emphasis on consumerism and the separation of the purchaser provider functions, introduced by the Conservative government has meant that the NHS has become increasingly bureaucratised and managerialised. Pilgrim & Waldron, (1998) note that user involvement was encouraged by a conservative government and embraced by a leftist user movement. User involvement in education also occurred in the context of health care policy dominated by consumerism (Forrest et al, 2000) but the notion of service users as a consumer has come under attack by a number of writers. Anthony & Crawford (2000) found in their research that there was a conflict between consumerist ideology and the statutory responsibilities of nurses, while Williams & Lindley, (1996) argue that changes in services are unlikely to be achieved just by a commitment to consumerism and similarly changes in power relations and equality in citizenship are unlikely to occur just as a result of a consumerist philosophy (Campbell, 1998). The whole concept of consumerism in mental health is flawed and it is questionable whether mental health can be regarded as a true commodity. Pilgrim & Rogers (1999) point to a number of difficulties associated with viewing patients as consumers including, the control over care that professionals have, the reluctance of professionals to share information and decision making, the unequal power relationship between patients and professionals, the lack of choice in services and doubts about whether users of services are in a position to make informed choices. Furthermore service users themselves raise objections to being defined in this way (Campbell, 1998) and as Barker & Peck (1987) retort:

Survivors of the mental health system are no more consumers of mental health services than cockroaches are to Rentokil (Barker & Peck, 1987, p.1)
The Labour government have gone some way to repealing the policy of separating the purchasing and provision of services but they have continued the managerialist philosophy and user participation, rather than being a by product of the consumerist ideology, is now seen as means of monitoring and improving quality of services (Minett, 2002). For the current government the impetus to involve service users is a main feature of their quality initiatives in a number of public services (DoH, 1999c; LGA, 1998). The quality framework for mental health services is encapsulated within three main initiatives: A National Service Framework which defines conditions and standards of services, the Clinical Governance policies which include guidance for clinicians and the Best Value policy in which there is a duty upon local authorities to deliver services to particular standards. Tunnicliffe (2000) suggests that these:

can all provide the means to develop a quality framework and that Users and Carers face both an opportunity and a challenge in participating in the quality agenda (Tunnicliffe 2000, p.8)

Reviews and policy in the NHS in general have also placed a greater emphasis on service users and upon patient and public involvement in many facets of health care organisation and services (The New NHS Modern and Dependable DoH, 1997; Patient and Public Involvement in the New NHS DoH, 1999b; The NHS Plan DoH, 2000; The Expert Patient DoH, 2001a). Most recently the government have established a Commission for Patient and Public Involvement in Health with responsibilities to monitor complaints and quality of services as well as involve the public in many aspects of decision making in the NHS. In mental health care user involvement has also been given a high priority. The government review of mental health nursing (DoH, 1994a) placed more emphasis on user and carer involvement in the education of mental health nurses whilst service user involvement in mental health services has been made mandatory by the publication of the Patients Charter for Mental Health (NHS Executive, 1997b) and the National Service Framework for Mental Health (DoH, 1999d). Locally the West Midlands NHS Executive has issued guidance to its Trusts on how users can be effectively involved in the development of mental health care (NHS Executive, 1997a) and the West Midlands Research and Development advisory board has a stated aim to facilitate user involvement in every stage of the research and development process (Howie, 2000).

There has therefore been a plethora of policies and documents that have either espoused the virtue of patient / service user involvement (Sayce, 1993; Patients Charter Mental Health Services, NHS Exec1997b; Partnership in Action, DoH, 1998a) or made it mandatory as part of the policy (NHS Community Care Act, DoH, 1990a; Care Programme Approach, DoH, 1990b;
In summary, the development of user involvement has flourished since the 1980s due to a combination of de-institutionalisation, pressure group activity, changes in political philosophy and subsequent policy development. The conceptualisation of people who use mental health services has changed over thirty years from patients to consumers to service users and, more latterly, even as being providers of services themselves (Pilgrim & Rogers, 1999) but user involvement can be based upon different and not necessarily compatible perspectives of anti-psychiatry, citizens rights and consumerism (Hird & Cash, 2000). User involvement may be seen as worthwhile by governments and/or by service users, who themselves may derive some benefits from being involved in decision making and in developing services, but conflicting ideologies and perspectives may also produce some difficulties and the benefits and problems of user involvement will be discussed in the next section.

The Benefits And Problems Of User Involvement.

Apart from the need to comply with government policy and guidelines there are a number of benefits to professionals in user involvement. Campbell & Lindow (1997) suggest that it improves job satisfaction, that it may improve clinical outcomes and that services are unlikely to improve unless service users' experiences and knowledge are taken into account. For professionals conducting research, Truman & Slade (1999) demonstrated improved response rates to service user interviewers and Rose et al (1998) contend that by using service users as interviewers they can obtain more open and honest responses. User involvement is regarded as essential to good practise both in care (Anthony & Crawford, 2000) and in education (Hopton, 1994) and may help to develop an alliance between students and users that can challenge power relationships (Hird & Cash, 2000). Professionals should regard users as experts in their own illness (DoH 2001a) and perceptions of users alter when mental health workers see patients as experts (Lindow, 1992). There are now a number of reports of users themselves benefiting from involvement both personally and practically (Simpson & House, 2003), in helping in their own recovery (Bennett & Baikie, 2003) and most importantly they are perceived as, and feel more empowered (Ramon, 2001; Morgan & Sanggarran, 1997).
However, user involvement does have some potential difficulties and it is questionable whether real empowerment and partnership with professionals has been realised. The issues of power and partnership will be discussed in the sections on these issues. When participating in a process such as research or teaching, users may become ill or go through periods of crises (Ramon, 2001). There are a number of barriers that will need to be overcome for effective user participation such as timing of meetings, using appropriate language and not professional jargon (Pattison, 2001), staff resistance and negative or paternalistic attitudes (Bowl, 1996; Anthony & Crawford, 2000)) and ensuring that there are the resources for proper consultation and preparation especially in education as user trainers will need both the skills to train and the time to prepare training sessions (Forrest et al, 2000). Worse still is the abuse of users that may occur if they are patronised or only consulted on trivial matters (Pattison, 2001) or as Shaw (2001) asserts, some involvement exists to give legitimacy to the project rather than to really engage with users. These examples of tokenism can be another form of disempowerment but Read (2001b) argues that involvement in training is more promising as it gives users a real opportunity to talk about things that matter to them.

There may also be organisational problems in developing user involvement strategies. Bowl’s (1996) study of local authorities found little evidence of any strategic development. Similarly Maza (1996) reports that senior managers and planners had little contact with users whilst Higgins (1994) found that a lack of a clear and unambiguous management lead, in relation to the purpose of user involvement, led to difficulties in frontline workers and local managers coming to terms with its application which could be aided, he suggests, by some formal education and training. The very culture of an organisation may not be conducive to user involvement according to Jackson (2001) who states that some organisations employ user workers but then do not provide the infrastructure to help them. These examples show that whilst government policy, and notions of good practise may espouse user involvement there is nevertheless a resistance, reluctance or lack of commitment to it which is confirmed in a study by Warner et al (2001) who interviewed a panel of users who felt that staff were not yet committed to or skilled at user involvement in any meaningful way.

A further problem of user involvement is that users views may be disregarded. This is often justified on the grounds that mental health service users are not a homogeneous group and users may represent their own needs rather than those of other users (Hostick, 1998) or if users are articulate they may be regarded as unrepresentative (Crepaz-Keay, 1996). However, as Beresford (1994) points out, most user group representatives are democratically elected and the representativeness of professionals and policy makers is rarely challenged whilst Crawford...
(2001) reminds us that representatives of service users hold a range of opinions about issues, such as therapies, in the same way that the views of psychiatrists and others vary. He notes also that some user representatives receive training that involves distinguishing between presenting their own views and those of others and argues that what is central to the concept of user involvement is obtaining the informed views of experienced service users. Users views may also be discredited on the basis that the professionals regard them as a symptom of their illness (Perkins & Repper, 1998) a process that Goffman (1961) referred to as 'looping'. In an evaluation of an advocacy project, that service users were involved in designing, Higgins (1994) reports a number of difficulties in implementing the scheme, including the belief that the patients council was unrepresentative, but also what he called the 'credibility issue' in which some nurses believed that patients stories cannot be relied upon.

The anti-psychiatry movement originated in the 1960's and 70's with the work of writers such as Laing (1967) Goffman (1961) and Szasz (1972) who were critical of traditional medical models of psychiatry and put forward other complex and detailed propositions to explain the experience of mental illness and the position of psychiatry. Users who express views that do not concur with professionals may be labelled anti-psychiatry according to Campbell (1996a). This may be a further rationale for professionals dismissing the views of users, according to Reynolds and Read (1999), who suggest that training courses which seek to promote user views and encourage an understanding of their perspective run the risk that these views can be labelled as 'anti-psychiatry'. The research that is the subject of this thesis seeks to find further explanation for this lack of commitment and attitudes towards user involvement particularly in relation to the education and training of professionals and the effect of user involvement in education and training will be considered in the next section.

Evidence Of User Involvement In Education And Training.

There are now numerous examples of service users becoming involved in many aspects of service development and delivery including clinical practice, commissioning, auditing, researching, recruitment and education and training (Bhui et al, 1998; Maza, 1996; McClelland, 1998; Rose et al, 1998; Wolf, 2001; Barnes et al, 2000). For the purposes of this research user involvement in education and training is of most interest but involving users in training mental health workers has only recently become widespread because of the aforementioned social policies although its value has long since been recognised. The Mind policy for user involvement suggests:
It can enable workers to understand more about the implications for users of their actions, their treatments, their approaches (Sayce 1993, p.4).

Lindow (1992) called for service users to train mental health workers as she believed that if users were regarded as experts in their illness they would be perceived differently. Indeed Hanson & Mitchell (2001), reporting on a course to prepare service users for a role in the classroom, note that the ‘role of helper and helped are reversed’ and that this alters student perceptions of people with mental health problems. In utilising the services of users and carers in seminar work with social work students Ramon and Sayce (1993) state that

Successive generations of students have commented on how thought provoking, useful and innovative they found the workshops … (Ramon and Sayce 1993, p. 66)

Basset (2000 a) reports similar sentiments in evaluating user involvement on a Diploma course whilst Coupland et al (2001) have shown the value in utilising real life case study videos made by users themselves. However, Hopton (1994) asserts that there are more fundamental problems within the culture of nursing that may militate against user involvement especially within pre registration nurse education, in which the curriculum has in the past been influenced by psychiatrists and concentrated upon a medical perspective of illness and care rather than a broader approach that may encompass other perspectives. The 1982 syllabus, however, did attempt to encourage a broader perspective and embrace a more user centred philosophy but Hopton (1994) argues that the syllabus was too abstract and did little to change practise. He recognised a need for more radical change with service users being employed as teachers. There are now reported examples of this in Australia (Happell & Roper, 2003), but Hopton (1994) predicted that this would not happen because the new political and economic trends would mean that teachers and others would be more concerned with trying to prove that only they could provide the best quality or value for money service. The mental health nursing review (DoH, 1994a) recommended that people who use services should participate in teaching and curriculum development however these recommendations rely upon teachers and trainers to implement them and there is little or no auditing of this in nurse education in this country. The justification for involving users in education is that they are 'expert' in their own illness. Fraher & Limpinnian (1999) point out that this is problematic in that both professionals and users make claims to expertise and it may be difficult for educationalists to include service users unless they challenge their own notion of professional expertise. However, some evidence of user involvement in nursing pre registration education in this country is now emerging (Wood & Wilson-Barnet, 1999; Repper et al, 2001; Minett et al, 2003) but this is due to the efforts of individual teaching staff rather than as a planned unified approach across the sector. There is
certainly little evidence of the radical approach suggested by Hopton (1994). More radical approaches have been reported elsewhere with mostly positive results. Morgan & Sanggaran (1997) utilised feedback from users to make assessments about student nurses performance. In a sample of 43 students there were only five negative comments from students about this procedure with most of them seeing the benefits of involving users. However, more students may have been rather more critical if they had failed the programme. In another Australian study Clinton (1999) reports on the value of a collaborative education project which involved student nurses studying with a group of people with mental illness. Clinton (1999) concluded that this helped to change stereotypical or negative attitudes of the nursing students because of the increased social interaction between students and users and the status of the two groups were the same. This collaborative approach was used by Bennett & Baikie (2003). An academic and a service user worked in partnership teaching undergraduate nursing students with the service user giving a presentation of his personal experiences. Bennett & Baikie (2003) asked students in an examination to reflect upon the service users input and report that there was evidence from the students' responses of empathy and increased awareness of their own attitudes. However, whether the change in attitudes is enduring and continues when the students have become fully-fledged professionals and are exposed to negative attitudes from other professionals remains to be seen. Furthermore this study is an example of self-reporting, and could have been misinterpreted by the authors. The actual users experiences of the students' attitudes may differ or students' attitudes may change as these are often based upon experiences of working with the mentally ill (Hugo, 2001) and can be positive or negative (McLaughlin, 1997).

The efficacy of involving users in education and training is articulated in many of the aforementioned reports and indeed by some students (Felton 2001) whilst Read (2001b) contends that user workshops often score highest on participants' evaluations of training days. However, as previously noted user involvement in education occurs because of the efforts of individual teaching staff. Basset (1999) contends that although there are policies about user involvement in training there are few action plans on how these will be implemented. This is confirmed in a report of the fourth mental health nursing conference where it was reported that there was minimal evidence of user involvement in some areas and criticism that education providers are often unclear why and what they want from user involvement (Grant et al, 2003). A more recent multi-disciplinary conference (MHHE, 2003) demonstrated numerous examples of good practise in this respect but a recognition that it was patchy and more could be done. As with all forms of user involvement, in education, user involvement can also be tokenistic and excuses can prevent the involvement of service users in teaching and curriculum development from occurring (Crepaz-Keay et al, 1997). Forrest et al (2000) provide a useful continuum or scale of user involvement in learning and teaching about mental health that ranges from no
consultation in curriculum planning to educationalists and users working systematically together. They assert that for any real change or commitment to user involvement in education to take place, user groups need to be supported and remunerated in the same way as educationalists and that the latter also need to challenge structures and systems within their own educational establishments to ensure that user involvement in the education and training of professionals becomes embedded within the curriculum.

Service user involvement in education and training at post qualifying level occurs much more frequently. There are numerous examples of this (Took, 1997; Town et al, 1997; Barnes et al, 2000) and there has certainly been an increase in service users becoming trainers and engaging in the education and training of mental health workers (Reynolds & Read, 1999). This proliferation has probably occurred because of the government policies mentioned earlier and that fact that NHS Trusts are audited against these policy objectives and standards (DoH, 1999b; DoH, 1999c). In the West Midlands region further guidance, on user involvement in training, was given to NHS Trusts (NHS Exec, 1997a) and training providers have been surveyed on this issue. The main rationale for user involvement is to change attitudes and practise. This may be more difficult with qualified staff who may have entrenched views and who have been working in particular ways for some time, although studies with other groups have certainly shown that short educational interventions and training can change attitudes and affect individual practise (Pinfold et al, 2003a; Pinfold et al, 2003b; Minett, 2003). The effect upon individual professional practise of user involvement in training will be discussed in the next section

The Effect Of User Involvement Upon Professional Practise.

There are few examples in the literature of the effectiveness of user involvement generally although Simpson & House (2003) suggest that if it is intrinsically worthwhile then it would not matter whether changes resulted from it. However, if user involvement in education and training is to be of value then there should be some demonstrable change in individual professional practise. There is a dearth of literature on user involvement in education generally and particularly on its effectiveness in changing practise. We do know from the literature which does exist that education has the potential to change stereotypical or negative attitudes (Clinton, 1999; Bennett & Baikie, 2003) and produce more empathic nurses (Wood & Wilson-Barnett, 1999) but it does not necessarily follow that individuals will change their practise. Williams & Lindley (1996) observe that presentations from service users can achieve changes in attitudes and behaviour, although they provide no evidence of this, and Hanson & Mitchell (2001) argues that the increased awareness that students gain from user involvement in education could encourage students in practise to focus on a person’s strength rather than their problems.
In one of the few studies in this area Happell & Roper (2003) did find some self reported examples of changes to practise that occurred as a result of a service users input into a post graduate course. In their study a user was employed as an academic to help deliver the course and the effect of her input was evaluated by a questionnaire to the students. The majority of students were positive (n=21) with only two who viewed the process negatively. The students commented on the benefits of the user input, how it had enabled them to be better clinicians and gave some examples of changes to the way that they practised. It must be noted, however, that this study is an example of self-reporting, which relies upon the memory and honesty of the subjects, and whether users themselves agree that the individual has changed their practise is unknown. There was no pre test to compare findings with, and this group of students could already have more positive attitudes towards user involvement, so it is not possible to conclude with certainty that measurable change occurred because of the course. However, although this is one relatively small study in one University and therefore not generalisable, it does provide some evidence as to the effectiveness of user involvement in changing practise. As the authors note, the purpose of the evaluation was not to measure attitudinal change or practise but perceptions of students as to the value of user involvement. They conclude that the positive responses of the students do create a sense of optimism for the future that there may be an increased role for service users in meeting healthcare needs. In this country the study by Wood & Wilson-Barnet (1999) also provides some optimism for the future as this study involved service users in pre-registration education. In this comparative study students received the same curriculum but a service user as well as a lecturer facilitated one group. The researchers used classroom observation, a questionnaire and video materials to illicit student responses. Wood & Wilson-Barnett (1999) were able to show that student nurses who were given experience of user involvement in the classroom were more able to empathise, less likely to distance themselves from service users and more likely to engage in individual care than students who had not had this experience. Again, this is one single case study that is not generalisable and there was no baseline measurement of students’ responses so it is not possible to state with certainty that these factors had occurred just because of the user involvement.

As previously stated there are numerous examples of user involvement in post registration education and training (Took, 1997; Town et al, 1997) but little evidence that any changes to practise are actually occurring. In a preliminary evaluation of one post graduate programme of inter professional education, in which users had substantial involvement, participants valued the user contribution to the course and provided examples of how their own practice had developed as a result of it (Carpenter et al, 2001). This study was carried out by independent researchers who stated that changes in working practices were made by course participants such as a
reduction in the reliance on the medical model and a widening understanding of holistic issues. In a separate paper on the same course Barnes, et al (2000) refer to course participants' examples of user involvement initiatives in practise that had been attributed to the course. In this study, as in all the studies discussed, the reported changes in attitudes or practise have been made by the course participants themselves or by the researchers and are not validated by users who may disagree that there has been any changes to professional practise or to the inequitable power relationships that exists between users and practitioners. This will be explored further after some discussion on the concept of partnerships between users and professionals. The effect then, if any, of user involvement in the education and training upon the practise of mental health workers is certainly unclear and no generalisable evidence has been reported and as Campbell (2001) notes that after a decade and a half of service user involvement there is no evidence that it is working and almost no research on how service user involvement in training mental health workers is developing. As previously stated one of the purposes of user involvement in education is to change professional practise and one aspect of this is the degree to which professionals work in partnership with service users. This notion of partnership working will now be discussed in the following section.

**Partnership Working Between Users And Professionals.**

A number of government policies in healthcare refer to the concept of partnership (DoH, 1994a; DoH, 1998a; DoH, 1999b; DoH, 2001a). The government review of mental health nursing contained a number of recommendations that referred to partnership and a determination that people who use services should be engaged in a new partnership with nurses (Butterworth & Rushforth, 1995). Recommendation one is concerned with the planning of care for patients or service users and suggests that care plans should be developed between professionals and service users and should be based upon individual users wishes and needs. Butterworth & Rushforth (1995) explain that this will mean that nurses must treat service users as equal partners and stakeholders. Government policy on the Care Programme Approach (CPA) also emphasises the need for user involvement and partnership between users, carers and professionals when making assessments and planning care with service users (DoH, 1990b). However the rhetoric does not match the reality and studies have found that service user involvement in the CPA can be minimalist with reports of lack of negotiation or involvement about care, users not receiving care plans and even a lack of knowledge of the existence of a care plan (North, Ritchie & Ward, 1993; Wolfe et al, 1997; McDermott, 1998; Simpson, 2001; Rose, 2001).
Writing from a service user perspective, Trivedi (1996) identifies a number of advantages to working in partnership including, improved communication, the potential for improved service provision and users being more active participants. However, she also notes a number of barriers or problems for nurses such as a reluctance to lose the security of professional status, anxiety about accountability, the threat posed to their roles if they are critical of services and the issue that nurses are in a contradictory roles of carers and agents of social control. Basset (2000b), also writing from a user perspective, is critical of the rhetoric on partnership, articulated in mental health policy and argues that partnerships are difficult to achieve with professionals who consider that they know best and a government who on the one hand talks about social inclusion whilst on the other develops policies such as compulsory treatment orders which are anathema to service users and professionals alike. Similarly, in questioning the imbalances of power that remain despite the numerous user involvement initiatives Campbell (2001, p.88) contends that ‘when service users are always invited but never invite, the true nature of partnership must be questioned’ and he goes onto point out that changes in government priorities from service user involvement and partnership to one of public safety renders partnership and compliance incompatible. These contradictions are also pointed out by writers such as Pilgrim and Waldron (1998) who state:

Consumerism emphasises personal choice and the user movement emphasises citizenship. Both of these are contradicted or negated by the powers delegated to service professionals under mental health legislation (Pilgrim and Waldron, 1998, p.100)

Writing as a nurse, McDougall (1997) is also critical of the concepts of empowerment and partnership and cites the unequal relationships in partnerships between users and nurses. He goes on to argue that as long as nurses have the feeling that they know best there can be no empowerment or respect for autonomy and he urges nurses to examine their oppressive practises and surrender their power to patients. In education, the papers from Happell & Roper (2003), Bennett & Baikie (2003) Barnes et al (2000) discussed in the previous section are examples of partnerships between users and educationalists and, as previously noted, there are relatively few of these reported in the literature. The latter authors describe a successful partnership in their case study of a multi-disciplinary postgraduate course in which service users had a major contribution. They note however that: -

the roles and responsibilities of users have been constrained by formal university requirements' and that ‘Partnership, in other words has to operate within a structure in which power lies with the educational institution, not to mention the course funders (Barnes et al, 2000, p.198)
Partnerships between educationalists and users should not be promoted unless the latter are prepared, supported and remunerated in the same way (Forrest et al, 2000) but this is unlikely to happen unless there is change in the culture of mental health nurse education, which relies predominately on a medical perspective of care (Hopton, 1994), or structural change, both within services and universities, so that a user perspective can be given equal consideration and value. Partnerships are based upon relationships and in mental health the relationship is an unequal one with professional workers having more power than the service user (Campbell, 1996a; Basset, 2000b). For partnerships to work a change in the nature of the relationship needs to occur with all partners being considered as equals and more power being given to the service user (Trivedi, 1996). The issue of how user involvement affects partnership working, and the effect user involvement has on professional power, is central to this research and it is this issue of user involvement and professional power that will now be discussed.

User Involvement And Professional Power.

User involvement may be regarded as a threat to professionals or one way in which professional power can be eroded. Professionals are able to maintain their power over service users by a number of strategies including, their resort to claimed knowledge and professional expertise, discrediting the views of service users, use of language, the status afforded to them as a profession and the statutory responsibilities that follow from this, for example, in their social control function. The social control function will be discussed in the section on theoretical perspectives and concepts of power. Iphofen & Poland (1998) argue that knowledge and expertise is the form of power most used by health professionals and Basset (2000b) asserts that there is paternalism amongst all professions in which professionals regard themselves as knowing what is best for their clientele. Service user and academic writers, who would argue that patients themselves are expert in their own illness, question this paternalism and concept of expertness. Perkins & Repper (1998) point out that in mental health there is a range of contradictory models of care and that mental health professionals have a particular form of expertise based upon frameworks that their professions have invented. For example psychiatrists explain mental health problems or distress in terms of disease and seek to treat the disease by medical interventions. In contrast psychologists seek to explain mental distress in a number of ways such as social, familial or psychological processes. Perkins & Repper (1998) assert that one thing that is shared by these models of care is that they were developed by people who did not have lived experience of mental health. Although Crawford (2001) reports that the British Medical Association now recognises that paternalism is no longer appropriate for the doctor – patient relationship, the result of this challenge to professional expertise is that many
service users are now turning to alternative forms of expertise, including self-help and user led
groups. This, of course, may also erode or challenge the power base of professionals. Lindow
(1993) suggests, one way of achieving power in moving towards user led services will be
through developing confidence in the expertise of users.

Individual service users and user organisations have campaigned for changes in psychiatric
services, especially in the way in which professionals manifest power and users are
disempowered (Trivedi, 1996). It has been argued that power imbalances prevent good nursing
care (Campbell & Lindow, 1997) and that the whole purpose of user involvement is to change
the balance of power but any power granted to users can also be taken away (Linett, 1999).
Campbell (1996b) suggests that patient councils and advocacy services are valuable
mechanisms for adjusting the imbalance of care but recognises also that the nurse / user
relationship must be one in which there is relative equality of power. However, despite the
rhetoric users feel that they have little or no control over service planning or provision (Maza,
1996). Although they view greater involvement positively their capacity to participate is limited
by an unequal balance of power and the ideology of services (Glenister, 1994). Individual
service users want to be consulted, involved in their care and share in the decision making
process whilst others campaign for structural change (Lindow, 1996; Crepaz-Keay, 1996). This
is an important distinction between empowerment which is a psychological concept in which
power is represented as an individual possession, and contrasted with power which is a political
term and refers to the structural conditions and power relationships between groups (Perkins &
Repper, 1998). Many Individual service users, and those who belong to user organisations that
are now being used, for example, in consultation processes and involvement in training and
service development, just want to feel empowered (Wallcraft, 1996) whilst those on the more
reformist wing of the user movement, who often refer to themselves as survivors, want
structural change (Crepaz-Keay, 1996).

The paucity of literature on the effectiveness of user involvement referred to earlier is also
apparent when looking for evidence of a threat to the power of professionals or their feelings or
fears of user involvement. This may be because there are few health care professionals or
managers who would dare dismiss the importance of user involvement now as it has become
politically expedient and forms part of the everyday rhetoric of policy makers and implementers
at local level. Indeed Hopton & Nolan (2003) argue that professionals have become competent
in using ‘politically correct’ language to maintain an illusion of inclusiveness. It has been
recognised, however, that user involvement may pose a threat to the power of professionals,
with suggestions that, professionals are ignorant, indifferent and fearful of user involvement
(Pattison, 2001), that it is threatening to all clinicians including nurses (Glenister, 1994), that
their opinions are interpreted as a challenge to professional expertise (Town et al, 1997) and that it may be too risky when applied to vulnerable people or being used by leftist workers (Ramon & Sayce 1993). Croft & Beresford (1993) provide a useful list of some of the common worries that service providers and purchasers may have including fears that; they will be criticised, their skills will no longer be valued, they will lose their power, they will not know how to work in the ways proposed and that their roles will be under threat. The latter point is shared by Trivedi (1996) who suggests that being critical of services and supporting users may pose a risk to the roles of nurses.

In a study evaluating a user forum scheme, which was designed to create a democratic power base for service users, McCullogh & Hasson (1998) elicited the views of the various stakeholders to the implementation of the project. They report that many hospital staff appeared resistant because they felt it would challenge their power base and become a threat to the responsibility of the primary nurse. However, the majority of community based professionals were more understanding of the project and felt the work should continue. This study gives no indication of the numbers of respondents or of other variable that may have affected perceptions of the project but it does indicate that superficially at least there is some disquiet about initiatives that seek to give power to user groups. The threat posed by user involvement can also be demonstrated in an Australian study (Morgan & Sanggaran, 1997) in which service users were used to assess student nurse performance. The purpose of this study was to find out how direct involvement of service users in providing feedback to students may influence the learning experience. Questionnaires were issued to 43 students most of whom were positive about the experience but there were, five students whose responses were negative about the participation of users. They discredited the feedback given to them because it came from people who are in institutions and the authors conclude that this reflects fears that border on prejudice and ignorance and that these students have very narrow views about mental illness. These authors offer no other explanation as to the particular characteristics of these students and do conclude that users have a role to play in students learning however the negative comments do suggest that there is a cadre of nurses who are reluctant to accept or are threatened by user involvement and the challenge for future research is to identify common traits amongst these groups and means by which their beliefs and attitudes may be changed.

Despite the rhetoric on user involvement and the plethora of initiatives to involve service users there is little evidence of power sharing, and reluctance by some professionals at least to give up their power. Individual professionals may seek to empower and / or involve service users but there is no real change in the structure of power relationships and user involvement at a policy making level is negligible. Senior management and planners have little contact with users.
(Maza 1996) and in a study of user involvement across 31 authorities Bowl (1996) found that there was little evidence of power sharing, few examples of involvement in management activities and pressure upon users by professionals to justify their position. Even the Department of Health are culpable, it seems, as Trivedi (2001) reports on her experiences as a black user member of the group who developed the National Service Framework. She points to being marginalized within the group, the lack of real consultation and the offensive and demeaning comments of some members.

According to Campbell (1996b) the user movement has brought about significant changes and that government, health and social services can no longer ignore the views of users. However he reminds us that:

Madpersons as empowered consumers of services and madpersons as equal citizens are two quite different propositions (Campbell, 1996b, p.224)

In a later paper (Campbell, 1998) argues that despite attempts at empowerment for those people diagnosed as mentally ill who are welfare consumers they will always be regarded as inferior. This is an argument for structural, attitudinal and cultural change in both the organisation and development of services but also in power relationships between professionals and service users. As Williams & Lindley (1996) suggest this is unlikely to be brought about whilst social inequalities remain because there are powerful dynamics that support the status quo in mental health services including service user powerlessness, the notion that professionals have exclusive expertise in relation to defining and dealing with mental distress, the power of professionals and the structural inequalities that occur in society including those between service users and providers. The development of the user movement, and subsequently user involvement, and the government impetus towards patient and public involvement are driving factors towards structural, cultural and attitudinal change but also poses a threat to the autonomy and power of professionals. In order to explain the reaction of professionals towards user involvement it is necessary to examine the nature of power and how professional power has developed. The following sections will review the theoretical perspectives on power, how the healthcare professions have developed their power, and some other examples of how this may be being eroded or threatened.
PROFESSIONS AND PROFESSIONAL POWER

Perspectives And Concepts Of Power And Authority.

Power is an essentially contested concept according to Lukes (1974) who argues that its meaning and people’s perception of power vary greatly depending upon their values, situation and experiences. Despite numerous years of theorizing and research there is no uniform conceptualisation of power (Hewison, 1995). The concept is not capable of formal verification therefore it is more useful to consider the different insights that alternative theories of power can provide (Cox, Furlong & Page, 1986). There are a number of theoretical explanations of how power and authority is manifested and divided within society. The terms power and authority have different meanings for social scientists. Authority may be defined as a manifestation of power that is seen as legitimate. Barry (1981) asserts that most analysis of authority is concerned with the distinction between de jure authority in which someone is obeyed because of a rule and de facto authority whereby someone can get their way without entitlement or resort to coercion. Giddens (1971) refers to Weberian classification of authority that has three elements. Legal or rational in which those who possess authority do so because others accept their right to authority, traditional authority that is based upon custom and practice and charismatic authority whereby the individual has some personal qualities which enables them to persuade others. These are what Weber referred to as ideal types and in reality all these forms of authority may be manifest in any given situation. For example in relationships between professionals and mental health service users the professional has legal authority invested in them by the state but may also assert their authority because traditionally professionals such as doctors and nurses have been regarded as the experts in defining and treating mental distress.

Philosophers, sociologists and political scientists have all provided theoretical perspectives on power. The classical elite theorists (Pareto 1963; Mosca 1939 referred to by Mowforth 1999) suggest that power lies in the hands of a few people and that this is inevitable as individuals are inherently unequal. There is an unequal distribution of power, not because of economic determination as Marxists would contend, but because those in power have innate talents and abilities that make them more fitted to their role. There are similarities between the philosophers’ classical elite theory and the sociologist Parsons (1954) functionalist view of power. For him some individuals or groups, in respect of the importance of their activities to society’s goals, have more power and this is functionally necessary for the well being of that society. In the health care arena doctors, and possibly nurses and other health care professionals would be considered as being functionally necessary, or as having the abilities for their role according to these perspectives. However both these viewpoints ignore hidden power that is the
ability of others to influence those in power. They also fail to recognise that power may be
exercised to further the interests of some at the cost to others (Wilkinson, 1999) and that talents
and abilities are subjective concepts.

Pluralists such as Dahl (1984) regard power as more diffuse and not necessarily involving
conflict and coercion but being about influencing others to change behaviour. Dahl (1984)
would argue that power does not rest in one centre but a variety of elite groups exist which
makes society more democratic and enables individuals from all social strata to exert some
influence in decision making, by for example pressure group activity. This explanation of
power distribution can be criticised because access to power remains unequal for some groups,
for example the disabled and the mentally ill, who are unable to articulate their demands.
Furthermore some groups such as those representing medicine, are able to exert more power and
influence over other groups for example other health professionals (Wilkinson, 1999).

For Marxists economic and political power are linked and any analysis of power must be related
to class interests (Poulantzas, 1978). In this thesis the state is not neutral but rather serves the
interests of the dominant class. One analysis of power refers to the existence of a power elite in
America, which is comprised of the military, politics and business (C. Wright Mills 1959,
quoted in Barry 1981, p.85) in which elite rule is based upon exploitation of the masses and
conflict occurs because elites and the masses have different interests. This is a conflict version
of elite theory and one that can be applied to Britain and to the study of professions as doctors
can be considered an elite within the healthcare system. Unlike the earlier elite theorists Mills
rejects the notion that elites have superior qualities and asserts that structural power ensures that
those at the top of the institutional hierarchy largely monopolize power. Major criticisms of this
theory are that it is unverifiable and that power is regarded as a structural relationship only and
does not take into account the will of individuals or their ability to act in creative ways (Aust et
al,1994).

The Weberian position on social closure and class is a useful means of explaining the high
status and power enjoyed by most professions and particularly medicine. Social closure is
defined as:

the process by which social collectivities seek to maximize rewards by restricting access
to resources and opportunities to a limited circle of eligibles (Parkin, 1982, p.175).

Exclusionary closure for Parkin occurs when one group attempts to secure itself a privileged
position at the expense of others. The excluded group on the other hand attempt to usurp their
superiors to obtain a greater share of resources. In terms of the professions the medical profession has been very successful in dominating the health care sector and in subordinating other health care professions by firstly regulating them and secondly by defining the territory in which these professions can operate. Some professions, such as nursing, have attempted usurpation but have not mounted a successful challenge to medical dominance.

It is important to consider how power is manifested in society, between groups and individuals, in order to understand the imbalance of power that exists between users and professionals. Power also needs to be considered as a feature of individual or everyday interaction or what Cavanaugh (1984) calls an interpersonal construct. The meanings and interpretations given to events and interactions by individuals are crucial, according to the symbolic interactionist perspective. Hewison (1995) uses this perspective to show how power is mediated at an individual level between nurses and patients through language and notes that although power is exercised through wider social structures the nurse-patient interaction is a microcosm of these social forces. His study of interactions between patients and nurses on an elderly care ward reveals that nurses demonstrated power through language in a number of ways. They used overt power to order or prevent patients from doing something or persuasion to get patients to do things without recourse to direct commands and most commonly they controlled the agenda by asking questions of patients that had a limited range of responses. Hewison (1995) was able to show that at an interpersonal level nurses were far from powerless and were able to exert a good deal of power over patients. This study though was carried out on an elderly care ward and it is not clear how much ability the patients had to resist orders or to assert themselves and it would be useful to consider, in a Weberian sense, how much authority the patients themselves considered the nurses to have as it is clear that in many instances patients and service users are not just passive recipients.

Symbolic interactionists have provided a detailed investigation into issues around psychiatry such as deviancy, the process by which people go mad and the labelling of mental illness (Samson, 1995). They show that language has a particular significance in psychiatry as the words that are used and the way in which people and things are named define roles and power relationships (Perkins & Repper, 1998). Psychiatrists, nurses and other professionals are able to define illness, wellness, disability and even deviance. The language associated with these concepts is applied as labels to individuals regardless of whether individuals agree with the professionals' interpretation of behaviour or events. So a further manifestation of medical power at an individual level is in that of 'labelling'. Labelling theory focuses on how people view themselves and how labels become attached to individuals (Scheff 1996) and those in power, and psychiatrists in particular, have more power than others in this respect and are able to apply
mental illness labels. Rosenhan (1975) has shown that once a label has been applied by powerful people it ‘sticks’ and follows the person into the future. Within psychiatric care the work of Goffman (1961) is also particularly important. Using participant observation and the theoretical perspective of interactionism in his work on Asylums, he demonstrates how the process of care leads to what he calls ‘mortification of self’. Individuals are stripped of their power, identity, roles and their whole lives are subjected to rules and schedules that are shaped by the needs of the institution and its staff. This manifestation of professional power is perhaps the most all-pervasive and this is perhaps one reason why the concept of patients as survivors as opposed to users of services has developed.

A post structuralist and post modernist theory of professional power can be found in the numerous works of Foucault (1974, 1976, 1977) who relates power to knowledge and questions how particular statements are made and what conditions make certain kinds of knowledge (discourses) possible or acceptable. Power is not generated in a structural fashion but is derived through interaction between individuals. Medical power is also mediated through knowledge and interactions and the power of the medical profession rests on its ability to persuade others to share their discourse. Foucault (1976) also uses the concept of panoptic surveillance by which he means that experts including doctors and nurses monitor us in many facets of our lives. In using a Foucauldian analysis Porter (1998) explains that the medical discourse enjoys a powerful position because firstly, other health professionals, including nurses, adopt the medical discourse and secondly, because medical language is inaccessible to patients the power of medicine is reinforced by its exclusive access to knowledge. Power relations in modern society consist of the surveillance activities of experts who monitor behaviour, make decisions about whether it fits into their concept of normal and act upon us if it does not.

In reviewing the perspectives on professions, power and authority it can be seen that professional power and authority can be manifested in a number of ways. Professions may dominate in the occupational hierarchy, and restrict the activities of other professions, as is the case with medicine and nursing and in doing so they may be seen to serve their own interests rather than the interests of society or those that they serve. Professional groups will also exercise their power and authority as groups and individuals over their clients in a number of ways including acting in a social control function as agents of the state, in attaching labels to their clients and in interactions with them. In the health care sector patients have less power than professionals partly because of the authority invested in professionals and partly because of the vulnerabilities they suffer as a consequence of their illness (Iphofen & Poland 1998). However as Giddens (1993) suggests, wherever there is power, and power disparities, there is resistance to that power. In recent times there have been a number of initiatives that have led
some commentators to suggest that there has been an erosion of the power of professionals and those issues will be examined in the final section of this review. The following section will examine how medicine has achieved its power and status both in society generally and in its subordination of other professions.

Medical Power And Medical Dominance In Psychiatry.

The emergence of a medical account of health and illness was the result of many factors such as the rise of science, economic and social transformations, the changing perceptions of medical knowledge, the reconceptualisation of the body and the development of hospitals (Jones 1994). This scientific approach to illness was also incorporated into the treatment of madness and using Foucault’s analysis, Tudor (1996, p.19) states that psychiatry also echoes a purely medical approach to mental health, referred to as the medical model, in which mental distress is regarded as a disease and is dealt with by diagnosing, treating and curing illness. In Foucauldian terms psychiatry has been immensely successful in persuading others to share their discourse as medical models of care predominate.

In the mid 19th Century a change also occurred in how mad people were perceived and treated. The new humanitarian approach, whereby lunatics were put in asylums and attempts to cure them were made, gave rise to a whole new branch of the medical profession and in 1851 psychiatry developed as a professional association. Busfield (1986) reminds us that the humanitarian approach did not apply to people of low social standing and Scull (1979) asserts that the principle of kindness as the only form of treatment, which occurred in some private asylums, was a threat to medical ambitions. He goes on to argue that medicine incorporated moral treatment into their own practices and as asylums became a haven for deviant or difficult people psychiatrists developed a social control function. The medicalisation thesis and the social control function are further expounded by Busfield (1996) who examines the role of the state in giving medical practitioners professional powers by licensing their activities and certifying patients. In a Marxist analysis this power can be interpreted as the psychiatrists acting in the interests of capital to control those who are deviant. Busfield (1996) points out that psychiatrists have responded by incorporating psychological and sociological thought into their practice but that they have been selective and moulded them into their own ideology. Furthermore they have been successful in subordinating other mental health professionals who have attempted to utilise other expertise. In a Weberian sense this can be seen as psychiatry being successful at social closure and creating and monopolising the field of mental health care.
From a neo-Weberian perspective in Freidson’s (1970) seminal paper on the medical profession he contested that the medical profession were motivated by self interest and not altruism and that they were particularly adept at advancing their social status and exercising their power by occupational strategies such as social closure, controlling their own work, monopolising medical practice and the subordination and domination of other health care professionals. In a later paper Freidson (1985) suggests that although medicine will have less control over the economics of health care its basic dominant position will remain the same. Although medicine has largely been superordinate amongst the health care professions the growth of alternative medicine, and the challenges to the credibility of psychiatric knowledge may be seen as an amelioration of the persuasive ability of medicine (Pilgrim & Rogers, 1999). Despite an extensive critique, Barney (1994) argues that psychiatry and the medical model remain dominant and he extends his analysis to other professions. He is also critical of Western economic systems and suggests that psychology and other ‘culture industries’ such as counselling help to suppress the real problems of capitalism the corollary of which is that the biomedical model is ascendant and psychiatric power undiminished.

In summary, the professionalisation, status and power of psychiatry therefore has been aided by the Enlightenment period and the medicalisation of madness. In the twentieth century the professionalisation process was assisted by a number of factors including, the 1930 Mental Treatment Act, which transformed the language used so that lunatics became patients and asylums became hospitals; the establishment of the NHS and the development of therapeutic activities (Tudor, 1996) and by the actions of the state and psychiatrists themselves. However medical hegemony and the subordination of other professional groups has been criticised from a number of theoretical and philosophical perspectives. The following section will discuss the place of nursing in the professional hierarchy and the ability of nurses to exercise their professional autonomy and power.

**Nurses Power, Autonomy And The Professionalisation Of Nursing.**

The position of nursing in the occupational hierarchy is more difficult to define than that of the medical profession because nurses in many instances are still subordinate to doctors, despite attempts to become autonomous, and nursing is still struggling to be regarded as a fully fledged profession. In a comprehensive history of nursing Abel-Smith (1960) has shown how the Nightingale reforms of nursing mirrored the Victorian class structure by creating a respectable occupation for middle class women but conversely the same reforms delayed attempts at professionalisation as Nightingale herself resisted registration. When nursing achieved registration by an act of Parliament in 1919, which formalised regulation and education, it was
largely regulated by the medical profession (Stacey 1988) who continued to influence the education of nurses until a new professional era emerged in the 1970s.

The lack of its own knowledge base relegates nursing to a semi-profession according to Etzioni (1969) whilst medicine remains an obstacle to occupational autonomy and authority for nurses (Keddy et al, 1986; Hugman, 1991) particularly within a hospital structure (Davies, 1983). Feminists from different traditions have also been critical of Western scientific medicine and its hegemony in occupational strategies therefore the status of nursing is determined in relation to the medical profession. For feminist writers the patriarchal structures of professions especially medicine discriminate against women and nursing has been subordinated because of its association with domesticity and because the workforce is predominately female (Gamarnikow 1978; Stacey 1988; Witz 1992). The analysis by Witz (1992) draws upon the neo-Weberian concept of closure and she postulates a theory of patriarchy in which women were excluded from higher education and therefore from influence in the public sphere. She suggests that, in relation to gender, closure is both exclusionary, and demarcationary whereby segregation into particular occupational groups is used as means of controlling them. She asserts that men dominate the medical, dental and legal professions and that they have all used these strategies to subordinate the predominately female allied occupational groups of nurses, hygienists and secretaries.

Although historically psychiatric nursing has had a larger proportion of males amongst its numbers than the other branches of nursing, medical superiority prevails. Symonds (1997) notes nursing has been disadvantaged in its quest for professional recognition by its identification as a vocation but in the male dominated specialism of mental health it has been presented as a skilled craft. Bean (1979) has shown that psychiatric nurses have traditionally accepted the authority of psychiatrists and according to Carpenter (1993) the professionalizing movement in nursing has failed partly because:

Mental nursing in particular, where larger numbers of working class men were concentrated, resented and resisted the incursion of middle class professionalizing women (Carpenter, 1993, p.121)

The problems or failure of nursing to achieve professional autonomy is summarised by Turner (1995) who cites absence of a strong professional association, conflict between family life and professional careers and the absence of a commitment to a career as key factors. To this can be added the gendered division of labour (Stacey, 1988) and the internal divisions within
psychiatric nursing (Carpenter, 1993) as factors that militate against professional status and autonomy.

Despite structural problems nursing did not give up its attempt to professionalise and a new professionalising era emerged in the 1970s. Changes in nurse education such as granting student status; the intellectualising of nursing through the development of nursing theory and the move to graduate status can be viewed as attempts by nursing to improve their professional position (Carpenter, 1993). Further examples at attempts to professionalise can be found in nursing practise with the development of new roles within nursing such as general management, nurse practitioners, consultant nurses and the development of nursing care plans. Porter (1992) is critical of many of these initiatives and argues that clinical and managerial elites within nursing bear little resemblance to the day-to-day reality of most nurses. In a later work Porter (1998) argues that nursing care plans, whilst being a usurpationary strategy, were, in reality, constructed according to the demands or wishes of doctors.

Further examples of attempts to gain professional autonomy, specific to mental health nursing, can be found in the emphasis on therapeutic activities such as counselling and family therapy. Many psychiatric nurses, in common with other mental health workers, have developed these skills and practise them as independent practitioners and the move to community care for the mentally ill, and the concomitant increase in multi disciplinary community mental health teams, has further helped to increase professional autonomy, although nurses are in competition with counsellors, who are also making claims for professional status, for jurisdiction over this type of work (Wheeler, 1999). Rogers and Pilgrim (2001, p.103) suggest that these new working arrangements are riddled with conflict, which they assert ‘centres around bids for professional dominance or autonomy’ whilst Morrall (1995) has shown that a covert hierarchical structure occurs within these teams with consultant psychiatrists seemingly attempting to dominate them. In his study he found that community psychiatric nurses (CPN) had to develop covert tactics to gain some degree of autonomy but even this was not real professional autonomy. Morrall (1995) concludes:

the clinical autonomy demonstrated by the CPN’s was not so much ‘de jure’ – a genuine and legitimate freedom of action over their practice – but ‘de facto’ that is they covertly constructed the conditions under which they worked (Morrall, 1995, p.19)

A recent study, of mental health staff working in Multi disciplinary teams confirms the continuance of medical hegemony when they found that some staff were upset by their lack of autonomy and that the medical model and views of the psychiatrist dominated (Warner et al
This is in contrast to Samson's (1995) argument that the movement away from asylums into the community creates a plurality of treatments and workers and destabilizes the authority of biomedical psychiatry.

The professionalisation and autonomy of psychiatric nursing is also difficult to achieve when nurses have to fulfil their statutory obligations in relation to controlling the behaviour and freedom of individual service users. Nurses have traditionally had to fulfil their obligations to the state and to medicine by being custodians of the mentally ill and enforcing treatments and compulsory orders at the behest of the doctor. In arguing that nursing cannot become a profession, because it has no legitimate ideology, Morrall (1998) suggests that a role in social control gives psychiatric nurses a market opportunity in the Weberian sense and that they should reassert their traditional allegiances with psychiatry. Rogers & Pilgrim (2001), however, note that within psychiatric nursing there are divisions between for example hospital nurses, who are keen to progress their roles by increasing powers of compulsion, and community psychiatric nurses who have tried to distance themselves from compulsory powers.

These arguments about whether or not nursing has successfully achieved professionalisation have concentrated on a structural analysis that makes assumptions that the whole workforce is acting in a collectivist whole rather than an individualistic way. From an interactionist perspective individual nurses may not be totally compliant and may use whatever power they have to agitate for change. This may be manifest by the development and actions of more radical groups or individuals, who challenge medical dominance. Turner (1995) cites several examples of nurse militancy and concludes:

These new features of conflict and lack of compliance appear to fit a conceptualisation of the nurse-doctor relationship that does not assume normative compliance within a system of patriarchy (Turner, 1995, p. 149)

However there is no real evidence that there is any real change in the professional autonomy of nursing in relation to their position in the occupational structure of health care. Although nurses have taken on more roles, hitherto seen as part of the medical domain, medical control over much of nursing work remains intact (Jones, 1994). The professional power and authority that nurses do have may be under threat from other factors and the next section will examine how the professional power and authority of nurses and other health care professions generally may be being eroded.
Current Issues In The Erosion Of Professional Power In Medicine And Nursing.

Professional power may be eroded by changes in social policy and by wider societal changes. Bottery (1998) found that for professionals in the public sector their vision, their practice and ultimately their role was constrained by institutional and societal changes. Annandale (1998) suggests that an increase in medical litigation, patient complaints and an emphasis on human rights may be seen to threaten the status and regard afforded to the medical profession. There is an increasing trend towards alternative medicine, which challenges the dominance of the medical model (Saks 1995) and there is greater access to medical information, brought about by developments in communication, which may democratise professional and public relationships (Buttle 2001). However the extent to which these changes will alter the fundamental position of medicine, both in the professional hierarchy and in relation to professional autonomy, is questionable and unclear as there is little, if any, evidence available.

In the case of the NHS there has been a plethora of policy changes in the past two decades that have challenged the authority and autonomy of professionals and particularly doctors. Blakemore and Symonds (1997) provide a summary of reforms that were undertaken by the Conservative government between 1983 and 1996 which include: an emphasis on consumerism; competition and flexibility in service provision; a more centralised approach to running the NHS which is often referred to as managerialism and the rise of primary care and the power that this has given to general practitioners as opposed to consultants. Blakemore and Symonds (1997) point to the prevailing trend of regarding health service users as consumers but note that consumer power does not lie in the hands of the user and that doctors have been more likely to select patients rather than the other way around. Annandale (1998) is also sceptical of consumerism as a means of empowering the user. She points out that the increasing litigation and rising complaints against health care workers are indicators of consumerism but these are rarely successful. She also notes that there is limited ability for patients (users of services) to exercise choice and concludes:

The new ideology of consumerism in health care may have less to do with enhancing the power of consumers for the sake of consumers, and more to do with putting the consumer at the centre of a market-led system as a means of tempering the power of the medical profession ... (Annandale, 1998, p.230)

The Conservative government of the 1980s and 1990s challenged the autonomy of doctors and introduced general management into the NHS through the Griffiths report (1983) which
according to Ham (1999) can be seen as a challenge to medical dominance as these reforms gave more power to managers and sought to make doctors more accountable. The introduction of managerialism, defined as an ideology in which efficiency and achieving objectives is the prime motivating factor, led to a clash of occupational cultures which was inevitable as managerialism is concerned with maximising efficiency and was at odds with the traditional hierarchical authority structure and entrenched power of the medical profession (Blakemore & Symonds, 1997). These authors also point out that despite opposition to managerialism the medical profession were forced to accept it and 15% of the new general manager appointments went to doctors. Quality assurance procedures were a key aspect of managerialism. Taylor (1996) provides a useful summary of the quality assurance measures that he suggests have shifted the balance of power away from clinicians onto managers. These include performance indicators, complaints procedures, clinical audit and quality management initiatives, but he concludes that if professionals would embrace these into their core activities it would help them recover some of their eroded authority.

The Labour government have also produced a number of policy changes and have gone further in the search for ways of making doctors more accountable (Ham 1999). New quality assurance procedures, termed Clinical and Research Governance, may also curtail the power of the professions, as they have to comply with guidelines issued centrally and by local managers. The introduction of the National Institute for Clinical Excellence, which requires doctors to follow clinical guidelines in treatment and prescribing, certainly curtails individual freedom and authority. In an early study of the implementation of evidence based practice guidelines within a psychiatric institution, Mitchell (1998, p.275) argues that clinical guidelines are an effective means of managerial control. In his study he found that there was broad acceptance of them by nurses but resistance by the doctors and concluded that 'a new managerial hegemony' had altered the balance of power and that there was a decline in medical dominance. The Commission for Health Improvement (CHI), which involves independent audit of the clinical performance of service providers, is cited by Ham (1999) as an example of an attempt to open up to public scrutiny variations in standards. Another initiative initiated by the Labour government, which may erode professional power, include the changes to some professional bodies. The professional bodies, which regulate nursing (the United Kingdom Central Council and the National Boards), have been replaced by a unitary Nursing and Midwifery Council in April 2002. Similarly the ruling bodies of the professions allied to medicine are also being reformed and replaced. It remains to be seen what influence this will have on professional power and more importantly whether medicine will be made to follow suit.
A further example of erosion of the power and autonomy of health care professional may be in the changes in roles of doctors and nurses for example as nurses take on some medical roles such as prescribing. In mental health care there are a number of specific initiatives in respect of roles that need to be considered. The emphasis on multi disciplinary working (DoH, 1999d), the recent radical review of skill mix amongst mental health staff as outlined by the Workforce Action Team report (2001) and the development of user led services which are being supported by local authorities (NHS Exec, 1997a) may all be seen to threaten the power of the professional. However in psychiatry new professionals such as psychologists and counsellors who may pose a threat to the autonomy and status of medicine, have emerged before and have been contained as subordinate groups within the medical hierarchy (Busfield, 1996) and it remains to be seen as to whether any new workers, or ways of working will threaten the roles and power of psychiatrists and nurses.

Social policy has, in many cases, influenced professional power and autonomy, but Rogers & Pilgrim (2001), using a number of examples of changing roles and work practises, show how professionals may influence policy makers to shape policy. They argue that professionals are able to obey, resist or adapt to political directives to pursue their own interests. Power, on the one hand, may be eroded by specific policies, such as the move toward community care or the purchaser provider split, which has given more power to general practioners, but on the other hand psychiatry remains the dominant profession in implementing the mental health act. Similarly, some, mostly hospital nurses, have embraced the increased role and power given to them by changes in ‘holding power’ legislation whilst community nurses have distanced themselves from it. These authors also point to the policy of multi-disciplinary working and conclude that:

inter professional relations are characterised by defensiveness, lack of role clarity and conflict. Much of the conflict centres around bids for professional dominance or autonomy (Rogers and Pilgrim, 2001, p. 103)

Conclusions.

Theoretical perspectives on power and professions help to provide a framework of analysis for how power is manifested in the healthcare sector. No one theoretical perspective however is adequate in explaining how power is mediated or how medicine became the superordinate profession in the health care division of labour. The sociological analysis of the professions is extensive and the aforementioned functionalist, neo-Marxist, neo- Weberian and post-modern accounts of professions are in themselves incomplete and riddled with contradictions. Turner
(1995) is critical of these analyses and concludes that a satisfactory explanation of this process will require both Marxist and Weberian perspectives whilst Stacey (1988) asserts that the feminist perspective is also important to shed light upon medical hegemony, especially in its subordination of nursing.

In reaching a definition of power then for the purposes of this research, power may be defined as the ability of individuals or groups to get others to do what they want them to, whilst empowerment is the gaining and use of power (Iphofen & Poland 1998). Power and authority may be exercised through coercion or by any of the types of authority referred to earlier but as Barry (1981) points out some would argue that:

power can never be ‘neutral’; every exercise of power involves the imposition of someone’s values upon another (Barry, 1981, p.80)

Whilst there has been a concerted effort by successive governments to erode the power of professionals, by numerous policy initiatives, there is little evidence yet of any real erosion of medical dominance in health services (Blakemore & Symonds, 1997; Ham, 1999) and some professionals remain in a powerful position to influence policy changes (Rogers & Pilgrim, 2001). Therefore medical hegemony remains intact but under constant threat by competing interest groups including nurses and other professionals and most importantly in the context of this research, mental health service users.

The developments in user involvement in mental health services have flourished since 1985 and have been brought about by the political climate, the changes in psychiatric care and the policies and ideologies of successive governments. Examples of user involvement in mental health can be found in the delivery and evaluation of services, in research and in professional education (Maza, 1996; McClelland, 1998; Rose et al, 1998; Barnes et al, 2000;). A review of the literature on user involvement in mental health revealed that much work is being done by government and within health and social services to encourage involvement but much of this work though seems to be carried out as part of managerialism, in response to government policy, rather than a genuine commitment by professionals to change practice, or by individual professionals who are more radical or innovative. Despite the growth in the user movement, user participation and the policies of successive governments to encourage user involvement and partnership working, there is still criticism of its effectiveness and of the government and professions within psychiatry to fully embrace the concept (Bowl, 1996; Basset, 2000b; Read, 2001a; Trivedi, 2001). However, there are examples especially in relation to research and training, where user involvement is both effective and is being evaluated positively by
professionals (Ramon, 2001; Rose et al, 1998; Rose, 2001; Barnes et al, 2000). There are problems and barriers to effective user involvement but these can be overcome and both users and practitioners can be beneficiaries (Campbell & Lindow, 1997). Evidence for changes to working practices and to changes in power relationships is minimal and real partnerships between users and professionals is difficult to achieve in a situation where one party may have a legal obligation to control the other, where there is no change to structural inequalities, and hence power relationships, or where resistant or negative attitudes prevail. The ideology of psychiatry is maintained by inequalities in power and status and involvement occurs on the basis of conflicting ideologies and attitudes (Glenister, 1994).

The research that has been conducted on user involvement does not address the issue of whether professionals feel threatened by it, whether they are willing to accept the users perspective, or whether they are willing to engage in meaningful or equal partnerships with users. There is also a paucity of literature on the effectiveness of user involvement generally and specifically in relation to its effectiveness in education as a means of changing professional practise. This research seeks to address some of these issues and examine how the user involvement on one training course has influenced the course participants in terms of their willingness to accept the users perspective, develop partnership working with them and change their own professional practise. This work is unique in that previous research into user involvement has not focussed upon professional power and autonomy or the reason why some practitioners appear to accept the rhetoric of user involvement, have more regard for the user voice and opinions and outwardly seek to change their practise by engaging in partnership working whilst other mental health professionals, feel threatened by user involvement and are resistant to changing their practise. Whilst there has been some research in this country into the effect of user involvement in education on changing attitudes and practise (Ramon & Sayce, 1993; Wood & Wilson-Barnet, 1999; Hanson & Mitchell, 2001;) this has not been completed in the context of professional power or sought to seek explanations for differences between professionals. This research seeks to address those issues and examine the effect of user involvement in education upon nursing practise and partnership working in the context of professional power and autonomy and the threat to that power that user involvement may bring to some nurses.
CHAPTER 3 RESEARCH DESIGN / METHODOLOGY

Introduction

The initial purpose of this study was to examine how a user led workshop was evaluated by the course participants. The review of the literature on user involvement and professional power in the previous chapter revealed a number of themes outlined in the introduction to that chapter. What became apparent from the review was that there has been little research into the effectiveness of user involvement in education as a means of changing practise, whether nurses feel threatened by user involvement and whether nurses are willing to accept users perspective or engage in equal partnerships with users. With that in mind this research sought to answer those questions and the focus of this study emerges from the literature and has two overall aims. Firstly to identify the extent to which mental health nurses value or accept the perspective of the service users delivering this workshop. Secondly to investigate professional autonomy and power in relation to user involvement and the degree to which nurses feel threatened or undermined by user involvement and the effect of this on changing practise and working in partnership with users. From these overarching aims the following research questions were formulated:

Research questions.

1. Are nurses resistant to or accepting of the 'user perspective' on the workshop that is being evaluated here?

2. Do nurses feel that their autonomy and power is threatened or undermined by user involvement and are they willing to engage in equal partnerships with users in order to change practice?

3. Is there any evidence of changes to professional practise as a result of the service user involvement on this training course?

The methodological approach adopted was informed by the research aims and questions but also by issues such as availability and access to research subjects. These issues will be discussed in the next section on research design.
Research design

In any research, selection of the research design is influenced by the research questions and the aims of the research (Cormack, 1996). In this study the researcher regarded the user led workshop as an opportunity to gain access both to an event in which service users were directly engaged, and to the mental health workforce. The research design therefore was influenced by the research aims and questions but also selected on the basis of the opportunities afforded to the researcher. The research design may also be influenced by the theoretical tradition or discipline of the researcher and philosophical questions and beliefs about the nature of knowledge. Cohen & Manion (1994) suggest that researchers adopt ontological and epistemological assumptions and positions and this influences their choice of research methods. For example if a researcher believes that knowledge is objective, real and can be measured he or she will be devoted to the methods of the natural sciences. Conversely if the researcher believes that knowledge is subjective and personal to the individual then they may also believe that the most appropriate methods of enquiry are those, which enable them to describe and explain individual meaning. This rigid division has been challenged by Hammersley (1992) who argues that although differences exist between the sets of methods used by quantitative and qualitative researchers, the two sets of methods do not belong within separate paradigms and can be used within the same study. Denzin & Lincoln (1994) also point out that qualitative research is so broad and that it has no theory or paradigm of its own. They state:

Qualitative research is an interdisciplinarity, transdisciplinarity, and sometimes counterdisciplinary field. It crosscuts the humanities and the social science ... is many things at the same time ... is multiparadigmatic in focus (Denzin and Lincoln, 1994, p.3)

Whilst it is true that a number of disciplines and perspectives utilise qualitative methods this may be because of practical rather than theory driven reasons. Scott (1996) addresses the question of whether there is one correct approach or whether different approaches are appropriate for different subjects. In his discussion he points out that many researchers use a particular method because of practical reasons and do not discuss epistemological concerns. In the social sciences qualitative methods have been used by a number of perspectives within psychology, sociology and in health and educational research. The commonality between perspectives is that they believe that social reality has to be understood from the point of view of the subjects being studied. Scott (1996) uses examples from humanistic and social psychology to explain that in these perspectives the individual has primacy and in studying
social behaviour qualitative methods are more appropriate as they allow the researcher to concentrate upon studying the ways in which the person construes their social world.

According to Bogden & Biklen (1992, p.33) 'most qualitative researchers reflect some sort of phenomenological perspective'. They emphasise that in this theoretical tradition researchers are concerned with understanding the meaning to the individual of events and interactions within their lives. Compatible with this is the symbolic interactionist perspective that is concerned with how individuals interpret and define behaviour. In this tradition researchers must enter into the world of the subjects in order to understand how people define events. Ethnomethodology is similar in that those proponents of this perspective are interested in how individuals make sense of their worlds and their lives. Cohen & Manion (1994) point out that ethnomethodologists tend to concentrate more on specific aspects of social life such as language and negotiation in social situations. The theoretical underpinnings and traditions are perhaps not as clear-cut and rigidly adhered to however in respect of educational research. Atkinson et al (1993) demonstrate that a number of approaches have been used in British educational research. They assert that:

In our view this research cannot usefully be portrayed in terms of distinct, internally correct traditions, ... However, we identified seven different types of approach associated with particular groups of researchers. All of these persist today, though there continues to be much cross-fertilization and internal innovation (Atkinson et al, 1993, p.25)

In summary this study is qualitative in nature, as the researcher has sought to record and analyse individuals personal perspectives and experiences, however it is recognised that the use of a questionnaire as an evaluation tool may be regarded as a survey and more akin to quantitative methodologies. The study is an example of descriptive research, which attempts to explain or ask how, or why a phenomenon occurs as opposed to the experimental methods of the hypothetico-deductive model, which attempt to identify cause and effect. In this study the researcher is also a mental health nurse and a colleague of the service users trainers who delivered the workshop therefore insider knowledge is gained from this, which enables the researcher to understand the social world of the subjects, the meanings individuals give to specific comments or phrases and an insight into the context, history and circumstances of the study (Bogden & Biklen, 1992). The research design and the methods used then were chosen because of practical considerations, opportunities offered, insider knowledge, epistemological concerns and the multi paradigmatic nature of qualitative research. These methods and their merits and limitations will be discussed in the next section.
Research methods.

The user led workshop and the course participants that attended it are the subjects of this research. A variety of professional and other mental health workers attended the course from across the NHS, social, and independent services in Warwickshire. Three methods of data collection were used. The researcher attended a number of these workshops, as a non-participant observer, collected and analysed the evaluation forms following the workshop and conducted semi-structured interviews with a number of course participants.

Evaluation As A Research Method.

The service user trainers who delivered the workshop developed an evaluation tool (appendix 1), which used mostly open questions and course participants at the end of each workshop completed these. A total of five workshops were observed and 43 completed evaluations collated. These evaluation forms can be regarded as qualitative data in this context as they used mostly open-ended questions to encourage participants to feedback their views and experiences of the workshop. Participants were encouraged to express their views about the content and value of the workshop and the issues of the user perspective contained therein. The phrases used by the course participants were analysed by themes a point that will be discussed in the section on analysis. An evaluation may be defined as an internal or external process that helps provide feedback on the impact or value of a project or activity (West-Burnham 1994, quoted in Lofthouse et al 1995, p.40), the purpose of which is to assess the effect or effectiveness of something such as a policy or service (Robson, 1993). Evaluations can be described as formative, which are intended to help in developing courses, or summative which concentrate on the effects of a course. In this study the evaluation is summative and being conducted internally to assess the participants response to the service being offered.

There are a number of methods, qualitative and quantitative, that can be used in evaluations including questionnaires, using open or closed questions, focus groups, observations, interviews and analysing documents. Methodological choices will depend upon resources available, numbers of students, the type of information required and external variables or political considerations such as whom the information is for and who may use the findings (Patton, 1987). Each method has its merits and limitations for example a quantitative approach to evaluation in which standardised measures, tick boxes or closed questions are used and analysed by fitting them into pre determined categories is useful when large numbers are involved and when outcomes or other measurable activity is to be evaluated. Stringer & Finlay (1993) suggest
that quantitative evaluations are generally regarded as reliable especially when large numbers are used and when data can be pooled to obtain a mean. However closed questions or fixed choice responses may be misleading, may lack validity, respondents are unable to write elaborate answers and response rates may be poor (Brindley et al, 1998). Furthermore highly structured tick boxes may reveal little of course participants’ true experiences or feelings (Chapple & Murphy, 1996).

Qualitative methods such as focus groups, open ended questionnaires and observations are more 'naturalistic' and:

focus on capturing program processes, documenting variations and exploring important individual differences between various participants experiences and outcomes (Patton, 1987, p.14)

In these methods however questions and data can be subjective and misinterpreted by both evaluator and participants. There may be evaluator bias and resource and time constraints. In a study of using qualitative methods for evaluation Brindley et al (1998) show that students were able to discuss more freely issues that were meaningful and important to them but they noted that vocal minorities and peer group pressure may influence the results but they conclude qualitative methods may provide more meaningful data. In this study no specific outcomes are being evaluated or measured and one of the aims of the study was to reveal how course participants feel about what is happening, their experiences and their perceptions about user involvement.

Semi-structured Interviews As A Research Method.

Semi-structured interviews with course participants were conducted after the workshop usually in the individual’s place of work. The researcher used a list of pre-selected questions to discuss with the participants in order to ensure consistency of questions asked (see appendix 2). These questions arose from the issues that emerged from the literature and have been discussed in the literature review chapter. They focussed on issues of professional power, working in partnership with users and their feelings about user involvement in mental health care and training and its impact upon their practise. The questions were open-ended and prompts were used in some cases. Interviews were conducted with twenty three participants fourteen of whom were qualified nurses and nine were non-professionally aligned workers (NPA’s) most of whom worked in the voluntary sector.
Interviews have been referred to as ‘conversations with a purpose’ (Burgess, 1984 p.102) and are sometimes classified as structured, in which the researcher uses a fixed questionnaire, and unstructured or semi-structured in which the researcher has a set of themes or topics. Semi-structured interviews enable the researcher to ask more open-ended questions rather than give a fixed choice as in a questionnaire. They also allow the researcher to ask specific questions but then elaborate or probe further depending upon the responses and this makes data gathering more flexible and adaptable to the interviewee (Johnson, 1994). Interviews are often used to find out the views of people and then compare and contrast them (Fraenkel & Wallen, 1993). The interview process relies on rapport being developed between the respondent and the researcher and this may help to improve response rate. This method is also enhanced if the researcher can draw upon his/her own experiences in the subject being studied (Burgess 1984). In this study the researcher was able to draw upon experience as a mental health nurse and also as a colleague of many users, some of whom conducted this training. This gives a valuable insight into the issues involved as discussed in the section on research design. Unstructured and semi-structured interviews are also useful for discovering meanings, values, beliefs and opinions and a skilled interviewer may encourage respondents to express these which can lead to eliciting unexpected or unanticipated answers or relationships (Cohen & Manion, 1994).

Interviews, however, can be time consuming and costly and it is not possible to access large numbers of people. Respondents may lie in their responses, misunderstand the questions or try to please the researcher. The researcher may misinterpret answers or introduce bias by using their own frame of reference and concentrating on specific topics or issues in order to seek answers that support preconceived notions. Interview data is also difficult to record and code and mistakes or misinterpretations may occur especially if there is a time lapse between the interview and writing up notes (Ackroyd & Hughes, 1981). The use of tape recordings would help to ensure that an accurate record was made but this was not possible in these interviews as the employers of the staff involved felt that this was too intrusive and threatening. In these interviews notes were written up during and immediately after the interviews, in an attempt to ensure accuracy, and the quotations used in the analysis chapter were written down verbatim.

Non-Participant Observation Of Workshops.

The researcher was a non-participant observer at the workshops conducted by the service user trainers. This involved taking notes of comments and interactions that occurred during each session and observation of course participants’ reactions to or comments on issues and statements made by the trainers in their teaching. The course participants were aware of the role
of the researcher as a non-participant and were informed that the research was broadly concerned with user involvement in mental health.

Participant observation is a qualitative technique used primarily to study specific groups or societies. Covert participation occurs when the researcher becomes a member of a group and his or her identity is concealed from all or the majority of the group. In non-participant observation the researcher acts chiefly as an observer, and those that they are observing are usually aware that the observer is conducting some investigation as in this study. For an educational researcher it may involve the researcher working in a classroom and observing the interactions between pupils and the teacher. In non-participant observation the researcher listens, observes and enquires in order to build up a picture or account of a situation. The researcher observes the interactions and behaviour of groups in order to derive concepts, theory or to generate hypotheses. The researcher attempts to see things from the point of view of those being observed so that he or she can explain norms, values and relationships, which are at work within that group.

Observer bias can occur in many research methods but in relation to participant observation it has a number of components. By having a specific role within a group this may influence how a situation is interpreted and it may be regarded differently if viewed from another role. Secondly as a researcher becomes engrossed in the role and the research, he or she may concentrate only on that which he or she wishes to observe. Consequently the researcher may miss vital information or may unwittingly misinterpret phenomena, or only record what he or she deems to be significant. Observer or reactive effects may occur with subjects changing or concealing behaviour because of the influence of the observer. This is most problematic when it is not recognised and affects the research in unknown ways. However observer effects occur in many types of research methodology, and the researcher may be aware of them and make allowances for them. Therefore although the researcher cannot help but influence the subjects he or she should be able to make informed judgements about the extent of this influence and account for them. In this study the researcher entered and left the field with the service user trainers and although it is recognised that responses may have been influenced by the researchers presence the overall frankness of the responses, both positive and negative in all three forms of data collection, demonstrate that any influence was minimal. Another practical problem occurs in trying to record data, which is difficult to do in the field. Also if there is a time lapse between observations and/or conversations and the recording of these events they may be forgotten. Distortions can occur and it may be difficult for the researcher to distinguish what actually happened from what he thought about it at the time. Atkinson (1981) got over this problem by working with the medical staff in the morning and writing up his notes in the
afternoon. Atkinson (1981) also points out that note taking can be practically difficult in that it is unnatural to be continually taking notes at certain times. Further there is the problem of selectivity in terms of what to put down and what to exclude. These problems of recording, the timing of writing up notes and selectivity can occur in interviewing also but in that technique the researcher may at least use aids such as tape recordings or spend time writing up between interviews. In this study the researcher made brief notes at the time of observation and immediately afterwards and any quotations used in the analyses chapter are verbatim.

Choice Of Method.

Open-ended responses, either through questionnaire or interviews, enable the researcher to understand or capture the perspective of the participants (Patton, 1987) and help to elicit opinions, values and beliefs and it is for these reasons that a qualitative approach has been adopted and these data collection methods used. The evaluation forms were used to obtain opinions specifically about how the course participants responded to the service user trainers, the content of the session, user involvement in education and the willingness or otherwise of the course participants to reflect upon the user perspective. The interviews enabled the researcher to conduct more in depth discussion about these opinions and values and draw out information about the effect that the course had on partnership working and professional practise. They also enabled the researcher to investigate the feelings and perceptions of the interviewees regarding user involvement and their own professional power and autonomy. Non-participant observation of the workshops enabled the researcher to generate ideas and issues to discuss in the interviews but also corroborate the data on the evaluation forms, as the interactions and behaviour of the course participants to the user trainers were directly observed. This use of triangulation of methods helps to increase the validity of the study and will be discussed more fully in the next section.

Validity, Reliability And Triangulation

There may be less emphasis placed upon the issues of reliability and validity in qualitative research than in quantitative research. Robson (1993, p.373) reminds us that some qualitative researchers see the process as more art than science and that 'phenomenological oriented researchers', who attempt to understand meaning of events and interactions, would regard these concepts as 'alien'. One of the major criticisms of qualitative research is that it is unreliable and whilst it may have high internal validity it is considered by many to be low in external validity. Reliability refers to the extent to which an instrument or study will give the same results when used under the same conditions on different occasions. This is easier in laboratory situations
than in social or educational research that often cannot be repeated. Validity according to Fraenkel & Wallen (1993)

refers to the appropriateness, meaningfulness and usefulness of the inferences a researcher makes (Fraenkel and Wallen, 1993, p.138)

Internal validity refers to the extent to which a researchers findings and conclusions are consistent with the claims he makes and cannot be attributed to some other factors whereas external validity refers to the ability to generalise the findings beyond the study sample. In reference to reliability and validity Kirk and Miller (1990) provide a justification for the use of non-quantitative methodologies. Qualitative research has, they argue, always retained the ideals of hypothesis testing research but by relaxing some of the narrow definitions of the hypothetico-deductive model it enabled the discovery of the new and unexpected. They further point out that most quantitative research techniques contain a number of checks on reliability but none on validity. Atkinson (1981) in his study in a medical school argues that the control associated with quantitative methods has to be surrendered in naturalistic research. He informs us that what he could do and observe was largely under the control of the consultants and sometimes the medical students. It may be the case that reliability and validity cannot be obtained in the same study as one is often sacrificed for the other however with regard to qualitative research Kirk and Miller (1990) conclude that it can be both objective and scientific.

The evaluation forms used in this research consist of a series of open-ended questions and responses from course participants can be compared. This documentary evidence is also more reliable because all of the evaluation forms were analysed and the researcher did not choose to analyse some and not others. The observation of the workshops however are less reliable methods as the researcher may misinterpret what is observed, may concentrate on specific issues and they are unique events that are not repeatable. Similarly the semi-structured interviews are less reliable methods because the researcher can make value judgments about what questions to ask, how to ask them and whether or not to probe. They do, however, increase the validity of the study in that they enable the researcher to seek clarification of issues and explore specific avenues.

The use of triangulation may also increase the validity of the findings. Triangulation of methods and analysis may be used to cross check ideas, themes, and theories and provide the more scientific rigour which some qualitative and all quantitative researchers demand. To reduce the subjectivity element, and to provide rigour, triangulation of method, data collection and investigator could be used. For example in studying the process of assessment in a school
or college the researcher could interview key subjects, examine relevant documents such as tests or feedback sheets and observe the students and staff when assessments are taking place. Data triangulation would involve gathering data from different settings and at different times whilst investigator triangulation uses more than one researcher to collect or analyse the same data. The purpose of this is to reduce the potential bias and misinterpretation that one researcher may have. If several researchers draw the same conclusions from a data set then this increases the validity of the findings and reduces the subjectivity of the study. The methodological approach used in this study was triangulatory in that three different methods of data collection were used. Denzin (1989) refers to the use of at least two forms of data collection as within methods triangulation, which he asserts, helps to increase the validity of the findings. Using more than one data collection method means that the disadvantages of a particular research method can be counterbalanced by the advantages of another. The interviews in this study, for example, allowed for in depth discussion and probing, which was not possible on the evaluation forms or through observation. As in all research the choice of methods is influenced by the opportunities available and ethical considerations in relation to both the methods being employed and the subjects being studied and these will be considered in the next section.

Gaining Access And Ethical Issues

All research methods pose ethical problems when choosing topics and subjects, collection and analysis of data, the writing up of reports and making recommendations. Researchers inevitably have to make choices about what to reveal, how to reveal it, how to protect subjects and where and how to disseminate information gained. These ethical dilemmas are compounded in qualitative research because the focus of the research, the nature of the relationship and the whole process of the study may change during the project. Scott (1996) argues that the epistemological status of the data is determined by the ethical decisions that the researcher makes. The information obtained may be modified in order to protect the participants or indeed in some studies, the participants may themselves provide clearance for the report (Yeomans, 1987). Scott (1996) contends that conflicts occur between the need to construct a credible account whilst protecting the rights of the participants he states:

... researchers either have to modify their views of reality (the epistemological dimension), or modify participants' rights to construct and reconstruct reality as accounts of it are placed in the public arena (the ethical dimension) (Scott, 1996, p.69)

Most professional bodies have codes of ethics, which give guidelines or rules, for ethical practice (Bowling, 1997) and these are dominated by concerns over the protection of subjects
and informed consent. This is often achieved by the use of forms for subjects to sign, and the development of ethical committees that review proposals and check that the proposed study ensures informed consent and protects the subjects. Bogden and Biklen (1992) point out that these procedures are less suitable in qualitative research because the relationship and the study itself evolve over time. Subjects can be told what is expected of them in an experiment or questionnaire but in qualitative research they are continually making choices about participation. In any research proposal only a minimal description of what may occur can usually be included.

The principle of informed consent is also less than straightforward especially in qualitative research. Burgess (1993) identifies four issues in relation to informed consent. These are that all aspects of the study should be disclosed, that information is communicated in a way that can be understood, that the participant can make a mature judgement, and finally that there should be agreement to participate. As Burgess (1993) points out this is not always easy to apply in practice as unpredictable events may occur during the project. Some participants may not fully understand and researchers have to examine the ethical dilemmas and ultimately make decisions based upon their conscience, moral values and beliefs. A particular problem with ethical committees or powerful individuals such as health care managers is that they could also act as gatekeepers and restrict access to specific types of data or individuals because they are themselves afraid of what may be uncovered. Researchers may also be faced with a conflict regarding their obligations as a researcher or as an ordinary citizen.

When reporting the study it may be difficult to keep the identity of the group or individuals within it a secret. By revealing identities or certain data a trust or confidence may be broken and even if pseudonyms are used others in the place of the study may well recognise individuals. The researcher will, therefore also have to decide how much to divulge, especially if contentious issues such as bad practise are revealed. There is also an ethical issue when the researcher has gained expressed permission for being part of a group or collecting data for one purpose and knowingly using the data for another. This dilemma is for the individual researchers conscience, which may or may not be influenced by professional codes of conduct. Spradley (1980) suggests that the American Anthropological Associations' principles should serve as a guide when conducting research of this nature however he warns:

research always pries into the lives of informants and that ‘it can be used to affirm their rights, interests and sensitivities or to violate them (Spradley, 1980, p.22).
In this study the participants came from a number of organisations including the NHS, social services and the voluntary sector. Mental health services however are jointly commissioned and one body Warwickshire County Council was responsible for commissioning this training. Permission to attend and observe the workshops and to collect and analyse the evaluation forms was obtained from the service user trainers and from the commissioners of this training. In the case of the latter they were the gatekeepers to the research site and permission was granted on the basis that the researcher provided a report that they could use to inform further training. Permission to interview the workshop participants in their place of work was obtained, on behalf of the researcher, by the commissioners of the training who sent letters to the employing organisations asking them to allow their staff to be interviewed by the researcher. The course participants also received a letter from the commissioners explaining that the workshop would be observed by the researcher as part of a study on user involvement in education. On the day of the workshop the researcher introduced himself to the course participants in order to gain their informed consent to observe the workshop, collate the evaluations and make arrangements for follow up interviews. This research did not directly involve current patients so ethical considerations about patient confidentiality did not apply. However the trainers are, by virtue of their past history and the nature of this work, vulnerable to criticisms therefore information obtained will need to be dealt with in a considerate manner. Similarly the course participants may feel vulnerable because their employers will see the report on the workshops. The researcher therefore assured respondents that their anonymity would be maintained and all responses and discussions would remain confidential.

How Data Is To Be Analysed

Data analysis can take a variety of forms and has some fundamental differences from the analysis that occurs in quantitative studies. Analysis in qualitative research is not a fixed point and is more of a circuitous process unlike quantitative research wherein data analysis occurs after the collection process has been completed. In qualitative research the collection and analysis stages overlap and as ideas and issues emerge through analysis a change in data collection may ensue. Analysis requires a good deal of reading and re-reading text and moving this around into various categories or themes. The qualitative researcher may have collected large amounts of text or recordings and may need to paraphrase these in order to structure them into manageable chunks. This would be anathema to quantitative researchers who might argue that the researcher might distort or manipulate the data to fit in with his or her purpose or ideas. Like the multiplicity of methods that are used in qualitative research there has emerged a variety of ways of analysing the data. Data from qualitative evaluations and documents might best be analysed by content analysis (Robson, 1993; Patton, 1987), whilst Dey (1993) cites a number of
techniques such as grounded theory, pattern coding and categorising. Dey (1993) goes on to argue that although there are numerous differences in language and approaches all these strategies are concerned with how to categorise data and make connections between them. Analysing the data is a time consuming task that requires a good deal of organisation. The scientificity and rigour is achieved by the process by which the researcher is able to organise, categorise, cross check and file his or her data. Robson (1993) provides a useful checklist of rules, which has been adapted from a number of approaches to analysis. These rules include indexing data, generating codes or themes, using analytical memos or notes, filing data, and being systematic and organised.

Content analysis originated as a quantitative technique wherein text was broken down into quantifiable units, but was later developed as qualitative tool whereby meanings and insights are elicited from the text (Priest et al 2002). In qualitative content analysis data is developed into categories or themes and some items may be coded into more than one category in order to permit cross-referencing and the generation of more than one theory (Bowling, 1997). Computerisation can be used in content analysis, as software can be developed to establish strict rules and codes, which as Robson (1993) states produces perfect coder reliability however Richards & Richards (1994) warn us about the danger that particular software can move a project in a certain direction and this may prevent the researcher from getting inside the data and understanding the meaning being ascribed by the individual.

In this study qualitative content analysis was used and comments on the evaluation forms, notes from observations and responses during interviews were coded in relation to the themes that were discussed in the literature review and outlined in the introduction to that chapter. The researcher highlighted relevant themes in the various transcripts, coded these according to the themes and recorded them on a chart. This process was conducted manually as the researcher did not have appropriate access to computerised software but it also enabled the recognition of other emergent themes. When conducting the interviews particularly and in analysing the data a number of sub themes emerged such as safety, risk and personal accountability, issues around the care programme approach, the effect of resources on practise and resistance to change. Data that fell into these categories were coded accordingly and some data would appear in more than one theme. These themes and a presentation of the findings will now be discussed in the following chapter.
CHAPTER 4 PRESENTATION AND ANALYSIS OF FINDINGS

Introduction.

Within the NHS, and public services in general, there has been an increasing impetus to developing patient and public involvement in those services. Involving patients and the public in mental health, or service users, as they will be referred to here, has evolved in a number of ways including planning, evaluating and delivering services, conducting research and in the training of professional staff. Numerous policy documents, making reference to user involvement have been issued by successive governments (DoH, 1994a; DoH, 1997; DoH, 1998a, DoH, 1999b) and in mental health services user involvement has been made mandatory by the publication of the Patients Charter for Mental Health (NHS Executive, 1997b) and the National Service Framework for Mental Health (DoH 1999d). For the current government the impetus to involve service users is a main feature of their quality initiatives in a number of public services (DoH 1999c, LGA 1998). The quality framework for mental health services is encapsulated within three main initiatives. A National Service Framework which defines conditions and standards of services, the Clinical Governance policies which include guidance for clinicians and the Best Value policy in which there is a duty upon local authorities to deliver services to particular standards. At the same time the user movement and subsequently user involvement in mental health has proliferated. The reasons, issues and problems associated with the development of user involvement are discussed in the first section of the literature review and are relevant to this research as they help to explain the rationale for the training course, that is the context of this research, and the reaction of the course participants to both the training course and the whole concept of user involvement.

The issue of professional power and partnership in the welfare professions is also of considerable interest because of the plethora of changes in social policy associated with health care including the emphasis on community care, increasing service user involvement, and the consumerist and managerialist philosophies that have been promulgated by successive governments. This research therefore is concerned with how user involvement and partnership is perceived by professional workers and the extent to which their power and autonomy may be eroded or threatened by this impetus for patient and public involvement. The research questions therefore are:

1. Are nurses or other mental health workers resistant to or accepting of the 'user perspective' on the workshop that is being evaluated here?
2. Do nurses feel that their autonomy and power is threatened or undermined by user involvement and are they willing to engage in equal partnerships with users in order to change practice.

3. Is there any evidence of changes to professional practise as a result of the service user involvement on this training course

The policy thrust for patient and public involvement, by successive governments, and the development of the service user movement are therefore two factors that have come together to change the view or criteria of what constitutes good practise in working with service users in mental health care. In tracing nurses' reaction to the development of user involvement, in this study it is argued that professionals have responded to this in two ways. One group feels threatened by user involvement, does not respect the views of users to any great degree and still regard themselves as the experts in knowing what is best for their patients/clients. These staff are reluctant or unable to change their practise to accommodate the changing criteria of what constitutes good practise in respect of user involvement. Because of the increasing influence or power of users and the policy or procedural directives to involve users in care and services, including exposure during training, some nurses have espoused the virtues and the rhetoric of user involvement but in reality their practise has not altered thus confirming other research that has shown that there is a lack of user involvement in the every day practise of some mental health staff (Wolfe et al, 1997; Simpson, 2001; Rose, 2001. Consequently these nurses do not regard users as equal partners and do not engage in partnership working.

Other staff however have been more accepting of the users opinions and are willing to regard the users themselves as the experts in their own illness. This second group are less resistant to change more accepting of the concept of user involvement, have more regard for the user voice and opinions and outwardly seek more equality and partnership working with users. This group also espouse the rhetoric but do make an effort to implement the policy and have sought to change their own practise as a result of the insight gained through increased exposure to user involvement on training courses such as the one that is the context of this research. There are therefore a number of issues that are linked to consider and discuss in order to examine the effect of user involvement upon professional practise and the reasons for the emergence of differentiation between these groups and any similarities in the characteristics of the individual members of these groups. These are social policy in relation to user involvement in mental health, the development of user involvement and the user movement, the professional power and autonomy of nurses and the potential that user involvement has to undermine or threaten
this, and the effect of this training course and user involvement generally upon professional practise and partnership working.

Description Of Data.

Data for this study has been obtained from three sources.

1) Non-participant observation of a number of workshops ran by service users on a two day training course for all staff in mental health care services.
2) An analysis of the evaluation forms completed by the participants of these workshops.
3) Semi structured interviews carried out with twenty-three of the participants of these workshops.

The data is to be analysed using content analysis and will be presented in relation to the themes that have emerged from the literature on user involvement, power and professional practise. These have been discussed in the literature review and summarised in the introduction to that chapter. In analysing the comments from the workshop participants, and in discussion with the interviewees, a number of sub themes have emerged. One of these, the concept of safety, risk and personal accountability in mental health care and its effect upon user involvement will be discussed in the section on professional power whilst the other three will be discussed in relation to professional practise and user involvement. These are:

- Problems and issues in relation to the Care Programme Approach (CPA)
- The effect of resources on professional practise and user involvement.
- User involvement and resistance to changing practise.

Specific comments on the strengths and weaknesses of the workshops will also be analysed using all three sets of data and comparisons of responses and viewpoints will also be made, where possible, between the nurses and the NPA's. Data from the observations, the evaluations and the interviews will be compared and interpreted in relation to the literature on user involvement and professional power, practise and partnership. These themes are outlined in the introduction section of the literature review and the data relevant to each theme will be considered in the sections that follow, although some data may be presented on more than one occasion where it has relevance to more than one theme. The first theme to discuss is the actual advantages or benefits that may occur through user involvement followed by the potential problems or limitations that may occur when there is dissonance between the policy and the actual practice of user involvement.
The Benefits Of User Involvement In Mental Health Care And Services.

There is a requirement of mental health professionals to comply with government policy and guidelines on user involvement but there are a number of benefits that accrue from involving service users in care and in education. One of these is that it may encourage reflection and enhance the learning experience when users are involved in delivering training.

Enhancing Learning And Reflection.

The proliferation of the user movement and the increasing governmental policy to involve service users in mental health care services has it seems meant that users views and needs are on the agenda in a number of contexts including service development and in educating mental health workers. This research shows that the majority of respondents, both nurses and NPA's, felt that user involvement was now an integral part of mental health services and that more of this needs to be encouraged generally and in respect of educating the workforce. Although some respondents felt that some examples used by the trainers were exaggerated they also commented that it made them more aware of how poorly service users can be treated and that to hear personal accounts was more enlightening and made them reflect upon the care that they give. This research clearly demonstrates the benefits of involving service users in training. Respondents very much appreciated the “user input” and from hearing real case studies and personal experiences. This was commented on in a number of the evaluation forms:

"Hearing about actual experiences and how it felt was revealing and enjoyable to have the viewpoints of users" (Ex1)

"I felt that the personal experiences disclosed by speakers really useful and hearing real case studies”(Ex 9)

"I found all of it valuable but particularly user perspective because as professionals we forget how or what the user is actually experiencing” (SM 6)

"They helped me with my future learning and has given me new ideas to share with colleagues” (Ex 8)

Furthermore at interview this was confirmed by a number of respondents who mentioned the value of listening to personal experiences and how this made it more real.
“I liked to hear the personal experiences of the users and how they had been treated by professionals. It makes it so much more real” (SM)

“It is very good to get personal experiences because you get first hand opinions not what professionals think happens. It comes from the horses mouth” (VC)

“This was the first time I have experienced role play from a users perspective and I was enlightened by it” (JL)

These comments demonstrate the value of using real life experiences or case studies during training. Basset (2000a) and Repper et al (2001) both point to the value of obtaining the viewpoints of users and in using real life situations in teaching and learning in mental health. Although the respondents in this study were all working with clients at the time, and therefore should have an awareness and first hand experience of some of the issues facing the mentally ill, this workshop made them more aware of issues and experiences that they would not otherwise have had access to, a fact also reported by Ramon and Sayce (1993). Wood and Wilson-Barnett (1999), in their study of involving service users in pre registration training suggest that involving service users means that student nurses are more able to empathise with their patients and less likely to distance themselves from them. Involving service users in the classroom reverses the roles of ‘helper and helped’ (Hanson & Mitchell 20001) and these authors suggest that course participants perceptions of users may be changed by meeting them in this type of forum. Using real life experiences and having them articulated by service users also helped the course participants reflect upon their own practise as the following comments obtained during the interviews show.

“It was very helpful in giving an insight into how we actually deal with our clients” (AH)

“It helped me to reflect upon interviews I have participated in” (CH)

“It made me think of what I do wrong” (ST)

“It did provoke thinking. At the time I felt very negative but now I can see what they were getting at. I think it’s a brilliant idea to involve service users in education. I hope that I would not treat them in the way that they demonstrated but now I have got over the prickly feelings about it I realise that well they must have got that view from somewhere” (CR)
The latter comment came from one of the course participants who admitted during interview that she was very negative at the time of the workshop but then stated that it had made her think about her own practises and the mental health services in general thus demonstrating that she had thought about the issues and reflected upon them. The effectiveness of provoking awareness amongst staff, by involving users in training, was reported by Ramon & Sayce (1993) and the workshop, and the discussions within them reported here, enabled the course participants to reflect upon services, their own practise and that of their colleagues, a point which will be discussed later in the section on user involvement and professional practise, but there is clear evidence from this study that the training sessions were thought provoking and encouraged personal reflection. It remains to be seen whether this appreciation of the users viewpoints will change or improve the individual’s professional practise but arguably it should make them more aware at least of the service users experiences and of their own effect upon those experiences. An appreciation of the users viewpoints and experiences may also lead to a recognition by professionals that users have more knowledge or expertise in relation to their own illness or problems than they had previously thought or given them credit for. This concept of the expert patient will be considered in the next section.

The Expert Patient.

The rationale for user involvement articulated in the aforementioned government policies is to improve services for the mentally ill and Campbell & Lindow (1997), in writing about the benefits of user involvement, assert that services are unlikely to improve without it. One of the reasons for this is that professionals need to take into account the fact that users do have knowledge and expertise of their illness and problems that can be utilised when planning care and services and in educating professionals. In this study a number of respondents, both on the evaluation forms and at interview, recognised that they could learn from the expertise of service users and that this would help them to meet the needs of users.

“It was the most valuable part of the course. To learn how users felt they are at the centre of it and so their view is the most important” (SM 2 5)

“Listening to users because theirs is the only true and valid opinion” (Ex2)

“We need their opinions about how we need to change and what their views are and what they need” (CH)
"I think that it is very important that they are involved with all aspects of the service. They are the people that can educate us about their needs and requirements" (KB)

"I am very much in favour of user involvement in education. I perceive users as being experts in their own illness and I see no better people to learn from" (JS)

"Users have greatest experience of their illness and this needs to be taken into account too much emphasis is put on paper qualifications" (KM)

This concept of ‘expertness’ is relatively new within health care, as hitherto professionals have seen themselves as the experts. The current government initiative to chronic disease management is aimed at encouraging professionals to regard users as experts in their own illness (DoH 2001a) and indeed Lindow (1993) has frequently argued that mental health service users have their own expertise. However as Fraher and Limpinnian (1999) point out this challenges traditional notions of expertise in contrast to Schon (1983) who argues that reflective practitioners can work in partnership with clients and that these challenges for them are relatively unproblematic. That may well be the case for those cited above who have demonstrated that they are reflective practitioners but for others, who may be unable or unwilling to be reflective, their own notion of professional expertise is grounded in the authority of experience and qualifications and user involvement may be more threatening. Hopton (1994) referred to an occupational culture within mental health nursing that would militate against using service users in education because they were viewed as a class of inferior person but there are now examples of more radical approaches to teaching and learning in mental health which involve service users (Barnes, D. Carpenter, J & Bailey, D., 2000; Repper et al, 2001) and a recognition that user involvement needs to be much more embedded in the whole curriculum. The aforementioned quotations do reflect a recognition amongst some professionals that users are indeed more expert in their own illness and that professionals can, and indeed need to learn from them, but this may be confined to those who can be defined as reflective practitioners. Some professionals then may be reticent, ambivalent or even cynical about user involvement and unwilling to recognise their expertise or value. When this occurs there is a dissonance between the policy objectives and what is practised and this may be manifested in a number of ways such as disregarding the views of users or just making a token effort to involve them to satisfy policy demands. These issues will be discussed in the following section, as they are some of the problems that may occur as a result of initiatives or policies to involve service users in mental health care.
Problems Of User Involvement In Mental Health Care And Services.

Rhetoric, Tokenism and Commitment to User Involvement.

There are a number of pitfalls or problems when involving users either in services, as researchers or as trainers. Ramon (2001) found that some of the services users who acted as researchers had periods of crises during the research period and Pattison (2001) questions whether the whole concept of user involvement is idealistic and wishful thinking rather than reality. He goes on to point out a number of problems to users including the complexity of running services and the fact that most citizens do not wish to become involved in shaping NHS services, the use of jargon by professional workers and management, the service users ability or understanding to make informed decisions and the abuse of users by organisations that involve them as a token gesture only. In this study a number of respondents at interview were in fact critical of the commitment to user involvement shown by the government, statutory agencies and individual professionals. The following comment specifically refers to and is critical of the governments commitment to user involvement

“It is just rhetoric its on their political agenda. For example the reforms of the mental health act and CTO’s (referring to Community Treatment Orders) despite adverse consultation it is still going through ‘I see it as rhetoric until you get more users involved nothing will change”(DP)

This notion of user involvement during the consultation processes as only rhetoric was also commented upon by Trivedi (2001) who was invited, as a former service user, onto a government led consultation group but found little opportunity to involve or consult with other users. In fact a number of current or former service users (Crepaz Keay, 1996; Read, 2001a) have written about their own involvement in mental health services and have accused the government and statutory agencies of tokenism. Tokenism in this context refers to a situation in which service users are invited to become involved or participate in some way but their voice, opinions, wishes and even needs may be disregarded or at best given little validity. A typical example might be a consultation exercise that is carried out where user views are sought but they have little power to change anything. Pattison (2001) cites an example in one English city which was unable to recruit a user for consultation because the user activists felt they would be better able to make an effective contribution to it by retaining total independence and lobbying from outside (p.201)
The following comments from professional staff were recorded during the interviews and demonstrate that some of them believe that their own or other organisations whilst espousing the rhetoric of user involvement are in fact only making a minimalist or token effort at it.

“Users should be involved at a higher level in the organisation. What goes on now is tokenism and a lot of rhetoric they should be involved in planning at a much higher level” (VG)

“It's essential that users are involved. We need to be working in partnership with each other but it's often a token exercise on the part of the managers. I feel it is in this Trust. I feel empathy with service users. Management are always saying that they are consulting with service users but in actual fact they do not. Service users and professionals are often coming from the same perspective but management are not taking their views on board” (VC)

“I think its brilliant but I don’t think it should be lip service. It did not feel democratic they were there because someone felt they should be. I don’t think the trust give much credence to user involvement. This trust may be better than others but not as good as it should be. It did not feel democratic they were there because someone felt they should be” (GW)

These feelings were echoed by a number of the non-professional workers who were equally critical of the statutory agencies.

“It isn't used the way it should be its very tokenistic User involvement should be the driving force behind services. We have service users who run their own companies sometimes it still feels tokenism”(JM)

“In statutory sector there is not much user involvement. To begin with it was lip service. Its not equal because users are being included where they are allowed in not where they may want to be included”(KM)

The criticisms here of tokenism may be a reflection of the need for organisations to respond to government directives without a clear strategy to do so. Maza (1996) pointed out that senior management have little contact with users themselves whilst Bowl's (1996) study across 31 local authorities showed that there was a lack of departmental strategies to involve service users and that it was individual staff that demonstrated this initiative rather than the organisation, a point reflected in some of the comments made. Jackson (2001) asserts that the culture of an
organisation may not be conducive to user involvement and that organisations may only do this because it seems the right thing to do. Indeed the comments above do confirm that despite all the policy guidelines the statutory services themselves whilst they espouse the virtues of user involvement, by setting up groups and initiatives within their own organisations, in reality this involvement may be minimalist and may be done to give legitimacy to the project as Shaw (2001) would contend, rather than to really engage with users.

Some respondents, at interview, were critical of the commitment to user involvement shown by individual workers, including their own colleagues as demonstrated by the following responses.

"Since I have been in assertive outreach it has made me think how we can adopt them (users) but I don't see much user involvement in the team I work for" (JL)

"On other courses though there has been a good rapport because users were with us all day. Just shipping them in for one session is just tokenism. 'There is too much tokenism. There is a lot of people out there who don't take on board what users have to say'" (KM)

The above comments on tokenism from the NPA's echo a concern that they have for both professional workers and the statutory organisations. However these workers have not been socialised into a professional ethos, they do not have statutory or legal obligations, in the same way that professional workers do, and they come from organisations such as MIND that have much more user participation embedded in their structures and philosophies at both decision making and operational levels. Whilst statutory organisations may be uncommitted and tokenistic they may also have other genuine difficulties as Reynolds et al (1997) point out. There may be shortage of resources or resources may already be allocated to buildings and services that users do not want but it does take time to change these and service users may expect to see or want immediate change especially if they have been consulted about services. Furthermore statutory authorities, and for that matter individual professionals, have legal responsibility both for the use of public money and to adhere to government and professional policy and guidelines for care and services. As user involvement has developed the lack of commitment to it may be regarded as problem, particularly by user organisations and users themselves as their expectations to be involved have increased. Tokenism may also be regarded as a form of abuse of service users and a further problem that may emanate from user involvement is when users are consulted or involved but their views are disregarded. This form of abuse will be considered in the following section.
A more disturbing form of abuse of service users occurs when their views are disregarded. This is not only deflating and insulting to the users but militates against changing attitudes and renders workshops and training courses less valuable. These views were expressed by a minority of participants in these workshops but were nevertheless apparent as the following statements from the evaluation forms demonstrate:

"Felt user perspective although valid was extremely negative and should perhaps include more balanced views to allow comparison of experiences" (SM 1 3)

"Negative attitudes being dominant in users discussion. It is difficult to work with low resources and achieve good results as it is" (SM 1 4)

"One of the speakers talking too long about his own experience. Hearing specific details was not beneficial" (SM 1 7)

All of these negative statements came from the evaluation forms completed by nurses. During the interviews some nurses also expressed views that were negative or more dismissive of the users perspective:

"It does have its uses. It is good to have a user perspective but users who step forward have had a negative experience and you rarely hear from those who have had a positive experience. I have had a lot of experience recently with different groups that have users and others on them. Some are trying to teach you to suck eggs. They are presuming that you are all the same and don’t find out how you act or practice" (NC)

"We would have to be careful who we used, there are some I wouldn’t have. Users are very good at dealing with feelings and that really hits home but some are quite destructive and some have their own agenda" (DP)

These negative statements were minority views compared with the overall positive comments received on both the evaluation forms and during the interviews. Similarly the author also observed a number of the training sessions given by the user groups and the overall ambience and impression that was gained was one of interest and willingness to listen to the views of the user trainers. However there may be a number of reasons for the negative statements outlined above including a lack of resources, which may be real or a rationalisation, denial that this
applies to them, and the uncomfortable feelings that may occur if the issues discussed by the user trainers are considered as personal criticisms. During the training workshops the service users did discuss personal experiences and gave examples of how they users had been treated themselves. In observing these workshops, and in listening to the examples given of personal experiences the author concluded that none of the workshop participants were criticised by the user trainers nor were the examples and personal experiences given by the user trainers meant as personal criticisms of the course participants or even professionals generally. Therefore there should be some other explanation for these negative statements and the implications that these individuals have disregarded the user perspective in this case. Perkins and Repper (1998) discuss a number of reasons why users perspectives are often ignored. They suggest that those who do disregard the expertise of personal experience often do so when it runs counter to their beliefs about their profession or practise and this often involves beliefs that the professional knows best as they alone have access to a specialised body of knowledge. They go on to explain other reasons that have been put forward for ignoring users perspectives including basic attitudes of staff and social structures in which it is presumed that those who are mentally ill may also be incompetent in other ‘spheres of life’. A further rationale for disregarding the users perspective or opinions is that the users views expressed are somehow unique and are not considered representative of the majority of users. The following comments allude to this in that they contain inferences that these users experiences may be somewhat different to others.

"Session seemed to relate a lot to generic working and did not apply to us in community. It would have been useful for a user to contribute who may have a more positive experience. They are out there" (SM 1 8)

"Felt that at times too subjective. One of the workshop facilitators had his own agenda they wanted to push that was not totally relevant at that time" SM 1 9)

"Not all users or their experiences are the same"(NC) (Questioning the value of this workshop and the particular user trainers)

"In long run it's a good idea to have user involvement but we have to be careful as not every user has had same experience" (VC)

This theme of questioning the ‘representativeness’ of the users is another means by which those who may espouse the rhetoric of user involvement, but do not really value the user voice or practise involvement, can justify their beliefs and actions. As Crepaz-Keay (1996) point out if service users are articulate and authoritative they may be regarded as untypical of mental health
service users generally. This could be another rationale for dismissing their views and does reflect a concern that the user trainers involved in these workshops may not be representative. Beresford (1994) points out the representativeness of policy makers and professionals is rarely challenged in this way and most user organisations, including the training groups involved here, are democratically elected and furthermore user organisations and activists are the people most motivated to be involved and most able to represent user views (Forrest et al, 2000). Only one person commented that they would have liked some input from another client group recognising, as did Hostick (1998), that the mentally ill are not a homogenous group and may represent their own needs rather than those of other users.

There were some other negative overtones from the course participants that were made during, one particular workshop that the author observed. These centred on the view that the user trainers just belonged to the anti-psychiatry movement and this may be used as a further justification for disregarding their perspective. During this session one of the user trainers was describing his own very negative experiences of psychiatry and how powerless the system had rendered him. This was a lengthy exposition and meant that the workshop became quite rushed and the trainers did not complete all the content that they had intended. It was apparent during the session that a number of the participants were distinctly uncomfortable about what he was saying and some of them tried to assert that these practises that he was describing did not occur now. There were some sceptical and disapproving glances amongst the audience with two nurses trying to justify why he may have been treated in the way that he was and insisting, that as they put it “it was not like that now”. The evaluations that were analysed from this workshop produced the following comments and provide evidence that some of the course participants held these views about the user trainers and therefore may not have listened to or reflected upon the message that was being delivered.

“Negative experiences appear to have harvested strong anti-psychiatry views. This bias being so aggressively voiced is not helpful” (SM 2 1)

“The negative attitudes towards psychiatry as a whole. Some opinions were about very dated practices” (SM 2 2)

“I found presenters previous experiences to be very negative, gave off flavour of anti-psychiatry” (SM 2 4)

“Feel that issues raised may have been of a personal note and were anti psychiatry as a whole” (SM 2 3)
These comments seem to be a justification for disregarding the user views with the respondents also denigrating or disregarding the perspectives of the anti-psychiatry movement. The anti-psychiatry movement that was prevalent in the 1960s and 70s was more about differing theoretical positions and the relationship between that and the development of user involvement is uncertain but the term anti-psychiatry according to Campbell (1996b) has now:

become a slogan that is routinely used by traditional mental health workers to denigrate and dismiss ideas that threaten their expert world view and status (Campbell, 1996b, p.221)

This seems to be the context within which these comments have been made and may be a further rationale for professionals dismissing the views of users, according to Reynolds and Read (1999) who suggest that training courses, such as this one, which seek to promote user views and encourage an understanding of their perspective run the risk that these views can be labelled as 'anti-psychiatry'. In contrast however Read (2001b) points out that the user led sessions on training days often score highest on participant evaluations, a point certainly confirmed in this study by the majority of participants, and suggests that user training has more promise for real involvement, rather than tokenism, as the users get an opportunity to talk and be listened to.

A number of the comments of the respondents referred to in this section were negative and they do demonstrate that there is a cadre of nurses who are less willing or able to reflect upon the opinions or perspectives of service users and give them due regard. The tokenistic practices referred to by some respondents provide evidence that there are some staff within mental health services who may be carrying out some of the policy guidelines on user involvement simply because they have to comply with procedures. Similarly the attitudes and feelings expressed by those who are dismissive of the users views are evidence that some nurses do not regard the opinions, of these users at least, as valid or applicable to modern mental health care and are unwilling to reflect upon them in order to examine their own beliefs and practices. It is this group of nurses who are less likely to change their practise or engage in partnership working with their patients. This does contrast with the comments outlined in the preceding section on the benefits of user involvement that demonstrated that some professional workers were in fact more appreciative and committed to user involvement. This contrasting data provides evidence of the premise that since user involvement in mental health has developed two responses to it have emerged one that espouses the rhetoric and complies only minimally with policy directives and another response that values user involvement and is rather more committed to it. These
attitudes, beliefs and willingness or otherwise to engage with the user perspective has implications for nurses professional practise and their ability to work in partnership with those that they serve. These issues will be discussed further in the sections on partnership working and changes to professional practise. A further reason why some nurses may be unwilling or unable to accept the user perspective, or to fully embrace the concept of user involvement, is that it may provide a challenge or a threat to their own professional power or autonomy. One of the challenges of user involvement is to change the balance of power between the professional worker and the service user and these issues of power and autonomy, and the threat that user involvement may bring to professional power, will be discussed in the following section.

**Issues Of Professional Power And Autonomy In Mental Health Services And The Threat To Professional Autonomy By User Involvement.**

Professional Power And User Involvement.

The impetus for user involvement, both from government policy and from user activists, may be seen as a challenge to professional power, authority and autonomy. Mental health service users have comparatively little power in their relationships with professionals when accessing or utilising services. The imbalance of power may prevent good nursing care according to Campbell & Lindow (1997) who provide a number of reasons for user involvement and argue that it is beneficial for both users and professionals whilst Perkins and Repper (1998) suggest that three things could be carried out to change the balance of power. Firstly more information should be given to users, who will than be in a position to challenge. Secondly services themselves need to be influenced by users in order to change. Thirdly establishing alternative support and services will help reverse the power relationship. At interview numerous respondents recognised that power could be taken away, one nurse talked a lot about how some of her colleagues were upset by the session and she had several examples of nurses dismissing the sessions and the users perspective. Some nurses echoed this feeling of being threatened by user involvement and a number of NPA’s also commented that user involvement was particularly threatening for professionals and may alter the balance of power.

"There is a potential for us to be more powerful and we have to be aware of that and acknowledge we have it for example if in care planning they wanted to set a goal and we felt was out of their reach we may say no" (CR)
"It's not totally equal if somebody did not want something and we couldn't agree with them we would enforce it, we do take things away from them, it's not giving them choice you just hope that you are making the right decisions and doing it in their interests" (FR)

"There is a difference in power. I have much more power and social advantage and it is difficult to get away from it is not equal. You can make it work but a lot of people we work with are emotionally and socially disadvantaged, which disempowers them" (GM)

Linett (1999) argues that the whole purpose of user involvement is to change the balance of power but also recognises that users do not have official kinds of power and that it can be taken away. This official power may be invested in professionals by their statutory authority, their knowledge and expertise and their experience. Authority may be defined as a manifestation of power that is seen as legitimate and Barry (1981) asserts that most analysis of authority is concerned with the distinction between *de jure* authority in which someone is obeyed because of a rule and *de facto* authority whereby someone can get their way without entitlement or resort to coercion. Power and authority may be exercised through coercion or by any of the types of authority but as Barry (1981) points out some would argue that:

Power can never be 'neutral'; every exercise of power involves the imposition of someone's values upon another (Barry, 1981, p.80).

However the authority or power that is being expressed in the aforementioned comments from the interviewees suggest that if nurses were unable to persuade the service users to accept their discourse then they would assert the power or legal authority that they can exercise if they choose to do so, and that this may involve both the imposition of the nurses will or values over the service user, and through their legal authority, coercion. Therefore despite the impetus for user involvement and partnership in mental health services and care individual practitioners, whilst they may espouse the rhetoric and agree or disagree with the principles or philosophy of user involvement, they may practise it only up the point where they believe it to be appropriate. If there is a dissonance between what the service user wants and what the individual practitioner believes is in the users interests then the professional worker is able to assert their authority and power over the service user. This may be justified on the grounds that the professional knows best through their expert knowledge and / or that they have a legal duty to comply with statutory and organisational procedures and are accountable for their decisions and practise. This concept of personal accountability and how that is justified and manifested was a theme that emerged during the interviews and will be discussed in the following section.
The issue of degrees of power and equality in the decision making process, in relation to managing the care of individual service users, was discussed during the interviews with the course participants. A constant sub theme that emerged from these discussions was the issue of safety, risk and personal accountability when planning or deciding upon care packages, and involving service users in these decisions. Mental health professionals, psychiatrists, nurses and social workers all have official kinds of power, which enables them to coerce patients or service users. The state has legitimised this official power by the powers that it has invested in professionals through for example the Mental Health Act and the Care Programme Approach, although the latter should involve service users, a point to which I will return to in a later section. In its most controlling form a manifestation of power or coercion by a professional worker may involve compulsory detention of an individual service user under a section of the 1983 Mental Health Act. A more subtle form of coercion may involve persuading the user to a particular course of events, such as taking medication, or as in the first quotation cited above the professional may refuse or say no to a service users request. In the following comments the interviewees refer to their personal accountability, their duty of care or their need to comply with organisational procedures.

“Its not equal I don’t think its 50/ 50 Users get less say than professionals’ ‘I hope it wont always be that way or how can we provide a service that they need? But at the same time I want to protect my registration and not make any mistakes’” (PU)

“Where its difficult is when there are outside things that impinge upon what you can do for example risk assessment. The Trust will look at accidents etc so there is a double bind. The culture of the organisation means that you have to be careful and what you would like to do is not always possible because you are concerned with what the effect of this might be upon you” (CH)

“But there are constraints. As I have said before there are systems and procedures that you have to abide by and that may prevent an equal partnership, as I may not be able to do what they want. For example if I cannot safely do something then I cannot do it or allow it to happen” (CH)

These comments demonstrate that these individual professionals feel under threat about what may happen to them if they do fully embrace user involvement and allow users an equal share in
the decision making process about the care or services that they receive. There is a reluctance to give up their power and take risks not because they do not believe in the philosophy of empowerment that is underpinned by the concept user involvement, but because of the need to act in accordance with what they regard as their employer's wishes in terms of following procedures and policies. Some nurses, whilst believing that they had to take into account procedures such as risk assessment, recognised that they were constraining or were used as a rationalisation.

"It should be equal in the fullest sense of the word. It depends upon environment for example. In an acute area it would have to be tempered because of safety and risk. But life without risk is no risk at all" (KB)

'We are so obsessed with safety and risk it has stopped creativity Situations affect the equal ness of it. We sometimes have to make decisions and take it out of their control" (KB)

"I suppose that if you have done your training a long time ago it was drummed into you to have that power and keep people safe. A lot of professionals use that as an excuse that they are keeping people safe and protecting them and others" (LP)

There were some other comments during the interviews that demonstrate a recognition or acceptance by some nurses that power sharing or empowerment was constrained in particular circumstances such as ill health or when the service user may be defined by them as being a risk to themselves or to others.

'It is never equal. At the end of the day at times people can become unwell and we may have to use the Mental Health Act' (VC)

"But we have our accountability. For example if someone is suicidal there are instances where you can understand but you may have to invoke a section and make your own judgment Plus when there are children involved or they may be suicidal then we have to act" (DP)

"When you are not involving aspects of the Mental Health Act or child protection. I would hope it should be as equal as possible' But then I can be constrained by boundaries such as if it affects others then I have to override that sense of equality' 'I have to fall in line with elements of compulsion I try to explain this to the client" (SW)
Although most service users are not compulsorily detained many of them are only too well aware of the covert power that mental health professionals may have over them. Campbell (1998) describes a number of factors, which lead to a sense of diminished autonomy and power for the service user. These include: the dominance of the medical model of distress, staff attitudes, the threat of compulsory treatment and the inequality between users and mental health care staff. As Bean (1986) argues when people know that they can be detained it is not necessary for anyone explicitly to threaten to detain them for a coercive effect. As far as informal inpatients are concerned the Mental Health Act Commission for England and Wales (1999) has also expressed concern about such de facto detainees because they will be outside the system of safeguards that are provided for formally detained patients. The above comments reveal that some of the nurse's interviewed recognised the inequality between service users and themselves and that there may be times when they have to invoke their official power in the form of initiating a section of the Mental Health Act if it was felt to be in the best interests of the service user. What is also apparent however is a sense of personal accountability and the need not to make mistakes for fear of a threat to themselves or their professional registration. Personal accountability in this form has increased with the advent of risk assessment and risk management in mental health. The concept of risk assessment has been used within mental health and social services to underpin and inform decisions about potentially dangerous situations for example the consequences of not taking a treatment or the maintenance of liberty for someone who is in a mental health crisis. The National Service Framework for Mental Health requires that:

All staff involved in performing assessments should receive training in risk assessment and risk management updated regularly (DoH, 1999d, p.43).

The workshops that are the subject of this research were in fact part of a training course on the Care Programme Approach and risk assessment so the latter concept is very much on the course participants mind but as one of the respondents quoted above asserts professional workers have become obsessed with safety and risk. In relation to aspects of public policy Gabe (1995) claims that the term risk refers only to negative outcomes or hazards but in its guidance on effective care co-ordination the Department of Health (1999a) recognises that there is a need for positive risk taking and that risk should not be seen solely as an assessment of the danger that an individual poses to themselves or other people. Rose (1998) however is very critical of the concept and advent of risk assessment being applied in health care services and posits the notion that
Psychiatric institutions are defined now not in terms of cure or care, but in terms of the secure containment of risk (Rose, 1998, p.265)

Rose (1998) goes on to explain that this containment has become all pervading and a form of social control and furthermore the mental health professions have become obsessed with risk assessment and risk management is now their central professional obligation. The corollary of this is that the clinical judgment of professionals is influenced by this way of working and that the threat of litigation and blame means that professionals are now more concerned for their own welfare in this regard and ultimately there is little positive risk taking. Legislation has been found to affect or hinder professional practise in public sector professionals. In relation to general nurses, Bottery (1998) found this meant direct patient care. In an attempt to show how users have affected their practise, Bhui et al (1998) explain how professional consultations are influenced by knowledge, personality, experience and charisma, which equates to Weber’s charismatic authority, but in their practise they have attempted to learn a more negotiating style of consultation. However they go on to point out that the legislative framework within which professionals operate dictates the degree of flexibility and therapeutic risks that professional can take regardless of their convictions about user involvement. In this study there is evidence that supports Rose’s views and that despite an expressed desire to share power or work with the service user on an equal basis, for nurses at least, there are times when meeting legal, professional and organisational imperatives are of more importance. So even those nurses who espouse the rhetoric and practise user involvement may not do so because of their lack of autonomy, ability to operate flexibly and / or because of a fear that sharing power with users in decisions about the care or treatment they provide may pose a threat to their own position. Although some nurses may be willing to share power on a more equal basis with service users, but are constrained by their statutory obligations, there are others who regard their power and authority as legitimate, not just because of the authority invested in them by the state but because it is legitimised through their expertise and knowledge a concept that will now be considered.

Professional Paternalism And Power Through Knowledge.

Authority is a form of power that is seen as legitimate and professional workers often claim this official type of power from their expertise, knowledge and professionalism. Iphofen & Poland (1998) suggest that this is the form of power that is most used by health care professionals in their dealings with clients or service users. In a Weberian sense health care professionals have, or at least assume, a certain amount of charismatic authority in their relationship with users. Traditionally health care professionals have been held in high esteem by the community at large
and their views are respected owing to their assumed knowledge, expertise and according to Ibhofen & Poland (1998) their commitment to caring. The following comments from interviewees confirm that some professionals make these assumptions about their knowledge or expertise and that the users views are somehow an affront to this authority:

"Some professionals do not want to listen to the voice of the user. They seem to have an attitude that they have the qualification therefore their view is right rather than that of the person who has the experience of the problem. This affects all professionals" (JP)

"They see people who are suffering from mental illness as not having a greater knowledge or right to use it, they have an attitude of how could you know as much as me I am the professional" (SM)

"Some colleagues though felt it was an affront to their professionalism but it was probably these staff that would ignore the service users" (DP)

"Nurses need to let go from the belief that they are the experts and recognise that they can learn from the user but some still see themselves as experts and want to lead the clients" (JL)

"I think that some professionals want to safeguard information that they have. There is territorialism amongst some professionals" (JS)

One nurse talked a lot about how some of her colleagues were upset by the session and she had several examples of nurses dismissing the sessions and the users perspective:

"Some colleagues felt threatened for example you could hear comments like we have done the training we have the degrees why are they trying to teach us" (NC)

And some nurses echoed this feeling of being threatened by user involvement:

"I did not like it at the time but on reflection now that I have got over the prickly feelings of feeling threatened by it its okay. It has all changed now and it’s a lot less paternalistic and once you see user involvement is not a threat to you its okay" (CR)

"Some of my colleagues were threatened by it because it was challenging and they were taking it personally" (KB)
A number of NPA's also commented during the interviews that the current emphasis on user involvement in mental health care and services may be particularly threatening for professional workers and may affect the balance of power between the service user and the professional worker. This is verified in the following responses.

"I think that they (referring to professional workers) should see it more often. More professional people should be exposed to that workshop. 'I found though the attitude of some people appalling and disappointing'. (Gave example of some comments from the audience and one professional worker in particular) "gosh precious discussion time has been wasted we don't need this" I was disgusted with their behaviour and attitude (referring to a professional whom she knew). "It's scaring wits out of them I should imagine. They see people who are suffering from Mental Illness as not having a greater knowledge or right to use it. They have an attitude of how could you know as much as me I am the professional" (SM)

"Some professionals do not want to listen to the voice of the user. They seem to have an attitude that they have the qualification therefore their view is right rather than that of the person who has the experience of the problem. This affects all professionals I think they can be very old fashioned and do not want to change" (JP)

"It may well diminish some of their power with user involvement users could say no"(ST)

"Some power might be taken away from the professional staff professionals may feel that their role is threatened" (PD)

"Professionals seem to be frightened that user involvement and any challenges to them for example a patient complaining may interfere with their careers" (LP)

"I would imagine that some professionals feel undermined by it" (user involvement) (JP)

There is still a paternalism of professions and all professions have a 'touch of we know best' (Basset, 2000b), but users now are claiming expertise through their own experience, which challenges traditional notions of professionalism (Fraher & Limpinnian 1999) and traditional notions of expertise are being challenged by the user movement and by individual service users. Perkins and Repper (1998) point out that the range of professional models used in mental health, despite being contradictory, share one feature that of being described by people who
have no lived experience of mental distress and there is evidence that many service users are turning to alternative sources of help mostly in support groups, user run services and to others who have had similar experiences. This as well as indicating an element of professional paternalism further suggests a reluctance by these professionals to accept users as equals and a dismissal of the ideas and issues that are important to users, factors noted by several writers (Campbell, 1998; Bowl, 1996; Perkins & Repper, 1998; Pattison 2001). The lack of regard for users views or ideas may be justified by professionals in a number of ways including emphasizing their pathology. In a review of the literature Pilgrim and Rogers (1999) identify four ways in which patients are denied a valid viewpoint. Firstly the disregarding of users views that do not coincide with that of the mental health professionals. Secondly the belief that service users are irrational and incapable of giving a valid view. Thirdly disregarding the views of users when they contrast with their carer’s opinions and finally the framing of views in terms that suits professionals. Concerns that user involvement is a threat to the roles and power base of many mental health care professionals is noted by a number of writers (Croft & Beresford, 1993; Glenister, 1994; McCullogh & Hasson, 1998; Ramon and Sayce, 1993). The latter authors suggest that this may be because user involvement is perceived as being too risky when applied to vulnerable people or it is being used by leftist workers and is likely to lead to irresponsible acts by service users and this perception results in professionals becoming defensive and refusing to take the user’s perspective seriously. The interviewees in this study certainly confirmed that some mental health professionals felt threatened and are defensive about user involvement but this was again a minority in contrast to the views expressed earlier about the benefits of user involvement and in the responses regarding power sharing, notwithstanding that for some this was within particular constraints. Therefore on balance this would seem to suggest that since the development of user involvement there are nurses who are more accepting of user views and user involvement generally but there remains a cadre of nurses who are unwilling to accept or embrace user involvement fully and / or feel threatened by it. Regardless of whether the philosophy of power sharing with users is embraced by nurses there are other constraints that may militate against nurses developing partnerships and sharing power in decision making with the user including their authority to act autonomously. These issues will be discussed in relation nurses position to medicine in the occupational hierarchy.

Professional Autonomy, Authority, Medical Hegemony And User Involvement.

All mental health service professionals use professional power in one way or another. Professional autonomy in decision making however, whilst it has always been the prerogative of the medical profession, is less clear for other professional workers who may have to defer to psychiatrists. Partnerships and alliances between other professionals, and occasionally users,
have occurred in order to influence the decision making process but ultimate authority rests with
the psychiatrist. Many psychiatric nurses, in common with other mental health workers, have
developed strategies and roles to gain some degree of professional autonomy. In one session
that I observed a discussion on power emerged when one of the users was discussing his
experiences within psychiatric care and in particular in relation to forced treatments. During
this discussion I heard one nurse state that she felt that nurses had more power now and that
psychiatrists do now involve both other professionals and service users when making decisions
about treatment and services. The other participants who disagreed very quickly challenged her
and in the discussion that ensued one course participant retorted:

"Psychiatrists feel that they are still in charge and should make the decisions, some are
still autocratic and there are a lot of decisions made when the user is not even there:
(SM2)

The other course participants nodded and agreed with this statement and there was no support
for the notion that power was diffused. This feeling that power remains in the hands of
psychiatrists was confirmed by a number of nurses during the interviews. Medical power was a
dominant theme in many of the interviews that were conducted with the course participants.
There was only one other example of a nurse feeling that she had an equal say or autonomy in
decision making. This nurse worked in a highly specialised team and she explained that all
decisions were made as a team and within team or business meetings. Even though most
interviewees were more positive about user involvement and would like to be more empowering
many of them felt that they only had a certain amount of autonomy in decision making in
relation to their patients as the following comments demonstrate when they were asked about
their own professional autonomy:

"The nurses opinion matters to a certain extent but in the end the doctor will do what he
wants" (CH)

"I am autonomous to a point but the medics still have the power and it makes you feel
powerless" (NC)

"Medics wish to keep autonomy and status it can be threatening the fact that I report back
to medics I am part of a structure of authority" (GM)

These examples confirm that the position of nursing in the occupational hierarchy of health care
professions has changed relatively little over time despite the attempts by nurses to become
autonomous professionals. Nurses in many instances are still subordinate to the medical profession, despite attempts to become autonomous, and nursing is still struggling to be regarded as a fully-fledged profession with the authority to make or share decisions, which of course may threaten the dominant ideology that is the medical model and medical authority Iphofen & Poland (1998). Although feminist writers (Gamarnikow, 1978, Stacey, 1988, Witz, 1992) have argued that the patriarchal structures of professions, especially medicine, discriminate against women, and nursing has been subordinated because of its association with domesticity and because the workforce is predominately female, in mental health nursing male nurses are to be found in almost equal numbers and, as this study shows, authority and power is still exerted by the medical profession. The dominance or authority of medicine remains intact in both institutional and community practice as the following comments from interviewees demonstrate.

"I don't think very much sometimes. I will make recommendations but others for example the GP won't listen. I have just had an experience where the GP said that the patient was a nuisance and would not see her so I am autonomous to a point but the medics still have the power. It makes you feel powerless. (DP)

"Particularly with medics power is imbalanced. However much you try to empower your clients in the community there is still an emphasis on the medical model" (VC)

"In the community it's shifting but psychiatrists still hold power and people are protective of their bit" (DP)

There is a power difference with doctors. Some nurses on this ward feel they cannot challenge the doctors because of the fear of being disregarded (JP)

And in a hospital setting using an example of a treatment regime prescribed by the consultant one nurse remarked:

"Varies with who patient and who consultant is. Sometimes you can be asked how patients are for example about their sections or about leave. Other times consultant may not ask you it depends upon what side of the bed they got out of. It's also to do with how well or unwell they are (referring to patients) if they are more well they can make their own decisions" (VS)
She went on to give an example of how hers and her colleagues' autonomy had been undermined by the medical staff when discussing giving a patient an injection: -

“We were not happy with it and we did not think he should have an injection. We had no autonomy we had a chance to verbalise it and en masse three of us tried but the consultant insisted. The other doctor followed the line of the consultant” (VS)

Bean (1979) has shown that psychiatric nurses have traditionally accepted the authority of psychiatrists. Although community nurses do operate more as independent practitioners than hospital nurses, these comments would support the view of Morrall (1995) who has shown that a covert hierarchical structure occurs within community mental health teams with consultant psychiatrists seemingly attempting to dominate them and that community nurses had to develop covert tactics to gain some degree of autonomy but even this was not real professional autonomy. Psychiatric nursing and professionalisation, in terms of clinical autonomy, also has problems in relation to its social control function. Nurses have traditionally had to fulfil their obligations to the state and to medicine by being custodians of the mentally ill and enforcing treatments and compulsory orders at the behest of the doctor. The above example of the nurses having to give a patient an injection despite their objections, illustrates their position as agents of social control subordinate to the authority of the medical practitioner, who have by virtue of their power and status achieved exclusive legislative authority for decision making that has been invested in them by the state (Busfield, 1996). Although Samson (1995) argued that the movement away from asylums into the community would destabilize the authority of biomedical psychiatry the data from this study would refute that and support the findings of Warner et al (2001) who found in a study of mental health staff working in Multi disciplinary teams a continuance of medical hegemony and that some staff were upset by their lack of autonomy and that the medical model and views of the psychiatrist dominated. This study confirms that view and there is no real evidence that there is any change in the professional autonomy of nursing in relation to their position in the occupational structure of health care. Although nurses may have taken on more or different roles, hitherto seen as part of the medical domain, medical control over much of nursing work remains intact and therefore any desire to involve users in decisions about their needs and care or may be tempered by the lack of authority or the need to defer to medical practitioners. This lack of power and autonomy may also affect the nurses ability or desire to engage in partnerships with service users and any power that nurses have may also be under threat by service users who themselves want more power over decisions regarding their care. These issues will now be discussed in relation to the idea of partnership working between service users and professionals.
The Notion Of Partnerships Between Service Users And Professional Workers.

The concept of partnership between service users and professionals has been articulated in a number of government policy documents (DoH 1994a; DoH 1998a; DoH 1999a; DoH 2001a) and partnership is regarded it seems as an essential ingredient for mental health services. The importance of nurses working in partnership with their patients was emphasised in the recommendations of the review of mental health nursing (Butterworth & Rushworth 1995) and this review further recommended that people who use the services, and their carers, should participate in teaching and curriculum development. Government policy on the Care Programme Approach (CPA) also emphasises the need for user involvement and partnership between users, carers and professionals when making assessments and planning care with service users (DoH, 1990b) and this aspect of partnership will be considered in the following section relating to user professional practise and user involvement. In this study interviewees were asked to comment upon what partnership meant to them and in what ways they would consider service users partners in care.

"It means you have an equal contribution you may have differences but it should be about valuing and respecting the opinion of the users" (CH)

"It's their care and the two of you are working together. Users should know as much as possible 99% of the time I do that. I have two examples of patients who in the past staff have not involved them and it has upset and shocked the patients now that I am involving them. But I think that they should have a say it is their care" (FR)

"Working together at the end of the day it is the client and their needs. Care has to be provided based upon the clients needs and that they are empowered to make choices" (VC)

"It means involving people in their treatment e.g. explaining everything full to them. Taking into account their views and needs about what their treatment is" (SM)

These comments demonstrate that these nurses at least show respect for and value the service users that they are working with and recognition that the care and services that are being provided should be based upon the service users needs and wishes. They also show, in contrast to some reports from service user accounts of their experiences of the mental health system, (Read, 1996; Lindow, 1996) that these nurses are willing to educate the user, give them full details of the treatment and services on offer and try to comply with service users desires. An awareness of the service users needs and a respect for them and their requests is also
demonstrated by some nurses, who value the expertise and experience that the user themselves have.

"Less of me proclaiming to be an expert and inflicting my views. Sharing expertise. I am more of the opinion now that they are the experts and I can learn from them" (JL)

"By them bringing their own expertise and their own experience of their illness. Could be involved in assessment and integrated care. I would be looking for their opinions" (GM)

The latter two comments made during the interviews were specifically in response to questions about partnership and support the notion that some nurses do now acknowledge the expertise of the user. This notion of patient or user expertise is discussed more fully in a preceding section on the expert patient. A further term that was used frequently during the interviews in relation to partnership working was collaboration.

"Joint working in identifying the needs of users. Collaboratively working with and identifying means to meet the needs of users" (JS)

"To me it means planning and doing and working collaboratively with them" (CR)

"Individually on a one to one basis there is a partnership. Collaboration with individuals on how I can help them. It could be extended with other agencies and teams" (SW)

"Forming care with you with what they want to achieve i.e. Care Plans. Plus you also have to take into account the family and their wishes and involve them. Also in setting things up for themselves for example in seeking opportunities" (NC)

These responses do suggest that some nurses are making attempts to work collaboratively with service users and in doing so they are willing to engage in true partnership working with them that involves enabling the user to participate in decision making regarding their needs and in planning their care. The need for and benefits of partnership were also echoed by the NPA's, who used the similar themes to the nurses of expertise, collaboration and sharing in care planning as the following quotations from the interviews show.

"In early consultation about illness and to take responsibility for some of their treatment or way that they access it. Very much a do together rather than have done to. Participating in their own care plan" (SM)
"I think that they are the key. They are the only ones with knowledge of themselves. Facilitate them solving their own problems and motivating self. You can only act as a catalyst. What we do at Mind is provide a protective environment and enabling space so that they can use the resources within themselves and their own strengths” “More effective collaboration and responding quickly and efficiently to users needs. Being specific to their needs and working towards what the user needs” (PD)

“They should be the one that is calling the reviews and what they want. The professionals are there to serve the client. Here it is the members’ decision regarding what they want to do” (LP)

“I see it as working together. National Service Framework standards are good as more people are involved. In the past we have all had different agendas. This makes the voluntary sector more respected and gives it more credibility. We are taken more seriously. “Planning services from their experiences and being involved in care plan. They have a role to play if they are able and willing to do so” (ST)

However during the interviews with the NPA’s there was some criticism of professional workers and scepticism that a partnerships approach to working was being fully incorporated by professionals working within the statutory agencies.

“We are a long way from being in a partnership. Until they (the professionals) respect that users have a brain and know what they want there will not be any true partnerships. There is a lot of fear amongst professionals about losing control and losing their power” (LP)

“It’s working alongside or together towards the same end rather than working in different camps. I think that there should be equal responsibility but the professional will always have the upper hand and users will only have little piece of the pie” (KM)

“Working as an equal. But I really do not see much evidence of service users being treated as equals. Sometimes it still feels tokenism” (JM)

“Its only fairly recently starting to happen. Professionals are only recently getting users involved. However the CPA is changing things and users here are consulted and worked...
with to develop their care plans. On the other hand I know others (professional nurses) who do write it and take it with them so it is about individual practice (AH)

The interviewees, both the nurses and the NPA’s, were mostly positive about the concept of partnership and recognised the benefits of working in partnership with the service user and in collaborating with them. All the respondents defined the government’s agenda on partnership in terms of trying to work together with users and both parties having an equal contribution to care planning and decisions about care and choice of treatment. Trivedi (1996) suggests that there are a number of advantages to working in partnership including improved communication, improved awareness of users needs, active participation from users, improved service provision and service providers doing their jobs in a better and more collaborative way. Many of the responses during the interviews do suggest that some staff at least are making attempts to work collaboratively and that they are recognising the opinions and expertise of the user and that this enables them to be more aware of the service users needs. However these staff may well be in the minority and the criticisms made by some of the NPA’s about their own and the service users experiences of professional workers and statutory agencies may indicate that partnerships are not as widespread or as meaningful as they might be. Bassett (2000b) reminds us that mental health services do not have a good record for co-operation or collaboration with each over and especially with service users and believes that partnership may be a worthwhile aspiration but calls for more co-operation first. In a research study of perceptions of hospital care Sharma & Carson (1996) found that patients and staff had differing perceptions of the value of various aspects of their stay in hospital. They concluded that in attempting to move towards a closer partnership with their patients mental health nurses needed to be aware that there may be differences in how they and their patients perceive care and that before partnerships can be developed these differences need to be explored. So whilst the nurses in this study may believe that they are collaborating and involving service users more effectively this would need to be corroborated by service users themselves before any claims to changes in partnership working could be made.

When asked at interview about whether they thought the partnership was an equal one most respondents felt that it wasn’t. In the following comments issues of power and authority, tokenism, constraints upon them and barriers to effective participation were all discussed by some of the interviewees.

"It's not equal somebody always has to make the decisions. 99% of the time its professionals who make the decisions even for informal patients" (SM)
"When you are not involving aspects of MH act or child protection. I would hope it should be as equal as possible. But then I can be constrained by boundaries such as if it affects others then I have to override that sense of equality. I have to fall in line with elements of compulsion I try to explain this to the client" (SW)

"Its not equal I don’t think its 50/50 Users get less say than professionals I hope it wont always be that way or how can we provide a service that they need. But at the same time I want to protect my registration and not make any mistakes” (VS)

"It is not equal. You can make it work but a lot of people we work with are emotionally and socially disadvantaged, which disempowers them. ”(GM)

"At the moment it is not equal. It is still too much of a medical model where some users see us as representing the Doctors and the system rather than the service user” (JL)

"It is never equal. At the end of the day at times people can become unwell and we may have to use the MH act. They might also have needs we cannot meet due to lack of resources. Particularly with medics power is imbalanced. However much you try to empower clients there is still an emphasis on the medical model” (VC)

These sentiments were echoed in the following comments from the NPA’s interviewed some of whom referred to professionals in general and some of whom identified the authority of the medical model as being a specific barrier to partnership.

"Even here it is not equal although we are more user led than most. We are constantly trying to please purchasers. History always comes into it and purchasers will not let you involve users to a great degree. They are still controlling what we do through a service level agreement and service users have no input into this. At the moment in my experience the Doctor has the final say but they should listen more” (JM)

"It isn't it? It is always on the professional’s terms whatever happens. If they (users) wanted to change their care plans and start afresh or ask for a review meeting. They (professionals) would not come and its unlikely that they would agree” (LP)

"That's quite difficult. For it to be a good working situation it has to be equal. If it’s not equal you have not got full involvement. It is not equal there is a lot of tokenism But (using example of self harm) professionals may have a duty which reduces equality” (ST)
"Professionals probably see it as 50 / 50 but users see it as 70 / 30 in professionals favour. Professionals still say let's work together but when it comes to the bottom line they want to make final decision and take control" (SM)

"Oh! God I don't think it is equal. On a one to one basis in theory it is on an as equal level as it can be. There is a power imbalance bearing in mind it is they who came for therapy. On a broader level it is not equal it is just being done. It is seen to be politically correct. I am not cynical by nature this is just in my experience. Good ideas are often floated around and in spite of a lot of talk there is very little action. If you are a user you are outside that and it is harder. Change is something that takes a long time even for employees. To be outside of that is even more difficult" (SB)

The rhetoric on partnership, articulated in mental health policy, is difficult to achieve with professions who may be constrained by a duty of care. Partnership is also difficult in the current climate where we have a government who on the one hand talks about social inclusion whilst on the other develops policies such as compulsory treatment orders which are anathema to service users and professionals alike (Basset, 2000b). The contradictions are pointed out by Pilgrim and Waldron (1998) who state:

*Consumerism emphasises personal choice and the users movement emphasises citizenship. Both of these are contradicted or negated by the powers delegated to service professionals' under mental health legislation (p.100).*

Trivedi (1996) outlines a number of barriers or problems for nurses of practising in a partnership way with service users including the fact that nurses are being placed in contradictory roles of carers and agents of social control. The issue of control, safety and risk management was discussed earlier but she goes on to identify other barriers to effective partnership working for nurses including; being anxious about accountability, a reluctance to cast off security of professional status and the idea that if nurses are critical of services and supportive of users this may pose risks to their roles. This latter notion is encapsulated in the previous comments about the medical model and the structure of authority and the claims by some nurses that they need to defer to a higher authority, in this case the medical profession. Hostick (1998) points out that nurses have traditionally disempowered users and suggested that partnership, rather than empowerment, seems to be a realistic goal. However, because of the barriers and the constraints to partnership referred to here nurses may not be in a position to form effective partnerships either and other paradigms for service user involvement may be
more appropriate. Barnes, Carpenter and Bailey (2000) refer to a paradigm of stakeholding in which all those with a stake, such as service users, their careers, professionals and service providers can work together as partners. They further suggest that partnership, viewed in this way, is a more realistic concept because it acknowledges differentials in power without demanding equality. They suggest that what is important is that the users' voice is heard, their opinions valued and that their views have influence and they further suggest that this was the model of partnership that was reflected in at least one of the policy documents specific to mental health referred to earlier (DoH 1998a). This being the case, this study would concur with the premise that partnership is indeed possible, and that there are some tangible examples of a willingness on behalf of nurses to work in this way, but within certain constraints or parameters. These constraints and parameters have been discussed in previous sections on professional power and medical hegemony and include the need for nurses to defer to medical practitioners in decision making and the overarching power of the medical model. A further constraint to working in partnership with service users that has been discussed in the section on safety, risk and professional accountability is the requirement for nurses to comply with their statutory obligations in relation to the nurses role in mental health legislation. One of the aims of working in partnership with service users is that care plans should be developed between service users and professionals and should be based upon individual users wishes and needs (Butterworth & Rushforth, 1995). This will require a change in the practise of mental health nurses many of whom have hitherto developed care plans themselves without involving service users (North, Ritchie & Ward, 1993; Wolfe et al, 1997; McDermott, 1998; Simpson, 2001; Rose, 2001). The user led workshop that is the subject of this research was entitled ‘Promoting partnership: involving users in their care plans’ (UETC, 2001; SWUF, 2001) and one of its aims was to change professional practise by encouraging user involvement. This issue of involving users to change professional practise will now be discussed.

Changes To Professional Practise As A Result Of User Involvement.

The importance of obtaining the viewpoints of mental health service users, in using real life situations and being as close to clinical reality as possible in teaching has been noted by a number of writers (Took, 1997; Basset, 2000a; Coupland et al, 2001). In the workshops that formed part of this study the participants were all working with service users at the time that they attended the training but this workshop made them aware of issues and experiences that they would not otherwise have insight into, a fact also reported by Ramon and Sayce (1993) in their paper on social work training. The discussions during the workshops enabled them to reflect upon the services in which they work and their own practise. Several respondents on
this workshop referred to their own practise on the evaluation forms in response to the question of what they found valuable in the workshop:

"Its interesting to consider user involvement in CPA as it is often neglected in a clinical setting, I think it will prompt me to involve users in the planning of care more regularly in future" (Ex 7)

"Hearing about users experiences enables me as a nurse to be more aware" (SM 1 7)

"User perspective good to see users views and makes you consider the way you practise and delivery of care" (SM2 3)

"To be able to listen to expectations and ideas of the service user. Somebody who has experienced the system and to be able to understand their perspective made me think about my practise" (SM2 5)

These comments demonstrate that the workshop has made the course participants reflect upon their practise and the perspective of the service user, which concurs with the view of Sayce (1993) who argues that user involvement in education can influence mental health workers to understand how their actions and treatments can affect service users. At interview the course participants were asked about theirs and their colleagues practise and whether the workshop had changed or affected how they worked. Several respondents suggested that their practise would be enhanced by this training workshop and gave examples of this such as making sure appointments run to time, ensuring privacy, changes in the way that the forms that they use are completed and more generally a greater level of awareness of the perspective, needs and wishes of the mental health service user. The following comments give tangible examples of both a raised awareness of the user perspective and the needs of the service user, but also of how the nurses interviewed have changed their own behaviour and the way that they work as a result of this workshop.

"Listening properly, telephone ringing and not being interrupted, the way you sit. I am more aware of this now" (JP)

"It makes me reflect that users views are paramount It has made me change the way that I do assessments (referring to assessments in an Accident and Emergency department) I don't fill in the form now but listen more to them. In the case of CPA forms though I do now get them to complete it with me instead of me doing it on my own" (DP)
"I am now more self aware about the way I am perceived by others. On the ward though in constantly saying I haven’t got time the patient may see it as not caring but on the ward it is that busy sometimes there is not time. But I always make a point now (as a result of the workshop) of giving patients time. If I make an appointment I make sure I am on time. I have two examples of patients who in the past staff have not involved them and it has upset them and it has now shocked the patients now that I am involving them. But I think that they should have a say it is their care" (FR)

"It did make me examine my practice but I had thought that I had made that transition many years ago' but it has made me more aware that patients can feel that they are not being taken seriously in terms of their needs. It isn’t always a viable excuse to say that we are short staffed" (JS)

"This user involvement can change practice. People are now more sensitive to users needs. There is a change in culture but that is probably due to national pressures" (GM)

"It was good for raising awareness that things can go wrong and you have to keep a watch on yourself but being a human being you have to realise you are not perfect. I now try to ensure that I do it with the client” (Referring to writing up the CPA documentation) (VG)

"Yes it will change my practise. I would like to think that I don’t act in that way but there are phones ringing and interruptions so it’s made me think. I now try to see patients where we won’t be disturbed for example when we having a therapeutic chat and with CPA documentation. I try to chat first and write up information” (VS)

"Yes I was aware of the scenarios but it has made me more aware and I would now put telephone on hold. You do know these things but this brings it home and you put it into practice ” (ST)

The first two comments that follow were taken from the evaluation forms and the remainder from nurses during the interviews. They also bode well for future nursing practise as they were made by service managers or team leaders who are suggesting that they will now look at the practise of their staff or colleagues and attempt to make changes to that and their own practise as a result of what they had learnt from this workshop
"It inspired me to strive to look at areas of good practise where I work" (SM1 2)

"They helped me with my future learning and has given me new ideas to share with my colleagues" (Ex 8)

"On a personal level it made me think about my own practice and I thought do I do that? And do I say those things? I think that it will also make me look at ways we could look at user involvement in my primary care team" (JL)

"This workshop might also affect others practice might make people more aware" (NC)

"It has made me more aware and I think now about the telephone interruptions that were allowed. The way she (referring to the trainer who was doing the role play) sat across the desk. I try to ensure that my staff and me don’t do that now" (SM)

If improvement in the quality of care and in services is to be achieved, and for user involvement this is the prime imperative for the Government and the training commissioners, then changes in professional practise need to be demonstrated. There are a number of reports of how involving service users in education and training can provoke reflection upon practise and influence attitudes and future practise. Ramon & Sayce (1993) report how user involvement in social work education was thought provoking for social work students whilst Felton (2001), a student nurse, believed that service user involvement in her training was one of the most important factors and crucial to how she would practise in the future. Wood & Wilson-Barnett (1999) found, also in respect of nurse education, that those students who were exposed to user involvement in the classroom differed from those who had not had any input from users in that the former were less likely to distance themselves from the users and more likely to take an individualised approach to care. In respect of changing or influencing attitudes, Williams and Lindley (1996) suggest that personal accounts and presentations from service users can achieve dramatic changes in the attitudes of some staff in mental health whilst Hanson and Mitchell (2001) in a study of user involvement in nurse education note that the roles of helper and helped are reversed and that service users are perceived by students in a more positive light and not just as psychiatric labels. In this study the overall constructive comments from the course participants on the evaluation forms, which were highlighted in the section on benefits of user involvement, certainly corroborate this view that many of these respondents have more positive views of service users as a result of their experiences at this training workshop. There is also some emerging evidence that the involvement of service users in the training of professionals will change practise. Carpenter et al (2001), referred to a number of initiatives that participants
on one course had developed because of the user input. This study provides a number of tangible examples to changes in practise that have occurred as a result of the user led workshop. These include more generally a greater level of awareness for the dignity of the service user, having more respect for service users by ensuring that they are engaged in active listening, giving more time to service users and ensuring appointments run to time, ensuring privacy in professional / service user consultations and most importantly, in the context of this training, changes in the way that the care programme approach and other assessments are completed. However these changes to professional practise are reported by the professional workers themselves and not the service users they are engaged with, who may have a different perspective, and it remains to be seen whether or not these changes and improvements to individual practise will be maintained.

During the data collection a number of issues or sub themes emerged that may militate against changing practise and provide evidence that changes to professional practise is not simply a question of training the staff involved. These include references to the Care Programme Approach (CPA) and the administrative work that it entails, resources or lack of them and a resistance by some professionals to changing their practise.

Problems And Issues In Relation To The Care Programme Approach (CPA).

The subjects of this research, and the user involvement workshop associated with it, were part of a training course about the CPA and a number of them made reference to the CPA during the workshops, which one would expect, but also comments were made on the evaluation forms and during the interviews although no direct questions about CPA were put to them. The CPA was developed in 1990 because the government were concerned about follow up care for people leaving psychiatric hospitals. It contained four key elements (DoH 1990b)

- Assessment of health and social needs
- An agreed plan of care and treatment
- Allocation of a key worker
- Regular reviews of and, as appropriate, changes to the care plans

The government did not prescribe how it would work, and left it to individual authorities to interpret, implement and develop specific procedures but they did emphasise elements of good practise and gave some guidelines, one of which was that service users should be fully involved in the development of their own care plans (DoH 1990b). Subsequent guidelines on how the CPA should be implemented were issued by government, all of which emphasised the need for
user and carer involvement (DoH, 1994b; DoH, 1995). Despite these guidelines early research commissioned by the DoH found evidence of only minimal involvement of users and carers (North, C., Ritchie, J. and Ward, K., 1993). The CPA has since been reviewed by government and changes made but the imperative to involve service users and their carers remains (DoH 1999a). Local authorities were once again left to develop procedures and policies and this training course was part of the training to be given to professionals about the procedures and policies to be adopted by them.

This study reveals some contrasting evidence and a number of problems in implementing CPA and reports by NPA's in particular that not all professionals are completing the CPA procedures appropriately and involving service users. During one of the workshops that I observed one manager of a voluntary sector organisation remarked that a number of people in her service were not involved in their own CPA plans at all. She stated:

"We have over a hundred members and I think that few have been involved in their care plans. Of these not all are on CPA but nevertheless it is just lip service" (referring to user involvement in care planning) (SM1 Obs)

This failure to involve service users in their care plans is corroborated by comments obtained during the interviews. Just two nurses were specifically negative about CPA.

"I try to do it with the client but not always" (VG)

"They want to feel cared for not all of them want their CPA forms" (NC)

But in contrast several NPA’s were more critical of the way that professionals were implementing the procedures for CPA

70% CPA's that we see are not completed in the section on occupation. I don't think copies of action plans only are enough either. 50% CPA's are not signed by the client and sometimes even in enhanced CPA we only get sent one page. Their voice should be listened to more. The CPA might be discussed with clients but the decisions etc that are made are not documented on the CPA. The CPA form should be fully completed and a record of discussions and agreements documented" (JP)
"From the point of view of the CPA it made me realise that we have been sold short on information about service users. The users rarely see it and I would be surprised if more than one or two here have seen it" (LP)

"It's only fairly recently starting to happen. Professionals are only recently getting users involved. However the CPA is changing things and users here are consulted and worked with to develop their care plans. On the other hand I know others (referring to other professional colleagues that she worked with) who do write it and take it with them so it is about individual practice" (AH)

The latter respondent was keen to stress that most community psychiatric nurses, with whom she worked, were good at involving service users, but that there were one or two who did not involve service users as they should. This supports the following evidence that a number of professionals were indeed seeking to change their practice and involve users more in the care planning process. So in contrast, both on the evaluation forms and during interview, a number of nurse respondents referred to being influenced by or to changing their practice, in relation to CPA, by the user involvement workshop.

"It's interesting to consider user involvement in CPA as it's often neglected in a clinical setting. I think it will prompt me to involve users in the planning of care more regularly in future" (Ex 7)

"Valuable part of training I am now able to see clearer how CPA works for users Very useful to hear how professionals and users see different aspect of CPA" (SL 2)

"Looking at CPA documentation and then using this as a tool to answer the posed questions"(Ex5)

"Service users feedback and feelings gave a real quality to the feelings and experiences of those people subject to CPA" (SL1)

"User perspective on CPA (the most valuable part of the course) I have never heard user perspective before" (R6)

"Longer time to discuss as very useful to hear how professionals and users see different aspects of CPA"(SL2)
“Yes it will change the way I practise. I would like to think that I don’t act in that way but there are phones ringing and interruptions. So it’s made me think I try to see patients where we won’t be disturbed for example if we are having a therapeutic chat and with the CPA documentation I now try to chat first with them and then write up information. This training might also affect others practice and might make people more aware” (VS)

“It makes me reflect that users views are paramount It has made me change the way that I do assessments (referring to assessments in an Accident and Emergency department) I don’t fill in the form now but listen more to them. In the case of CPA forms though I do now get them to complete it with me instead of me doing it on my own”(DP)

“The new CPA should be done with the client. (Gave example of client) He was aware of it and given lots of choices about care etc and we worked together with him. Quite a few (referring to professional colleagues) are doing this and it is promoted now. I have heard that clients are asking for it if they haven’t got it” (VC)

I now involve the users more in forming the care with me in what they want to achieve for example in care plans. Plus you also have to take into account the family and their wishes and involve them (CH)

The purpose of the workshop was to influence professionals so that they would involve service users more in this aspect of care, and so comply with government policy and with the procedural guidelines for implementing the CPA (DoH, 1990b; DoH, 1999a). Comments such as these then will be well received by policy makers and managers of services, who are responsible for implementing government policy, as well as service users who are desirous of more involvement in their care (Read, 1996; Lindow, 1996), as they provide evidence that the attitudes and practice of some professional workers at least are changing. In an evaluation of the implementation of the CPA in one authority, Carpenter & Sbaraini (1997) surveyed and compared service users who had a care programme against those who did not and found that those service users who had a care programme felt more involved in planning their own care and treatment, had more choice and were better informed about rights and services. They go on to suggest that this implies that the CPA is more in line with what users want from services. Unfortunately a number of studies have found that service user involvement in the CPA can be minimalist with reports of lack of negotiation or involvement about care, users not receiving care plans and even a lack of knowledge of the existence of a care plan (North, Ritchie & Ward, 1993; Wolfe et al, 1997; McDermott, 1998; Simpson, 2001, Rose, 2001). This study more positively does confirm that some professionals at least are seeking to change their practice, by
involving service users more, in relation to CPA at least, which should in turn enhance or improve the care received by service users and be more conversant with both their needs and the requirements of government policy. Nevertheless, this change amongst a few professionals in this study has been a long time coming as the policy of CPA, and its emphasis on user involvement, has been in place since 1991. What may be of significance here is the fact that on this occasion, staff have received training in the changes to procedures and that there has been some significant user involvement in that training which was well received and appreciated by the course participants. The majority of service users or indeed the NPA's who are working with them however will not yet have felt the effect of this.

A further problem of the CPA that was discussed in a number of the workshops and in some interviews was the issue of bureaucracy or administrative work involved in the process. There were numerous discussions and comments during the workshops, that were observed by the author, that the systems and polices within which the course participants workplace, need to change and they felt that much of the paperwork and "bureaucratic process of form filling" as one person put it, militates against developing relationships and spending time talking to users. One professional worker admitted during the workshop that he had completed a CPA without the service user because his manager had insisted upon it and that of the 16 clients on his caseload he had had only completed 9 forms because of the burden of the paperwork involved. He remarked.

"I was told we were going to be audited so I had to do it I had previously made 8 attempts to do it but the client did not wish it. I was told I had to do it by my boss due to the audit even if the person does not want to join in the CPA even without partnership. I was unhappy about it (SL obs)

This issue of burdensome paperwork was a constant theme that was discussed by the course participants during the workshops as the following comments, noted by the author whilst observing workshops, demonstrate.

"A lot of pressure is put on us to complete the paperwork. When they were introduced we were told to complete them within three days we now have to do them in five days therefore it is the system within which we work that is the problem" (SM1 obs)

"We have been told to complete the form in 5 sessions. We realise that we need more time but our managers want us to. Another difficulty is we are not sure who is accountable when we complete these forms. We have a problem when we have no other information we
need to know some information and it's difficult when we don't. We can get into trouble. It's another problem with the admission process but we have to do it even though we know the process is wrong. It's still a paper exercise and I had no idea they (referring to patients) could refuse to do it" (R obs)

"I can't think that they are in the clients best interests. Putting people in boxes in psychiatry is not appropriate when it's not an exact science A lot of pressure is put on us to complete the paperwork" (SM1 obs)

"It's done as a number crunching thing (referring to CPA) its done for central government" (Ex Obs)

At interview, although direct questions about the CPA were not asked, some nurses made remarks about the CPA that support the view mentioned above that the paperwork and bureaucracy of it is burdensome.

"I know that there are a lot of difficulties with CPA it has become an information seeking document not a simple tool for co-ordinating care. I am really concerned about this" (KB)

"It's a massive bulk of paperwork if not necessary. It reduces the time we have to spend with patients" (VS)

The over emphasis on administration commented upon here was in fact referred to in the review of the CPA (DoH 1999a) and the changes that were made were designed to ameliorate this. The guidelines refer to reducing bureaucracy but blame this on individual management practices rather than as a fault of the policy itself. They state:

The burden of additional paperwork, an over-bureaucratic system and the duplication of information gathering have been recognised as major concerns in relation to the implementation of the CPA. In practice, the perceived bureaucratisation of the CPA has arisen as a result of differing management practices around the country. In some areas, the CPA has operated successfully without entailing burdensome paperwork (DoH, 1999a, p.18).

There have been reports of concerns regarding the documentation used in care planning and attempts at developing more simplified versions of the process (Hamilton & Roy, 1995) and it has been suggested that the process is merely an extension of what occurs already and that the
CPA is simply good practise anyway (Rospopa, 1998). These reports however were written by professionals about procedures that they were implementing rather than by actual accounts of service users experiences of CPA and Rose's (2001) findings regarding the lack of service user involvement leads her to conclude that

It will turn into an ossified bureaucracy rather than a system designed to deliver quality, needs-led care (Rose, 2001, p.50).

Although the evidence from this study suggests that some professionals are now involving service users more in the care planning process, the extent of power sharing is unclear and there remains clear concerns that the bureaucracy of the process is regarded as more important to managers and that the imperative to comply with procedures may ameliorate the ability of professional workers to fully involve, empower or meet the service users needs and wishes. The emphasis upon paperwork in the process of completing the CPA documentation restricts the amount of time professionals have and is a similar issue to another theme that occurred frequently that is the lack of resources that are available to meet the needs of service users.

The Effect Of Resources On Professional Practise And User Involvement.

A further theme that has emerged from the data collection and analysis, that may be a mitigating factor restricting user involvement in professional practise and in particular in the care planning process of CPA, was that of lack of resources. A number of respondents referred to lack of resources and how this would impinge on what they could do either in developing care plans or in relation to their own professional practise. The author whilst observing the workshops noted the following remarks.

"We do tend to do that (referring to not taking enough time with clients) and not take time. It's done because of historical and resource reasons and the systems we are in" (SM1obs)

'There may be unrealistic goals and the service users may want things that we don't have the resources for' (SL obs)

"It is difficult to work with low resources and achieve good results as it is" (R obs)
This concern over the lack of resources and its effect upon the ability of professionals to fully involve and meet the needs of service users were substantiated by comments made during the interviews.

"Plus the resources might not be there. A patient may want something like a therapy etc but if it is not there well then that's it" (CH)

"It does not always occur all of the time (referring to user involvement). Some are too ill. Sometimes things have to be done quickly i.e. if you haven't got the time you cannot involve them" (SM)

"It should be a service that is needs led as opposed to service led. But this does have managerial implications such as resources. There may be equality in appointment times venues etc but why should users have to give up work time etc just to see staff and why should we just have a 9 to 5 service" (JS)

"They might also have needs we cannot meet due to lack of resources. However much you try to empower clients there is still an emphasis on the medical model" (VC)

"We need to fit service to client not the other way around but then things are geared to what resources are available" (AH)

"The telephone thing did strike home and it is distracting. But the layout of the building here and the resources make it difficult to ensure privacy" (JM)

The issue of concern over lack of resources as an inhibiting factor in user involvement in care planning has been reported by Anthony & Crawford (2000), who also found that nurses value the concept of user involvement but resources such as time and a busy health care environment could restrict patient participation in planning care. Similarly a study by Carpenter & Sbaraini (1997) found that although professionals were positive about the effects of CPA on meeting users needs and were committed to the philosophy of it nevertheless in their study they found that professionals also commented that it was time consuming, had procedural problems and was very difficult to implement with existing resources. In a discussion contrasting CPA with systems of working in Australia and the United States, Rogers and Pilgrim (2001) argue that the CPA has emphasised an administrative system and does not define what is good or best possible clinical practise. The evidence revealed in this study implies that the CPA review, and the subsequent guidelines issued, (DoH 1999a) have not been altogether successful in that some
professionals still feel burdened by the process and procedures that they work within and that resources, both in terms of facilities available for service users and their own resources in terms of time, may be further inhibiting factors against fully involving service users in care planning and treatment. Furthermore the philosophy of the CPA, both in terms of user involvement and as a need led approach, may be accepted by professionals but may not be enacted because of the burden of bureaucratic procedures and lack of resources. However in the context of this study, this may be as a result of local policies and procedures, which may be particularly time consuming, because they are reliant upon paperwork, or because they have not been simplified sufficiently as they have in some areas (Hamilton & Roy, 1995), rather than the policy itself. Whilst the burden of bureaucracy may be a justification for any lack of user involvement in the CPA process this could be a rationalisation on the part of the professionals themselves and a further explanation could also be because some staff are just unwilling or resistant to changing the way that they practise, a point that was also made by a number of respondents and will now be examined.

User Involvement And Resistance To Changing Practise.

One further theme that emerged during data collection was that of a reluctance or resistance on the part of professional workers to change the way in which they work. This occurred most frequently in relation to questions of power when a number of those being interviewed were very critical of colleagues who they said had felt threatened by user involvement and went on to refer to a resistance to changing views and practise: -

"Some of them felt it was an affront to their professionalism they did not like their practise being challenged by users. But it is probably these staff that would ignore the users and are stuck in the practice they won't change" (DP)

"There is resistance to user involvement and having users in the workforce there is hidden resistance it is not necessarily overt and often comes from management" (GM)

"Many felt that they were being told how to act and what to do and do not like this coming from users"(CH)

"Views are changing but some people are resistant. Still some small group of people feel threatened by change and aren’t too welcoming of working with service users"(VC)
The aforementioned comments came from nurses who were referring to their colleagues but these sentiments were also expressed by some NPA's who were critical of, and referred to professionals practise in more general terms: -

“When we talk about care plans we have an open file system. I suggested it should or could be taken away and viewed by the user. The professional could not grasp that they were horrified at the thought. Until they can shift their mindsets they (the professionals) are fighting the challenging nature of user involvement and will not change. (JM)

“The professionals are even now trying to find ways around the paperwork its as if they can't accept the changes that are coming and are looking for loopholes” (JP)

“There is a lot of 'you will do it the way we like it’ they are not flexible”(ST)

“I found though the attitude of some people (referring to professional workers) appalling and disappointing. I was disgusted with their behaviour and attitude. There is a definite discomfort in some of them they see people who are suffering from Mental Illness as not having a greater knowledge or right to use it and they have an attitude of how could you know as much as me I am the professional” (SM)

When asked about the characteristics of these staff who they felt were resistant to change in each case they commented that it was the older or more experienced staff who were reluctant to recognise the perspective of users and some believed that this it was because training was different now: -

“It is often those over 50 the dinosaurs. They can be very old fashioned” (JP)

“It’s the older age group those that have been over 10 years in psychiatry and often the in patient staff” (DP)

“Those that have been here a long time. The old school they haven’t changed with the times. There are just a couple of them in my area but most people have made the change”(VC)

“Some people who have been in nursing a long time would benefit by being a little bit more aware. Sometimes people can have the attitude that they (users) don’t need to know.
They just do it and they believe that the user does not need to know about it this occurs more in the older nurses, as training is different now” (SM)

“There are traditional workers who would be reluctant to change. Those who haven’t been updated or moved sufficiently with psychiatry in for example user involvement and psychosocial skills. Those who have been trained 20 / 25 years ago. The old school. Recently trained nurses are okay as user involvement is part of their course now” (JS)

“Older age group who have been 10 years in psychiatry” (DP)

“Its especially those who have been in practise a long time the older members of staff. It is them that need to change” (CH)

Two of the respondents, who were themselves senior members of staff, could cite several examples of how difficult they had found it to get colleagues to change their practise and doubted that this training would make any difference to those staff. Accepting new concepts, new ideas, different ways of working, changes to roles and implementing change is both individually and professionally challenging especially if it runs counter to an individuals beliefs, perspective or what they traditionally regard as normal practise. Linnett(1999) refers to user involvement as threatening role boundaries and points out that when roles become blurred confusion and anxiety result therefore people end up preferring the security of traditional roles. It may also be difficult for professional staff to ally themselves with service users as this threatens the status quo within mental health services and to consult and collaborate with service users may carry the risk of reprisal and coping with individual and institutional resistance (Williams & Lindley, 1996). Change in any form can be both personally and professionally threatening and, as Glenister (1994) argues, clinicians find active participation from service users particularly threatening however what these comments may reflect is an underlying culture in some professional groups or individuals that may militate against change, a point noted by Hopton (1994), who concluded that user involvement: -

Is likely to be mechanistic and superficial and will not engage with the underlying historical, ideological and structural problems which affect mental health nursing practice (Hopton, 1994, p.56)

This study has shown however, that some nurses have changed their practise but for those who have not, or are resistant to change, there may be some common characteristics. Although a
number of respondents cited older or more experienced staff as being more reluctant to change. It may be more about education, personal values, attitudes or experience as well as the socialising influence of some professional training or exposure to these attitudes from other peers or superiors. Morgan & Sanggaran (1997) have found that these attitudes still exist in some pre registration students nurses. In their study of utilising service users to provide feedback to students nurses upon their performance they found that a minority of students questioned the validity of service user involvement and the authors concluded that this was due to ignorance, prejudice and constricted views about mental health. A further inhibiting factor to changing practise may occur as result of lack of commitment from senior management. In the earlier section on problems of user involvement a number of quotations form respondents referred to tokenism or lack of commitment form management within their Trusts. Some of these are repeated here:

"Users should be involved at a higher level in the organisation. What goes on now is tokenism and a lot of rhetoric they should be involved in planning at a much higher level"  
(NC)

"It's essential that users are involved. We need to be working in partnership with each other but it's often a token exercise on the part of the managers. I feel it is in this Trust. I feel empathy with service users. Management are always saying that they are consulting with service users but in actual fact they do not. Service users and professional are often coming from the same perspective but management are not taking their views on board"  
(VC)

"I think its brilliant but I don't think it should be lip service. It did not feel democratic they were there because someone felt they should be. I don't think the trust give much credence to user involvement. This trust may be better than others but not as good as it should be. It did not feel democratic they were there because someone felt they should be"  
(GW)

"In statutory sector there is not much user involvement. To begin with it was lip service. Its not equal because users are being included where they are allowed in not where they may want to be included"  
(KM)

"Since I have been in assertive outreach it has made me think how we can adopt them (users) but I don't see much user involvement in the team I work for"  
(JL)
It has been reported that management is very important to enabling change within an organisation. Carpenter et al (2001) in their study of the effectiveness of a particular training course, that had user involvement as a large part of its core, found that it was very difficult to implement anything learnt on training courses and that changing own or colleague’s practise was also difficult unless there was support from the organisations hierarchy. Similar conclusions are drawn by Henderson (2001) who further contends that the gap between manager and practitioner is widening and that senior management are becoming more distanced from clinical practise. Mills (2002) reports that in her experience some managers have not wanted service users to come to meetings and Maza(1996), also found, in a user involvement project on care planning, that senior management had little contact with users. So although it is not possible to draw conclusions in this study as to the role of managers on individual professionals resistance to change one influencing factor may be that senior management themselves are not acting as role models or setting examples of good practise.

**Conclusions.**

The data taken from the observations of some the workshops, the evaluations forms completed by the course participants and from subsequent interviews with them provide some contrasting evidence of the effect upon nurses of user involvement in education and training. The user led workshop certainly raised awareness amongst many of the course participants of the perspective and feelings of service users and in doing so provoked many of them to reflect upon their own and their colleagues practise. There was recognition amongst many of the course participants that service users have knowledge and expertise of their own illness and that nurses can learn from them. Many positive remarks and discussions, about user involvement, the effect that the workshop had on course participants and the changes made to practise, were heard during the observations of the workshops and recorded during the interviews. These were also complemented by statements made on the evaluation forms. The workshop can be regarded as a successful training event in that it did have an impact upon many of the course participants in that they have reported subsequent changes to attitudes and practise. However in contrast there were a number of negative discussions and remarks that demonstrate that some nurses are less enthusiastic about user involvement and furthermore user involvement by nurses may be tempered by other imperatives even by those who are more committed to it. Some general conclusions from this study and to the reaction of nurses to the increased impetus for user involvement will be discussed in the final chapter.
CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

Introduction.

In the past fifteen years user involvement in mental health care and services has proliferated. This has occurred for a number of reasons including, changes in government policy, in which service user involvement and partnership working between service users and professionals has been encouraged, the development of a more radical, articulate and demanding service user movement who are desirous of structural change, more empowerment of service users and a recognition by service users of their own needs and expertise in their illness or problems. The user movements development has been enabled by a number of factors including, the emphasis given by government upon patient and public involvement in health and social care, changes in human rights legislation which helps to empower individuals, the closure of hospitals which may curtail the power of professionals and the increasing importance given to the concept of consumerism within health care. The expected outcome of these developments, and the purpose of government policy on user involvement, is to change professional practise and encourage more partnership working between professional workers and those they serve. One method of changing the attitudes and practise of professional staff is by education and training and more specifically, by involving service users in this so that the user perspective and expertise can be utilised.

The purpose of this research was to investigate whether nurses would accept the user perspective, what affect this training would have on their professional practise and partnership working and whether or not these nurses felt that their power and autonomy is threatened by service user involvement. Some general conclusions from the responses of the course participants in relation to user involvement, professional practise and partnership working can be made and these are discussed in the next section.

General Conclusions.

The first research question asks whether course participants are resistant to or accepting of the 'user perspective' on the workshop that is the subject of this study. Although there is some contrasting data it can be concluded that there were benefits of involving service users in the training course. There was a raised awareness, amongst the nurses who participated in the course, vis-à-vis the user perception about their experiences, what they feel about services and what issues are important to them. Listening to real case studies and experiences provoked individuals to reflect upon the care that is given to service users. It also enabled nurses to
reflect upon their own professional practise and a number of them reported changing their practise as a result of what they had learnt from listening to the service users opinions and experiences, a point that will be returned to in relation to the third research question. There was also recognition by some of the course participants that service users have expertise or knowledge about their own illness and that professional workers need to learn from the service user in order to provide the best possible care and services. Overall it can be concluded that there was willingness, by the respondents in this study, to listen to the views of the service user and an acceptance of their perspective. However there was also a feeling amongst a number of the respondents that user involvement generally was not always embraced either by individual professionals or by the organisations that they worked for and a belief that a minimalist or tokenistic effort to involve service users was being made in some quarters.

The view that all professionals do not embrace user involvement is also corroborated in this study. In contrast to the conclusion that there was an overall acceptance of the user perspective there were negative comments about the course and the user views from some respondents. A minority of respondents disregarded the service users views and justified this on the grounds that the service users on this training course were either not representative of service users generally or were just espousing an anti psychiatry viewpoint. Some respondents may be using these views as a rationalisation to justify their own professional beliefs and practises. Furthermore the tokenism referred to earlier may mean that some professional workers are only carrying out some of the policy guidelines on user involvement because they have to comply with procedures rather than because they believe in the principles of it. Therefore a further conclusion that can be made from this research is that there remains a group of nurses who are less willing or able to reflect upon the user perspective or give service users due regard.

The second research question is concerned with whether nurses and other mental health workers feel that their autonomy and power is threatened or undermined by user involvement and whether they are willing to engage in equal partnerships with users in order to change practise. In general it can be concluded that most nurses and NPA’s in this study are willing to work in partnership with users and collaborate with them in planning care and in sharing decisions. But it can also be concluded that there remains a group of nurses who are less willing or able to reflect upon the user perspective and give the service user due regard for their expertise or their ability to share in decisions about their own care. This group of nurses are a minority but as some of their colleagues, both nursing and NPA’s, have reported they are less likely to change their practise or work in partnership with the service user. This group feel threatened by user involvement and are resistant to changing the way that they practise.
Both nurses and NPA's also recognised that the partnership is not an equal one and that there are barriers to working in partnership with service users. Despite the fact that many of the course participants were positive about the workshop, about working in partnership with users, about user involvement generally and in their own practise their commitment to user involvement may be tempered by other imperatives. These include the need to comply with statutory obligations, organisational procedures and policies and the need in some instances to defer to medical practitioners. These requirements mean that failure to comply with them, or to take what may be regarded as a risk if they allow service users a greater say in the care or treatment that they receive, may pose a threat to the individual and so even those who are committed to the philosophy of user involvement may not practise it when their job or role is under threat. Evidence was also found that those who do espouse the rhetoric of user involvement, might practise it only to the point where they deem it to be appropriate. This may occur when there is a dissonance between what the user wants and what the practitioner believes to be in the best interests of the user. So it can be concluded that the extent to which real partnership working is practised, or partnerships between nurses and service users can be regarded as equal, or the extent to which power is diffused is constrained by other factors and any changes to practise may be welcomed by service users but real power sharing may be minimal.

The third research question asks whether there is any evidence of changes to professional practise as a result of the service user involvement on this training course. There were a number of reports by individual practitioners that their own and their colleagues practice had changed as a result of this workshop. There were more positive views of service users as a result of this training therefore more likelihood that mental health staff would involve them in the process of care. Changes to the practices of individual workers involved a greater level of awareness for the dignity of the user, more general practises such as keeping appointments correctly, active listening and more compliance with the wishes of the service user. Most importantly, in the context of the purpose of this training, there was more involvement of users in the assessment process, and in care planning, as the nurses reported changes in the way that the procedures for CPA were carried out by themselves. However as stated in the previous section there remains a group of nurses who are unlikely and / or unwilling to change their practise. These nurses may nevertheless espouse the rhetoric of user involvement, because that is currently both a policy and an organisational requirement, without actually practising it. For this group of nurses the workshop has not been successful as there has not been a demonstrable change in their attitudes or practise.
A further conclusion that can be made from analysis of the interviewees' responses is that there are extraneous factors that may restrict the ability of nurses to change their practise and involve service users in the CPA. These factors include the bureaucracy or administrative work involved in the process, the emphasis put on this by the nurses managers, and the lack of role models or good practise in user involvement amongst management. A further factor that may restrict the ability of nurses to fully involve service users in the CPA was the lack of resources. This perceived lack of resources was concerned both with the time available to nurses to work with users in care planning as well as the physical resources to meet the service users wishes. So regardless of whether or not they agree with the principle of user involvement or whether they want to change their practise because of what they have learnt on this workshop these factors meant that some nurses believe that their practice, in relation to the CPA at least, would not be able to change.

Finally it can be concluded that in tracing the reaction of nurses to the user involvement on the training course that is the subject of this research, and to user involvement generally, there has been a mixed reaction and two distinct groups have emerged. Some nurses, although they may espouse the rhetoric of user involvement and partnership working, because of the increasing impetus for user involvement in all aspect of care or because of the policy directives, they have nevertheless felt threatened by user involvement. These nurses have been resistant to policy developments, are tokenistic in their acceptance of the user perspective and subsequently reluctant to change their practise. They do not regard users as equal partners and do not engage in partnership working. In contrast the second group are less resistant to change more accepting of the concept of user involvement, have more regard for the user voice and opinions and outwardly seek more equality and partnership working with users. This group also espouse the rhetoric but do make an effort to implement the policy and change their practice accordingly. However even in this group user involvement and working in partnership with service users may be negated by extraneous factors, the need to defer to others or issues of professional and personal accountability. This research has demonstrated therefore that service user involvement in education and training can have a beneficial effect upon the working practises of professionals and the contribution of this study to the field of knowledge about the effects of user involvement will now be examined.

**An Evaluation Of The Research And Its Contribution To The Field.**

This research confirms the conclusions from other studies that when user involvement in education and training is appreciated and valued by course participants (Felton, 2001; Read, 2001b) that it is effective in provoking awareness and reflection (Ramon & Sayce, 1993;
Bennett & Baikie, 2003), in changing attitudes towards service users (Williams & Lindley, 1996; Clinton, 1999) and in changing perceptions of service users (Lindow, 1992; Hanson & Mitchell, 2001). Whilst there are now many examples of user involvement in education and training (Took, 1997; Town et al., 1997; Wood & Wilson-Barnett, 1999) there is a paucity of research on how service user involvement in training mental health workers is developing (Campbell, 2001) or the effect of training upon professional practise. Some evidence of changes to practise has been reported from Australia (Happell & Roper, 2003) and some generalised changes to individual practise have been reported as a result of service user involvement on a Masters course (Carpenter Barnes & Dickinson, 2001). This study however does provide some unique evidence of tangible changes to practise, notably in the process of the Care Programme Approach (CPA), that have occurred as a result of the training course and the success of involving users in training to change the working practises of some nurses.

Those nurses who have changed their working practises may have done so because they are willing or able to re-conceptualise service users as having knowledge or expertise in their illness, because they wish to work in partnership and/or because they believe that service users do have a right to be involved in decision making about care and services. The professionalisation process in nursing, as in most other professions, has meant that nurses have laid claims to specific expertise and they have engaged in occupational strategies such as exclusivity, in the same way that medicine has (Freidson, 1970) and counselling needs to if it is to become a profession (Wheeler, 1999). Furthermore mental health nurses have made attempts to gain professional autonomy (Morrall, 1995) and act independently in decision making about care. This research has demonstrated though that professionalisation can incorporate individual action, as there are nurses who are willing, in part to give up some claim to unique or expert knowledge, recognise the expertness and perspective of the service user and give up some of their professional autonomy in doing so. In contrast the study also provides evidence that there remains a cadre of nurses who are disinclined to acknowledge the user perspective, resistant to user involvement and reluctant to shed any of the concomitants of professional status, the corollary of which is that they are unwilling or unlikely to change their working practises. Therefore for this group of nurses this education course was ineffective.

This study confirms the assertions and findings from the literature about professional power and the effect of user involvement upon professional power and autonomy. Previous studies have demonstrated that despite the increased emphasis on user involvement now there is little evidence of power sharing (Bowl, 1996) and professionals still hold power over the service user (Pilgrim & Waldron, 1998). Despite the efforts of successive governments to encourage user involvement and partnership working, either to foster a culture of consumerism or as a means of
improving quality, at least some nurses and managers of services have failed to conceptualise service users as having expertise in their own illness, as consumers with equal rights or as individuals with whom they should share power and decision making. There is recognition by the respondents in this study that professionals do hold a certain amount of power over service users and that the power relationship is unequal and whilst there are examples of partnership working real power sharing is minimal and therefore the balance of power has not changed which according to Linett (1999) is the whole purpose of user involvement. Linett (1999) also recognised that service users do not have official types of power and that it can be taken away. Therefore the structural change demanded by the user and survivor movement to enable empowerment (Ramon & Sayce, 1993) has not materialised and some nurses preserve their power as there has not been any attitudinal or cultural change which is maintained by the structural and social inequalities that support the status quo in mental health services (Williams & Lindley, 1996).

In contrast it has been shown in this study that a number of respondents do wish to empower the service users that they work with and may well be prepared to accept structural change and subsequently change the power dynamics that exist between themselves and the service users. This may be because this group of nurses have re-conceptualised service users as having expertise in their illness, as individuals with specific rights or as deserving equal partners in the process of planning and organising care or services. The literature revealed a number of professional rationalisations and constraints for ignoring or dismissing service users views such as representativeness (Crepaz-Keay, 1996), homogeneity of user groups (Hostick, 1998), as symptoms of their illness (Goffman, 1961; Perkins & Repper, 1998) because more articulate or radical users are labelled anti-psychiatry (Campbell, 1996a) and because of the culture of nursing that may militate against user involvement (Hopton, 1994). This research however has shown that some professionals at least, do wish to act as autonomous practitioners, accept or engage with the user perspective and do not use these rationalisations to dismiss service users views. So in the theoretical tradition of the symbolic interactionists individual nurses can to some extent act independently of structural factors and whilst Goffman (1961) uses this perspective to show how power can be stripped from patients this research has examples of how some nurses have empowered service users by their individual action.

Notwithstanding the notion, as symbolic interactionists would contend, that human action is individual, and in the context of this study that individual practitioners are able to act autonomously, there are examples of when this is controlled by external forces. In this research even those who espouse the rhetoric on user involvement and partnership working may take power away from the service user because they are constrained by structural factors. They
may work within a background of being subordinate to the wishes or authority of the medical profession and their own managers so even though individuals may have re-conceptualised service users and wish to work differently with them any desire to act autonomously and empower service users has to be carried out within the structure of power relations that exist. Furthermore, those nurses who espouse the rhetoric on user involvement and wish to empower service users may also be constrained by their own personal or professional accountability. The need to comply with statutory obligations and organisational polices also demonstrates that structural factors can inhibit individual action. In this regard this study is original in that hitherto whilst there has been recognition that power sharing is minimal (Bowl, 1996; Pilgrim & Waldron, 1998). This has previously been explained in terms of how professionals are able to maintain power over service users through for example paternalism (Basset, 2000b) or expertise (Perkins & Repper, 1998). There has been little acknowledgment or research that many professionals are desirous of empowering service users but are constrained by extraneous factors. These findings have important implications for managers of services, policy makers and the commissioners of education and training that will be discussed in the next section.

**Recommendations For Change And Implications For Practise.**

In this research it has been demonstrated that there is little shift in the balance of power between nurses and service users and that even for those nurses who want to work in partnership and/or in an empowering way there are constraining factors. For change to occur and to ensure or encourage partnership working there needs to be a clear direction that permeates down to individual professional staff from management. Hutchinson (2000) recognised that if users are to gain some control over their lives there needs to be a shift in the balance of power and that this can only be achieved by involving users at all levels of the mental health system. It is recommended therefore that service managers and policy makers need themselves, to be role models and take a lead in the user involvement policy by involving service users in planning, designing and evaluating services as well as developing user led services. As Lester et al (2004) asserts:

> Only when users are routinely involved at every level of the mental health system will genuine partnerships between users and mental health practitioners be possible (Lester et al, 2004, p.11)

The conclusion that statutory and organisational policies may militate against user involvement also means that managers and policy makers need to be cognisant of the effect of policies and procedures that they design. It is recommended that a review of procedures be undertaken with
a view to ensuring that nurses have sufficient autonomy, resources and support from their
managers to enable them to work in partnerships with service users and crucially, to share in
decision making about care and services with service users without fear of managerial
retribution.

It is clear from this research that service user involvement in training is effective in encouraging
reflection, changing perceptions and attitudes and in helping to change some working practices.
It is recommended therefore that service users be always involved in the education and training
of professionals at all levels within mental health. This involvement could include course
design, delivery, evaluation and assessment but as minimum service users must be able to give
their perspective on the content of the training course so that practitioners can engage in critical
reflection upon how their practices will effect the service user. Commissioners of education and
training need to be aware of the barriers and problems faced by both service user trainers and
education providers in order to overcome them and ensure that service users can engage in
training. There are a number of guidelines for good practice (NCMH, 2003; NIMHE, 2004) and
it is recommended that commissioners should utilise these when commissioning education and
training.

Hitherto research into the CPA has concentrated upon and found that user involvement
in care planning has been minimal (Wolfe et al, 1997; Simpson, 2001; Rose, 2001) so this
research has important implications for nursing practice in that it has shown that training can be
effective in changing the way that nurses engage in care planning. In a recent synopsis of a
department of health research programme on partnerships Farrell (2004) found that:

For any member of staff gaining confidence and skills in involvement work requires
experience of the benefits of involvement and training and education in the methods of
involvement (Farrell, 2004, p.3)

It is further recommended therefore that when designing procedures for CPA for example,
policy makers and service managers must provide professional workers with the requisite
education and training, which would involve service users, before any procedures are
implemented in order to ensure that these staff have the necessary skills and confidence to carry
them out.

A key question that remains for managers, policy makers and commissioners of education is
how can they change those who are resistant to partnership working and user involvement as
this research has shown that there remains a group of nurses who do not engage fully with the
concept and are reluctant to change their practise. In a recent review of mental health service delivery, Lester et al, (2004) identify a number of ways forward to overcoming the barriers and resistance to user involvement. These include amongst other things changing the value base of professionals, which involves treating service users as equals, and overcoming practical barriers such as time resources. As previously stated in the first recommendation user involvement needs to be embedded into all aspects of mental health care and until that occurs it is unlikely that the concept will be regarded as the norm by all practitioners. It is beyond the scope of this research to investigate why some nurses are resistant to change or why the involvement of service users in the training course was effective in changing some nurses but not others. The following section will therefore discuss the limitations of this study and identify areas for further research.

**Limitations Of Study And Directions For Further Research.**

The training course that has been the subject of this research was conducted for a number of mental health professionals in one geographical area including mental health nurses, social workers, psychologists, occupational therapists and staff from the voluntary and non-statutory agencies. The focus of this research though has been upon mental health nurses although non-professionally aligned workers (NPA’s) were also interviewed and data from those interviews has been used. Nurses and NPA’s were chosen for interview because they were by far the largest group of staff in involved in the training and it was not possible to obtain a reasonable sample size from other professional groups. It may also be the case that other groups have dissimilar attitudes and perspectives as they have been trained and socialised into their professions rather differently. The professional and legal obligations of other staff in mental health are not the same as nurses and these are variables that would affect attitudes and working practises. It is not possible to conclude therefore whether or not the service user led workshop was effective in changing the attitudes and practises of staff from other professional groups and this is one limitation that is apparent in this study. Further research with each distinct professional group would be required in order to ascertain the effectiveness of user involvement in education and training in changing the attitudes and practises of other professional staff and / or whether they feel threatened by the impetus of user involvement within mental health services.

Nurses in this study have been regarded as one discrete group and no differentiation has been made between hospital and community nurses, or nurses from different specialities within mental health and again sample size would have precluded this. But although all mental health nurses share the same education and training at pre registration level, and the same statutory and
legal obligations, nurses working in different specialities do nevertheless have rather different roles, may have had different post registration training and their ability to act as autonomous practitioners certainly varies between fields of practise. Therefore a further limitation of this study is that these variables are not accounted for and any further research on user involvement, and particularly in relation to power and autonomy, may wish to distinguish between nurses working in the community and nurses working in hospital or between nurses from different mental health services. Further research may also wish to take into account the grade of nurse, the level of responsibility that each practitioner has, the ability of the practitioner to act autonomously and their relationship to other professions, for example, medicine.

The findings of this study have shown that in reaction to user involvement generally, and to this training course, two distinct groups have emerged in that one espouses the rhetoric but may not change their attitudes and practise whilst the other group may espouse the rhetoric and change their practise, but within certain parameters. However it has not been possible to provide enough evidence as to the reasons for this differentiation between the groups. Some of the respondents in the interviews referred to specific characteristics of a group of nurses who are resistant to change and these included references to age, when these nurses were trained and being institutionalised. A further explanation could lie in how these nurses conceptualise service users that is as patients, clients, users, their point of view vis-à-vis, service user expertise, empowerment and equality. A future direction for research therefore may seek to find evidence for specific individual characteristics and an explanation as to how to change the attitudes or practise of those who are more resistant to change or conceptualise service users in negative ways. It would also be useful to identify in future research whether people move between groups and if so in what direction and most importantly why they move and whether or not education is effective in producing that change in direction.

Finally the findings from this study have provided some examples of changes to individual professional practise and evidence of professionals working in partnership with users in providing care. Claims of working in partnership however are not yet supported by service users themselves. It was beyond the scope of this study to seek the opinions from service users about real power sharing, partnership working or changes to practise. Whilst it can be concluded that a number of course participants made claims to changing their practise as a result of their experiences on this training course these have yet to be corroborated by the recipients of care themselves and it is unknown whether these changes have been sustained. Further research is needed to investigate whether nurses have indeed maintained those changes and are continuing to work more in partnership with service users and involve them in decisions about their care. A future direction for research should of course involve the service users themselves.
to examine their perceptions of professional practise, whether they feel that they are now more involved and the nature of any partnerships between themselves and professional workers.
APPENDIX 1

Evaluation Form

<table>
<thead>
<tr>
<th>Workshop</th>
<th>Promoting partnership: involving service users in their care plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Venue</td>
<td></td>
</tr>
<tr>
<td>Trainers</td>
<td></td>
</tr>
<tr>
<td>Name: (Optional)</td>
<td></td>
</tr>
<tr>
<td>Profession/Job: e.g. psychologist, voluntary sector, nurse, social worker.</td>
<td>Please state: -</td>
</tr>
</tbody>
</table>

Please complete the following in relation to this workshop only

1) Which aspects of the workshop did you find most useful and why?

2) What aspects of the workshop did you find least useful or enjoyable and why?

3) Please comment on the training methods used?

4) What changes if any would you make for future events?

5) Are there any comments you would like to make?
APPENDIX 2

Questions For Interview

❖ Introductions and reassurance about confidentiality, inform re note taking.

1) Questions and prompts re user involvement:

How did you feel about the user led workshop that you attended?

Were there any particular aspects that stand out?

How do you feel about user involvement in education/ training in general?

Prompts:
What did you learn from this session?
Was there anything you did not find of value?
What do you feel about user involvement in mental health generally?

2) Questions on practice

What effect will the workshop have on your practice?

Could you give any specific examples?

What about the practice of others or the systems you work in?

Prompts:
Are there any changes to procedures or practices that you would like to see as a result of this workshop?

3) Questions on professional power and autonomy

How would you define professionalism?

How do you feel about your own professionalism in relation to user involvement?
What do you think the effects of user participation are on professional autonomy?

Prompts:
How much professional autonomy do you think you have when dealing with patients/clients?

4) Questions on partnership with users

Recent government documents refer to partnership between users and professionals. Could you comment upon what that means to you?

In what ways would you consider users as partners in care?

Prompts:
To what extent is the partnership equal?
APPENDIX 3

Course Details And Research Subjects:

| Course Details                          | The course was commissioned by Warwickshire Social Services Staff Development Commissioning Unit who were responsible for commissioning post registration training for all mental health workers within Warwickshire.
|                                        | The training course referred to in this study is concerned with providing training to professionals on implementing the CPA policy and risk assessment and is entitled ‘Implementing the new CPA, providing quality in mental health services’ (Konzon, 2001). The course was a two-day multi agency programme on the implementation of the new integrated CPA, following the government review (DoH 1999a).
|                                        | The workshop that is the subject of this research was part of the aforementioned course and consisted of a two hour session entitled ‘Promoting Partnership: Involving Users In Their Care Plans’.

| Course Trainers / User Groups           | The workshops were delivered by mental health service users who belong to one of the two user groups in Warwickshire.
|                                        | • South Warwickshire User Forum (SWUF).
|                                        | • User Empowerment Training Consultancy (UETC).
|                                        | These groups are comprised of individuals who have used mental health services and who have completed a course in training. A number of different service users were used in each workshop.
<table>
<thead>
<tr>
<th>Observation of Workshops</th>
<th>A total of five workshops were observed at various venues throughout the county. The researcher was a non-participant observer and played no part in the training course.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Forms</td>
<td>At the end of the workshops course participants completed an evaluation form. A total of forty-three evaluation forms were collated and analysed in this study.</td>
</tr>
<tr>
<td>Course Participants</td>
<td>These were members of staff from both the statutory and independent mental health services in Warwickshire. They were comprised of nurses; social workers, psychology assistants, occupational therapists and staff from the independent sector who may not have any professional training. These are referred to as non-professionally aligned workers (NPA’s).</td>
</tr>
<tr>
<td>Interviews</td>
<td>Semi-Structured Interviews were conducted at the course participants’ place of work with fourteen Nurses and nine NPA’s.</td>
</tr>
</tbody>
</table>
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UETC (2001) ‘Promoting partnership: involving users in their car plans’ (Workshop as part of training course), Konzon, L. *Implementing the new CPA, providing quality in mental health services*, Unpublished Training Materials CPA and Risk Assessment Training Warwickshire Social Services Staff Development Commissioning Unit.


